MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Wednesday, January 12, 2005 10:13 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.
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ALAN R. NELSON, M.D.
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

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P R O C E E D I N G S

MR. HACKBARTH: Welcome, everybody.

We have a long and interesting agenda, and quite a few votes that we need to take. So we will have to pay close attention to the time, both in the staff presentations, I urge everybody to be as concise as possible. And likewise, if all of us as commissioners can be as brief as possible, that will be hopeful.

When we get to the public comment session we need your help in brief comments, to the point. I would ask people not to read from documents. Number one, that takes a lot of time. Number two, it's really not very effective in terms of communicating with the Commission. As I have asked in the past, if someone before you in the public queue has made the comment you are going to make, just simply say I agree with that comment. You don't need to repeat it.

First up on today's agenda is specialty hospitals, Julian?

MR. PETTENGILL: Good morning. In this session Ariel and I are going to discuss recommendations included in the draft report to Congress on specialty hospitals. I will walk you through the payment policy recommendations and then

Ariel will discuss the non-payment recommendations.

These proposals represent the culmination of a year of study and discussion, in which we have examined many of the dimensions of the specialty hospital phenomenon using a variety of methods and data. Thus, the recommendations we are proposing rest on qualitative and quantitative findings from a wide range of analyses, including the site visits we made, meetings with representatives of specialty and community hospitals, analyses of federal self-referral statutes, and data from our survey of specialty and peer hospitals. And of course, also analyses data from the claims in the cost reports for the Medicare program.

The principal findings from these analyses are shown on the first slide. The analyses support five principal findings. First, physician-owned specialty hospitals do not have lower Medicare costs per case than other hospitals. In fact, their costs are higher, though not significantly so.

Second, specialty hospitals concentrate on certain DRGs, some of which are relatively more profitable than the average. And they focus on relatively low severity patients within those DRGs, that is patients that would be expected

to be relatively more profitable than the average.

Third, specialty hospitals tend to treat lower shares of Medicare patients than other hospitals.

Fourth, specialty hospitals' financial impact on community hospitals thus far has been limited. This is early in their development and that's something that could change.

Fifth, some of the incentives for patient selections can be reduced by improving Medicare's hospital inpatient payment system.

Note that we did not attempt to compare the quality of care between specialty and community hospitals. The Secretary of HHS is required to do that in a forthcoming report.

Based on these findings, we offered three draft payment recommendations at the December meeting. In developing, the recommendations, we separated the potential policy changes based on the limits of the Secretary's authority under current law.

In this first recommendation, we're talking about three actions that the Secretary can take now. First, the Secretary should refine the DRGs to more fully capture

differences in severity of illness. Our analysis showed large differences in relative profitability across severity classes within the DRGs. The differences create financial incentives to select low severity patients. But these incentives could be reduced if CMS set payment rates based on refined DRGs.

Second, the Secretary should base the relative weights on the estimated cost of furnishing care in each refined DRG rather than average charges. This would reduce distortions in the weights and related differences in relative profitability that arise because of difference in hospital markups across hospital departments.

Third, the Secretary should base the weights on the national average of hospital-specific relative values, relative costs, within each refined DRG rather than on standardized costs. This would more effectively eliminate differences in relative profitability that arise because of differences across hospitals in the level of their costs.

The second draft recommendation addresses changes in the outlier policy that would require legislation. 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.

This recommendation addresses two problems that affect accuracy of payments in all DRGs. First, we take 5 percent from every case in every DRG, even though some DRGs have almost no outlier cases. As a result, we are paying 95 cents on the dollar in DRGs that have few outlier cases. This makes them automatically less relatively profitable than the average.

The second problem is that the high charges for outlier cases are included in calculating the DRG relative weights. In DRGs that have a lot of outlier cases, this pushes the weights too high. Consequently, we overpay for cases in DRGs that have lots of outlier cases. In these DRGs, outlier cases get outlier payments but they also get regular DRG payments that are too high. And because the weight is too high, the non-outlier cases in these DRGs are also receiving too much. And that makes them relatively more profitable than non-outlier cases in other DRGs.

Adjusting the weights for outlier prevalence in each DRG instead of the current 5 percent payment reduction would largely solve both of these problems.

The third recommendation addresses the transition

problem. Our payment stimulation showed that the four payment policies recommended earlier would affect all hospitals, including both specialty hospitals and community hospitals, and many hospitals would see significant changes in their Medicare inpatient payments. To mitigate the effects of these payment changes, these policies should be implemented over a transitional period.

I'm going to turn now to the implications of these recommendations. The policy changes are intended to be budget neutral. The Secretary is required to maintain budget neutrality when changing the DRG definitions or the DRG weights. The outlier payments would remain prospectively budget neutral, as they are now.

Actual spending impact, however, might vary depending on how CMS deals with potential upcoding associated with DRG refinement, and also on what sort of transition mechanism is actually adopted. These policies should have little or no direct impact on beneficiaries. But as we have seen, adopting these changes would alter the distribution of payments among hospitals.

Making these payment improvements and designing a transition policy will not be simple tasks and we recognize

that CMS has other priorities and limited resources. Issues that would need to be addressed include the potentially large number of payment categories created by DRG refinement, potential increases in payments resulting from improvements in coding, rewarding avoidable complications, and the burden and time lag associated with using costs rather than charges.

We have consulted with CMS and identified some approaches to address these issues. For example, in the report, we described a method CMS could use to recalculate costs every several years rather than annually. This would be like periodically benchmarking the relative weights.

Now Ariel will discuss the nonpayment issues and recommendations.

MR. WINTER: So draft recommendation four, first I'll read it and then I'll explain it. The Congress should extend the Medicare Modernization Act's moratorium on physician-owned single specialty hospitals by one year. At the last meeting we proposed eliminating the whole hospital exception entirely but we changed this recommendation based on your comments at the meeting. The rationale for this is as follows.

Specialty hospitals are a relatively new phenomenon and we want to be cautious about inhibiting their development without a fuller understanding of their quality and efficiency. However, until the Congress and CMS make the changes to the inpatient payment system that we've discussed, the current system creates an unfair competitive advantage for physician-owned specialty hospitals by rewarding the selection of certain types of cases and patients.

For these reasons, the Congress should extend the MMA moratorium on physician-owned specialty hospitals by one year. This would give Congress and CMS time to begin making these changes to the payment system. The moratorium is currently scheduled to expire on June 8, 2005 and this recommendation would extend it to June 8, 2006.

Here are the implications for the recommendation. It would not affect Medicare spending relative to current law. We do not anticipate any adverse impact on beneficiary access to and quality of care. In terms of the provider impact, this recommendation would discourage the development of new physician-owned specialty hospitals for an additional year. Physician-owned specialty hospitals that existed

before November 18, 2003 or were under development by then would be able to continue accepting patients referred by physician investors. But their expansion would be limited and they would not be able to increase their number of physician investors.

The next topic 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. Gainsharing has the potential to encourage hospital and physician cooperation to deliver care more efficiently and to counter the silo effect created by separate payment systems for physicians and inpatient hospital care. But it could create incentives for physicians to sting on care and to refer patients to the hospital with which they have the most lucrative arrangement.

The OIG has ruled that gainsharing is prohibited by a provision in the Social Security Act that prevents

hospitals from paying physicians to reduce services to beneficiaries. We believe the Secretary should have the authority to approve gainsharing, but with safeguards to address these concerns with quality and inappropriate referrals. These safeguards could include specifying the cost-saving actions in advance and capping payments to physicians based on their number of prior year admissions.

Here's draft recommendation five. The Congress should grant the Secretary the authority to allow and regulate gainsharing arrangements between physicians and hospitals so that quality of care is protected and financial incentives that could affect physician referrals are minimized. This recommendation should have no impact on Medicare spending. There should also be no impact on beneficiary's access to and quality of care. And finally, this should help hospitals deliver care more efficiently.

This concludes our presentation and we would be happy to answer any questions.

MR. HACKBARTH: I suggest we divide the discussion into two parts. Let's first talk about the payment related changes. Any comments or questions about those?

MR. MULLER: Ariel, I think, as we mentioned last

month, this is an excellent body of work that you've contributed here as in terms of our understanding of the payment system. And I endorse most of it.

I do have a specific question about the outlier change that we're recommending, which I think is recommendation two. I know there were some changes made last year to change the threshold for outlier payments that should help us avoid some of the windfalls that certain systems were able to secure from outlier payments. The recommendations we're making in recommendation one by going from a charge-based system to a cost-based system should also alleviate some of the concerns we have.

My recollection from the data we had last month is that even in those cases where outlier payments are received, that the proportion of costs they cover are still considerably -- the amount of payments are still considerably below cost. Is that an accurate recollection, that even in outlier cases the payment is about 80 percent of costs? Is that accurate?

MR. PETTENGILL: The payment is 80 percent of the cost above the outlier threshold, which means that there's a gap between the regular payment rate and the threshold that

you would have to consider to be uncovered costs.

MR. MULLER: I think the import of some of the comments were that having this outlier system does lead to some extra payments. Some of those extra payments are intended to make up for some of the gaps in the payment system. In a payment system that is all based on averages, obviously some cases require more payments but just because, as the word says, they are outliers.

So I think we shouldn't leave the impression that the outlier policy leads to payments above costs if, in fact, the gap is -- even without outlier payments, there are already getting paid roughly 80 percent or somewhere between 80 and 100 percent of costs. That's still considerable gap in what they're being paid on the outlier cases.

MR. PETTENGILL: The issue here is that the charges associated with the outlier cases are folded into the weights in calculating the weights. What that does is it pushes the weight up too high.

MR. MULLER: Recommendation one should take care of that; right?

MR. PETTENGILL: No, recommendation one does not take care of that entirely because even if you were to

switch to using costs, for example, the costs associated with outlier cases would still be included in calculating the weight. The only way to clean them out is to make a reduction in the weight that reflects the extent to which you have outlier cases or outlier payments in that DRG.

MR. MULLER: What I'm trying to draw the distinction between is costs that are real should be recognized by the payment system, if appropriate. Charges that, as was shown last year, that are kind of totally unconnected to costs was something that we wanted to avoid. And that's the reason for changing some of the thresholds last year.

But I don't think we want to imply that costs that are appropriate and real should therefore be ignored in terms of determining the weights of the DRG.

MR. PETTENGILL: It's a question of if you continue to include the costs associated with the extraordinary cases, then you push up the weight too high and you end up overpaying all of the other cases in that same DRG.

MR. MULLER: I don't want to belabor this. I'm just saying I don't agree with the word too high. I think

appropriate costs should be recognized by a payment system. To say that they're too high, if they're appropriate, I think is a misleading use of the term.

MR. PETTENGILL: Let me put it another way. If you don't do this what will happen is that in those DRGs that have lots of outlier cases, the non-outlier cases will be relatively more profitable than other cases in other DRGs. And if that's okay, then don't do it.

But if you do that, you are maintaining incentives that now exist to select patients in those DRGs.

MR. MULLER: I think the overall thrust of what we're trying to do is get away from encouraging that kind of skimming based on severity. I'm just suggesting that there are appropriate outlier costs and cases that obviously qualify for that, given their severity. And to just take away the kind of payment for those outlier cases may be going too far, especially since there's not evidence that we're paying more than costs for those kind of cases.

MR. HACKBARTH: Ralph, from my perspective I don't think this is about our concluding that outlier payments are too high. The issue here is the calculation of the DRGs.

In the current method of calculating outlier

payments means that we are overpaying for DRGs that also tend to have a high number of outliers and underpaying for the other DRGs that don't have a lot of outliers. So it's not a judgment about oh, we're paying too much for outliers. It's that we are overpaying and underpaying in the base rates for the different DRGs because it skews the calculation of the weights.

MR. MULLER: I think even the terms -- there's a lot of policies we have that we try to make budget neutral so when we pay rurals or we do IME or we do DSH or we do community access or so forth, we take it out of the overall budget. To say therefore were are underpaying the other DRGs, I think is a little bit of a loaded term. Obviously, the extent to which we take that out of the overall budget, we could say that about almost all of our policies, that we tend to underpay the other DRGs by taking some special payments.

DR. MILLER: I'm sure there's much disagreement here, I think the statements that Glenn just made and I think could be reconciled to what you were saying. Those statements about over and underpaying refer to the non-outlier cases in those DRGs. I think your point is,

perhaps, you would agree that this process of building it into the weights does distort the weights. And particularly for people who don't hit the outlier threshold.

And then your point beyond that is because it's 80 percent of cost after you hit the outlier threshold, we shouldn't be making statements that we're the outliers. That's how I organized the comments in my head.

MR. HACKBARTH: And stated that way, I agree. This is about distributions of payments paying accurately so far as possible.

MR. MULLER: We have other big issues on this topic. I think moving towards the cost-based system, I think, goes a lot towards meeting some of our concerns that the charge-based system allowed for much more variation in that than we want. And I think the cost-based system alleviates a lot of that.

I think also taking the outlier pool and spreading it just inside specific DRGs rather than all the DRGs is something I'm not in favor of because I don't think the evidence is clear on that yet.

MR. HACKBARTH: Other questions or comments on the payment recommendations?

Let's move on to four and five.

MS. BURKE: Glenn, I'm sorry.

I wonder Julian, because the issue arose and has arisen in the context of some of the comments, I wonder if it's worth taking just a moment to clarify the issue with respect to DSH and the combined effects of DSH and the payment of DSH and how the outlier policy that we have proposed doesn't alter that scenario? Because there have been issues as to whether or not it would put those institutions at a disadvantage. I wonder if you might state for the record the sort of relationship between those two before and after the proposed change?

MR. PETTENGILL: It would basically remain the same. The outlier policy piggybacks on the regular payment policy. So to the extent that you have DSH and IME payments, that raises the outlier threshold. Hospitals that have lots of DSH and IME payments will find it much more difficult to reach a level of loss that would qualify for outlier payments. That's the current policy and it wouldn't change under the new one.

MS. BURKE: I think the issue that has arisen is not knowing, in fact, how this will play out, particularly

how the adjustment in the outlier policy will play out in terms of individual hospitals. I think the point that we want to be clear is that the issue exists today in terms of the interaction with DSH that remains the same post-adjustment. The question is to whether or not where you hit the trigger, in terms of the outlier policy, will be somewhat more complicated. But it's more complicated today because of DSH.

MR. PETTENGILL: For any hospital that treats a wide spectrum of cases there would be instances in which the outlier threshold for a DRG would fall. And there would be other instances in which it would rise.

MS. BURKE: But just to clarify that there's no intention to change that relationship of exists?

MR. PETTENGILL: No.

MR. HACKBARTH: I agree with that. This issue is not altered by the recommended change here. Some people will argue that the existing policy of incorporating DSH in the calculation and making it more difficult to hit the outlier threshold is an inappropriate policy. That's a discussion that we can take up. I hope that we're going to be able to, next year, look at the DSH payment formulas and

how those dollars are allocated. We can address it in that context but I don't think it's directly implicated here.

Any other payment issues?

Let's move on to recommendations four and five on the moratorium and gainsharing respectively.

Let me just offer some thoughts on the moratorium and an issue that isn't raised in the recommendation. That is the whole hospital exemption. Let me start with the whole hospital issue.

As you will recall, we did include in our draft recommendations in December a draft recommendation for repeal of the whole hospital exemption. I included it in that package because I think that there are significant important arguments that might lead one in that direction, towards repeal that is. And I think in our report we ought to include that discussion of why that is an option, a policy that we may wish to pursue in the future.

Personally I reach the judgment that that is something that we ought to look at more in the future but it is not the right step to take at this time. I believe that for several reasons.

First of all, due to the limited amount of data we

have at this point on specialty hospitals and their performance. The thesis in favor of specialty hospitals offered by their proponents is that they will, among other things, improve efficiency and improve quality of care. As Julian reported, the data that we have to this point does not support the efficiency hypothesis, our findings actually that the costs are higher not lower, although the results are not statistically significant.

One of the reasons that they're not significant is that we have such a small sample of institutions, a limited amount of data to work on. As people will remember, we are reaching back to the year 2002 for data on this, at which point there were relatively few specialty hospitals.

So my own judgment is that given that we're reaching back to 2002 and we have limited data, we don't have a strong analytic foundation on which to base a judgment about efficiency.

With regard to quality, we have not looked at that at all, certainly not because of a lack of interest. A number of commissioners have said they were very interested in that question. But the Department of Health and Human Services was given the assignment by Congress to study and

compare quality of care. So that has been outside the purview of our work.

So those are some, if you will, analytic reasons why I think it would be premature to reach a definitive judgment about this issue.

In addition to that, my own personal experience in running a large physician group, including a significant surgical practice, leads me to at least understand and sympathize with concerns that we've heard during the site visits from physicians about the unresponsiveness of at least some community hospitals to issues that physicians consider to be very, very important to their practice, issues that relate to their ability to practice efficiently, provide high-quality care and satisfied patients.

I have lived that story. I have spent many, many hours listening to surgeons raise those same issues about a truly excellent hospital. It was our partner hospital. So it rings true to me.

And then finally, from my perspective, when in doubt we ought to err on the side of more competition not less. We have evidence from some of our site visit reports that, in fact, the entrant of a competitor hospital, a

specialty hospital, had a constructive aspect on the community hospital and encouraged them to make appropriate and good changes in how they operate.

Having said all that, again I reiterate that I think this is a close issue. Among other things, I continue to have concerns about how this sort of financial arrangement might potentially affect clinical judgment. So I don't think that we ought to just say no, this isn't a problem. I think that we may well need to come back to this in the future and look for ways to craft rules of the game that would get us the best of competition without the worst of compromised clinical judgment and incentives. Exactly how we might do that I don't know, but I think there may be some ways that we could approach it.

So those are my personal thoughts on the whole hospital exemption. I'll be very brief on the moratorium.

I think that it is critically important to extend the moratorium. I said I am in favor of competition. I am in favor of fair competition. I very much agree with comments that Ralph has made several times on this issue that if the system permits people to win, make a large profits by selection of take patients, whether we're talking

about the hospital payment system or the payment system for private health plans, that has an incredibly damaging affect on the system. So we need to get about this work of the payment reforms. It's difficult work. It won't happen overnight. We've got to assure that the industry, the specialty hospital industry, does not rapidly develop in the absence of these payment reforms.

Those are my thoughts. I welcome those of other commissioners. David?

MR. SMITH: First, Julian, Ariel and Mark, this has been terrific work over the last several months. I'm sure I speak for everybody else. I am much appreciative. You have helped us understand a lot and also understand what we don't know.

I should begin by, I'm concerned Glenn, as you are, with the impact of financial arrangements on clinical decisions. I'm also concerned with the broad phenomenon of skimming, whether or not that has to do with any impaired clinical decision but the development of a system that has a significantly lower share of Medicaid patients or of a system that has a significantly lower share of charity patients in competition with a system that is obliged to

maintain both that patient mix and services like fully staffed and operating ERs does trouble me about this phenomenon.

While I appreciate that caution about not throttling competition, I also think we need to be careful not to let this genie out of the bottle precipitously and until we understand more. I thought the consideration of removing the whole hospital exemption from Stark II was a step in that direction. And I appreciate both what you said and more importantly what we don't understand as a cautionary reason not to do that.

But I still want to be careful and I want this commission to signal its care clearly not to let radical and anticipated but not well understood changes happen without taking steps to try to -- prophylactic steps. I think the recommendations that have been made, particularly the DRG recommendations and the recommendation of Congress regarding outlier payments, go a long way. And I support those.

I think the moratorium is important. I'm concerned that the moratorium be linked to progress on the DRG change recommendations and the gainsharing recommendation. I have two concerns. While I don't think

an open-ended moratorium is ever an incentive to get things to happen, I'm afraid the 12 months, given the complexity of what we want to happen, isn't adequate. I'd like to see the moratorium be structured longer than 12 months and either/or. Either 24 months, to pick a number, or when the DRG recommendations that we have made have been implemented and when the Secretary has taken steps to implement the gainsharing recommendations. Those would help level the playing field.

And thirdly, the text has and does strongly suggest that we ought to, that Congress ought to be concerned about the whole hospital exemption. I'd like to have that text be even stronger than it is so that both the record of this meeting and the March report reflect that concern. And then make the recommendations that have now been crafted with a longer moratorium tied to completion of recommendations one, two and four, I think it is.

MR. DURENBERGER: Mr. Chairman, thank you and thank you for all the work that you've put in on this very challenging issue. Special thanks to the staff for taking all the time they did get to go into the middle of America, in particular, and lots of other places to assess the issue.

I am the designated beneficiary representative on the Commission by law, I guess, and by appointment. So I just want to begin by reflecting my support for the way in which you have stated your position. And the fact that you put forward all of the options a month ago, made us consider them and made everybody else consider them. And then in a very thoughtful way came back and presented your recommendation to us. And I intend to support that.

I would be even stronger from the evidence from medicine on going farther on payment changes. Not just hospital DRGs but the entire incentives in payment system to subspecialization to disintegration rather than integration of health care, to the commodification of health care, as some of us call it. There's a very, very serious problem in this country.

If the question before us is the influence on clinical decisions of subspecialization, particularly the technology related to subspecialty economics, then I think the argument is all over. All of us who have watched John Wennberg's work know that physicians in America -- not all of them, but a lot of physicians in America -- have an economic interest in the decisions that they make. And as a

beneficiary, that bothers me. As a politician/policymaker, it's always bothered me. But you can argue with the fact.

The Institute of Medicine, five years ago now, told us that the quality problem, the overuse of medicine in this country, a lot of it driven by payment systems, a lot of it driven by physician economics, is a problem. Everybody knows you never ask a surgeon whether you need surgery. You know what the answer is going to be.

And this is America today. And I'm just not convinced that any of us or anybody in policymaking position in this country has done an adequate job of analyzing the impact of that reality. It's not just selfish doctors or greed or something like that. It's what's happened to the system itself. The commodification of this entire system.

Venture capitalists all over America are looking at opportunities up and down, disease management and all the rest of that sort of thing. And you cannot help but be influence in some way by that.

So I think it's a much larger problem, which is why I support your recommendation that we just not go for a simple whole hospital exemption but we force somebody in the system to look at the bigger picture and deal with that.

And if they need more than an extra year to do, I would suggest that.

Finally, the question for me as a beneficiary in this reality is not so much how badly do specialty hospitals hurt community hospitals. The question is simply to what degree to the economic benefits to the physicians affect her clinical judgments and the population health of the community? That is the community/hospital argument.

Are we, in effect, going over time to shortchange population health by concentrating on knees and hips and hearts and that sort of thing? Again, that's a much larger issue than I feel confident to decide. Somehow or other 17 of us can come up with a solution for it.

But I'm happy to hear how many of my colleagues on this commission are committed to not just sending a report to Congress and then forgetting about this issue but to believing that we owe a responsibility in advising the Congress in the future about how better to deal with this whole issue.

MS. DePARLE: Thanks. I agree with much of what both Dave Smith and Dave Durenberger just said. I think this problem is big enough that we are going to have to

return to it and continue to look at it. I could have supported the elimination of the whole hospital exception but also understand the concerns that you and others have raised. But I do expect that we will want to return to it and continue to look at it. I think that the text of the chapter should say so.

In particular, as I've said several times, and Arnie and others have said, I and you both would like to see the evidence, to the extent that CMS can tease some out, about quality. Because we all have views about what might be there and yet we don't have any hard evidence about it. So I hope we'll be able to look at that.

I would also support extending the moratorium, as I think I said at the last meeting. I tend to think that a year probably isn't quite long enough. I don't know that we need to have a long debate about whether it needs to be 18 months or 24 months or whatever, but I think practically speaking a year probably isn't enough time to begin to deal seriously with this, given that this goes to CMS. And we all know that they have a lot of pressing issues on their plate. I would prefer to see it longer.

MR. DeBUSK: Ariel, Julian, I certainly appreciate

a lot of hard work on a tough subject. But there seems to be a suggestion that fixing the prospective payment system will solve a great deal of the problems. Well, there's a set of problems that will not solve. What it's going to take, in my opinion, is some revision of the Stark law to address that. And that is the imbalance which Dave addressed earlier of the fact that specialty hospitals have I guess a disproportionate -- for lack of a better word -- number of Medicaid patients and also the poor patients. Until you address that, along with revisions of the DRGs, it's not going to fix the problem, in my opinion.

I think in the language something needs to be tied on, whether it be 18 months or 24 months, something to the effect that until Congress has time to act on revising the Stark law. In my opinion, it's going to have to have some type of revision to address this other issue.

DR. NELSON: My first consideration is the best possible care for patients and not stifling innovation that may help bring it about. I prefer mandatory financial disclosure reporting as an alternative to an extension of the moratorium as described on page 46. Physician owners should disclose their investment interest to patients,

inform them of alternative facilities, inform them that they may obtain services elsewhere and that they will not be treated differently if they do so.

After expiration of the moratorium, with payment refinement and full disclosure, the growth of specialty hospitals could well be for the right reasons, which is a better product.

DR. STOWERS: I totally agree with a lot of the comments here and I definitely, Alan, agree with the disclosure thing.

We keep talking about the physician incentive that I think as we continue to look into this might be helpful to quantify a little bit. The amount of incentive here that we're talking about I think could be important along the way. What I'm getting about that is in a lot of cases the physicians have a 1 or 2 percent investment in the product. And if you look at the actual take-home investor income off of a particular patient, it may be in the matter of a few hundred dollars. I think the national average is 2 percent of physician-owns in one of these.

I'm just saying it makes a difference when you're trying to decide where to send the patient or what might be

-- does it make a difference if the incentive there to that physician is several hundred versus $5 or $10?

I think somehow quantifying that a little bit might be helpful.

DR. REISCHAUER: There was an example in the text, I think, wasn't there?

DR. STOWERS: I didn't see where it actually got down to a dollar amount.

DR. REISCHAUER: It was actually surprisingly large.

MR. HACKBARTH: Part of the issue explained in the example is that even though the individual physician's share of the ownership may be small, if they're part of a group where the individual physician is not just benefitting from their own referrals but from those of the other physicians in the group there can be a magnification of the financial gains.

DR. STOWERS: Another thought I just hadn't heard before is that there's considerable variability among hospitals in the amount of Medicaid and the indigent and so forth that tends to cause certain hospitals obviously in the community to have and to really step to the plate on the

indigent and the Medicaid. But there are some that are extremely low in these categories. I think it would be important in this that when we're talking about hospitals in general, it would be helpful to see where they sit in that scale.

MR. HACKBARTH: Let me just pick up on that, Pete. I think all of us would agree that right now the burden of providing care to Medicaid recipients or uncompensated care is not evenly distributed. That's an issue that long predates specialty hospitals and it's an issue that has very important implications for the system.

And to say that stopping specialty hospitals is going to materially alter that problem, fix that problem, I don't think that's the case. Among community hospitals, some do a lot of uncompensated are, have a lot of Medicaid patients. Others do a few. So that's an important issue. But to address it you need measures that are appropriate to its scope. And it's huge.

MR. DeBUSK: Maybe this is time to address that. The revision of the Stark law should even more so be in order.

MR. HACKBARTH: Obviously, we can take up this

issue or any issue in future cycles. It's part of the DSH issue that we alluded to earlier and how those payments are distributed and whether they are distributed in the best possible way to achieve our policy goals.

To try to add that on to this already challenging subject, I think, is maybe too much to accomplish right now.

I have Sheila, Ralph, Bob, Jay and Carol, and then I think we're going to have to move ahead.

MS. BURKE: Very briefly, following up on Alan's comment, I don't think any of us believe this isn't about quality and about outpatient care. I think our desire in all of these things is to make sure that people are getting care in the most appropriate setting in the most appropriate way.

I also want to underscore that I also don't think it's all about money. I think these decisions to invest in these hospitals and create the hospitals are made for a variety of reasons, not the least of which is the challenges that physicians face that Glenn pointed out with respect to their practice and their access to services and their ability to have operating room time and a variety of very serious and very legitimate issues which I think underscores

reason for, as David points out, the need to look very carefully at a level playing field and the establishment of opportunities for gainsharing and the ability of community hospitals to set up similar kinds of relationships.

But I must say, similar to Nancy-Ann, I am and have been increasingly troubled by the development of these hospitals and what it says about what we intend a hospital to be and what we intend service mix to be in these communities.

I similarly believe that the moratorium may, in fact, not provide sufficient amounts of time as currently structured to get the answer to some of those questions. And I worry that, in fact, we may need to think about how long it will take CMS to make the adjustments in the payment schedule.

But I do think we need to come back to this question. I do think we need to come back to the question of the whole hospital exemption and what it means in terms of the relationship of physicians and what it means, frankly, for patients in terms of -- the disclosure, certainly, is a part of that. But I'm not sure that that is the only answer.

But I think, Glenn, you're taking us in the right direction. I do worry about the time and whether we will have sufficient time. But I do think the work on gainsharing, making it a level playing field in reality. But the fundamental question about what is it a hospital ought to be? What ought a community be able to expect?

And we can't answer all the questions around disproportionate numbers of low-income patients. I mean, there are those serious questions. They did precede this issue. Whether this exacerbated it or not, the answer to this is not the answer to all of those more fundamental questions.

But I do think we have something going on here that has to cause us to pause. And I think we need to come back to this fairly quickly and figure out what's going on, and the whole hospital piece has to be a part of that.

MR. MULLER: The issue of specialization is a difficult one, not just for health care, but very specifically for this commission. We like specialization at times because, as economic theory indicates to us, you get some real advantages in terms of cost and effectiveness. We don't always like it as much when it leads to proliferation

of imaging and other kinds of technology that, as Dave Durenberger pointed out and has been pointed out in Wennberg and Fisher's work, to be one of the major drivers of the increase in health care costs in this country. So I think we have a real ambivalence about this. People obviously, in an era like this like to cloak themselves in market terms and be more efficient. Obviously, when one cloaks themselves in those terms and then uses it as a way to skim patients, some of us don't like that because that's not market efficiency. That's misusing a payment system. And I think the work that Julian and Ariel have done have exposed that under the guise of more efficiency we're really allowing a lot of incentives for skimming to go on. I think appropriately these recommendations do address that.

I think we have a lot of difficult things to think about as we go further in this issue of specialization and I'll get in a moment to the physician-owned issue as well.

For example, it's much more attractive to patients and physicians to not have operating room schedule interrupted by emergency cases. But we shouldn't pay institutions that don't have emergency rooms, and therefore don't have operations interrupted by emergencies, as if they

had that kind of capacity. I think we should move in that direction, to have much different payment policies for places that don't have those kind of characteristics.

To say that places that have emergency rooms are less efficient, I think is an inappropriate use of that term because it makes the cost structure of that kind of institution -- i.e., the normal community hospital -- cost effective. It obviously has an effect on physician convenience and patient convenience. But then to say that somehow that makes it less efficient is again something that concerns me.

I agree with the points that Dave Smith and Nancy-Ann and Sheila have made that this recommendation, which I support, I think probably doesn't go far enough. Whether we want to go beyond that I defer to your judgment on that, Glenn. But I think I would be in favor of the repeal of the whole hospital exception. Because these hospitals, as the data indicates in the chapter here, we're talking about 15-bed hospitals for orthopedic hospitals. We're talking about 50 or 60-bed hospitals for the specialty hospitals.

By and large and general, maybe in rural areas hospitals have 14 to 50 beds, but that's not a normal

definition of a hospital, especially in the areas where these are growing, based on the data.

So these really aren't as much hospitals in the traditional sense of the work. Again, going back to my sense of what kind of benefits do we want from specialization, do we want to have a lot of encouragement for 15-bed hospitals? Do we want to call those hospitals? Do they get the kind of benefits that hospitals have in public law, tax exemption, et cetera, and so forth?

So I would be in favor of a whole hospital exemption but I am agreeable to taking more time to consider it. I do think, as Dave and Nancy-Ann and Sheila have said, tying this more to the ability of Congress and CMS to implement some of these changes is something that I'm in favor of. So either language in the recommendation, language in the text that ties this together I think would be language I'd like to consider. But I think the moratorium, in any case, is quite important because I think, as the evidence has been so powerfully been demonstrated here, is the payment system is now allowing behavior to go forth that really undermines its legitimacy. I would prefer that we not continue that.

DR. CROSSON: Thank you.

I support the body of the recommendations and I also support the perspective that you've given us, Glenn, on this.

I think that my sense of the discussion so far is that the Commission kind of considers this an interim set of recommendations. I think that's sort of clear from the discussion. And I think that's right, because I think the recommendations we have, while they are proportionate to the degree of development of the issue and to the body of evidence we've seen, nevertheless leave a few issues unresolved.

So I would support us taking this issue back up again potentially as early as the summer and watching the development of the recommendations that we've made, specifically looking and following to see whether or not the rebasing of the DRGs that we've recommended actually begins to be implemented, whether the work is put in place, exploring among ourselves whether there is a regulatory approach to try to mitigate some of the concern about the impact of financial incentives on the clinical decisonmaking process.

I think the issue of the whole hospital exemption, the current position which is to not call for that, I agree with that.

The issue of the moratorium length, it would seem to me -- and again, I think I support where we are right now -- it would seem to me if we do what we've said, and that is to pick this issue up again relatively soon since if this recommendation goes forward we're talking about 18 months from now already. I think there would be time within that period of time to make another recommendation about the moratorium if in fact some of the issues we've been concerned about are not being addressed. I think all of the issues then come back on the table.

Thanks.

MS. RAPHAEL: I'll follow up and say, similar to what Jay just said, which is I believe this is an important set of issues. I know I've spent a lot of time trying to understand where I come on. I consider this sort of we're on a journey. I don't think we're at the destination.

I do believe that there is an element here of not holding back innovation. There are a lot of trends here. More procedures in physician offices, ambulatory surgery

centers. There's a lot going on.

And I don't think we can restrain, nor should we restrain, all of those developments unless we have very solid evidence to make those judgment calls.

I do believe there is an issue about standards. What are the standards that we should expect for something that we label a hospital? What are the expectations that people in a community ought to have of any such institution?

I think we ought to take a look at standards. Should there be a standard around having emergent care? Should you be open at 3:00 a.m. if you label yourself a hospital in a community?

Thirdly, I think there is an issue which I'm struggling with, which is how do we align physician incentives and views with those of institutions? Because as the head of an organization I spend a lot of time trying to get my clinicians to feel a sense of ownership. And any change we make, any reengineering involves a long process of buy-in and inclusiveness.

I think that is a fundamental issue that we're facing. In the chapter on physicians, we talk about how influential physicians are in shaping the health care

system. So I'm trying to understand how we get that sense of ownership, that sense of investment that the outcomes and the results really matter, that you are pivotal to how things evolve, at the same time that we don't allow the kinds of conflicts that are driven by economics and lead to skewed clinical decisionmaking. And that's kind of the point I'm trying to find in all of this.

I do feel, on that last issue of conflict of interest, we need to be consistent throughout this whole report and however we come out in one area, it has to be a thread that we can carry throughout the entire report. This issue comes up in a number of other parts of our report later on this afternoon. And I do believe that whatever points we make here need to kind of be consistent with what we're going to say in other areas, as well.

MR. HACKBARTH: In my comments earlier I focused on the moratorium in the whole hospital exception. I just want to be on record, though, as strongly supporting the gainsharing. I truly believe, and my own experience tells me, that physicians and hospitals working together within some sort of common financial framework can achieve more than those whose incentives are pushing them in different,

indeed sometimes opposite directions.

And so I think that authorizing gainsharing within a set of rules that protects us against abuse can be a significant step forward, not just in improving efficiency, but also improving collaboration in the name of improving quality for patients.

I just wanted to be clear about my views on that.

DR. REISCHAUER: Like Nancy-Ann and many others, I was quite sympathetic at the last meeting towards a move to eliminate the whole hospital exemption, but in the course of the last month or so have become convinced that this is a whole lot more complex issue than it appeared at first glance, not just the issues that Alan raised with respect to innovation, quality, efficiency, but also that the terms we're using oversimplify things.

Nancy-Ann brought up the example of physician ownership of a more comprehensive hospital. And that's a different kind of situation maybe from the more narrow specialty hospital.

I think that this is an issue that we should discuss more comprehensively in the future, in the not too distant future, and think of options, not just elimination

or preservation, but are there intermediate options in which we maybe could develop safe harbors that if the hospital met a number of tests -- which I think Carol alluded to -- its fraction of uncompensated/Medicaid care was no lower than 40 percent of the average of the market area, or something like that. Or it had 24/7 emergency capacity. If it services of X number of DRGs, or something like that. Then you'd be less concerned about this and could go forward.

There seems to be some disagreement or concern about the length of the extension of the moratorium, and I share David's concern there. We have 12 months in the draft recommendation and David threw out 24 months. I suggest we split the baby and have it go through 2006, or until CMS moves forward, whichever is first. I think you are implying whichever is second, and that's like saying could be never.

And as I said at the last meeting, I think there's a definite need to keep the fire burning under the pot. And that gives us plenty of time also to come back and revisit this issue.

MR. SMITH: Bob, Carol asked if I thought that was a friendly amendment.

DR. REISCHAUER: It was intended to be.

MR. SMITH: I would suspect you have no better reason for 18 than I have for 24, except that neither is 12.

I think the key here is tying it to progress on the DRG recommendations and the gainsharing recommendation. I think we ought to try to figure out a way, and I'd be happy to do it, for 18 months or 24 months, figure out a way in the text of the recommendation to tie it to whichever comes first. Not simply -- well, extend the moratorium and extend the moratorium for -- I'd stick to 24 months, but again I have no better argument than you do.

But if the Secretary does with respect to what is in his authority, Congress takes action on the outlier DRG recommendation, and there is progress on the development of gainsharing provisions prior to whatever date we put in the recommendation, the moratorium ought to expire.

MR. HACKBARTH: So it sounds like you're agreeing with if those things happen before the date set, that -- right, whichever is first.

Any other comments on Bob's proposed amendment to number four?

If not, let's go back to number one. On draft recommendation number one, all in favor?

Abstentions?

Opposed?

Draft recommendation number two, if we could put that up.

All in favor?

Abstentions?

Opposed?

Draft recommendation three, all in favor?

Abstentions?

Opposed?

Draft recommendation four, Bob's offered an amendment to that to extend it to 18 months or when the work on -- go ahead, Bob.

DR. REISCHAUER: Just for simplification purposes, January 1st, 2007, which I think is seven days short of 18 months.

MR. HACKBARTH: Are we, under your proposal, including the language, the either/or, in the recommendation or in the text? How would you like to see that handled?

DR. REISCHAUER: I'm looking at my friend.

MR. SMITH: I'd like to see if we could handle it in the recommendation itself. I don't think it's

mechanically difficult, so maybe the staff could give us a draft and we could vote on this one later.

MR. HACKBARTH: Why don't we do that, because I'd like to have the specific language out before we have a vote.

DR. REISCHAUER: I think it's going to be harder than you think to include.

MR. HACKBARTH: Let's try it and then we'll bring that back. We've worked the schedule so we could have some time tomorrow morning to consider that.

DR. CROSSON: Just a clarification as to intent. The either/or issue would be the issue of action on the rebasing of DRGs, not any of the other issues?

MR. HACKBARTH: I think that's what we need to sort through, what's all included under the either/or, what language. So rather than having an extended discussion of that now, let's take that up when we come back with a proposed draft tomorrow morning.

DR. STOWERS: Do we need the gainsharing in this one?

MR. HACKBARTH: That's next.

DR. STOWERS: Okay, I'm sorry.

MR. HACKBARTH: I see, in the either/or list. I'm sorry, Ray.

DR. STOWERS: In the either/or list, it seems to me like the gainsharing thing might be a little bit separate here. It seems to me the primary issue here is to get the DRGs reorganized, as far as looking at the incentives to build more hospitals and what the market is going to bear and that kind of thing.

I'm just saying, for simplicity, this may want to relate to --

MR. HACKBARTH: I'd ask that rather than having a discussion right now, since we're behind schedule, let me think about it and I welcome thoughts from people during breaks and what not. And then we'll come back with a proposal on what to include and how to word it tomorrow morning.

But before we leave this topic all together, we need to do recommendation five on gainsharing.

All in favor of number five?

Abstentions?

Opposed?

Okay, excellent work, Julian, Ariel, over the

course of months now. Thank you very much.

Could I ask the people who are leaving to leave quickly and quietly.

Next on the agenda is home health: assessing payment adequacy and updates.

MS. CHENG: This is the final presentation in a series of three that we've used to discuss home health update payments for this year's March report to Congress. I will briefly review the factors in our analysis and respond to several questions that were raised in previous sessions. Our focus today is on the update recommendation for home health payments for calendar year 2006.

As we've mentioned in previous meetings, three factors from our update framework suggest that payments in this sector are adequate. Beneficiaries' access to care is good, though some beneficiaries continue to experience some problems. We found that 99 percent of Medicare's beneficiaries live in an area that was served by at least one home health agency. And when asked nearly 90 percent of beneficiaries responded that they had little or no difficulty accessing home health care.

We've also found that quality of care has improved

slightly. For example, the percent of patients who improved in ambulation and locomotion rose from 34 percent to 36 percent. The percent of patients who improved in their ability to bathe rose from 57 percent to 60 percent.

We also found that home health agencies appear to be entering the program. We found 500 new certifications of home health agencies, although all of these might not be truly new agencies, as they might have been branches of agencies who were already in the program.

The evidence that we have on volume is somewhat mixed. 2.4 million beneficiaries used home health in 2001. That number increased in 2002 to 2.5 million and again in 2003 to 2.6 million. The number of episodes has also increased from 36 million to 37 million from 2002 to 2003. However, the amount of service within an episode appears to be continuing its decline. The average number of minutes and visits per episode declined in 2003 by about 8 percent.

Another factor in our analysis of adequacy is the relationship of Medicare's payments to costs. We are projecting a decrease in the projected margins from their current level of 13.6 percent to 12.1 percent for all agencies freestanding in the aggregate.

As we've seen in years past, the financial performance of individual agencies varies widely around this average margin. About 20 percent of all agencies have negative margins in 2003. Those agencies provided 15 percent of the episodes of care used by Medicare beneficiaries. In contrast, 25 percent of all home care agencies had margins in excess of 25 percent.

When we looked back to the beginning of the PPS we find that most agencies have accumulated positive margins, as shown on this slide. 80 percent of all agencies have a positive three-year margin. 20 percent of agencies have negative ones.

At a previous meeting you asked us to look into the phenomenon of rural agencies decreasing their service areas. I'd like to thank my colleagues Sarah and Chad for turning around an analysis of P since our last meeting to respond to some of your questions.

We did find evidence of this phenomenon. rural agencies reported serving fewer ZIP code areas on average in 2003 than they did in 2003. However, we found that rural beneficiaries report better access to care than their urban counterparts, and they reported better access to care than

their urban counterparts both before and after the rural add-on expired.

We also found that utilization of home health services increased in both urban and rural areas from 2002 to 2003, from 630 episodes per 10,000 beneficiaries in rural areas to 640 episodes per 10,000 beneficiaries.

We also included in our analysis a consideration of the changes in costs per episode for Medicare home health agencies. We examined costs for a cohort of agencies that were in our database for three years. We found that between 2001 and 2003 aggregate costs per episode fell by 1 percent. This aggregate effect is the combined effect of some agencies cost reductions and other agencies cost increases. At the 75th percentile of cost change, costs grew 5 percent. But at the 25th percentile, costs fell 2 percent.

We found some relationship between size and cost that was not surprising. Larger agencies appear to be better able to control their costs than smaller ones. We also found that rural agencies costs fell by 13 percent. Decreases in visits and minutes per episode are likely to be the primary influence behind the decrease in cost per episodes. Also, some agencies report improved wound

dressings and technologies such as point of care computers and telehealth that allow them to improve nurse productivity and reduce their costs.

Rural agencies also reported rationalizing the travel patterns of nurses to increase productivity and reduce their costs.

The combination of generally positive indicators of access and quality, along with more than adequate current margins and slow cost growth suggest that agencies should be able to accommodate cost increases over the coming year without an increase in the base payments.

This brings us to our draft recommendation that Congress should eliminate the update to payment rates for home health care for calendar year 2006. The implications of this recommendation for spending would be a decrease relative to current law by between $200 million and $600 million for 2006 and between $1 million $5 million -- I'm sorry, $5 billion over five years. The implications for beneficiaries and providers would be no adverse impacts on access to care are expected. And this recommendation is not expected to affect providers' ability to provide care to Medicare beneficiaries.

The final section of our chapter will discuss our exploration of concerns about the accuracy of the home health PPS. In a previous meeting we discussed the variation in the average number of minutes per episode within payment groups. This wide variation is not unexpected, given the large bundle that's included in home health payments and the lack of product definition. If the variation in minutes is related to the variation in costs it raises questions whose answers may lie in the case-mix system, the source of the variation and costs among agencies or the product definition.

We also found that some patient characteristics, such as the availability of informal caregivers, obesity or heavy smoking, appear to be related to high costs. However, these patient characteristics are not included in the case-mix adjustment system.

MedPAC continues to probe the home health PPS in our mandated study of the relationship of case-mix and financial performance that's mandated for later this year in the fall. We will also explore alternatives to the PPS in the next few months.

With that, I would wrap up my presentation.

MR. HACKBARTH: Questions or comments for Sharon?

MS. RAPHAEL: I think that Sharon has done a very good job and I think the data, at least if you look at the trends, seems to have some consistency here.

My only commentary is that I really feel that we have to do this update in the context of a reexamination of this system because there are 20 percent of the providers who have negative margins. It's not entirely clear to me that this is in any way reflective of inefficiency. It may very well be reflective of selection. We just don't know enough.

I also believe, from my own experience, that some of the providers that struggle the most are those who really are a longstanding part of the fabric of their community. And I don't believe you should allow one house to crumble before you have another place to move to. And I don't think we should allow some of these organizations who are really part of their communities, and have been part of their communities for many, many years and do many other things besides just a post-acute care visit to sort of evaporate while we kind of look at some of these issues.

Some of this is skewed by the variation. There

are some people who are very good at this. There are others who are much less sophisticated and not as good at this, if it's selection that drives some of this.

So I just want to be careful because it's particularly those organizations who see the dually eligible, see the ones who are more chronic, less task oriented. And lower costs are lower because people are providing less visits. That's what I understand from all of this. That's the main reason. There some gains in technology and all of the rest of it, but it's primarily at the margins. The main reason seams to be a decrease in visits. And we should just be mindful of this as we look at the payment system long-term.

So I just want to reiterate that I think it is important to look at the bigger picture here and not lose sight of it.

DR. SCANLON: I would agree totally with what Carol just said. I think you've done an excellent job in portraying the current situation, but it does suggest both what we're thinking about with respect to the current update. But it also raises the much bigger question about the appropriateness of our current PPS for this service, in

particular.

I think as we move forward, we're going to be thinking about this with respect other services, as well. Does the PPS framework that we've have -- it's now a little over 20 years -- is it suitable in terms of trying to target payments to where they're most needed, as well as to think about the financial situation of the Medicare program? I think we're going to come to the conclusion that we need innovation.

This benefit, in particular, because we have a very undefined service and we have, in some respects, been more heroic about the PPS structure than anywhere else. We're trying to define a 60-day episode payment where there's incredible latitude. And to say that what we see in terms of the differences in margins among agencies is a selection problem is being polite. I think, Carol, at the end you got to the heart of this, fewer visits in many cases. Sometimes those fewer visits may be inappropriate and we have no system that will detect whether that's happening or not.

MS. DePARLE: I just want to say I agree with Carol and with Bill. I think it's time. The system now has

been in place for six or seven years. This industry had a wrenching experience in making such a big change, both to the PPS and to the new system of data collection and I think has done a good job of improving quality. And it's a good time to revisit all of that.

Of course Bill, as we know, part of the reason for the PPS is that it was felt that the old system encouraged too many visits. At least in the aggregate that may have been true. We don't know for sure whether this one might be encouraging too few. And as Carol has pointed out, many times what impact it may be having on those particularly frail elderly who might be dual eligibles and who need a lot of care.

So I think it's a perfect time, if we have the resources, Mark, to really drill into that.

DR. MILLER: We do plan to do that and we have some of it on the agenda for the March, April, June part of our cycle; right?

MS. CHENG: Yes.

MR. DeBUSK: I agree with my colleagues about what's going on here with home health. The OASIS system, certainly we've had some experience with it now, and realize

that we've definitely got holes, especially with the diabetic patient, and probably obesity plays in here, as well. So it's certainly well in order to take a look at it again, I would think.

DR. REISCHAUER: In the absence of Mary's presence, I feel compelled to say something about the rural areas. And that is in the body of the draft chapter here, which I thought was excellent, there's discussion of the rural add-on and the elimination of it and the reappearance at a lower rate and that kind of thing, and what impact did it have.

I think there's an assumption that this is unneeded maybe. I think that's a premature conclusion. When we're running at margins of 13 percent and elimination brings it down to 8 percent, that might be true. But in theory this is going to move to a more normal margin. And if the average for the industry as a whole is six or five, then you might get a very different answer.

I don't think you've said anything, in a sense, wrong. I think it's the tone and the conclusion that some people might jump to. I think we want to be a little more circumspect.

MR. HACKBARTH: Other questions or comments? Okay, let's proceed to the votes or vote.

DR. MILLER: Actually, can I say one other thing to the set of comments that were made about this? We do have language in the text and you should look about the need to get into the guts of the system and look at it more completely. If you don't think it's urgent enough or stark enough, or whether adjective you want, you should make sure that you comment on that so that it jumps out at the reader.

MR. HACKBARTH: We're voting on the draft recommendation.

All in favor?

Abstentions?

Opposed?

Okay, thank you very much.

The next item is skilled nursing facilities.

MS. LINEHAN: I'll review the most recent evidence regarding SNF payment adequacy and present the draft update recommendation for fiscal year 2006. Sally will discuss our recommendations to improve SNF quality monitoring.

Since you've seen this evidence at previous meetings, I'm going to hit the highlights for all these

factors in our framework.

The evidence we have suggests that the majority of Medicare beneficiaries have access to SNF services, but that patients needing certain services such as expensive drugs, specialized feeding or ventilator care may stay in the hospital setting longer before going to a SNF. This finding may point to problems with the distribution of payments in the payment system.

In terms of supply, the number of hospital-based SNFs declined. The number of freestanding SNFs increased. But the net effect was the overall supply of Medicare-certified SNF facilities participating in Medicare remained about the same between 2003 and 2004.

In 2002, the most recent year for which we have data, the volume of SNF services provided grew.

Based on our discussion with experts, we've presented information in our past meetings and in the draft chapter on the need for quality measures that are specific to the care provided to short-stay patients receiving skilled care as distinct from the quality measures for long-term care patients receiving custodial care.

In keeping with this principle, we examined two

sets of quality indicators for SNF patients to determine quality trends. And we found that rates of readmission to the acute-care hospital for five potentially preventable conditions all increased slightly between 1999 and 2002. These increases are small.

We also found that in 2002 SNF patients had lower than expected rates of mortality, higher than expected rates of readmission and lower than expected rates of discharge to the community within 30 days, compared with rates based on 1996 patterns of care.

Our analysis of the Nursing Home Compare quality indicators for short-stay patients found that facilities improved on one measure and had no change on another.

Sally will review why these measures may not present a complete picture of quality in SNF care.

The current evidence regarding access to capital is similarly mixed. Non-profits continued to have limited access to capital and large for-profit nursing home chains, however, appeared to have improved performance over recent years with several reporting spending to construct or expand facilities.

As you've pointed out in the past, nursing homes

derive only a fraction of their revenue from Medicare. Medicaid and other payers are the source of 88 percent of nursing facility revenues on average. The industry has expressed and continues to express concern about inadequate Medicaid payments but currently regards Medicare payments favorably.

For example, one recent financial industry report claimed that a major chain's revenue growth was being driven by an increase in their Medicare census. Nevertheless, the industry is concerned that potential future refinements to the Medicare payment system will affect their ability to subsidize Medicaid payments.

This brings us to our margin information. In fiscal year 2003, Medicare margins for all freestanding SNFs, which are about 90 percent of all SNFs, averaged about 11 percent. Based on these 2003 cost report data, we estimate that 2005 aggregate Medicare margins for freestanding SNFs will be 13 percent. Margins for rural facilities, which are about one-third of total facilities, are higher than those for urban facilities.

Our analysis found that SNF cost growth since the implementation of the PPS has greatly declined from the pre-

PPS period and providers will continue to respond to incentives in the PPS to control cost growth. Between 2000 and 2003 average annual per day cost growth was 3.6 percent. These findings indicate that SNF market basket increases, which ranged between 3.3 and 5.0 during this period have generally approximated SNF cost growth over time. However, we also found variation in this growth at the 25th percentile. Average annual change in Medicare costs per day was 0.4 percent and at the 75th percentile it was 7.9 percent.

In light of the factors just reviewed, draft recommendation one is that the Congress should eliminate the update for SNFs in fiscal year 2006. Because current law provided for a full market basket increase, this recommendation would be a decrease in current spending relative to current law of between $200 million and $600 million in 2006 and between $1 billion and $5 billion over five years. This recommendation is not expected to adversely effect Medicare beneficiaries' access or providers' ability to provide care for Medicare beneficiaries.

Draft recommendation two is one the Commission has

made for the past two years. It's for a temporary measure to correct for problems with the RUG-III-based payment system until the payment system is refined.

In the BIPA, the Congress directed CMS to study alternative systems to the RUG-III-based payment system. A report on this study, including proposed alternatives to the RUG-IIIs was due to Congress no later than January 1, 2005. This report on the results of the research has not yet been released, so it's unknown when or whether any changes to the SNF payment system will be implemented.

Until a new classification system is developed, the Congress should authorize the Secretary to remove some or all of the rehab payment add-ons and reallocate the money into the non-rehab RUGs.

This would not affect federal program spending relative to current law. The recommendation has the potential to improve beneficiary access to non-rehabilitation RUGs and could have redistributive impacts on providers as payments are reduced for rehab RUGs and increase for non-rehabilitation RUGs.

DR. KAPLAN: I'll quickly run through the results of our study on SNF quality which I presented last month.

As you might remember, Karen Milgate worked with me on this.

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 only three quality indicators specific to SNF patients. They are delirium, pain and pressure ulcers. The experts we interviewed believe that the SNF-specific QIs are too limited. First, fewer than one-half of SNF patients have the assessment needed for measuring these indicators. In addition, the experts thought that these indicators did not reflect whether beneficiaries benefit from their SNF care or reach the goals of their care.

Instead, the experts recommended other indicators, rehospitalization, discharge to the community, and improvement in functional ability. Two of these indicators can be created and analyzed from administrative data currently collected. Improvement in functional ability would require addressing activities of daily living at admission and discharge.

In response to your comments, we have added the second bullet to this draft recommendation. The draft recommendation is CMS should develop and use more quality indicators specific to short-stay patients in SNF; put a high priority on developing appropriate quality measures for pay-for-performance, and collect information on activities of daily living at admission and discharge.

The implications of this recommendation are that there is no impact on federal program spending relative to current law. This recommendation would be expected to improve quality of care for beneficiaries. There would be no administrative burden if the assessments at admission and discharge could replace existing assessments.

That's our presentation.

MR. HACKBARTH: Questions or comments?

DR. SCANLON: I think this is an excellent job in terms of summarizing where we are. I guess I have a comment and then a question. The comment relates, in part, to the argument that's been made many times about the issue of Medicare needing to compensate for Medicaid payments. I think the Commission has been in the right place on that, that Medicare payment rates are focused on the Medicare

program and getting access for Medicare patients.

I think though we need to be cognizant of the fact that there may be a point in time where access is an issue and that we need to think about then what are we going to do, in terms of even if there is sufficient Medicare margins do we need to do something to increase payments to assure access? Or do we want to think about substitute kinds of services, potentially allowing people to remain for longer periods of time in the hospital as a substitute if it's impractical to use skilled nursing facilities.

A quick comment about Medicaid payments. I spent a lot of time before I went to GAO working on nursing home payment. This idea that Medicaid provides inadequate payment is something that has existed since the day the Medicaid program began. The reality is that Medicaid programs pay less than what nursing homes would like. But in many, many states they may pay what you would regard as an adequate payment. They're based on the cost that the homes have. They're targeted well towards what the state is interested in buying and they actually may be able to provide lessons for Medicare in terms of targeting money toward care resources as opposed to administrative

resources.

It's a real question of whether or not they are too low because the reality is that the industry has been here with us for the last 30-plus years always saying that the rates are too low.

My question goes to draft recommendation three and it's that issue about being able to collect the admission and discharge assessments replacing existing ones. Part of it is the practicality of that. For the admission one, we currently have a requirement of within the first five days; is that right? If we say it has to be at admission it will probably get closer to day one but not necessarily.

The discharge one would seem to be a new requirement unless we're giving up the potential to have an assessment that may change payments for days toward the end of a stay.

DR. KAPLAN: I agree with you. Ideally, we would have had the time to look at how often the RUGs change from assessment to assessment. That would determine whether you could substitute or not. But we didn't really have time to do that. I don't know how to really change anything to reflect what you said.

DR. MILLER: But Sally, I thought the thinking here is that there are points in the stay where assessments are made and that there is some science to that, but not necessarily day five is better than day six type of science.

I think the question is if you were worried about a significant increase in burden, you would swap out one of the later assessments for assessment at discharge.

DR. SCANLON: I guess the question would be that -- is it day 30 that's the second assessment?

DR. KAPLAN: The second one is the 14th day.

DR. SCANLON: The question would be if it's day 14 or day 30, would you actually postpone that, saying this person is going to be leaving here within 10 days and we'll do the discharge assessment then?

It's a difficult question because it anticipates that you can say I know when this person is going to leave and that assessment is going to be soon enough. That's where it may not turn out to be true that you can replace that last assessment.

MS. RAPHAEL: I agree with Bill. I'm not sure that these are substitutable because one is sort of a monitoring process and another is sort of where have we

come.

I had a radical notion which probably is too radical for adoption. But as I was thinking about this -- and I do think you're headed in the right direction by looking at rehospitalization, discharge home, and what are the functional results here. We have the OASIS, which now is doing that in the home and community-based setting and does track on a lot of the functional outcomes.

And I was just wondering is there some way to take a shortened OASIS? Because one of the things we're struggling with here is post-acute care and trying to look at post-acute care across settings. For all those who need post-acute care, how many land in nursing homes, rehab facilities, home care, and why? And how do the results compare for the dollars that we spend? And since we feel the MDS has limitations, rather than create yet another instrument, I'm wondering if there is some way to adapt this one that has been disseminated pretty widely?

DR. KAPLAN: I think it's an interesting suggestion. We are planning to look at the post-acute assessment instruments this spring.

I think in the chapter we originally set out and I

believe it still says that our experts really didn't feel that a full assessment was needed at discharge, that the quality indicator, that the ADLs are really needed at discharge. And perhaps anything else that you might want quality measures. If you still wanted to do the pain and the delirium and the pressure ulcers, okay fine but you do those at discharge, as well. But we're not talking about a complete assessment.

Part of my concern about using a short OASIS would be that the MDS ADLs are very, very different from the OASIS ADLs. I think you need basically the same metric at admission and discharge to be able to compare whether there's improvement or decline or whether there's stabilization.

That's my only thought. I just want to assure you we are looking at a post-acute assessment across assessments for the spring.

MS. BURKE: I just wanted to follow-up on Carol's comment. She raises actually a critical question which we discussed in varying ways but in this suggestion I think she suggests we really focus on it. That is there are a variety of ways one can care for a patient post-hospitalization.

And why someone ends up in home care or in a skilled facility or in a rehab facility, I mean how one navigates is sometimes specifically related to what has to happen in other cases. It's less clear why certain choices are made.

And the extent to which we can begin to look at the quality of the determination and the appropriateness of the setting and therefore the outcome as a result of the setting that is chosen, that we begin to look at those in a uniform rather than as distinct and separate entities, I think would advantage us enormously. I don't know how complicated that would be. But Sally, to the extent that you're looking at some of these issues in the spring, I think this whole question of looking at whether we can begin to tie this together more clearly, that they're not distinguished from one another entirely, and where the patient appropriately belongs and how one looks at whether progress has been made or not, I think would behoove to us over the long-term.

So a more complicated question, but I think Carol raises a very good point, that we really ought to look at this in a more comprehensive way and sort of linked.

MR. MULLER: With regard to recommendation two, I

know we've made it before and I'm in favor of making it again.

I want to speak specifically to some of the learnings we have across our payment systems. Obviously, given the discussion this morning and the work that's gone on around the rebasing of the DRG system in hospitals, I think this is evidence once more where we can learn from that work and bring it into both, in this case obviously the nursing home, and the previous conversation on home care, in terms of tying payments to costs.

And so I think in some sense perhaps one can anticipate some of the issues that will keep emerging in home care and SNFs as we get more and more into this prospective payment. So I think this is consistent with the learnings there, the recommendations there. And again, we've made the recommendation before and I'm very much in favor of making it again.

DR. REISCHAUER: I'd just like to ask Kathryn if we have any understanding at all on why rural margins are higher than urban margins?

MS. LINEHAN: Well, the components of the payment are higher for rural areas. Like the therapy component for

rural facilities is higher than the therapy component for urban. This is pre-wage index adjustment.

So I looked at this yesterday, anticipating that you might ask this question. The total rate pre-wage index adjustment is greater for rural facilities for rehab RUGs and greater for urban facilities for the non-rehab RUGs. So that might have something to do with it.

The rurals also -- I looked at our historical cost information. The rurals have lower costs. But interestingly, they've had similar, almost identical cost growth to the urban facilities but from a lower base.

DR. STOWERS: Building on what Carol and Sally were saying a minute ago, I don't think there's any doubt in the field that part of this increase in volume that you're talking about in skilled nursing has come across because of the PPS system in home health, that it's cut down the number of aides, and especially aid in those type visits, therefore being more dependent on having a family member at home if you're going to use the home health.

So there's a lot of physician decision now occurring that sends them on to skilled nursing instead of home health care.

I'm just wondering, do we come out ahead or behind overall between home health and skilled nursing? And just looking at it all more in a global way. But there's no doubt that shift has occurred out there.

MR. HACKBARTH: Total cost to the Medicare system?

DR. STOWERS: Yes, cost to the system? Have we come out ahead on this or behind? Would we be better off in going back and increasing the number of assistant and aide visits in the home health care system?

Because I think we're paying more in the skilled nursing system now than we were paying for the aide visits and so forth in the home health. And I'd sure rather have them home than in a skilled nursing facility.

I think we need to take a look at that. But that shift occurred very definitely after the home health PPS. I don't know what Carol thinks, but at least in our communities it did.

MS. RAPHAEL: [Inaudible] showed that in the work that he did.

MR. HACKBARTH: Can you address Ray's question specifically about the net effect on Medicare?

DR. MILLER: When we looked at -- to many of these

questions some of you will recall we put together the post-acute episode database, did some analysis I want to say about two years ago. We were looking at the shift in patterns post-PPS. We did not, for probably good technical reasons, say okay, dollar for dollar where do we stand? Although I can't remember exactly why we didn't do that.

But in revisiting this issue we can go back and update that dataset, look at the shifts in patterns. There may be some issues and ways to reach to your question.

And then as I think Sally said a minute ago, we're trying to look at what elements could be common in an assessment instrument, in a sense to build the apparatus to push perhaps change in the future instead of coming at it through the payment systems, if you see what I'm trying to say.

MR. HACKBARTH: Let's proceed to voting on the recommendations.

All in favor of recommendation one?

Abstentions?

Opposed?

On recommendation two, all in favor?

Abstentions?

Opposed?

On number three, let me just ask for a clarification, Bill. Were you suggesting that we ought to basically drop the third bullet out of the formal recommendation?

DR. SCANLON: I don't think we should change the recommendation. I think that maybe in discussing it we might say that we expect the administrative burden to be minimal. But I think it's important we get that kind of information.

MR. HACKBARTH: All in favor of draft recommendation three?

Abstentions?

Opposed?

Thank you, very much. Good work.

We will now have a brief public comment period.

MS. SMITH: My name is Alyse Smith and I'm with the American Health Care Association.

First of all, I want to thank the staff for recognizing our concerns and we do hope that there will be some text in the report expressing the concern we have regarding the overall financial picture of the sector. We

know that MedPAC does not take the total financial picture into account and indeed, we have been here time and time again pleading with you to do so. And to go on record we simply want to plead with you one more time.

This sector has a very low overall margins. I saw a figure recently in one of the investment reports of somewhere between 2 and 3 percent. Something is pulling the margins down to that level and it would have to be Medicaid.

We have our own data that show, at least I think for 2002, that there was an enormous disparity between cost and revenue, something like $11 per patient per day.

Now I can't get into a contest with Commissioner Scanlon, but maybe we could draw one conclusion. And that is that even during the heyday of the cost reporting period, and now under PPS, that Medicare has been indeed carrying Medicaid all of these years. And that's why those skilled nursing facilities are still in existence.

I would just ask or make the statement that at this point depriving the sector of the market basket update has the potential to invite back in the instability that this industry was plagued with. And remember, that funding stability is critical to quality care. Thank you.

MR. MERTZ: Good morning. I'm Alan Mertz. I'm President of the American Clinical Laboratories Association. I'm actually commenting on a topic that's going to come up at 12:45 on strategies to improve care.

MR. HACKBARTH: Can I ask you to hold your comments then to the afternoon public comment period? It's very helpful to us, both in terms of understanding the content of what you say and managing a process to have them done in the proper order. Thank you.

MR. MERTZ: Thank you.

MR. FENIGER: Randy Feniger with the American Surgical Hospital Association. I do not have a prepared statement, as per instructed. But I'm old enough now that if I don't write some notes I'll forget what I want to say.

I want to thank the Commission for the extent of its debate on a very complex issue, and of course compliment the staff on the work that they have done over the months. I appreciate the very careful consideration of what you know and what you don't know and the caution with which you then approach the recommendations that you voted on and still have under discussion.

I particularly want to express my appreciation to

Mark Miller for taking time out of what must be an absolutely horrible schedule to listen to me whine one more time before this meeting.

I make a couple of general observations. First, many of the things that you talked about, not only today but at other meetings, touch on a lot of systematic issues within the health care system. I think you recognize that. I hope the report will reflect the fact that you will not lay every cent at our doorstep, that you will deal with issues relevant to these hospitals. Some of the broader issues that have emerged as a result of this discussion that aren't addressed specifically in your recommendations you can come back to as you've indicated. But I hope that it will be clear that there are distinctions and differences in the writing.

I have, as has the association, argued in the past that we do not think an extension of the moratorium is required. We feel that the DRG changes, once you even make the recommendation the market will respond. I base that on the four messages I have right now on my cell phone from market analysts wanting to know what you did.

However, if you are going to proceed with a

recommendation relevant to a moratorium I think, as was discussed, it is extremely important to create a dynamic pressure on the process, both at CMS and Congress within that recommendation. We support the changes to the DRGs that you voted on today. We've made that very clear previously. That is unchanged. But we are only one voice before Congress and before CMS. There are others who perhaps don't like us as well and who might resist those changes both before Congress and CMS.

We would hate to be held hostage to that kind of environment. So we hope you can use the recommendation on the moratorium as a way of creating pressure on all the stakeholders to move forward with the recommendations that you've made on DRGs because I think that would be a productive step. I think otherwise we're just sort of swept under the rug and the issues don't get addressed that you have clearly recognized.

I thank you for your time.

MS. COYLE: Carmela Coyle, with the American Hospital Association.

Thanks to the Commission and to the staff for a lot of terrific research and hard work on the topic of

specialty hospitals. Just two quick points.

First of all, I think the Commission's discussion around the self-referral issue and the concerns that were raised are very important. Hoping that some of that discussion, which I think would be very helpful to policymakers, can be reflected in the final text in the March report.

Second, as Commission and staff consider a redraft of recommendation four this evening and the definition around implementation of payment, I would just respectfully suggest that you consider implementation of all of the payment recommendations, that is recommendation number one, two and three, and consideration the addition of recommendation of gainsharing, as well.

Thank you.

MR. HACKBARTH: Okay, we well we convene at one o'clock.

[Whereupon, at 12:08 p.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION [1:12 p.m.]

MR. HACKBARTH: In just a minute we're going to turn to pay for performance, but let me just make one scheduling not first. Earlier when we were talking about specialty hospitals, and specifically the draft recommendation four on the extension of the moratorium I said we would consider some changes in that and then revisit it tomorrow morning. Rather than do that tomorrow morning, we are going to do it at the end of today's session. I think we have had the thinking that we need to do on it and we may as well it done quickly.

So with that scheduling note, let's now turn to pay for performance. Karen?

MS. MILGATE: This is the final discussion before the March report of pay for performance and information technology.

We began this process two years ago when we evaluated strategies to improve care and concluded that Medicare must lead efforts to improve quality through financial incentives. At the same time, the Commission found that accelerated adoption of information technology also had the potential to improve quality. We developed

criteria for determining when settings were ready and design principles for the program.

In this session we will discuss our recommendations for hospitals, home health agencies, and physicians. For our analysis we consulted providers, purchasers, quality experts, researchers, accreditors, and government agencies including CMS and AHRQ. It is their hard work and enormous progress measuring quality in the last few years that provides the foundation for these recommendations.

MS. CHENG: In pay for performance we're at the beginning of a journey and part of the trip involves building the next stretch of road. To start the journey, Congress must enable CMS to pay providers differently. Our chapter provides principles that Congress could instruct the Secretary to use to design the program, and starter sets of measures to suggest for hospitals, home health agencies, and physician setting.

At the same time, the Secretary needs to make preparations now for the immediate future to maintain the momentum. The Secretary should establish a formal, open process that includes CMS, researchers, providers and

quality organizations. That process should reexamine and refresh measures, and each of our recommendations for these three settings is accompanied by a recommendation to enhance the starter set for that setting.

The process should coordinate with other entities who are implementing similar programs. And it should include an important set of incentives for IT, to decrease the burden of reporting quality information and to facilitate improvement efforts for the future. As the measure set improve and the burden decreases, the share of payments that are linked to performance can increase.

Taking the initiatives that I've just described will create opportunities to continue to reshape the incentives of the system. Medicare should incent providers to improve efficiency as well as quality. MedPAC can continue to explore the concept of efficiency and efficiency measurement, including longitudinal efficiency.

There should also be rewards for providers who improve the outcomes of care for their patients in other settings, such as doctors whose patients do better in hospitals, or home health agencies who manage their patients' care to transition to nursing homes. Future

incentive strategies might be able to align the goals of providers across settings, such as physician and hospitals, and encourage them to adopt such as IT that would allow them to increase coordination and to improve outcomes.

Our first recommendation is based on the finding that hospitals as a setting are ready for pay for performance. These four groups of measures are all possible candidates for a starter set for hospital P4P. Ten process measures are already being reported to CMS by almost all inpatient, acute care PPS hospitals, and also by many of the critical access hospitals. Many hospitals are also beginning to report information on an additional 12 measures. Together, these 22 measures include indicators for AMI, heart failure, and pneumonia, and for surgical infection prevention. The surgical infection prevention measures apply to all surgeries and are not limited by condition.

Mortality measures derived from claims are widely used to measure outcomes. However, the adequacy of risk adjustment and small sample size is a concern for many of these measures. Nonetheless, AMI and CABG mortality are possible candidates for a starter set. With an enhancement

to our hospital data, a wider set of outcomes, including potentially avoidable complications, could also be possible.

There are 30 safe practice indicators that have been endorsed by NQF and integrated into a survey tool that is currently in the field, and that survey tool was developed by the Leapfrog group. The 30 safe practice indicators could add measures of the structure of care, such as the documentation of end-of-life directives or reading back verbal orders for care or medication.

Finally, patient experience of care is an important aspect of quality, and when the final standardized survey is released later this year it too could be in an initial set if measures to pay for performance in hospitals.

There have been some concerns about the breadth of available hospital measures. The process and mortality measures do not capture all patients that hospitals care for. They do include conditions that are important for Medicare's population, and adding safe practices and patient experience are both comprehensive sets in terms of the patients in hospitals. This may mean that you may wish to begin hospital pay for performance with a smaller amount of payments attached to the initial set of measures.

This brings us to our first draft recommendation. That the Congress should establish a quality incentive payment policy for hospitals in Medicare.

Our second recommendation is based on the finding that home health care is also ready as a sector for pay for performance. The outcome-based quality indicators already provide dozens of measures of the functional improvement, stabilization and clinical progress of home health patients. These outcomes are not limited to a narrow set of conditions. They can be applied to nearly all of an agency's patients. Among these measures, 10 have been endorsed by CMS, AHRQ, and professionally by NQF. These measures are already collected and calculated by CMS.

In response to some questions that you raised at our past meeting, we looked at the ranges of outcomes scores among agencies. In nine of the 11 publicly reported measures there was a range of 90 percentage points from the top to the bottom, and in 10 of the 11 there were standard deviations of about 10 percentage points. This suggests that these measures can distinguish among agencies.

Also in response to comments that we've received as we've develop this sector, we have made a statement about

adverse event measures. Adverse events, such as falls or avoidable hospitalizations could enhance the home health measure set by providing information on patient safety, but better measures are needed.

Process measures and patient experience measures could also enhance the starter set and more fully capture the range of patient goals in this setting, from achieving independence, to functional improvement, to staying safely at home.

This brings us to draft recommendation two. That the Congress should establish a quality incentive payment policy for home health agencies in Medicare.

MS. MILGATE: Our third recommendation for physicians is based on the finding that physicians are also ready to begin a pay-for-performance program. Physicians are central to the delivery of all kinds of care in all different settings, and thus, their participation in this program is critical.

Further, without information technology it is difficult for physicians to keep up with, and apply the latest clinical science and to appropriately track and follow up with patients. This is true for primary care,

especially for patients with chronic conditions, but also true for surgeons and other specialists to ensure follow up after acute events and coordination with other settings of care. We find many measures of quality for physicians are available, but the lack of a data infrastructure makes it difficult to obtain the information. As opposed to other settings of care, the only currently collected information on physicians is claims.

Therefore, to begin a pay-for-performance program, the program could first use structural measures of the functions and outcomes of information technology use. What I'm talking about here are systems to manage patients such as whether physicians use patient registries to track their patients and identify when they need certain preventive services, or systems for detecting drug-to-drug interactions. These types of measures could apply to all types of physicians, have the potential to improve important aspects of care such as coordination across settings and over time, and at the same time increase physician ability to assess and report on their care.

In addition, the program could use process measures. However, to the limit the physician burden of

data collection, the Commission has stated their support for only using claims-based measures at least initially. Here, by these types of measures I mean such measures as whether beneficiaries received appropriate follow up after an acute event, or whether they were receiving appropriate diagnostics. These process measures based on claims would put no burden on physicians, and current research is finding that claims-based process measures are available for a broad group of beneficiaries and physicians.

However, while broadly applicable, the depth of information on each kind of physician is unclear, and we do know that claims-based process measures are not available for every single type of physician. Therefore, we may need to have a transition strategy in this particular sector.

One strategy to address these limitations of claims-based measures would be to collect information on both structures and process, but at first only distribute rewards based on the structural measures. Information on process measures could be fed back to the physicians, and I might be useful to have a keep certain when the process measures would be used for rewards. This would encourage specialty societies and others to further develop the

process measures.

This transition time would also allow CMS time to develop the capacity to link additional data with physician claims, which we will talk about in a moment, to enhance the ability to use claims-based measures on physicians.

Draft recommendation three reads that Congress should establish a quality incentive payment policy for physicians in Medicare.

The implications of draft recommendations one, two and three are the same so put them all on one slide here. The spending implications are that because these recommendations redistribute resources that are already in the system they would not affect federal program spending relative to current law.

For beneficiaries, it should improve the quality of care over time.

And for providers it will result in higher or lower payments, depending upon the quality of their care.

MS. CHENG: The next set of recommendations address improvements to the data that we've alluded to as we've gone along.

The first of these recommendations is that CMS

should require hospitals to identify which secondary diagnoses were present on admission on the claims forms. This additional information would significantly enhance our ability to identify which complications were present on admission, and from those, which were potentially avoidable that developed during their stay in a hospital. It would also improve our capacity to risk adjust mortality and complications. Currently, claims do not distinguish between health conditions that developed while a patient was in a hospital and those that were present upon admission. Several quality organizations have also endorsed this concept.

Our second recommendation to build for the future is that the Secretary should develop a valid set of measures of home health adverse events and include adequate risk adjustment. Patient safety is an important aspect of home health care because one of the primary goals is to keep patients safely at home. Measures of potentially avoidable hospitalization or emergent care could provide information about patient safety. However, the current measures cannot adequately identify cases that were due to poor care, nor are they adequately risk adjusted.

MS. MILGATE: The next two recommendations are aimed at greatly enhancing physician measures that are based on claims, and they look at the additional information of lab values and prescription data. These data would be linked through beneficiary and provider identifiers to physician claims to give a much more complete picture of patient care.

First, lab values. Through physician claims what we can know is whether a particular lab test is performed. However, if we actually know the lab value it tells us whether the patient values were in healthy ranges or not.

Therefore, the recommendation is that CMS should require those who perform lab tests to submit laboratory values using common vocabulary standards.

Reporting lab values on claims is not without precedent. Dialysis facilities report two types of values on their claims. This recommendation does not, however, require providers to report the values on their claims, but those that perform the test to do so. We recognize this does include some physicians and hospitals however.

Laboratories tells us that linking clinical systems with claims systems and standardizing the vocabulary

is a complex undertaking. Therefore, a two to three-year transition before requiring the values may be necessary. Chantal will talk later about using common vocabulary standards and the effect that might have on adoption of information technology.

Linking prescription data with physician claims could help identify a broader set of patients with certain conditions and help determine whether they filled or refilled prescription, or received appropriate pharmaceutical care.

Draft recommendation seven reads, CMS should ensure that the prescription claims data from the Part D program is available for assessing the quality of pharmaceutical and physician care.

The implications of draft recommendations four through seven for spending and beneficiaries are the same. For spending, they would not affect federal program spending relative to current law. For the beneficiaries they are expected, together, to improve the quality of care for beneficiaries.

However, the provider implications of draft recommendations four through seven do vary. For the two

recommendations aimed at -- CMS would do the research on improving home health adverse event measures, and they would also develop the strategy for linking Part D data with physician claims. So those two have no provider implications.

However, the recommendation requiring hospital coders to identify which secondary diagnoses were present on admission would increase in some increase in training for hospital coders. The recommendation on reporting lab values would also result in some increase in burden for those who conduct laboratory tests.

DR. WORZALA: I want to summarize quickly our discussions on information technology. Briefly, over for the course of the past year we've found that IT has considerable potential to improve quality as well as our ability to measure it. In addition, greater use could increase coordination of care across settings by facilitating information exchange. There are also some links to improved efficiency for both providers and the health care system.

Despite the potential of IT we know that diffusion is low but growing. This is partly due to the significant

barrier to adoption, which include cost, the difficulty of successful implementation, and misaligned financial fitness.

Given what we know about the potential benefits of IT and the barriers to adoption, what could be done to accelerate diffusion? As we have addressed that question we have kept in mind the constraints on further action which include the riskiness of IT investment, the need to avoid unintended consequences from federal actions, and the fiscal realities that we discussed in our context chapter. When considering possible recommendations we kept in mind the considerable efforts already underway in both the public and private sector and sought to complement those activities rather than duplicate them.

We considered a number of possible actions to accelerate IT adoption organized into three strategies: offering financial incentives, helping providers navigate the IT market, and promoting sharing of health information among providers. I won't discuss all of those actions now as we went through them in December. Just want to highlight a few areas.

Regarding financial incentives, we do have a companion recommendation on pay for performance that I'll

come to in a minute. We had also discussed requiring the use of information technology. We noted that CMS and Congress could mandate use of IT by providers serving the Medicare population. This approach would clearly accelerate adoption of IT. However, given the low current state of diffusion and the difficulties of successful implementation, providers could find a requirement to be overly burdensome. As the market develops, however, requirements could well become appropriate.

On helping providers navigate the IT market, the draft chapter describes the considerable efforts already underway. On promoting sharing of information among providers -- I will come back to the lab recommendation in a moment -- and we also under this heading discussed the merits of a loan fund to support community information exchange projects. We did conclude that at present the administrative cost of a loan fund and the fiscal realities we face outweigh the benefits.

Our recommendation on pay for performance reads, Congress should direct CMS to include measures of functions supported by the use of information technology in Medicare initiatives to financially reward providers on the basis of

quality.

The kinds of measures we're talking about focus on the quality-enhancing functions that are supported by IT rather than the tool itself. I think Karen described some of those. The recommendation recognizes that pay for performance will incentivize IT adoption in three ways: by including measures are supported by IT use, by holding out the incentive for additional quality payments for those who do well on those measures, and by making it easier to measure and report quality.

We're explicit about the inclusion of IT-related measures in pay for performance for two reasons. The first is its potential to accelerate adoption of IT, which we think is an important goal in itself, as well as the importance of IT for enhancing our ability to measure quality. In addition, over time all sectors will probably benefit from greater IT use. Therefore, this particular recommendation applies to all settings in which there is a pay-for-performance program.

We do state in the chapter text that it's important to include IT-related measures in the physician sector from the beginning. This has been done in many

private sector initiatives and also in Medicare under a QIO project. We also note that as IT use grows, measures of IT use itself could be included, as could measures of electronic exchange of information across settings.

The implications of this recommendation; there should be no impact on spending. For beneficiaries, we expect improved quality of care. For providers, there could be some redistribution of payments.

Now I'll circle back to the recommendation Karen presented earlier, that CMS require those who perform lab tests to submit laboratory values using common vocabulary standards, focusing on the use of standards and how that will encourage electronic exchange of clinical information and adoption of IT.

One of the impediments to maintaining and sharing clinical data is a lack of standardization. If labs adopt common vocabulary standards, providers will be better able to incorporate lab data into their existing electronic medical records or data repositories, and use it for their own use as well as sharing it with others when they refer a patient. In addition, we've been told that having access to clinically important data like lab values increases

physicians' willingness to use IT systems.

Currently, most labs have unique internal codes for identifying their tests, but vocabulary standards do exist, such as LOINC, which has been endorsed by the American Clinical Laboratory Association and the College of American Pathologists. It is already used as an alternate code set by some large labs and has been adopted by the federal government for use in its health programs, including by CMS.

To adopt the standard codes, a lab would need to map their local codes to the standard, and also ensure that the laboratory information systems can accommodate and transmit the information. While larger labs have begun some of this work, a phased implementation may be needed for smaller labs, including those in hospitals and physician offices.

One final point. While this recommendation is on lab values, use of standards in other clinically important areas like pharmacy and radiology should also be promoted over time.

That's the end of our comments.

MR. HACKBARTH: Let me just start with a few

comments, if I may. I think that this is perhaps the most important thing that we have been working on recently, and there are some formidable challengers for that title. But I think in terms of the capacity to move the health care system in the direction that it needs to go, which is first and foremost, better care for patients, I can't think of anything more important than this.

As I have said several times in recent meetings, I believe that given the challenges that the Medicare program faces, I think one of the difficult tasks before us is to begin distinguishing among various providers based on their performance. They are not all created equal. There is abundant evidence accumulated over the last decade to document that some providers do a better job than others. To continue payment systems that pay them as though they are all performing equally well on behalf of patients is a tragic situation, in my view.

What we have before us now is, admittedly, but a step in the direction that we need to go, and the road is quite a bit longer than just this one step. As we move down the path of pay for performance I have no doubt that there will be an occasional misstep or two where we will do

something that we regret, use a measure that isn't appropriate or whatever, and there may even be some bad consequences of that.

But I think those risks need to be considered in the context of continuing a payment system where we are absolutely neutral or even pay more for poor quality. The costs of that system are enormous and we see the evidence all around us.

So I'm thankful to the staff. You have done a great job in doing the analytic work to prepare these recommendations. I fully support them. I do believe it is important to proceed in a careful, measured way down this path. I don't want to create unnecessary opposition to these very important steps, and I think we have got, not just in the recommendations but the accompanying text, some very important thoughts about how to build support gradually over time for this important initiative.

We have talked often in the last couple years about initially setting aside something like 1 percent to 2 percent of payments to go into the pay-for-performance pool. We have emphasized that that is a first step and that over time we would expect that amount to grow as the measures

improve and broaden. I fully support.

In the first instance here I think it might be prudent on our part to err on the side of 1 percent as opposed to 2 percent in some of these cases. Specifically, what I have in mind is with regard to hospitals and physicians, and the principal issue is the breadth of the measures. If we're going to begin creating this pool out of base payments, we want to be sure that there is a reasonable opportunity for providers to earn the rewards for good performance, and to do that you have got to have an appropriate breadth in the measures.

To some extent we can deal with that by using structural measures that are crosscutting without regard to condition, but I still think it is appropriate to begin with a smaller step there.

When we get to the discussion of the update factors, of course there's also an implication for that discussion; these two relate to one another in important respects, the size of the pay-for-performance pool and the update.

Let me stop there and open it up for questions and comments.

DR. SCANLON: Glenn, I think I agree with about 90 percent of what you said, and the part where we may disagree comes down to exactly which steps we're ready to take at this point in time. I think it is absolutely critical that where the Commission started last year, to start going down this path of paying for differences in the performance among providers.

In some respects it's sad to look at the measures that we're going to pay for, in the sense that we're asking people to do these things which are so basic, and you wonder about. this is what a high-quality provider is. Unfortunately, today maybe that is the case because there are others that don't do even these basics.

Where I have some concerns that I think differ from yours, Glenn, are in terms of how ready we are in specific areas. The first one would be the question of home health. Part of that is the discussion we had this morning, which is about the ambiguity and ignorance that exists about exactly what the benefit is to entail. The fact that we're glad to look into that, we may be thinking about a new payment system for it in the future and I guess I would say I would hold off in terms of doing anything with respect to

pay for performance until we've clarified what we're going to do with respect to home health.

Because even though the current measures may differentiate among agencies, I guess there's a question of, do they differentiate accurately among agencies? In home health you've got a range of agencies, some that are very small, and some that may be specializing in one kind of service versus another. You don't have to provide all services in home health to be an agency. You have to provide skilled nursing and one of the other skilled services. So in that context I worry about the fairness of different measures with respect to home health agencies.

The other area where I have concern is with respect to physicians because I don't think of them as a homogeneous group either. We've got very great differences by specialty in terms of what we expect them to be able to do. I think even going to structural measures doesn't solve the problem. The expectations that we are going to have for IT use on the part of physicians differ by specialty. If you look in our text, most of the things we talk about, the IT use seems to apply more to a primary care physician than it does to some specialists. The question would be, how are

we going to differentiate the reward for different specialties, even on these structural measures that we were talking about?

I would suggest maybe at this point we think about the idea of what the Congress did in the MMA with respect to the chronic care initiative, which is to create a pilot. It isn't a demo. It's something that is being tested but it can go forward without further congressional action if there is adequate evidence that it's working positively and there's a determination made to that effect.

MR. HACKBARTH: Bill, can I just pick up on your point about home health? I share the concerns that you and others stated during our earlier discussion about the imprecision, if you will, in terms of the home health payment system, and the lack of clarity around the product, and all that. I very much agree with that.

Can that not, however, be a reason that it is especially important to begin paying for performance in home health? This actually starts to add definition as to what we're buying in an area where the definition is all too vague.

DR. SCANLON: I think we need to know before -- it

would be like a stab at providing definition with not the certainty that we know we're aiming in the right direction. You mentioned that there is a tie between the pay-for-performance recommendation and the update recommendation. We just this morning voted on an update recommendation that was zero. So we are now talking about, potentially, if we had set aside money for pay for performance, negative rate changes for some segment of the industry, and I think that may not be fair for some portions of the industry, but not because of anything that they've done. It's because we don't understand the services that they're providing, and we haven't captured it.

Our discussion of this says, things could be developed. I'm just not optimistic at this stage that they're going to be developed in time.

Some of the issues that we talked about this morning about post-acute care, and the differences among providers, and how we could potentially deal with things in common, and maybe we could affect some substitutions among them, these have been discussions that have been going on for over a decade, and we haven't cracked the nut yet. We haven't solved these problems. We still are, in some

respects, at a loss when it comes to describing what happens in post-acute care for every type of provider.

That's why I think we need to do more work here before we, in some respects, take this live and say, this is the pay-for-performance system, let's move forward, because it's not ready to specify and rely on future refinements. I think we need to work harder for the initial definition.

MR. BERTKO: I'm going to add my strong support to pay for performance. Again, I think the staff has done a terrific job on giving you the status quo.

I would then like to add to it that I'm a little more optimistic than Bill on some of the measures, and I'd like to speak specifically to some physician work that I know Arnie and I are working on.

First of all, there is a convergence with the private sector for under-65 folks. A lot is going on, and to the extent we can build and have a spillover effect in both directions, I think that's very important.

Secondly, I would like to at least stress that the measures ought to be practical and have a low burden, either on the people reporting them or the ones measuring them.

Now to get specifically to the physician aspect,

just as one of the many -- and I don't know as much about home health, for example -- RAND and others are doing some perfect that is emerging just now. We're working with RAND, and I know Karen or someone has been in touch with them. Let me only report back to you a little bit of pilot results I saw today. Looking at a very large commercial database, we find that as many as 30 specialties can have some reports on them and by mid-year or so, the RAND people should have an answer on how well it works. It's doing something right now.

One of the questions I think we ask ourselves, is it time for MedPAC to make a recommendation like this? There's so much work being done on the private sector that it is worthwhile.

The second part is, are the doctors measured well enough in this case, the physicians. We found that something like 70 percent to 85 percent of the physicians who were actually doing work had enough measurable events as RAND would define them in this particular thing, could show up and have a statistically credible, however the research has defined it, ready there.

So is it done? Does it work? I can't say that

it's done and it works today, but it is so close that I think we will know enough, and Arnie's folks will know enough, and a lot of the Leapfrog and other employers will know enough within the next 12 months that it makes sense for us to say, yes, let's move the ball forward on this in a recommendation because there is a process time with CMS to get this stuff done. So I would strongly urge us to say, move forward.

Thank you.

DR. CROSSON: I support this. I think this is an important report. I feel like I am standing on the dock in Spain 500 or 600 years ago watching the Nina, the Pinta, and the Santa Maria sail. The fact that there's three staff members here is just an accident. Of course, we also are armed with the knowledge that Columbus and his friends go there in the end, which I think is helpful in this regard.

DR. REISCHAUER: And they spread smallpox and killed all the native population.

DR. CROSSON: Bob, I was just staking out the metaphor ground.

I'd also like to compliment the staff on the report, particularly for two things. Number one, the

comprehensiveness of it, given the nature of it. And also the success at marrying the two issues. That is, pay for performance and the use of clinical information technology, which is very important. Because ultimately, I think we're going to find as it pays out, that a lot of the initial activity is prologue for another set of activity once we have more ubiquitous information, clinical information technology, when in fact issues like the breadth of measures, the problems with risk adjustment for outcomes, and the cost of doing all of this is going to improve a lot. So I fully support the report.

I particularly support the parts that suggest that the process of pay for performance should be linked progressively to the implementation of clinical information technology because I think that's really where this ends up.

Thanks very much.

DR. NELSON: I also support the notion of pay for performance, and in the past have been a supporter of not just rewarding when a laboratory test was done, but making sure that the laboratory test was consistent with quality improvement. But I have concerns about the requirement in recommendation six that require lab results to be reported

across the board. Let me give you two reasons for that.

The first goes to the ubiquity of the physician office lab and what an intrinsic part of practice it is in primary care for his or her practice. I am reminded of a visit to the United Kingdom some years ago, when visiting a general practitioner's office there was a centrifuge and a microscope with cobwebs on them that were not used anymore because the health system didn't pay the physician for providing that service in the office. Consequently, they didn't. So the patients had to go across town to the hospital to get simple laboratory tests that our patients are used to receiving the results of almost immediately, whether it's a urinalysis, a strep screen, prothrombin time monitoring for anticoagulation; the simple tests that are part and parcel of every primary care physician's practice that are done in office and done quickly, and acted upon while the patient is there, rather than the patient having to go to a commercial lab and perhaps wait till the next day for results.

That is such an important part of practice, and yet it is, in some of strain already with CLEA requirements and relatively low payments, and so many practitioners are

up in the air about whether to keep their office lab open as a patient service now. If we require them to go back and collect enormous amounts of results that may or may not be relevant at all to pay for performance, that could easily be the additional burden that leads them to say, to heck with it, I won't offer lab services. If my patient needs a hematocrit, if they have a go across town to get it, too bad, that's not my problems.

The second reason relates just to the huge amount of orphan data that will be collected and input in some fashion, largely from office labs. To some degree it's less of a burden with commercial labs. But all of these orphan data that are not part and parcel of anything we're measuring. They just happen to be a lab result for which Medicare made a payment. It obviously was important to the care of the patient but not necessarily to evaluating the performance of the clinician.

So I believe that this recommendation either ought to be just contained within the text of the report and not as a recommendation, or it should be modified in a way that at least we ask for a list of laboratory results to be developed that do have a direct relationship with payment

for performance. If we want to know what blood sugars are, or hemoglobin A1Cs, or cholesterols or other things as part of monitoring performance improvement, then we ought to ask for those things and not ask for every perhaps irrelevant laboratory test.

MR. HACKBARTH: So focus that requirement as opposed to make it. Any reaction to that?

MS. MILGATE: We haven't done an analysis and I don't know if anyone has of what specific lab values could be linked with currently available measures. Clearly, as measures evolve for physicians, that set of whatever we might currently use could grow.

We had considered at one point in time whether it would be possible to identify those and then just require those particular ones. I guess one of the thoughts we had was that that might even be more difficult because then you are actually asking a lab to distinguish. You'd give them a list of what they need to report rather than just having a process where they would link the claims with the clinical data. They'd have to then distinguish between the values. So that was just one thought. But we don't know exactly what percentage of lab values are already embedded in the

definitions of certain measures.

MR. BERTKO: I guess carefully, repeating again, let's keep the burden down, but there is some link, as yet not completely understood, between resource use and quality. I understand what Alan said about the small offices, but every lab test that Medicare pays costs money and at this point I think it might be both easier, as Karen indicated, to collect as much as possible rather than try to distinguish which are important and which are not.

MR. DeBUSK: I'm just wondering from the standpoint of the volume of paperwork, these lab tests now, what percent of these could be done electronically, could be submitted for payment, do we know?

DR. WORZALA: Almost all lab claims are now submitted electronically to CMS. What we're saying in this recommendation is you would add the lab value to the claim for the lab test, so it would become part of the same data stream. So there is not a separate data stream to CMS. It's still the same data stream. You're just pulling these values off the claim and analyzing them for the purposes of quality measurement.

DR. NELSON: But the lab result is not currently

on the claim.

DR. WORZALA: That's correct.

DR. NELSON: Somebody has to go back after that test is completed or whatever, locate it, find it, match it with a claim, and then submit it for payment, if indeed we required that.

DR. STOWERS: Which would delay payment.

Glenn, I also am absolutely, as you know, for payment for quality, and it's a very good chapter. I just having this nagging thing in the back about how we are approaching this in somewhat of a silo approach from the volume control issues that we have over on the other side, or the efficiency of medicine. We have a silo here where we're talking about paying more if certain tests and parameters are met and that kind of thing, and over here we're looking at the volume of x-ray services and other things like that.

I can very easily in the practice just run all the tests and meet these of things. But the other side of the coin is, it has to be done in an efficient manner. So I really think somewhere down the line we're going to have to get to physician payment that relates both to efficient

health care as well as meeting the quality parameters. I know that has happened a lot in the private sector, but we seem to be going down a pathway that maybe someday these two will come together. I'm wondering if early on we ought to be going down that thought process or connecting these two together.

MR. HACKBARTH: I absolutely agree.

DR. STOWERS: I know in fee-for-service it's more difficult to do that, but we've got to be thinking that way sometime.

MR. HACKBARTH: I absolutely agree that that is the objective to which we need to go. In reading the rewrite of the chapter, early on it talks about where we want to go, as we requested at the last meeting, gives us a better sense of the road map, I think.

I for one, and I suspect Arnie would agree with me, we could even strengthen that language further. The Holy Grail for me is that we get combined efficiency and quality and longitudinal measures, so that we're not looking at just narrow pieces of care, not just the hospital admission but also a sense of what went on before and after, and we reward good performance on a combined set of

measures.

Now the tricky part is how you get there. In fact Nick I know is another person that agrees on this. And the importance of bridging some of our existing payment silos in Part A and Part B is another part of that task. So directionally, I think we're all headed in the same place. I think the steps that are recommended here are consistent with going in that direction and probably as fast as we can get there. But I'm open to thoughts.

DR. WOLTER: In thinking about all this it's good to hear how far along RAND is coming, but I think practically speaking, some of what Bill pointed out is going to be true. There's going to be, potentially, a somewhat uneven rollout of where the early opportunities are and where the early information. I wonder if we should be acknowledging that in the text, that there may be places to start that are riper than others, which would mean that they wouldn't necessarily involve all physicians in the first wave of this.

In that regard, one obvious spot would be to involve those physicians who are involved in the hospital measures which, as narrow as they are, are relatively

speaking, pretty well developed. Or on the outpatient side, do we want to pick very prevalent, high-cost chronic diseases like diabetes and have some of the early work occur there? That might make a lot of sense.

There's a little bit of tone in the chapter suggesting that all physicians are somewhat equally ready, and I'm really not quite sure that is true. So we might want to think about that in terms of the text.

Then just to pick up on a couple of the other comments that have been made. We really should connect some of the dots in this work. One would be physician measures that connect with the hospital measures. Another would be the gainsharing conversation, where certainly any approach to gainsharing might link to these payment areas for physicians and hospitals, and then focus on efficiency as well as on quality. You could see a lot of this coming together over the next several years.

Then lastly, and this has come up at several of the meetings, I think 1 percent of the standardized amount for hospitals is a pretty big incentive. I don't think it's much of an incentive on the physician side. So whether we'd want to think about that or not would be a question.

MR. HACKBARTH: Nick, would you just elaborate on that, why you think it is substantial for hospitals and less so for physicians?

DR. WOLTER: If you're a hospital with $100 million of Medicare inpatient net revenue and you are at a 3 percent margin, 1 percent of that inpatient revenue is one-third of your Medicare inpatient margin. Whereas, if you're a physician earning $150,000, 1 percent of your Medicare revenue will be whatever your Medicare mix is, and then only a percent of that, and it will be a vanishingly small part of your own individual income. The magnitude is just quite a bit different.

MR. HACKBARTH: Although what we have heard from many physicians is that they feel that the growth in their income has been tightly constrained, so it feels like their personal profit margin, if you will, has become quite small. That they are being squeezed by lower rate increases on the payment side, and rising costs. Although it's, strictly speaking, not the same thing as the hospital margin, psychologically it may not be that much different. You're closer to this, obviously, than I am so I take what you say very seriously.

DR. WOLTER: Just on that really quickly. I think that physicians are reluctant to see yet another thing that limits their Medicare revenue, and particularly with the SGR problems that they're so concerned about, so that is exactly true. But really as a percentage of their income, I don't know how much 1 percent will get their attention. They may just see it as another irritation rather than an incentive.

MR. HACKBARTH: Just for the sake of clarity and for the benefit of people in the audience who haven't followed all of our conversations on this. We talk about 1 percent or 2 percent as a first step. Now how big an incentive that is is dependent on the rules for paying out the pay-for-performance pool and how many people qualify.

We have, I think appropriately, avoided trying to write the payment formula to say how stringent the tests would be and how many would qualify. We have simply laid out broad guidelines instead saying that we think there ought to be rewards for both absolute high levels of quality and rewards for improvement.

My own notion of this, however, is that we are probably talking about less than half of the providers in a given category qualifying for pay-for-performance payments.

So if you're talking about spreading 1 percent over one-third of the population, there is a leveraging effect. And you're talking about the average in the pay-for-performance pool being a 3 percent additional payment. It's because of that I think that as a first step, again, it's enough to get people to sit up and take notice potentially.

DR. REISCHAUER: Just to add to that. Our discussion has always assumed that as the information and data and mechanisms for doing this fairly and accurately improved, the size of the pot would get bigger and bigger. So this is more initially a signally device that we're serious, we're moving in this direction and you'd better begin to play the game.

DR. MILSTEIN: I'd like to join some of the previous comments that staff, I think did a wonderful job of balancing some of the consideration pro and con that have already been raised, and I certainly empathize and believe there is validity to one set of voices that is saying go slow, and the idea of, first, do no harm, not only in care but also in policy. And using Bob's metaphor, we don't want to spread smallpox

But that said, I do think it's time to let the

ship embark, and from my perspective there are three reasons. First, related to just the magnitude of the opportunity cost of allowing the current equilibrium to continue. If you believe the Institute of Medicine's report just on safety alone, during the course of this discussion about 10 Americans will die, and a substantial fraction of those will be Medicare beneficiaries related to the current equilibrium which we have not incentivized quality.

If you take a bigger perspective in thinking about Dave representing Medicare beneficiaries, we do have RAND research published a while back and largely forgotten that with respect to the chronically all, which is what mainly challenging Medicare patients, something like one out of seven patients with a chronic illness is actually functioning in life at a substantially reduced level due to flaws in the quality of their treatment. Not an insubstantial number when you multiple one in seven times all Medicare beneficiaries.

In essence, to build on Bob's metaphor, we've already got smallpox. The question is, what we do to treat it?

The second reason I think it's time to embark is I

do think we do have a good enough starter set to go forward. Whether it's good enough, really in my experience in the quality debates that have raged over the last 10 years, really depends on which side of the quality equation you're on. If you're being judged, we're not ready. And if you're in the position as a consumer or a beneficiary of flying blind with respect to quality, 51 percent accuracy is better than the current equilibrium. And we have many measures that well exceed 51 percent accuracy and point you in a better direction.

In addition to supporting the idea of a very temporary bridge using IT measures, which I think is a great idea as long as that's a very short-term solution. Also I want to support Nick's suggestion. It think it was an excellent suggestion, with respect to those specialties that are more inpatient focused, like surgery, for an interim period letting their performance measures, which are currently largely absent and not developed, ride with the hospital measures of the facility with which they are affiliated with respect to what is largely surgical or procedure care that is specific to the specialty.

Last, the other reason we need to let the ships

embark has to do with the fact that for the poor people within hospitals and within physician groups that are trying to actually seriously manage quality, the cost of the tools to seriously manage quality, which involves bringing in engineering talent in addition to IT, is way beyond non-zero. It's significant. You can't do it without some kind of funding rationale.

I agree with the point that with respect to some specialties we have to wait a little while before we begin to open things up in terms of a larger percentage of money being linked to performance. And I certainly endorse the idea of starting immediately with best available efficiency measures. Affordability of Medicare, I don't know whether it's the issue of the day but it's certainly near the top, and courtesy of very well respected researchers like the team of Dartmouth, we have at least a starting place.

My feeling is, yes, there are some specialties where we don't have specialty measures. But if you look at those progressive specialties that have moved forward to come up with good performance measures, Society for Thoracic Surgery, American College of Cardiology, it didn't take them 10 years to put it together. They put it together,

particularly if you're talking about process measures, they put it together in 18 months if you look at the groups like the urologist and the ophthalmologists.

So I think if we have a period where we say, don't push down on the accelerator quite so hard, let's link that to a time fuse and give the specialty societies a reasonable, but not infinite, amount of time to come up with version 1.0 for that subset of specialties for +which we don't currently have good measures.

On the lab tissue and Alan's point, for me that's a challenging issue. I agree that access to laboratory tests and physician offices is a major matter of patient convenience. I thin, it has to be balanced by the fact that it is indeed a threat to patient health if results from lab values are not available electronically right away the next day when the patient shows up in the emergency room. So Alan could probably guess which side I lean on that, but I would say I agree with Alan's point about the cost but I think it's time to move forward. Our ability to measure quality would be so much better if we did have electronic laboratory feeds from all those who were administering lab tests.

So bottom line, I guess I'm saying I think it's time to signal, I think via a majority of our updates for the foreseeable future, that it's time to start treating the smallpox. If you look at this in a frame of reference, last year, as we've talked about before, the U.K., another industrialized country looking at pretty much the same equilibrium and pretty similar quality numbers, decided to put 18 percent of primary care physicians into a pay-for-performance pool, and we're arguing about whether it should be one or two points. I think the earlier point is right, more is better than less.

And framed against a very reasoned U.K. decisionmaking, I just think my notion would be to make a general comment like, a majority of the update, at least for physicians and hospitals, until such time as the smallpox epidemic begins to be measurably reduced. Because we don't really know how much it's going to take for quality management to be much more heavily prioritized within physician offices and hospitals.

DR. SCANLON: I was very positively impressed by the U.K. case, but it's exactly that case that bothers me, which is the U.K. made this change for their primary care

physicians. I think that may be totally appropriate. It's the issue of extending it further to all physicians, and in some instances having to stretch beyond some level of reasonableness in order to do that. If we could focus on some specialties, then it's very, very different. As Nick has indicated, we're not ready on all of them.

DR. MILSTEIN: I think we're in agreement. My notion would be for those specialties where we're just not there, let's in the interim let it rest on structural measures such as IT implementation as specified by the certification commission established under MMA in terms of what constitutes robust level of functionalities. But let's attach a time fuse to it so that within 24 months the specialty societies are motivated to come up with something we can use.

MR. HACKBARTH: Let me just elaborate. The recommendation we have on physician pay for performance is very simple. It just says, proceed. What I had envisioned was that in the text we would go a bit further, and my own thinking on this is that initially we might start with the structural measures that cut across many, if not all, specialties. Then concurrent with that, basically say that

we believe that we ought to be moving towards condition-specific measures of performance with some haste, and basically put the various specialties on notice that that is the plan.

I agree with Arnie that maybe we ought to be quite specific about that interval and create an incentive for specialties to come to the table and say, yes, here are the appropriate measures for our specialty. And the implicit incentive for them to do that is the possibility that we will start reducing payments across the board and if their specially doesn't have measures then they just get the reduction and not the potential gain. So you want to light the fuse, bring people to the table, create an incentive and an opportunity. As Arnie said, there is evidence that specialties can, with some dispatch, come up with an initial set of measures that would work for their specialty.

That's the dynamic that I would like to see described beyond the simple recommendation, proceed with pay for performance with physicians. So I welcome reactions to that.

MR. SMITH: Arnie said a lot, and you earlier, Glenn, said a lot of what I wanted to say. A couple of

observations. I think we ought to be modest not simply about what we think these relatively modest starter set measures can achieve, but we also ought to be modest about where we think there's enough power in this equation to drive behavior. We are assuming that some very small number, 1 percent distributed over half the population of physicians, not only will get us quality improvement, but it will get us investment in IT. Let's an awful lot to get out of what I think -- I think Nick was right -- it feels like a very small number. But this is, as you said earlier, this is breakthrough stuff. We ought not to try to break through beyond what we know.

I do think we ought to strengthen the signals in the text. The discussion of maybe it would be a good idea to make IT adoption a condition of participation, that text on page 49 could be strengthened. The introductory text which talks about ramping up, beginning at 1 percent or 2 percent, or as you've taken us to 1 percent, but signaling clearly that we intend to ramp this up, both as we know more and as the system has more opportunity to accommodate it.

I think starting where we want to start -- I think the staff has done a -- or where the recommendations would

have us start feels right. But sending a signal that this really is a point one status and there are more versions to come, and we expect them to come very rapidly. We believe they can come rapidly. We believe the incentives ought to cause them to come rapidly. I think sending that signal more strongly than we currently do would be a good idea.

MS. RAPHAEL: I wanted to speak a little bit about the issue that Bill raised on home health care. And at the risk of having two contradictory thoughts in my mind at the same time, I'm not going to spend a lot of time on how to get there because I think the proposal of using the chronic care improvement program as a model and doing some testing and experimentation here is fine. But I think that we should chart a direction in home health care, as well as begin to think about how to pay for what we value.

While there are questions about the product and the benefit, the fact is that most of the people that we take care of have congestive heart failure, diabetes, CVA, a joint replacement, et cetera, and we know what we are trying to achieve in those cases. We know what the goal is. We know we want to improve their functioning or stabilize their functioning. In addition to which, I think setting a

direction here helps us to move from looking at what we do as a transaction to looking at what we do as managing the case to a good outcome, and how we intersect with the rest of the system. Because in home health care you have a powerful effect on unnecessary rehospitalizations, on emergent care, on the physician interaction, on whether someone ends up in a skilled nursing facility, et cetera.

So I think it's important to begin to chart that direction. And beyond trying to have payment for what we value, I think we do send a signal to a lot of people in a lot of different places about where we're headed. I think we're also uniquely positioned in home health care because, remember, we do have OASIS. We have inculcated a way of, at point of service, measuring function. I think Sharon was responsible for this, you did a good job at saying that we're not there with adverse events. It's too small a sample. We need to do a better job in risk adjusting. The process of care is important, intervening quickly, but we're not there either. But it's the starter kit. I think we should at least begin with some kind of starter kit and maybe test some different approaches here.

MR. DURENBERGER: I think the two figures of

speech I'll take away from this discussion are the Nina, the Pinta, and the Santa Maria, and what Arnie said about three people dying in hospitals while we're sitting here talking about what we're going to do, because that's one way to look at the American health care system. I do this in speeches in Minnesota and I say the same thing, today Minnesota hospitals will kill three of your family members that don't have to die. I wish I didn't have to say that, except that it's a reality.

So my first comment is, I hope that the way in which we write up pay for performance as an imperative doesn't look like the Nina, the Pinta, and the Santa Maria. It really ought to carry with it the sense of urgency expressed in all of the research that you cite, when you look at it as somebody who's lost a family member, or somebody who's going to have an error visited on them or whatever. So that's the first observation. It's all here either in this section or in the update section, there's a lot of patient safety work and stuff like that. So it's all here. I think it's the emphasis.

The second one is, I don't believe we're living in a country in which our choices are the Nina, the Pinta, or

the Santa Maria. I think there is a Concorde at the Barcelona Airport, if you want to look at it that way. It's just that when we look at this as the national system we're inclined to say, we want everybody to take off at the same speed, we expect them all to get to the same destination, called the New World, even though we know ahead of time they're not going to know when they get there if they get on one of those three boats.

So what's the Concorde? There's one of them sitting right over there, Jay Crosson and Kaiser Permanente. You want to combine hospitals and physicians and so forth. It may not be the Concorde, but it's pretty -- so what I'm suggesting is that the gap between where we are, and what we are getting, and where we ought to be, for a lot of people in a lot of communities is not that great, because of the fact that all health care in this country is local. It's not national. We stuck here trying to come up with national measures and things like that.

But there are a lot of people who are getting high-quality care, safe care, effective care, efficient and so forth. Not perfect, but they are getting it. The problem is, the doctors that give it to them, the hospital

that gives it to them are not being rewarded by this payment system. So if we sit here and debate, do we raise them 3.5 percent, I'm thinking, there's a whole bunch of people there who are dragging down the margin. You know what I mean? And because they're dragging down the margin we've decided we've got to give everybody a 3.5 percent increase.

We're doing nothing for the people that are putting $100 million a year into performance or productivity-oriented redesign of hospital systems. and emergency rooms, and all this throughput stuff that you guys do in hospitals and never get paid for, unless the private payers will do it for you.

So the second part of this -- so we're hopeful about getting there more quickly -- that I would love to see is the accent on, there are some -- as we did in our discussion about the physician, what are some of the pilots and things like that, we really do need to tell people that all of these things do not happen the same way everywhere in this country, and for very good reason. Because motivated physicians and hospital systems and people who care about coordinating care and managing care, whatever you want to call it, have actually taken the risk of losing money if

they don't do for it right the first time.

So some way in which to express that there are basically two Americas here. There's one like this and then there's this other one that needs a push and a shove and so forth. Hopefully we will encourage, sort of like speeding up the process of getting from here to there, and when we get there we all know where we are.

And for those who don't know where we're going, there's plenty of places they can go to find out. They shouldn't have to wait for the Secretary to do an analysis of all this information and then educate people on how to get there, because the examples abound.

So I hope that -- I mean, I really am so appreciative of the fact that you've thought about making some recommendations when we get the updates that reflect this difference because we need to begin the process of rewarding the people that are already doing for Medicare beneficiaries what we expect them to do.

DR. MILSTEIN: This is a proposed supplement for consideration of the next version of this. Listening to Dave talk -- and I held my comment during the specialty hospital discussion of improving the payment system because

I thought this comment was really better placed in this discussion. But I think that what we're going to do in terms of the percentage of money at risk in the first year or two probably is not going to remotely offset the costs of those providers that are seriously managing performance. But as we hopefully build up over a period of time we'll finally get to, as we talked about last time, the so-called therapeutic dose.

But I want to say there's also symbolic value in what we're doing. And in addition to -- to push the metaphor way to far -- to letting the ships go forth in terms of pay for performance, there's another thing I'd like us at least to discuss, maybe at a subsequent meeting, and that is to essentially stand up next to the example of one of Dave's insurers in Minnesota and as a form of symbolism say that we do recommend that as of date certain that Medicare's payment system no longer make payments to hospitals and physicians for so-called never events that have been spec-ed out and endorsed by multiple stakeholders at the National Quality Forum. These are things that no health care institution with a modicum of safety protections should ever allow to occur, such as wrong limb surgery.

I think as part of the symbolism, in view of the fact that we're not going to have a therapeutic dose in the first year or two, I'd like to at least consider making that recommendation. Whether it falls within P4P or payment reform I leave to others.

MR. HACKBARTH: Jay, I think you've now surpassed Bob. You have the longest running metaphor of the MedPAC. So you're in the lead. But he'll try to take it away from you.

MR. MULLER: I'm going to stay away from the metaphors because I think we get in a lot of trouble on some of those.

Just listening to the conversation this morning and this afternoon and contrasting it to some of that this morning, we see both the urgency I think -- and Arnie has been very forceful on this, of putting some serious bucks behind whatever we want to do, yet this morning we were looking at, in some of those spreads, 20, 30, 40 percent spreads on profitability, and here we're debating 1 percent. So just noting that in terms of there won't be as many eye bankers resting on this one today as they were on specialty hospitals.

I think, secondly, where we're going, this is important. Listening to Dave Durenberger and Arnie and others, if we're going to focus on, as obviously a very graphic measure, reducing unnecessary mortality, in these settings you go after certain kind of measures where there's a greater likelihood of reducing that.

On the other hand -- and I'm not trying to pose a false choice here -- if you are looking at making sure everybody gets a chance to participate in this process, all physicians, all hospitals and so forth, you have a more diffuse set of measures. And I think we're tempted to do both. We want to have a powerful impact and yet we also want to make sure everybody gets a fair chance to participate in whatever pools we create.

I think part of the thinking on this work as we keep going down this course, and obviously this is a theme that's going to occupy this commission for a long time to come, is to see whether we want to hone that a little bit more in terms of what our policy objectives are in terms of the kind of performance we want out of the health care system. Because, obviously, there is a strong desire on the part of everybody to make sure that everybody gets a fair

chance at some of these quality improvement payments and so forth.

On the other hand, if you think of where the bang for the buck may be in terms of objective measures, especially as we ultimately move more towards outcome measures rather than just the structural process measures, we may have to have a more specific set. I offer that not in the sense of trying to derail anything today, but I do think just listening to the discussion one could go in quite different directions depending on what you are ultimately trying to achieve through the quality payment.

MR. HACKBARTH: Thank you. Let's now proceed to the votes. We have got a lot of very important ideas to include in the body of this chapter. Everybody has had the opportunity to sign up as a reviewer of this chapter. I would just ask that those of you who do, I want to capture these excellent comments, but we do have a schedule that we need to work by, so please closely follow whatever schedule Sarah gives you. Your comments will have a greater likelihood of getting in the final report if you get them in early as opposed to late.

DR. NELSON: Glenn, I was confused about whether

or not you intended to make a relatively broad recommendation for an incentive payment policy for physicians and leave some of those specifics to the text, or whether you want to go forward with recommendation six now, for example. One of those having to do with lab results, the other having to do with drugs.

MR. HACKBARTH: I'm not sure I'm following. So we have the broad recommendation of establishing quality incentive payments for physicians is number three. You have expressed some concern about the breadth of recommendation six with regard to labs. I hear some disagreement.

DR. NELSON: I heard some discussion about being very forceful in our recommendation with respect to pay for performance, but then leaving some of the details about additional data elements and so forth for discussion within the text. Now I'm not hearing it that way, but that was what I wanted clarification on.

DR. MILLER: Are you asking whether to take recommendation six and have it as a discussion in the text instead of a recommendation?

DR. NELSON: That's right. And I do so because we talk about the administrative burden. We had a report two

years on the administrative burden, and I have very little feel on exactly how big the administrative burden attendant to this would be at this point.

MR. HACKBARTH: Frankly, I guess I'm on the side of thinking that this is such important information to develop our tools further that would be reluctant to see it put solely in the text. I would be happy to say that we would like to see it done in a way that is with a minimum burden. I don't, frankly, know enough about the issue to judge whether focusing it on certain types of lab values, as you suggested, is the way to go or not.

DR. NELSON: That's fine. I'll just cast my vote.

MS. RAPHAEL: These three are being added to our previous ones for Medicare Advantage and kidney dialysis; is that correct?

MR. HACKBARTH: Yes. Thank you, Carol. I meant to mention that at the outset. Just so there's no confusion in the audience, last year we recommended a pay for performance for both Medicare Advantage plans and dialysis facilities and physicians. We don't reiterate those in this report. That doesn't mean we've forgotten about them. In fact we do allude to that in the text several times, as I

recall. But, absolutely, those recommendations are still strongly held.

So let's turn to the votes. Draft recommendation number one, which as I recall is hospitals.

All in favor?

Abstentions?

Opposed?

Number two is home health agencies.

All in favor?

Abstentions?

Opposed?

Recommendation three is physicians.

All in favor?

Abstentions?

Opposed?

Number four is including secondary diagnoses, whether they were present at admission, on the claims form.

All in favor?

Abstentions?

Opposed?

Five is urging the development of additional home health measures on adverse events.

All in favor?

Abstentions?

Opposed?

Six is include lab value on claims.

All in favor?

Abstentions?

Opposed?

Number seven is the prescription claims data.

All in favor?

Abstentions?

Opposed?

Now we've got IT, recommendation eight.

All in favor?

Abstentions?

Opposed?

And that's it. Thank you very much. Good work.

Now we turn back to payment adequacy and updates for three provider groups: hospitals, dialysis services, and physicians.

Jack, whatever you can do to help us catch up a little bit I would appreciate. Whenever you're ready, why don't you go ahead.

MR. ASHBY: This presentation will address payment adequacy and updates, along with a payment distribution issue, for hospital inpatient and outpatient services. Before I start, just a moment, at the last meeting we had Tim Greene and Jeff Stensland participating in our hospital presentation. This month we have Dan Zabinski, as you can see. But this is a big enterprise and I just wanted to make note of the fact that two other staff members helped with the research and preparing our chapter. That would be Craig Lisk and David Glass. We wanted to thank them for their participation.

As I said at the last meeting, the evidence is mixed this year for hospitals and I would like to start by briefly reviewing some of the material that shows that from the last meeting.

First, most of the indicators that we use to assess payment adequacy present a positive picture. Access to care remained strong, as indicated both by the number of hospitals participating in Medicare and the share of hospitals offering a representative set of inpatient, outpatient and ancillary services. Volume of services continues to rise. Quality of care results are somewhat

mixed, with improvements on both mortality and clinical effectiveness measures, but with deterioration on some patient safety measures. And finally, access to capital remains strong, as indicated most directly by large increases in construction spending and bond issuances.

But hospitals financial performance under Medicare has declined. The overall Medicare margin fell to minus 1.9 percent in 2003, although we do expect it to rise slightly to minus 1.5 by 2005. By far the largest factor in the margin decline of 2003 was unusually high cost growth, particularly for inpatient costs per discharge. We provided evidence that the rate of cost growth has moderated for the year ending in 2004. We had consistent evidence on that from two sources: a survey of 580 hospitals that we sponsored with CMS and BLS surveys of compensation and employment growth for the industry. Then along with cost growth, policy changes played a significant role in our projection to 2005, including those scheduled for 2006.

To explicate the pattern of high cost growth, we first presented evidence that higher cost growth has resulted from lessening of financial pressure in the private sector. We showed this in three ways. First was over time.

The lack of financial pressure from private payers in the late '80s and early '90s was accompanied by cost growth nearing double-digit levels. That turned around through the rest of the '90s. But then again in the early 2000s, private insurers lost bargaining power due to provider consolidation and consumer preferences for continuing choice of providers. Once again, that has resulted in lack of pressure, and in turn, high cost growth.

Second, we showed that individual hospitals facing less financial pressure had higher cost growth.

And third, we showed that in markets where there is less competition, hospitals in those markets on average had larger cost increases.

Finally, we showed that hospitals with consistently negative Medicare margins have both high cost in the absolute and high cost growth. And that if on order of the one-fifth of hospitals with both high inpatient cost going in and continued high cost growth had held that cost growth to just two percentage points above the market basket then our estimate of the overall Medicare margin would have been positive for 2005 rather than negative.

As we approach the question of appropriate updates

for inpatient and outpatient services, we need to explain two key components in our framework. The first consideration is that we no longer have a technology factor in the update because the MMA introduced a new technology add-on payment for inpatient services which is not budget neutral, and we only had non-budget neutral technology payments on the outpatient side.

Second, the Commission's productivity factor currently stands at 0.8 percent. This is based on a 10-year average of total factor productivity in the general economy.

Most of the factors that we have considered point towards the conclusion that payments are adequate. This starts with the notion that the level of cost increases that we observed in 2002 and 2003 is basically unsustainable. Then there's the fact that private insurers have not been contributing to cost containment in recent year, that the rate of hospital cost growth appears to be coming down, that a minority of high cost, high cost growth hospitals, those that appear not to be efficient providers, have played a significant role in pulling down the industry-wide margin.

Then perhaps most importantly, that our other indicators of payment adequacy, access to care, quality,

volume, and access to capital, present a positive picture. But at the same time, the negative aggregate margin does give us some cause for concern. It leaves hospital with little cushion for dealing with pressures that may arise in the coming year.

Considering all of these factors on both sides, we are suggesting update recommendations of market basket minus 0.4 percent.

Before we formally present those draft recommendations, we want to consider for a moment the interaction with the payment for performance recommendations that you just approved. Payment for performance would result in a larger share of payments going to hospitals with high quality attainment or quality improvement. As Glenn alluded to, we would suggest that the payment-for-performance pool for hospitals be set toward the smaller end of the range which we had previously suggested as 1 percent to 2 percent.

With this approach then the majority of hospitals would end up with a net impact from update in P4P in the range of 2 percent, sending a strong signal to restrain cost growth. But Medicare would also be giving high quality

hospitals a net increase above the market basket, providing a strong incentive to improve quality.

The next slide shows our recommendations, and rather than reading them let me just state for the record that they provide an update of market basket minus 0.4 percent for both inpatient and outpatient payments.

On the inpatient side, the recommendation would increase federal program spending by $200 million to $600 million in year one, and by $1 billion to $5 billion over five years. On the outpatient side, the recommendation would decrease spending by $50 million to $200 million the first year and by less than $1 billion over five years.

We expect no major implications for either beneficiaries or providers.

Now we turn to a distributional issue. Our rural report three years ago focused on the sizable gap in financial performance under the inpatient PPS between urban and rural hospitals. But our projection indicates that the provisions of MMA will completely eliminate this gap once the 2006 policy is in effect.

For outpatient payments, on the other hand, urban and rural hospitals were in rough parity as of 2003, but

rural hospitals' outpatient performance is expected to drop by 2006, creating a gap in performance. That gap would be somewhat larger for the subset of sole community hospitals and other small rural hospitals.

Two policy changes lie behind this development, as Dan will explain.

DR. ZABINSKI: The two special outpatient PPS policies that Jack referred to include the hold harmless payments that sunset at the end of 2005 and transitional corridor payments which sunset at the end of calendar year 2003. This slide shows key features of those two payment policies.

Hospitals that qualify for hold harmless payments under the outpatient PPS receive the greater of payments under the PPS system or the payments that the hospital would have received in the payment system that preceded the outpatient PPS. Currently hold harmless payments are targeted only to rural sole community hospitals and other rural hospitals with 100 or fewer beds.

Under transitional corridors, hospital received PPS payments plus a fraction of the difference between the payments from the system that preceded the PPS and the

actual PPS payments. These payments are targeted to all hospitals that do not qualify for hold harmless payments.

Extending either of these policies would improve the financial circumstances of rural hospitals. But we believe the hold harmless is the better of the two policies to extend because the hold harmless policy targets specific rural hospitals while the transitional corridor is broader, targeting both urban and rural hospitals.

However, the hold harmless should be extended for just one year, through calendar year 2006, because it has some imperfections. That is, hold harmless payments are directly linked to hospital costs so the hold harmless policy may reduce incentives for hospitals to hold their costs down. Also, this policy does not specifically target hospitals with relatively poor financial performance. Consequently, hospitals with very good financial performance can receive hold harmless payments.

To summarize, the advantage we see in extending the hold harmless payments in one year is that it gives time to identify whether some rural hospitals have higher costs for reasons beyond their control. Once identified, policies can be developed, if necessary, to address the problems

faced by rural hospitals.

For example, in MedPAC's June 2001 report we show that low volume hospitals have relatively high cost per case because they cannot take advantage of economies of scale. Most of these hospitals are rural and many are isolated. This is one avenue in the coming year we may want to address regarding hospital payments.

So in summary, we recommend that Congress should extend hold harmless payments under the outpatient prospective payment system for rural sole community hospitals and other rural hospitals with 100 or fewer beds through calendar year 2006.

The estimated spending impact would be to increase federal program spending by $50 million to $200 million for one year.

In regard to beneficiaries and providers, this policy will help ensure access to hospital care among rural beneficiaries and improve the revenue for many isolated and small rural hospitals.

That concludes our presentation.

MR. HACKBARTH: Let me just start with a couple thoughts about the update. Like so many others that we are

dealing with in this meeting, this is a difficult issue and a close call in some important respects. My own thinking about the hospital update is as follows. Using our adequacy framework we see mixed results. We see the low and declining margins that we have discussed several times now. Access stable, capital spending increasing at a rapid clip, and the quality results mixed for hospitals.

An issue that we identified last time was whether Medicare ought to increase its payments to accommodate cost increases that, at least in my judgment, are induced in substantial part by private payment policies. There are other factors as well, as Nick and Ralph pointed out at the last meeting in terms of nurse wages and the like, and I don't want to for a minute overlook those, but in by judgment an important factor in what has happened is private payers, in response to their customers, have adopted configurations, free choice arrangements, no restrictive networks and the like, that have significantly reduced the leverage of private payers in their negotiations with hospitals.

Concurrent with that, there's been significant merger activity among hospitals and at least some markets

that have increased the leverage of hospitals in those negotiations. And we have seen the evidence in terms of payment-to-cost ratios of what has happened as a result of those market development on the private side.

That for me raises the question of can the Medicare program afford to accommodate those cost increases, given all of the many demands that are on the program as it now stands?

In addition, I have been striving to implement our revised statutory mandate which has asked us to look not at the performance of the average hospital, but try to make update recommendations to the Congress based on an assessment of what is required by an efficient hospital. I don't think we've arrived yet at the analytic framework and metrics for doing that.

For me, however, two pieces of analysis have been very helpful innovative in moving in that direction. One is the analysis of the hospitals that have consistently lost under Medicare, and what we found there was that in very important respects they appeared to be poor performers relative to their peer hospitals in the same marketplace; lower occupancy rates, higher costs, higher rates of

increases in costs.

The other analysis I think Jack was alluding to as I walked in from my break, which was that you can also cut the data and look at hospitals that have high costs and high rates of increase in costs, and what happens to your margin analysis if you were to take those institutions out saying they don't meet the congressional standard of efficient providers.

Obviously, in either case, the persistent loser analysis or the latter analysis, it changes your sense of what the average margin is and the average financial performance is in the industry.

For all of those reasons I believe the market basket minus 0.4, coupled with the pay-for-performance program that will increase payments to the best performing hospitals on quality is a reasonable and appropriate recommendation for us to make.

DR. MILLER: This is a really minor technical point. Actually in that analysis, and Jack, just to be clear, it's not removing those hospitals, it's just holding their cost growth to say, two points above the market basket.

MR. ASHBY: We actually gave them a little bit of the benefit of the doubt.

MR. HACKBARTH: Thank you.

DR. MILLER: It's the same concept.

MR. MULLER: The fact that the margins are now minus 1.9 and predicted to be minus 1.5 probably doesn't surprise too many of us after the years we've been discussing this. Since the Balanced Budget Act of 1997 I think there's only been one year in which we've actually had a full update. Am I correct in my recollection?

MR. ASHBY: Market basket.

MR. MULLER: So we've had sometimes freezes, sometimes market basket minus one and so forth, so seven, eight years of that kind of cumulation will in due time lead to margins deteriorating, and that in fact has occurred.

I think some of these indicators of access, such as are hospitals dropping out of the other program, it's such a big step to just drop out of the Medicare program. It's not like an individual physician dropping out. Hospitals really by and large can't survive. So whether one gives as much weight to that as margins I think is not as appropriate.

Certainly, on one of the other measures, the access to capital, certainly it's noticeable to many people that when you can borrow at 2 percent or 3 percent you're going to do more capital accumulation than when the rates are 10 percent or 12 percent. In addition to that, it takes many years, as the chapter has pointed out, to make decisions to expand facilities, and for many years after 1997 there just was not, in the environment of BBA and post-BBA, it took quite a while for hospitals to feel comfortable they can make facility expansions, especially as demand has gone up again.

So I think to me the weight of our adequacy analysis I'd focus much more on the minus 1.9 than I would on some of the other factors.

Secondly, as we look at cost, it may be that there is a more lax environment the last four or five years in the private market, and Mark and I have agreed on that, the atmosphere has been more lax. But as the chapter points out, 25 percent to 30 percent increases in malpractice are not a function of laxness in cost control. There's something else going on in the market. Double-digit growth in drug costs a number of those years is not just lax. And

double-digit growth in imaging, which is incorporated inside inpatient payments and have to be absorbed inside of that, drive up costs as well.

And as you referenced yourself, Glenn, the nursing costs have been growing at least twice the regular market basket over these years, and especially at a time that there has been clear evidence coming out that patient outcomes, specifically around mortality, are worse when nursing staffing goes down or less qualified nurses of there. There's just clear evidence now that Americans want nurses and well-qualified nurses in their hospitals, and if one has to pay 6 percent, 7 percent, 8 percent salary increases to get there, that's a cost increase above inflation. Furthermore, a number of states have followed the California example, are now mandating minimum staff ratios, so there's a regulatory environment there to make sure that there are more nurses in hospitals.

So while there are some cost components that are very much under control of management, the ones I just listed, malpractice, nursing, drugs, imaging, I'm not sure you could argue those are that controllable in this time period. So I think the fact that costs have gone up

considerably more than inflation is not just a function of the private market acceding to these cost increases and being more lax. I think there is some underlying reasons that have driven up the cost in those four categories. I can go beyond it but I don't want to belabor it. So I wouldn't go as far perhaps the chapter has in saying that the cost growth is just because there hasn't been stringency in terms of cost measurement.

The third is, as you noted yourself, there are vehicles for us to reward better performance. We just had a discussion of pay for performance. There's different opinions as to how much to put into that, but we have different policy options that can in fact reward better performance. Pay for performance is one, but we have other policy processes.

It's interesting that sometimes a hospital is called a loser and other times it's called a critical access hospital, depending on what part of the country it's in. Obviously that kind of geography has a lot to play with how hospitals get categorized. So if somebody has low occupancy in the middle of Mary's area it may have one kind of label to it. If it's in a more crowded area it may be classified

as a loser. So I think we should be a little careful in how we use those terms.

MR. HACKBARTH: But, Ralph, it's a different circumstance. If we have a hospital with low occupancy rate and there are lots of other hospitals around, surely we ought to judge that differently than if we have a hospital with no other hospitals around and low occupancy rate. I wouldn't defend for a moment that we've always draw those lines well around the critical access hospitals. But an urban hospital that has a 40-some percent occupancy rate is a problem to me. It's a problem to your institution.

MR. MULLER: No, I agree with that, too, that there are, in certain settings, hospitals that have low occupancy that we should not support in the same way. But those are also not lost to me that those kind of -- the way in which we define critical access hospitals don't always target as well either.

My major point on that is, we have a variety of policy levers that can target those we want to reward as better performing hospitals. The theme that we've taken up most fully in this year's discussion is the pay for performance. That's not the only level that we have. We

have, for other policy purposes, we have DSH, we have GME, we have critical access, et cetera, and I think we should keep reminding ourselves we can't always taken them on in every policy cycle, that those policy levers are available to us as well, and we can use them.

If we really want to start going more down the line of distinguishing between hospitals that provide more value to the Medicare program and those hospitals that provide less value to the Medicare program, we should keep thinking along on use of those policy levers rather than just saying, let's take something off the update because some of that will go to hospitals that are less worth of that kind of update, especially if a lot of these cost pressures, as I've indicated, are very much outside the control of the hospitals.

I therefore conclude in thinking that we should stay with the full update we were talking about last month. I understand the cost pressures that the program is under. It's under many cost pressures independent of this update, such as the additions to the program in a variety of areas in the course of last year. So I think having now moved from margins that were, as the chapter indicates, on the

inpatient side from the mid-teens down to less than five, and on the total margin to negative range, which I think was highly predictable over the last three, four years, this is the time that I think our payment adequacy formula should indicate the need for a full update rather than one that's less than that.

DR. WOLTER: I would certainly also want to emphasize that there are some true cost drivers, in addition to discipline in the private sector, and that's been pointed out. I would say that maybe the tone in the chapter doesn't capture that as well as it might.

I also think that the technology discussion is one that I worry about a little, because although the mechanisms for paying for new technology may catch certain devices and specific individual technology, it's really not addressing the magnitude of the investment in technology and clinical information systems that will needed to improve productivity, improve quality and those things. And I worry that we're suggesting that a technology update for those things is no longer necessary because other things in the program cover that.

As far as pay for performance covering less than a

market basket update, I really don't know what the timing of that would be, nor how it would track to the hospitals that might need that. In particular I guess I worry that there are parts of the country where the ability to cost shift into the private sector is less robust than in some other parts of the country.

In Montana, for example, we have 21 percent uninsured. I think something around 40 percent of all small businesses are able to provide insurance, and that number is dropping monthly. The benefit designs are quite thing, and what's happening is the burden is now being shifted to individual employees as businesses try to deal with the healthy premium increases they have seen on their side.

As I look at the context of the Medicare chapter, I see that over 15 or 18 years, proportionately Medicare costs and reimbursement have gone up at about the same rate as in the private sector, but not always over the same five or six years. Certain one conclusion one might draw about the last five or six years is that the market basket or less than market basket updates going on in the public sector have been part of the driver for faster increases into the private sector.

So I'm quite worried about the recommendation, and I think that the 25 percent or so of hospitals who are positive-negative, positive-negative over the last five years might be the ones most jeopardized by continuing less than market basket updates.

Lastly, I would say that market basket itself, in the face of the cost pressures we are facing, I think creates create a fair amount of cost discipline. Because when you're seeing only market basket update in the face of labor, technology, and malpractice increases that are significantly above that, you really have to work pretty hard to control your costs. So I worry a little bit about an oversimplified conclusion as to what is going on.

MR. HACKBARTH: Since our conversation last week, Nick, I have been thinking about the point that you made about the difference between Montana and a big city in terms of the number of people that have private insurance, and the type of private insurance, and the ability, as you put it, of hospitals to cost shift to private payers.

Stepping back and looking at the big picture here, part of what worries me is that unless we slow the rate of increase in health care costs what's going to happen is that

more and more people get priced out of the insurance market. I think that process is well under way. So more communities become like yours, and fewer become communities that have strong private insurance.

The dilemma that I see us facing is that when, for a variety of reasons, private payers have been forced to back off from controlling costs, if Medicare also backs off -- so my concern is, and this is an oversimplification, but private payers, because of the backlash against managed care have been forced to back off in terms of things that would help stem the increase in costs, that create rising costs for Medicare as well and then Medicare backs away, there is more fuel for the spiral upward, and then more people lose insurance and then we have got a real bad cycle going on.

I don't have any illusions about a 0.4 reduction stopping that, but I am very reluctant to see Medicare back away from this difficult task.

DR. MILSTEIN: The relationship between this recommendation P4P is complex and subtle. One of the things that strikes me as we talk it through is our presumed acceptance of a zero sum game, where essentially if we want to protect the Medicare budget we have to limit hospital

increases. Reflecting back on a comment I made earlier about research that's been -- I'll call it measurement research, applying to hospitals. It is already quite well documented by nationally respected research teams. I wonder if it doesn't point to an avenue by which both hospitals and Congress as a fiduciary of the overall rate of Medicare spending might find converged interests.

I guess what I'm thinking about is, is there a way of providing some opportunity for update relief for any hospital for which there is evidence that over the course of a period of time they have improved longitudinal cost efficiency, using the methodology of measurement defined and well published by Elliot Fisher and the Dartmouth research team? That's an opportunity for gainsharing between Congress and whoever is responsible for federal budget control, and hospitals.

What this refers to is the opportunity for hospitals to document that they have reduced -- for patients who are sufficiently seriously ill to have an initial hospitalization for a chronic illness, that they were able over a subsequent time period to substantially reduce total Medicare spending based on the ability of the hospital and

their associated medical staff to improve so-called longitudinal cost efficiency.

It impresses me as an area of this recommendation that, whether it's this year or maybe next year -- I'll leave it to Glenn in terms of what is practical, but it's an opportunity to link congressional signaling that they want efficient hospitals more generously rewarded. It's an opportunity for both the taxpayers and hospitals to enjoy an opportunity for gainsharing on both sides and potentially emancipate hospitals and Congress from this zero sum psychology.

MR. DURENBERGER: I think that's where I was too. At first I wanted to agree with something Nick said about technology. It strikes me -- and I don't know whether it's still in the report but it was the last time we talked about it -- that because there's this new technology add-on that came out of MMA we can get rid of the technology factor, and I think they were intended for two different purposes. I think the technology factor was there to enable, as Nick already pointed out, the acquisition of support systems, organizational and other systems. So it feels more like apples and oranges.

But what Arnie said I've been thinking about in terms of what I need to do to educate myself, because I think the standard that the Congress is now setting on the efficiency standard needs to be defined and needs to be much better understood so that we can all contribute to its progress.

I would love, for example, to see the statistical array of all the hospitals in America, or whatever it is, the way you spoke about earlier, and with the background of some of the factors that play in, just so I can understand what is going on here.

The second thing is to understand better what I spoke about earlier, which is productivity. I'm not in the hospital business, nor serve on a hospital board, but my impression is we cannot literally save productivity in a hospital except by -- definition of productivity is the same as productivity in the rest of industry. Because while productivity in my mind is everything you do to enhance quality, safety, satisfaction, lower cost and everything from the beginning of the process to the end of the process when you hand it over to the consumer, in medicine it's from the entry point into the hospital by referral, emergency

room admission, whatever it is, to the outcome. There are critical decisions that have to be taken in there, and the way in which those decisions are improved upon from time to time in that whole process, it seems to me enhances quality, safety, efficiency, effectiveness and all of the things that the Institute of Medicine said we should be getting out of the system.

Yet as I said earlier, there are hospitals in this country in communities with growing populations and things like that, that have the capacity to deal with this problem. There are hospitals in Duluth, Minnesota where the population never grows; it just gets older, that don't have this capacity and yet we expect all of them to achieve some kind of a standard of productivity, efficiency or whatever it may be. They don't know all have the financial capacity within. Just look at the Medicare part of it, to do that.

So all I am saying is -- I'm not saying rewrite something, change that. I'm just saying sometime, maybe in the afternoon after a MedPAC meeting I would love to -- I don't know if you'd have to organize it for everybody, but I'd love to go spend some time with the staff and just look at this whole issue of what does the Congress expect by way

of efficiency? Is it productivity? How is it done? How is it different in the hospital system? And what is it that we can do to contribute to that process between now and next year when we come back to look at this process again?

DR. MILLER: I am more than willing to offer to take you through. We've done a lot of thinking and writing and it has shown up in different places on productivity and how we think about it here. Also, Glenn has made references in this meeting to trying to think through different metrics to get at the efficient provider. And I'm more than willing for all of the staff to sit down with you and crank through all the pieces on that and put it in front of you so you have a good sense of it.

DR. REISCHAUER: Just to remind everybody that there is no assumption that the 0.8 relates to the hospital sector. It's the economy-wide, multi-factor productivity average over the last 10 years, and for lack of ability to measure it in hospitals we are just assuming that it is achievable. And to the extent that it is not achievable, we pick it up in later years when we analyze the adequacy of payments. But there could be other factors that make payments adequate that in fact don't relate to productivity,

so it's a little bit squishy.

I just want to pursue Nick's observation about the situation in Montana and ask Jack whether the information in his analysis doesn't, in a sense, make this partially self-equilibrating, in the sense that you have estimated that the lower the margin on non-Medicare business -- in other words, uncompensated care, private payers, whatever -- the slower the growth of Medicare costs.

MR. ASHBY: Right.

DR. REISCHAUER: And yet we provide an update that is uniform across the country, so in year two that group is relatively better off than those who are in the areas where, in a sense, the non-Medicare margins are higher.

MR. ASHBY: That is indeed what the analysis found, but it is suggesting that some communities have been able to live with lower rates of cost growth, and we have no evidence of adverse outcomes of that. In communities that have chosen to input their own resources to support a higher increase, I guess the implication is they can't be something that Medicare can control. But remember the other side of it, the other communities made do with the lower rate of growth when there was pressure to do so.

MR. HACKBARTH: Jack, also we looked at the relationship between competition in markets and costs and rate of growth, as I recall. My recollection of the finding was that where there was more competition we found lower costs and lower rates of growth. So to the extent that communities like Billings tend to have fewer competitors -- I'm not saying this is necessarily true for Billings in particular, but the general direction of the effect is for them to have higher costs and higher rates of growth if there are fewer competitors.

MR. ASHBY: Right.

MR. HACKBARTH: Any other questions?

DR. CROSSON: Yes, just to note as we proceed towards a vote that actually this will be the third vote on hospital payment that we will be making today, not the second. The report already talks about the interface between the issue of cost management and efficiency and pay for performance. But actually what we called earlier the specialty hospital issue, when we reflect on the first recommendation, it has a much broader effect than just on specialty hospitals.

So if you put the three together, I think it

presents a somewhat compelling story of rewarding not only efficient hospitals and those that have cost management in place, those that are able to demonstrate higher quality, but also those that serve broader community service needs as opposed to only serving those service needs which have high margins. While these are three separate issues we've taken, I think at some point in the text it might be useful somewhere to put them all together and paint a picture because I think it is a compelling and responsible picture.

DR. WOLTER: Just will quickly, I would be remiss if I did not also make my annual comment that I do worry about the issue of outpatient versus inpatient margins. I know we have moved away from that because of the so-called accounting issues, but over time if we find ourselves not paying attention to one area growing increasingly negative, we may find that incentives change and site of care decisions get made that aren't the most appropriate. So I'm concerned if that totally falls off the radar screen over the next few years.

MR. MULLER: DURENBERGER: Let me just add one thing. With the big drop in inpatient margin shown, there is hardly anything left in the inpatient margin to deal with

the accounting issue as Nick referenced it. Basically we've always argued, or Jack and others have argued there's enough cushion in the inpatient to cover the rest. There's not much cushion left in the inpatient because the inpatient margin has gone from 15 percent in 1997 to, it looks like about 2 percent in 2003, so there isn't much to shift out of there any more.

MR. HACKBARTH: But just to be clear, I don't think that Jack's argument has been that there's enough in the inpatient to cross-subsidize the outpatient. I think the point has been, the only way to fairly assess, given concerns about accounting practices, is to look at the integrated cost, inpatient and outpatient, compared to the combined revenues inpatient and outpatient.

MR. ASHBY: Whether there's enough money in the system.

MR. MULLER: Let me state it more clearly then. That with the so-called accounting issues where the argument is there's an incentive to transfer overhead to those areas outside of the PPS inpatient to the outpatient which only went PPS three or four years ago, the argument always was more overhead was shifted to the outpatient and therefore

the outpatient looked worse than otherwise would. That's what I meant.

MR. HACKBARTH: I didn't want to quibble with you, Ralph, but I just wanted to make sure that we weren't endorsing a policy of cross-subsidization, but rather trying to figure out the fairest way to calculate costs and revenues and I think that's a bit different.

Before we proceed to all our votes let me just spend a minute on recommendation three on the hold harmless for rural hospitals. I remember that when we did the rural report in June 2001 we spent a little bit of time asking the question whether there was any reason why outpatient PPS should not, could not apply to rural institutions, and we raised some of the questions that Dan alluded to about economies of scale and the like, and at least to the best of my recollection I don't think we've ever gone back to those.

MR. ASHBY: Right.

MR. HACKBARTH: So I think from my perspective, the spirit of recommendation three ought to be not just that -- because it has rural attached to it we say, let's pay them more money and forget about it. I would only want to do three if we really intend to go back and think there are

some meaningful issues about the appropriateness of outpatient PPS and whether there ought to be adjustments made. So if in fact we have a serious intent to do some more work on it, let's say we will buy a year of time with this. But if we don't think there are any real issues there, I don't want to just throw money at it to make it go away.

DR. MILLER: Actually what I was going to say is, we have a couple of things underway which are behind-the-scenes because we haven't gotten enough done to bring it forward, and they've probably gotten a little behind where we were going. But we're building some models to do some simulation to look at the outpatient and see if that can lead us down the road to revisiting the outpatient PPS on a more broad basis of looking exactly at what's bundled together and how the payments system works. Having the staff behind us is really complicated because I was looking for some eye contact here. Is that about right, Chantal?

DR. WORZALA: Yes.

DR. MILLER: Chantal says I'm okay. So that's been churning in the background. It's been in fits and starts, given some of the work flow, but we do in fact have

that intent.

MR. MULLER: Just a procedural question on the voting. The recommendation up there is at market basket minus 0.4. I don't want to vote against that if that's the only one that's up there. I would rather vote on a market basket. Is there any procedural way of dealing with that, or would you rather not deal with that?

MR. HACKBARTH: I'd rather vote on this draft recommendation. So on recommendations one and two. This is one and two because it's inpatient and outpatient?

MR. ASHBY: Separate payment systems, so you have to have separate updates.

MR. HACKBARTH: But we think of them together. I think we ought to have one vote on the two.

DR. MILLER: Yes, I think that makes sense.

MR. HACKBARTH: Right, for all the reasons we just discussed. So it is recommendation one/two.

All in favor?

Abstentions?

Opposed?

Thank you.

Then we have recommendation three about the rural

hold harmless for outpatient.

All in favor?

Abstentions?

Opposed?

Okay, thank you.

Next is payment adequacy in updates for dialysis services. Whenever you're ready, Nancy.

MS. RAY: Good afternoon. This is our third discussion about the adequacy of payments for outpatient dialysis services.

During today's session you will be asked to consider and vote on the recommendation about updating the dialysis payment rate, the payment that facilities get for providing a dialysis treatment, also referred to as the composite rate for calendar year 2006. At the end of the presentation we will quickly review some of the issues concerning the new legislative and regulatory changes in dialysis payment policy that we anticipate looking at in the coming months. And there is our agenda.

I would just like to highlight some of our findings of our payment adequacy analysis that we have already presented to you. Our adequacy framework considers

the volume of services furnished by providers. For dialysis we look at it in terms of spending because it's a common metric for both composite rate services and dialysis injectable drugs.

In total, spending has gone up 10 percent per year between 1996 and 2003. Spending is increasing faster than the annual patient population growth of 6 percent during this time. This growth is driven more by drugs than by spending for composite rate services. Spending for composite rate services is increasing slower than drugs. That's because composite rate services is a function of the growth in the patient population. CMS generally pays for only up to three dialysis treatments per week.

Epo spending is a function of both the growth in the patient population and the number of units furnished. And spending for other dialysis injectables is a function of patient growth, units, and price. Pre-MMA, other injectables were paid 95 percent of AWP.

Moving to our comparison of Medicare payments to providers' costs, we examined the appropriateness of cost by looking at trends in cost growth for freestanding dialysis facilities. I would like to just review a couple of points

we made last month.

Per treatment cost for composite rate services furnished by freestanding dialysis facilities increased by 2.2 percent per year between 1997 and 2003. By contrast, the growth in input prices as measured by CMS ESRD market basket grew 2.6 percent.

I would like to point out that the 2.2 percent average annual growth rate between 1997 and 2003 is an average. There is significant variation in the cost growth among providers. Per treatment costs increased by 0.3 percent per year for facilities in the 25th percentile of cost growth. By contrast, costs grew 4 percent per year for facilities in the 75th percentile. Again, this is between 1997 and 2003.

So let's turn to the aggregate Medicare margin. This includes payments and costs for composite rate services and drugs for freestanding dialysis facilities. This is our final calculation of the 1999 and 2003 margins and our final projection for 2005. The aggregate margin was 7.6 percent in 1999 and 4.2 percent in 2003. Our final projection of the 2005 margin is minus 0.03 percent, a small change from what I presented to you last month which was minus 0.2

percent.

Between 1999 and 2003, the majority of facilities had positive margins; 67 percent in both years. Only 8 percent had negative margins in both years. The decline in the margin from 2003 to 2005 is a function of two factors. First, the composite rate payment was not updated in 2004. And second, it's the impact of the MMA. The law and the regulation result in shifting dollars from freestanding facilities to hospital-based facilities in 2005.

To be clear, the MMA updated the composite rate in 2005 by 1.6 percent. The impact on both composite rate and injectable drug aggregate payments is 1 percent, because composite rate services are roughly 6 percent of the total. But for freestanding facilities, CMS estimated the impact on payments, that payments would increases by 0.4 percent in 2005.

So I would just like to review our market factors that we discussed in October and December as well as today. To review, access to care appears to be good. Capacity has increased. The number of hemodialysis stations grew 8 percent per year between 1993 and 2003 compared with the patient growth of roughly 6 percent per year. Volume of

services is increasing, and access to capital appears to be strong. Per unit cost growth for composite rate services is moderating. This evidence suggests that payments in the aggregate remain adequate in 2005 to cover the cost of efficient providers.

Moving to the second part of our framework is changes in providers' costs in 2006. The CMS ESRD market basket estimates input prices will increase by 2.9 percent.

So this leads to our draft recommendation, that the Congress should update the composite rate by the projected rate of the increase in the ESRD market basket index less 0.4 percent for calendar year 2006. This recommendation includes half of our goal for productivity because of the uncertainty in payments due to changes in law and regulation in 2005.

Moving on to implications then. Because there is no provision in current law to change the composite rate in 2006, this recommendation will increase federal program spending relative to current law by between $50 million and $200 million for calendar year 2006.

In terms of beneficiary implications, it will increase beneficiary cost-sharing. No adverse impacts on

access and quality of care are anticipated.

And for providers, it is not expected to affect providers' willingness and ability to serve Medicare beneficiaries.

Now I just want to briefly review again some of the changes that the new law, that the MMA and the regulation do to outpatient dialysis payment policy now that we are in 2005. We are anticipating coming back to you in the coming months with additional work on these issues.

First of all, the MMA makes the biggest changes in dialysis payment policy since the composite rate was implemented in 1983. It pays average acquisition costs for most, but not all, dialysis injectable drugs. It shifts the drug margin to the composite rate through what we call the add-on adjustment to the composite rate. And it adjusts the composite rate for case mix.

I want to clear, again, what the add-on adjustment is. It represents the profit margin associated with all separately billable drugs furnished by freestanding dialysis facilities. So that's both Epo and all other injectable drugs. And it represents the profit margin from erythropoietin furnished by hospital-based facilities. It

will be 8.7 percent of the composite rate in 2005, which is roughly $11 and change.

We have raised certain issues with the payment system in 2005 in your draft chapter and we would like to continue to look at these issues. We think that the MMA has taken a small step in modernizing the payment system in terms of its implementing its case mix adjustment. But the MMA and the regulation has created some problems, and we have raised these in the chapter and plan on continuing to analyze them in the coming months.

First, the law does not bundle the composite rate and injectable drugs, which we point out is a necessary and critical step for modernizing this payments system. The law continues different payment for both composite rate and injectable drugs by facility type. There's differences between freestanding and hospital-based facilities. We have raised concerns about the design of the add-on adjustment in terms of its complexity. We have also raised concerns about the sustainability and the comprehensiveness of the average acquisition cost data as obtained from the IG. And last but certainly not least, payment is not linked to quality in 2005. Of course we made this recommendation in our March

2004 chapter.

That's it.

MR. HACKBARTH: Questions or comments?

Okay, let's proceed to the votes. We're going to pause just for a second to see if we can get Ray in for the vote.

All in favor of the recommendation on the screen for the update?

Abstentions?

Opposed?

Okay. We had just the one recommendation, right?

Okay, thank you.

Next is physicians. Whenever you're ready, Cristina.

MS. BOCCUTI: My presentation this afternoon will be quick, just like Nancy's.

First I will discuss our payment adequacy assessment, which includes a review of access, supply, and volume measures that you have seen before. A new piece of information that I'll present today will be our comparison of Medicare to average private insurer reimbursement rates for physician services. Then I will review the cost changes

expected for 2006, and conclude with the draft recommendation you saw in December for your discussion.

Our assessment from beneficiary surveys on access to physician services finds that the majority of beneficiaries report little or no problems accessing physicians in 2004. A small but consistent share of beneficiaries, however, report having problems, particularly transitional beneficiaries. Those are people who have recently moved to an area or switched to Medicare fee-for-service. We found that Medicare beneficiaries have the same or better access to physicians as privately insured people age 50 to 64 in 2004. Large surveys show slight improvements between 2002 and 2003.

On to supply indicators. Exit and entry analysis shows that physicians who started seeing Medicare patients outnumbered those who stopped seeing Medicare patients. Thus, the number of physicians billing Medicare has increased faster than the Medicare population. So the ratio of physicians to Medicare beneficiaries has increased. Survey data indicate that most physicians are willing to accept new Medicare beneficiaries.

Specifically, the National Ambulatory Medical Care

Survey found that 94 percent of office-based physicians accepted new Medicare patients, among those physicians with at least 10 percent of their practice revenue coming from Medicare. This marks a one percentage point increase from 2002.

We also looked for trends in the number of different patients physicians saw; that is, their beneficiary caseloads. Median Medicare patient caseloads were generally steady between 1999 and 2003. We saw a small growth in several consecutive years, but annual fluctuations through 2003 were less than 5 percent. So our median caseload analysis does not suggest a decline in access.

Finally, participation and assignment rates continue to grow slightly, but both were already high in 2002.

This chart gives you a good picture of volume growth and you've seen it before. Our examination of claims data show that the volume of physician services per beneficiary has continued to grow steadily over several years. Across all services, volume grew about 5 percent per beneficiary between 2002 and 2003. Among broad categories of service growth rates vary, but all were positive. And as

in past years, the volume of imaging and tests grew the most. A few specific services decreased a little in volume, but there is no evidence that the decreases are due to inadequate payments.

Another factor in our payment adequacy assessment includes a comparison of Medicare's payment rates for physician services with average private insurers payment rates. We did not have the data in time for last month's meeting so this is the first time you're seeing the 2003 analysis. As in previous years, we contracted with Chris Hogan at Direct Research to update similar analyses he's done for us in the past. Chris is here today in the audience and he'll be able to answer any technical questions you have, but I am going to review the key findings for you know.

As you can see in the chart there's virtually no change between 2002 and 2003 in the ratio between Medicare and average private payment rates. Averaged across all services and areas, Medicare rates were 81 percent of typical private rates, identical to the 2002 figure. Thus, Medicare and average private fees both rose a similar modest amount in 2002, leaving the ratio of Medicare to private

fees essentially unchanged. So the bottom line is that Medicare payment rates on average are lower than private payment rates, but the difference is much smaller than it was in the mid 1990s and has remained very steady in recent years.

The second part of our framework is to look at changes in costs for 2006. CMS estimates an increase in input devices of 3.5 percent in 2006. This number could change slightly as CMS revises its quarterly MEI updates. As you know, within this total CMS sorts the specified inputs into two major categories: physician work and physician practice expense. Physician work is expected to increase by 3.4 percent, and physician practice expense by 3.6 percent.

This last projection includes an 8.4 percent increase in PLI, which continues to be the fastest growing input cost. However, its share of total expenses is rather low, about 4 percent. You can see here that while other expenses such as employee compensation grew less rapidly than PLI, they take up a considerably larger share of the physician practice input costs.

So with all this in mind here again is the draft

recommendation for your consideration. The Congress should update payments for physician services by the projected change in input prices less 0.8 percent in 2006. The 0.8 percent deduction accounts for a goal in productivity growth as estimated from trends in multi-factor productivity. So drawing on the numbers from the previous slide, the recommendation would update payments for physician services by 2.7 percent for 2006.

In consideration of Medicare spending implications our estimates indicate that relative to current law this recommendation would increase Medicare spending by greater than $1.5 billion in one year and $5 billion to $10 billion over five years. Keeping in mind that current law calls for substantial negative updates from 2006 to 2012 under the SGR. For example, in 2006, the statute currently assumes about a negative 5 percent update. So the reason these spending scores is so high is that any positive update would score as a large spending increase. Over time, however, the SGR would take out this increase and the score over a longer period of time would thus be lower.

Under beneficiary and provider implications, this recommendation would increase beneficiary cost sharing but

would maintain current beneficiary access to physician care and current physician supply for Medicare patients.

Thank you.

MR. HACKBARTH: Questions or comments?

MR. DURENBERGER: I had a question about the interpretation of the ratio between Medicare and private pay. I just don't understand that. It looks so simple but I don't get it.

MS. BOCCUTI: The private payment rates are average across geographic areas and types of services, but they're physician services, so that is an average. Then you have the Medicare average payments, and when you combine --

MR. DURENBERGER: Across all areas, across all services?

MS. BOCCUTI: So what you're looking at with this chart is the percent of Medicare payments to private. So you could look at the 2003, that is 81 percent. So the average Medicare payments are 81 percent of the average private payment rates.

MR. DURENBERGER: Where does that show up on the chart? How do I read that?

MS. BOCCUTI: See the 0.8 as a ratio?

MR. DURENBERGER: Thank you.

MR. BERTKO: Can I make a comment just to generally validate what Cristina has said and Chris Hogan? The numbers, in a general sense, make sense to me in the following way. While there are a variety of private sector payment mechanisms, fee-for-service, capitation, other kinds of stuff, many are linked to Medicare fee schedules these days in PPOs and HMOs. Then secondly, my measure across the industry is that the trend in total per member per month, or per beneficiary spending in the private sector area for physician services only is roughly the same as the Medicare growth rate. So the two are pretty closely linked, so nothing up there would surprise me for the last couple of years.

MR. HACKBARTH: Although my recollection is that this ratio varies significantly market to market.

MR. BERTKO: Yes.

MR. HACKBARTH: So this is a national average.

MR. BERTKO: And service --

MR. HACKBARTH: And service to service.

MS. BOCCUTI: It's averaged across geographic areas and services, but physician services.

DR. STOWERS: We are all confused just a little bit with this chart, the one before it. This is rate of growth in each one of those major procedures, tests, right?

MS. BOCCUTI: Percent growth per beneficiary.

DR. STOWERS: In volume of services?

MS. BOCCUTI: Yes, in the use of services per beneficiary.

DR. STOWERS: To help us, if imaging therefore is decreasing in its rate of growth over the last --

MS. BOCCUTI: It's increasing at a decreasing rate. It grew less rapidly than it did the year before, but it still grew higher than other categories of service.

DR. MILLER: So instead of 10 percent or 12 percent it's in the area of 7 percent or 8 percent.

DR. STOWERS: The difference.

MS. BOCCUTI: Right. It's still growing faster than others.

DR. REISCHAUER: Except for tests.

MS. BOCCUTI: That's true, but it increased at a slightly slower rate than the year before.

DR. MILLER: I recall us discussing this chart, whether it told that story.

MS. BOCCUTI: I was hoping that the cumulative line would help capture it.

MR. HACKBARTH: Other questions or comments?

DR. MILSTEIN: Another comment again related to the linkage between this and P4P. To the degree we allocate more points to performance, and within those performance points we allocate more weight to total longitudinal efficiency, we begin to help both ourselves and physicians who would otherwise be facing negative updates in future years out, because we begin to incentivize physicians to pay attention to, and manage total spend growth in the Medicare program, and thereby create some savings pools by which we can be more generous in the future and help physicians out with this imminent SGR overhang problem.

Do you need to remind me what we recommended with respect to our pay for performance for physicians, whether we did or did not allocate a majority of the update to performance?

MR. HACKBARTH: Again, the recommendation itself simply says, move towards pay for performance for physicians. In the text, the approach, if you will, towards that objective was to begin with 1 percent and focus on the

structural measures that cut across specialties, the ones that are information related.

In keeping with your suggestion about lighting the fuse, concurrently say that the plan is to move towards condition-specific payments drawn from an across-the-board reduction in rates, a broad pool, and urge the specialties to work with the Secretary to develop measures of performance so that they can qualify for that two years hence or some date.

DR. REISCHAUER: Cristina, the spending implication is the implication of changing the physician update for one year, right?

MS. BOCCUTI: There is two, so there's the one year which is $1.5 billion.

DR. REISCHAUER: But we aren't saying -- the policy is one year. The SGR can't recapture really an of that in the first five years because it is maxed out, in a sense, but it will pick up some of it by the tenth year, right?

MS. BOCCUTI: Right.

DR. REISCHAUER: So this is a lot different than if we said we want current policy replaced by this policy

forever.

DR. MILLER: Yes.

DR. REISCHAUER: I just wanted everybody to be clear.

MS. BOCCUTI: The implications are just for a one-year change.

DR. REISCHAUER: Everybody should realize that is why we keep coming back every year to this.

MR. HACKBARTH: Others?

Okay.

On the draft recommendation, all in favor?

Abstentions?

Opposed?

Thank you.

Next up is a discussion of some other issues in physician payment policy.

DR. HAYES: Good afternoon. We are here to review the chapter for the March report on issues in physician payment policy. The chapter includes a section on measuring resource use, and we have a draft recommendation for your review and voting in that section. Another section on managing use of imaging service, and we have multiple

recommendations there. And we're also available to answer any questions you have about the third section of the chapter which concerns ideas for modifying the SGR.

We will begin with the section of the chapter concerning measuring resource use. Before we get into the recommendation itself let me just mention a follow-up item from last month's meeting. There you talked about the administrative burden associated with measuring resource use, the burden for CMS. That, coupled with other activities, such as pay for performance, could put a strain on their resources and we just want to point out that the beginning of this chapter will include a discussion of that issue and the importance of adequate resources for CMS so that these efforts can succeed.

As to the recommendation itself it reads as follows, the Secretary should use Medicare claims data to measure fee-for-service physicians resource use and share results with physicians confidentially to educate them about how they compare with aggregated peer performance. The Congress should direct the Secretary to perform this function.

This recommendation is essentially the same as the

one that you saw at last month's meeting, we just reworded it slightly to improve its readability.

The implications of this recommendation in the area of spending, we could expect that this measuring resource use activity could reduce the volume of physician services over time, but from a budget scoring standpoint it's not estimated to affect program spending relative to current law.

For beneficiaries, we anticipate no adverse impact on access or quality. To the extent that physicians adopt more conservative practice patterns, beneficiaries may pay less in terms of coinsurance and Part B premiums.

Finally, for providers, from the perspective of physicians and providers of services this recommendation has the potential to affect the volume of services that they furnish over time.

MR. WINTER: I will move on to the imaging section. Our draft recommendations on imaging are based on a lot of research by several staff members. This slide summarizes our work on this issue over the last couple of years.

You heard from a panel of experts at the meeting

last March about private sector efforts to manage the use of imaging services. We subsequently interviewed several private plans and radiology benefit managers to learn more about their approaches. We reviewed the literature on quality of imaging services, and programs to improve quality and control volume growth. We commissioned studies of the legal and implementation issues, and we also consulted with several physician specialty groups and organizations that accredit imaging providers.

Here's a summary of the proposed recommendations that I'm going to present this afternoon. The first set of policies are based on approaches being used by private plans. The second set are ways to strengthen the Stark self-referral law as it relates to physician ownership of imaging centers.

Before we discuss the proposed recommendations I'm going to take a few minutes to review the difference steps involved in an imaging service and then address a few questions that were raised at prior meetings.

This diagram lays out the steps of an imaging service and it's the same one you saw at the last meeting. Start from the top, a physician orders a diagnostic test for

a patient. Next, a provider performs the study. And if the provider is paid under the physician fee schedule, they bill for the technical component of the service. Finally, a physician interprets 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. In addition, the same physician who orders the study may also perform and interpret it.

We're going to be discussing policies that would affect different stages of this process.

There were several questions at the last meeting about facilities that sent images to radiologists at a remote location for an interpretation, a practice known as teleradiology. We have done some research on this issue. Some hospitals and outpatient clinics use this process to ensure that images are interpreted when there is no radiologist on site. For example, radiology studies done on emergency room patients during off hours.

Radiologists can bill Medicare for the interpretation as long as they are a Medicare provider and

the interpretation is provided in the United States. Some hospitals used overseas radiologists at night when their in-house radiologist is off duty. The overseas radiologist provides a wet read, or initial interpretation of an image, and is not paid by Medicare. The in-house radiologist does the formal interpretation the next day and is paid by Medicare.

At the September meeting, Arnie asked whether there is research on whether growth in imaging services improves patient outcomes.

Going back to the first box on our diagram, the question is whether studies are being ordered that provide little additional clinical value. There is evidence that certain imaging services improve outcomes. For example, image-guided biopsies and mammography screening.

But does more imaging in aggregate lead to better outcomes? Elliott Fisher and his colleagues at Dartmouth have shed light on this issue. In their published research they have found that large geographic variations in the use of health care services are not associated with better patient outcomes.

At our request they also analyzed whether imaging

services, specifically, are related to better outcomes. They ranked all U.S. regions by the intensity of imaging use, which is similar to their general methodology. They then examined whether long-term survival in three cohorts varied in regions with higher and lower imaging use. The cohorts were beneficiaries of heart attacks, colon cancer, and hip fractures. They found that increased use of imaging services was not associated with improved survival in any of these three populations.

Measuring physicians' use of imaging services should encourage more appropriate use. Our first recommendation for this chapter, which Kevin just explained, deals with measuring the use of all services. Part of this effort should focus on imaging. The unit of analysis should be the physicians who order studies because they determine whether a test is appropriate. But CMS should also look at radiologists' use of services because they can influence what tests physicians order.

CMS would develop measures of imaging volume for a patient seen by a given physician and compare these measures to peer benchmarks or clinical guidelines. CMS would then confidentially provide this information to physicians. The

goal is to encourage physicians who order significantly more tests than their peers to reconsider their practice patterns.

Now will move on to draft recommendation two. The Secretary should improve Medicare's coding edits that detect unbundled diagnostic imaging services and reduce the technical component payment for multiple imaging services performed on contiguous body parts.

The rationale for this is that better coding edits will help Medicare pay more accurately for imaging services, thereby helping to control rapid spending growth. Private vendors estimate that their coding edits reduce imaging spending by about 5 percent for their commercial plans. Based on this experience, we expect better coding edits to reduce physician fee schedule spending, but we have not estimated the magnitude of these savings.

Assuming it would reduce Medicare spending, the recommendation would also decrease beneficiary premiums and cost sharing. Because past coding edit changes do not appear to have reduced beneficiary access to and quality of care, we don't expect these changes to affect access and quality.

Providers that bill for unbundled or multiple imaging procedures would experience a decrease in Medicare payments. However, we do not expect the recommendation to affect providers' willingness and ability to provide quality care to beneficiaries.

Now I will move on to draft recommendation three. The Congress should direct the Secretary to set standards for all providers who bill Medicare for performing diagnostic imaging services. The standard should cover the imaging equipment, non-physician staff, image quality, supervising physician and patient safety. The Secretary should select private organizations to administer the standards.

This would address the second box on our diagram, the provider who performs the study. There is evidence that providers vary in their ability to perform quality imaging studies. Poor quality studies can lead to repeat tests, misdiagnoses, and improper treatment. Establishing national standards that would apply in all settings should improve the quality of imaging services, thereby increasing diagnostic accuracy and reducing the need for repeat tests.

Since the December meeting we have added the

supervising physician to the list of features that standards should cover. We think that each provider should have a supervising physician who is responsible for overseeing the imaging process and ensuring that each of the other standards, such as staff qualifications, is met. This physician should also make sure that the images produced facilitate proper interpretation. Thus, the supervising physician should be someone who is qualified to interpret imaging studies, which is the subject of the next recommendation.

Similarly, Medicare's rules for independent diagnostic testing facilities require that each facility have a supervising physician who is proficient in interpreting diagnostic tests. Several private accreditation programs also require that the imaging provider have a supervising physician who is qualified to interpret studies.

Now we're on to draft recommendation four. The Congress should direct the Secretary to set standards for physicians who bill Medicare for interpreting diagnostic imaging studies. The standard should be based on the training, education, and experience required to properly

interpret studies. The Secretary should select private organizations to administer the standards.

The rationale for this is similar to the previous recommendation. There is evidence of variations in the quality of physician interpretations and reports. Inaccurate interpretations and incomplete reports could lead to improper treatment. Ensuring that only qualified physicians are paid for interpreting imaging studies should improve diagnostic accuracy and treatment.

These standards should also apply to physicians who interpret imaging studies performed in a different location, which refers back to the teleradiology issue.

Now for the implications for recommendations three and four. We expect these two recommendations to reduce Medicare spending based on private plans' experiences, but we have not estimated the size of these savings. The recommendations should reduce the number of poor quality tests that need to be repeated. In addition, some providers would probably be unable to meet Medicare standards, thus reducing the overall number of studies.

The recommendations should improve care for beneficiaries because better quality studies should increase

diagnostic accuracy and reduce the need for repeat tests. To the extent that spending is decreased, beneficiary cost sharing should also decline. Some providers will likely be unable to meet Medicare standards, or they may have to incur costs to meet the standards. For example, they might need to invest in newer equipment, higher credentialed technicians, or obtain additional education. It should be noted that many imaging providers already receive accreditation by private organizations and are familiar with these types of standards.

Now we're going to discuss ways to strengthen the rules restricting physicians' investment in imaging centers to which they refer Medicare or Medicaid patients. The Ethics in Patient Referrals Act, also known as the Stark law, established these restrictions. The law states that they apply to radiology and certain other imaging services. At issue is whether nuclear medicine should be considered a radiology service and thus subject to the Stark law.

CMS answered no to this question in its Stark II final rule, but recently indicated it was rethinking this decision.

Draft recommendation five is, the Secretary should

include nuclear medicine and PET procedures as designated health services under the Ethics in Patient Referrals Act.

Physician investment in facilities that provide nuclear medicine services is associated with higher use. Such investments create financial incentives to order additional services and to refer patients to facilities in which the physician is an investor, thus undermining fair competition. This recommendation would prohibit physicians from owning nuclear medicine facilities to which they refer patients, but they could still provide these services in their own offices under an exception in the Stark law known as in-office ancillary exception.

Move on now to the issue of physician ownership of entities that provide services to facilities covered by Stark. This diagram helps explain the issue and it is one that we shoed you last time so I'm just going to briefly review it today. The Stark law prohibits physician A at the top from owning the imaging center, shown at the bottom right, if he or she refers patients there.

However, the physician can own a company, at the bottom left, that leases equipment or services 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. Thus, when the physician refers patients to the center for a procedure, he or she is able to indirectly share in the profits. This creates a financial incentive for the physician to refer patients to the imaging center, which could lead to higher use of services. It also gives the imaging center a competitive advantage over other facilities.

The Stark law was intended to minimize these undesirable effects. These arrangements are allowed because CMS defines physician ownership under the Stark law as ownership of the entity that actually submits claims to Medicare or Medicaid. Physicians can own companies that lease equipment or services to providers without any restrictions.

Draft recommendation six. 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 physicians from owning companies whose primary purpose is to provide services to

facilities that are covered by the Stark prohibitions on self-referral. There is a concern that if HHS closes off this type of financial arrangement new ones will emerge that create similar incentives. We think the best way to address this issue in the long term is to examine whether there is mispricing in the payment system with regards to imaging services. But because this analysis and any changes that might result from it will take time, we should in the meantime reduce these kinds of opportunities.

Now we will review the implications for recommendations five and six. The recommendations should decrease physician fee schedule spending because they would reduce the financial incentive for physicians order additional imaging studies.

To the extent that fewer studies are ordered, beneficiary cost sharing would decline. We don't expect that beneficiary access to and quality of care would be affected.

There would be some impact on physicians. They would no longer be able to refer Medicare or Medicaid patients to nuclear medicine facilities in which they are investors. Also, they would no longer be able to refer

patients to a provider that contracts with an entity that they own if that entity derives a large share of its revenue from that provider. But these changes should help level the competitive playing field for providers.

This concludes the presentation and we'd be happy to answer any questions.

MR. HACKBARTH: Let's just go down the row here.

DR. CROSSON: I have a question about the implications part, specifically the estimate that there would be, or there might be savings from the profiling, if you will, but that it doesn't get counted or scored as reduced spending for recommendation one relative to current law, but then the other five recommendations it does. When I read number one I said, I guess what that means is that the estimated impact of this is immaterial relative to the projected 5 percent reductions under the SGR, so it wouldn't be counted. But then the other five say there is reduced spending, so then I got lost. So what is the distinction there?

DR. MILLER: I'll take a crack at it. I think your confusion is entirely legitimate and I think part of it is because we're not only -- there's the scoring issues but

there's what we're able to produce, so let me back up and tell you.

I think what we're saying is -- let's take the coding edit one for the moment. I think what we're saying there is that based on what we've seen in the private sector and based on the certainty of the policy, were it implemented, we feel confident that some set of reductions in spending would occur, but we're not able to produce an estimate. We have been trying to work with information we have from the private sector and apply it to Medicare claims data and work through that process. But bluntly, we just are not far enough along to tell you whether it's -- enough concrete to say, we think it falls within this range, like we're doing with the rest of them. So we're a little softer here on all of this.

The profiling -- and now I'm free-forming a little bit here -- is even softer than that. Recall, it's an educational policy. It's not linked to their payment, so particularly as we're pitching it we're saying, we're giving it to you, we're giving it to you in confidence and it's for educational purposes. We believe that profiling has the potential to reduce expenditures, but we are not asserting

that this step would produce savings. I think that's my best take on what we're doing.

Does that answer your question?

DR. CROSSON: I think what you're saying is these are guesstimates at best, and that recommendation one seems to be subjectively a little less than the other five. But doesn't this interface, when you're talking about reductions in Medicare spending relative to current law, since current law includes the 5 percent reductions over the next umpteen years, doesn't that -- or am I making a mistake here? Wouldn't you have to project that something was going to result in --

MR. HACKBARTH: Volume changes interact with the SGR to the extent that they affect whether you exceed the SGR target in any given year. Right now, however, we are paying -- or the fee updates are to make up for excess spending in previous years. So even if it saved money today, it wouldn't alter the fact that there would be a 5 percent reduction in 2006. That's necessary to pay for, I don't know what years' excess spending. So it would not have an immediate direct impact on the SGR calculation. I think that's right.

DR. MILLER: I think it's further complicated because this is an administrative action. Even in the current environment and at great personal risk I'm going to make this statement, and I'm going to look at Scott because he and I have gone over this a couple of times.

But even in the current environment with the maximum cuts, if there was a legislative action that said, halve physician volume tomorrow, for whatever sets of reasons -- just said, okay, I'm going to pay every other bill, so it's very concrete, very clear how you would achieve it, it would in fact score as a savings. So you can get volume reduction savings even in the presence of the maximum cut, but what's really changing is how long it takes you to dig out of the trench. And I'll tell you, this is really complicated.

MR. BERTKO: First of all, I wanted to say again a good report and I'm going to agree with Mark's interpretation or answer back to Jay for draft recommendation one. In the private sector, people are using it to construct PPO networks, as well as there is one large company that I know of that is using it primarily as an education process. Overall, I'll remind everybody, trends

in medical care in the private sector have gone down over the last couple of years, but it would be very difficult in my mind to tease out the aspect of this out of that particular company's trend.

That said, I wanted to just reaffirm strong support for these things, and in contrast to some of the discussion we had about measurement tools for quality measures, this one is there. People have been using it in the private sector for the last three, four, five years. There is a decent amount of experience with it. There are still things to be learned, which I think CMS could learn along the way, but we should absolutely move forward with it here because of its potential, and I think this draft recommendation is a very good first step.

MS. BURKE: I'd like to ask a question first and then I guess just raise a cautionary note. My question, because I was the one that asked the question last time about how the offshore interpretations operate, I want to be sure I understand what it is that you said, which is that they are most frequently used in the case after hours or in the case where there is no one on site available, but that Medicare doesn't pay for it.

MR. WINTER: Medicare does not pay for services that are provided outside the United States, even if they are provided by a Medicare provider.

MS. BURKE: And we assume they are paid for in what fashion? Where do we think that money comes from? And we think that someone else reinterprets it in the morning and then bills for it under Medicare? Am I understanding that right?

MR. WINTER: I've spoken to some hospitals and a radiologist whose practice is involved in teleradiology and what we heard is that they get this initial read using an overseas company to prevent having a radiologist be on call overnight. So it's a little more efficient for them, and then they do the formal interpretation the next day and bill for that. So in essence, they swallow the cost for the overseas radiologist.

MS. BURKE: But then we get billed in the morning for the second interpretation.

MR. WINTER: For the formal read, right.

DR. MILLER: But it's billed only once.

MS. BURKE: I understand. Query to what extent that second reading is a thorough reading, but I'm going to

assume that it is, so the billing is fully -- that's the same amount of work, I'm sure.

Thank you. I just wanted to be sure I understood that.

My one cautionary note, and let me preface it by saying that I fully support the recommendations that are being made and appreciate the point that's been made that the private sector has been doing this for a number of years, as John suggested. But we are going into an interesting world, I think, in having the Secretary established standards for certain kinds of physician activity.

I was double-checking with Bill to find out whether there is any other instance in which Medicare has by regulation established specific requirements on behalf of physicians who are qualified to bill for certain kinds of activities. I don't recall any, but that there may be some there that I don't immediately call to mind. But we're going in an interesting area where one might imagine, whether it is in cardiology or in a number of other areas, Medicare may suddenly get into the business of beginning to take over, arguably, the responsibilities that previously

were taken by licensing boards, by accreditation, by certification through specialty societies. So it is something that I think we ought to take some care.

I fully appreciate the reasons. I fully appreciate the issues that have arisen. Certainly, quality questions about the ability of individuals in this case to interpret and therefore provide or avoid repeat x-rays or tests. But one might imagine this going further, and I think it's just something we ought to pause and we ought to track fairly carefully because it sets the Secretary up in an interesting situation.

I understand that in the case of the private sector, there are a series of decisions made about privileges. That has not historically been something, I don't believe, that Medicare has been engaged in. It is a new area and it's not entirely clear to me that Medicare may or may not be the right place for all that to occur, but just something that I think that is relatively new and could easily begin to go into areas, and perhaps appropriately so. But I think it's just something that I would raise a cautionary note about.

MR. HACKBARTH: Just two quick reactions, Sheila.

On the first issue of the second read, I think it's important to keep in mind that the radiologist reading it in the morning has the professional liability, and given that, my guess is that they probably do give it a serious read.

On the second issue, and Bob raised this at last meeting, I think we are breaking new ground by suggesting that the Secretary ought to set standards, so I don't want to diminish that. On the other hand, we do start down that path with accreditation for hospitals and other providers, and what we have done in the past is, generally speaking, delegate that to another body. That could be the path that this takes as well.

MS. BURKE: Yes, and I don't disagree with you at all. Long history of having done it in the context of facility-based service. Far less history in doing it on the basis of individual providers. And the accreditation of an entire facility has different issues than our deciding on the credentialing of an individual physician in this case over certain kinds of procedures. Again, I'm not suggesting that I would oppose it. I think what we're doing today is the right thing to do. But it is new ground and I think it is a far more complicated question than perhaps exists in

the context of large institutional providers.

MS. RAPHAEL: I just want to pick up on one point on that, which is I think there is some confusion in my mind about what we mean here, because this say set standards, which has a different connotation. If you're setting standards, whether it's facilities or individual providers, that is very broad, and there is a whole enforcement function that goes to setting and enforcing standards, which has a different connotation from accreditation, in my mind, and credentialing. I think we do need to spend a little time being sure we are precise about what we mean here. Right now it is very, very broad.

MS. BURKE: If you look specifically at the draft recommendation, it specifically states, standards related to training, education. That is not particularly broad.

MS. RAPHAEL: That's more credentialing.

MS. BURKE: That's my point. Again I am not opposing it. I'm just saying that we're going into the real world with respect to Medicare's relationships and we have these hospitals that are deemed organizations. It's a different and new world for us.

MR. HACKBARTH: But help me, Carol. I understand

the point Sheila's making and the distinction between doing this for institutional providers and individuals, so I've got that. I'm not sure I understand what you would like to see changed.

MS. RAPHAEL: I'm just worried that we're going to get into a whole regulatory framework here, which can become a mighty framework. In the sense of standards on training, training needs to be given for X hours, recurring education needs to be six hours per year. Then we talk about the supervising physician, the non-physicians and setting standards for all of those people.

If seems to me, in my mind I see it as potentially very broad. Then my question becomes, what is the responsibility of the Secretary for making sure throughout the nation that these standards are being met on an ongoing basis? Or we passing this on to a private organization that is going to credential and give the seal of approval to these individual providers, and that in and of itself will be sufficient? So I think I'd like some clarification on that.

DR. MILLER: No problem. Let me take a shot at it. Let me take a shot at both of these points.

The point on Medicare breaking new ground is well take and we tried, unless I missed this, we tried specifically to write to that in the chapter to make -- don't miss this big deal happening here. You should look at that and make sure that it's -- if it needs to be bigger, we'll make it bigger. So completely understand that and we are trying to point to, this is a break with precedent. We're not trying to do anything fast here. We are trying to be clear in text. That is that point.

To your point, let me try two things. For myself, I think I have been using the words accreditation and standards in my head interchangeably as we have talked about this, and I wonder if it would satisfy you if in front of the two times that standards are mentioned, in the first sentence and the second sentence, we said accreditation, whether that would accomplish your concern.

Then let me deal with the third point on enforcement, enforcement and how this is administered. I want to be clear but we're saying here. We are not deeming the authority to a private organization. We're saying that the Secretary sets the standards, so that the standards are set by Medicare -- back to your point. Then the

administration of those standards, and what you said, the certification and so forth, would be done by a private organization.

So I just want to be clear, the standards would be set by Medicare, notice, comment, rulemaking process, and then the Secretary would allocate the administration of this out to private organizations. And the private organizations would in fact come in, look at the techs, or send images to be passed through the machines to see if they are properly calibrated, those types of things and then say, okay, this facility is certified to bill Medicare.

I'm not feeling like I got to you.

MS. RAPHAEL: I think what you're saying is -- let's just take image quality -- that the Secretary would set a standard for image quality. Then a private organization would go and test a certain number of images to see whether they met the standard for quality.

DR. MILLER: You got it. Which organizations do now in the private sector. As a service they'll come to an insurer and say, we'll give you all kinds of things, help you manage your radiology, and one of those paths is to go and certify the equipment, the technicians, make sure that

the pictures are accurate and calibrated properly, that type of thing. There are organizations out there doing it. Not nationally, I mean not in all parts of the country, but there are organizations that do this.

MS. RAPHAEL: But it is true that the Secretary should close off for some providers the opportunity to continue to do this based on the degree to which they meet standards. That has got to be part of the Secretary's responsibility.

DR. MILLER: The only thing I would say about your sentence is it's not a question of should. The Secretary would set the standards. To the extent that this organization went out and said, you are not meeting that standards, that facility or that physician's office would not be able to bill Medicare.

MR. WINTER: If I could just speak for a moment to what Medicare is currently doing with regards to requiring accreditation. There are several carriers that do require that facilities billing for vascular ultrasound, and in some cases echocardiography, for the technical component, receive accreditation, and there are a couple of options they allow for that, or have their technicians credentialed by certain

societies. There's at least one carrier that also requires that physicians interpreting echocardiography meet certain standards. There is a variety of choices. They can be privileged by a local hospital, they can be certified by their specialty society. So that is the state of play right now in Medicare.

DR. STOWERS: I can see it through real clear on the facility part, but on the person providing the professional services, do we mean by setting standards, accreditation standards such as they are board-certified? So there we're still leaving the medical decision of what board certification is, or that kind of thing, up to the accrediting body? Or are we saying that the Secretary is going to say they have to have so many hours a year in training for -- because we have got an accrediting body out there, and a licensure board. Now is there going to be another board that they have to appear before and be inspected by or take exams from?

DR. MILLER: The process that we envision here is that the Secretary would probably look at different organizations that are currently doing accreditation of different physicians, would look at the training that people

go through. So for example, as part of somebody's medical training it may be that the determination is that their training encompasses this. Others might not have that training, so in that instance there might be an additional education requirement.

But the process we would see, through notice and comment, is that the Secretary would look across the various organizations, consult with a range of organizations, including different specialty groups, look at education curricula and then say, okay, I think that to be properly trained to interpret an MRI you should have these kinds of qualifications. Then that would be done as notice and comment, final regulation, and then administered through the private organizations.

So it could involve that. It could say that if you have been accredited by some board, that is sufficient. Or it could say, you need that accreditation and 100 hours of some additional training.

MR. HACKBARTH: I think we want to be careful to avoid specifying too much here about how the Secretary would exercise his or her judgment on this. I think the important policy point is that we're worried about the proliferation

of equipment that is not appropriate, up to the task in terms of meeting technical standards, run by technicians who are not prepared properly to do so, images read by clinicians who do not have the proper training. There are a number of different paths the Secretary might reasonably take to address those concerns.

It may be through notice and comment, a rulemaking establishing explicit specific standards, or over time it may be by saying, this private body, it has appropriate standards established through a legitimate process. If you're accredited by that entity, that's good enough for me, the Secretary. I don't think we want to wall off different paths.

MS. BURKE: Glenn, I am not in any way trying to force us to specify. My concern is that we are going down a road that previously had been largely maintained by certifying agencies, by licensure boards. The facility and equipment issue I think is a somewhat separate issue. But in this case they could decide to deem the American College of Cardiology, who in turn may be the interpreter of who is and who isn't qualified. That's an option. Or they could decide the American Board of Internal Medicine. Or they

could decide John Brown's Check on Your Credentials Association.

I don't believe we ought to specify it, but it is ground we have not previously broken. And I understand that private companies have done this and have been privileging based on a variety of things including whether or not you have this, that or the other. But for Medicare, this is a new world, and you might imagine it could go in a variety of directions, and it could certainly spread far beyond imaging into a variety of areas where we decide that the Secretary ought to be in the business of deciding what is adequate continuing education, what is in fact required in terms of licensure, renewal or certification, or boards; an area that we have historically not been in.

So I simply am concerned about going down that road without a better sense of where we might go, not intending in any way to try to answer it in this recommendation, on the physicians side particularly.

DR. CROSSON: There is a major risk here of wordsmithing, but I think some of the terms are important and I think as it applies to physicians the term ought to be certification. I think when you look at what the specialty

boards are looking at right now in terms of maintenance of the certification, some of this might very well fit into the plans that they're developing. So as opposed to accreditation or --

So it might be more proper, to get to the point, to say something like, the Congress should direct the Secretary to require certification for physicians who bill Medicare. And then something like, the certification should be based on standards approved by the Secretary, based on the other things. That could then lead the Secretary to either set the standards or accept, for example, standards set by the American Board of Radiology or whatever.

MS. BURKE: [Off microphone] That's a big leap for us to take. It may be the right leap but it is a leap that I would not take without a lot of analysis.

DR. CROSSON: Why is that a larger leap? I don't understand.

DR. MILSTEIN: I want to question whether this is such a big leap. Maybe staff could remind us as to how Medicare goes about assuring that physicians who are pathologists are adequately qualified to bill Medicare for pathology services.

MR. WINTER: Currently, Medicare will pay for medically necessary services provided within the physicians' scope of practice for the state in which they are licensed. So there are no limitations.

MR. HACKBARTH: Let me go back. This came up a bit at the last meeting and Bob used the example of a psychiatrist billing for surgery, which Medicare itself does not prohibit at this point. Now what we depend on there is the institutional structure that exists within hospitals to basically protect Medicare beneficiaries against that and assure that only properly trained people get into the OR with a knife.

The problem that we have that is different in this area is because of the wonderful advances, technological advances in the size of the equipment and the cost of the equipment, this is spreading out into settings that don't have that sort of institutional framework and protection for patients. So in the face of that we can either say, Medicare doesn't do that and good luck to you, or we can say, the health care system is changing and Medicare needs to respond. That's where I am, that we need to respond.

MS. BURKE: [Off microphone] I don't disagree

with you, although you use psychiatry as an example and there have been tensions for years about who does surgery. It is not about the psychiatrist. It's about the general internist. There are lots of questions about privileges and about specialty societies and about who's certified to do what.

But my cautionary note here is, I don't disagree that this is a unique set of circumstances, but it is putting Medicare into a situation they've never been before, and it is not at all clear to me how they will in fact deal with this. I am concerned that we are about to hand over a whole new responsibility to the Secretary and to the agency without some thought as to what -- I think, for example, putting in certification, just putting that into the recommendation raises a huge set of issues. Not every physician in this country is certified.

Query whether we have now made a judgment that that is a minimum standard for practice. Maybe we are, but that's not something we have ever discussed and I think it raises a series of questions. If that is the point, then who do we want to have certify them? Is it the specialty boards, is it somebody else? Do we assume that each of the

specialty groups is the best person to do that, and have we simply stated that is now the new standard for reimbursement by Medicare, that you must be certified, and we are prepared to say that?

MR. HACKBARTH: My thinking in response to that, as I said earlier, I don't think we want to be overly restrictive in describing how this ought to be implemented. I don't think we have the factual foundation for that. I agree with you on that.

So in that case, my inclination is to avoid terms of art that will imply there's a very specific approach that needs to be done. Instead what we want to do here is say, here's the problem and the Secretary ought to have authority and a range of tools. That they carefully vet the options and say, this is the best way to address the problem. So I would stay away from terms like certification, accreditation, that mean very specific things to people.

Does that make sense?

We are running out of time. I've got a number of people on the list.

DR. REISCHAUER: I just want to ask Ariel, you implied that many providers are close to this mark and I was

wondering, if we could do an analysis of Medicare imaging claims would 70 percent be done by outfits that John's company would say are okay, or is it 4 percent? Because if it's 4 percent then this is a huge problem and there's a big transition problem and it would take a long time. If it's over half, we're sort of there.

MR. WINTER: This would be difficult to do because we don't have information in the claim about whether the provider was accredited or not. What we could do though is for providers located in carrier regions where the carrier require some kind of accreditation, we could tally those up and divide them by the total number of claims for those kinds of providers across the country.

We have received data from at least one of the major accreditation organizations on the number of facilities and pieces of equipment that come under their accreditation programs. I'm referring now to the American College of Radiology's programs for MRI and CT, and it's a fairly high proportion. It's not everybody. I don't remember the exact number but it's a fairly high proportion nationally.

DR. MILLER: Ariel, just other thing. In our

conversations with the imaging management groups, was there any information in any of the stuff that they gave us that said, when we went out and implemented these kinds of standards this many facilities met them or didn't meet them? Do you happen to remember anything in your reading on that, just as a different data point?

MR. WINTER: That's a good point. There are two published studies which have data on this issue. One study looked at the BlueCross-BlueShield plan of Massachusetts which went out and surveyed 1,000 imaging providers and found that roughly one-third had some kind of deficiency, and 20 percent had deficiencies that could be remedied relatively easily, 10 percent had deficiencies that could not be remedied easily.

The other journal article looked at another plan which surveyed 100 non-radiologist offices and found that about three-quarters had some kind of deficiency, but many of those were incomplete reports. A fewer proportion had just equipment problems or technical problems.

MR. SMITH: Glenn, I will try to be brief. I think you are exactly right. We want to stay away from terms of art here, accreditation and certification. I think

that objective might be helped in respecting both Sheila's desire to press ahead -- which I agree with -- and to moderate and signal that we understand how knew these waters are.

I think this recommendation might be better off without the second sentence. They are not quite terms of art like certify and accredit, but it does begin to suggest a checklist that the Secretary is supposed to create. And what we're really talking about here is standards. I think that captures the broad hope that you had for the recommendation, keeps it intact, but doesn't begin to say those standards should.

Who knows what we've left out of the second sentence.

DR. REISCHAUER: The text could go into this, such things as, and describe them.

MR. SMITH: That's right.

MR. HACKBARTH: I would be fine with that. Other reaction to that, just move the content of the second section into the text?

Okay.

DR. MILSTEIN: A couple of comments. First, I

think that given the performance problems that have been described, though Sheila's point is well taken, we're moving into a new area, I think the evidence suggests that this is might be a good area for the Secretary to move into. And it certainly aligns with the IOM report Leadership by Example, which basically says Medicare -- the point they're making as the aggregate effort of the licensing groups and peer view groups is not solving this problem. I think most of us would believe the Secretary should solve the problem last, but I think we have a lot of accumulated evidence that the problem is not being solved. And for the reasons Glenn described, it's likely to accelerate.

With respect to standards, I hope the text will elaborate that this is a very flexible term. If we want innovation to seep into health care, and we want the health care industry to have a prayer of meeting that 0.8 percent productivity target, what we really, I think, are hoping for is a standard that would be a minimum performance level and not be overly prescriptive as to how expensive or well trained the person has to be to do it. It's really the performance that we care about, not the inputs.

My last question for discussion is, and this is

really based on my personal experience on the front lines in the private sector in terms of coping with the utilization problem, is does the recommended expansion of the physician self-referral prohibition go far enough? One of the things that we're saying on the private sector side, and I don't know whether staff found evidence of it in Medicare fact-finding, are physicians practices largely aided and abetted by revenue increase consultants. They're essentially transforming overnight into, I'll call them radiology mills. It's primary-care practices that are doing so many studies that all of a sudden radiology is -- even if they had prior equipment, radiology as a percentage of billings is going from 10 percent to 60 percent.

So the question is should we consider a recommendation with respect to extending the self-referral prohibition that would begin to address physicians who are providing other services but whose percentage of billings to Medicare may be relative to some peer-review base -- because orthopods do do more imaging than others -- exceeds a certain threshold. So we essentially begin to pull into this physicians whose practices have evolved into, in essence, 60 to 80 percent of billings are radiology based.

DR. MILLER: Can I ask a question? Would the profiling piece pick that up?

MR. WINTER: It could if you linked physicians ordering to those actually performing. We'd have the data, right?

MR. MULLER: Let me comment, given both what you said earlier, Glenn, the proliferation of technology which is only accelerating and has no end in sight in terms of its rate of increase.

I think, going back to the discussions on both profiling, pay for performance and so forth, it's going to be a sufficient challenge in well-developed institutional settings to do this. The notion that we can do this in a whole variety of new settings, whether it's Arnie's example just now of internists doing radiology and so forth, kind of stretches in my mind the capacity of the system to capture this after-the-fact.

There may be some sophisticated places like Kaiser and so forth who have enough capacity to do this. But I think by and large, when you start thinking about all of the settings in which this could be done, to think one can capture this after-the-fact in profiling, I just don't see

how it can be done.

So I think for all the reasons that have been discussed the last half-hour, not just trying to do this after-the-fact through performance measurement, but doing some of it, in some sense, before the fact, even if one doesn't want to use words like credentialing and authorization and so forth. But having some sense that there should be some threshold that one has to pass before one can start using all the technology that is now available.

One thing we know about our system vis-à-vis other systems, other countries and so forth, is we let a lot more technology get out there. And then the notion that once it's out there that one can control it, I think is just a little beyond our capacity. So I'm with Sheila, in terms of saying we're in a new area.

On the other hand, given all the work that this commission has now done over the last few years, it shows how much technology diffusion is driving these underlying cost trends. And then we tend to go back and hammer the nail we're know how to hammer, which is price increases and so forth. And yet we find it very difficult to deal with

technology diffusion.

So I would say the general thrust of these recommendations, I think, is fairly powerful. We obviously have to leave it to the Secretary, for all the reasons you and others have indicated, the specification of this. But relying just on after the fact either profiling or reviewing and so forth, I think is well beyond the capacity of the system to implement in most settings.

MR. HACKBARTH: I agree with that, Ralph. I see them as complementary tools and not either/or.

DR. CROSSON: I'm sorry, but I just want to jump back in one more time. And that is to say that I have no problem with removing the second sentence, nor do I have any problem with not putting in loaded political words. But we have to recognize that if we're saying set standards, then the implication is then those standards have to be applied to individuals. And issues like training, education and experience, someone or some entity needs to make a judgment if those standards apply to that individual.

Now that is, I think, certification. I think that we have to be clear on the fact that that is what we're saying.

DR. NELSON: They could be qualifications. There are a whole host of things they could be other than certification.

DR. CROSSON: Let me just finish. I didn't mean to use the term certification in this regard to indicate that I wanted or was suggesting that individuals who are not board certified should not be allowed to do this. That's not what I was suggesting. So if you want to call it qualifications or whatever.

But it isn't simply setting standards. The implication of this is for somebody to take the standards and apply them one by one to individuals, practitioners, and determine whether that practitioner is eligible to bill Medicare. Now the thing that comes closest to that, if you will, currently is certification.

But I just want to make sure that that is distinct from board certification. But that the entities that come close to doing that now, applying those standards subjectively and objectively to individuals, are the specialty boards. And they may very well be the ones who end up doing this.

DR. STOWERS: I think it's exactly what you were

saying. I think if we're saying here that he's going to set the standards that they have to have for that particular procedure or certification by the Academy of Orthopedics or whatever, then that's a different thing than them giving specific medical standards for doing that, or it's an approved standard-setting thing.

But getting down to naming hours of training and that kind of thing, I think is just opening up a whole bag of worms in this certification.

The other thing in the chapter, we all skirt around it but what we're really saying here is that the system is failing, the certification is failing, and that kind of thing in this new arena. I don't know how much we're saying that to really make the point. It might be kind of a warning shot out to the rest of the medical world and other things that they need to be gearing up for this type of thing and change in technology. Because that's really where it ought to be occurring, is back in that certification and standard-setting process that done pretty well for us over time. But this whole thing in skirting it.

MR. HACKBARTH: Here's what I propose. I think it's very important that is the text we flag that yes, this

is new ground. I think we also need to explain why we think it's ground that needs to be walked upon. And the circumstances that I think are unique with regard to the proliferation of imaging technology and require us to do something different than we've done historically.

I think we ought to strive, both in the recommendation and the text, to avoid, as I said earlier, terms of art that basically dictate particular approaches to the Secretary.

Having said that, I agree with your logical chain about the sort of steps that are required. But we ought to leave maximum flexibility for the Secretary to work through options, work through different types of entities to work with, and make judgments. We would be getting ahead of ourselves if we become too detailed, too prescriptive here.

With regard to the specific recommendation, I suggest that we drop the second sentence and basically move that to the text as part of the discussion I just mentioned. So that is what I'd like to proceed with a vote on.

In fact, while we've got this one and we have got it all fresh in our heads, why don't we go ahead and vote on it.

MR. WINTER: That's the only change then, to the recommendation; right?

MR. HACKBARTH: Yes, just the one.

So it's both the second sentence and three and four, the two parallel recommendations for the physician and for the facility/technician. Why don't we go ahead and vote on three and then four while it's fresh in our heads. Mentally delete the second sentence.

All in favor of recommendation three as modified?

Abstentions?

Opposed?

Then on recommendation four as a modified, all in favor?

Abstentions?

Opposed?

Now let's go back to number one, which is the resource measurement. All in favor of recommendation one?

Abstentions?

Opposed?

Recommendation number two, which is on page 10, on coding edits, all in favor?

Abstentions?

Opposed?

Does that cover it? That's right, there were the Stark-related ones. We're on recommendation five, all in favor?

Abstentions?

Opposed?

And finally, on recommendation six. All in favor?

Abstentions?

Opposed?

That is it for this. Thank you very much, good work

Now what I would like to do is return to the specialty hospital discussion.

MS. DePARLE: Are we not going to talk about the SGR and at all of that?

MR. HACKBARTH: To conserve time, and since there's not a specific recommendation, we didn't envision another presentation on it. In case you couldn't hear it, Nancy-Ann's question was about the SGR and alternative paths that Congress may wish to take in reforming the SGR if it wants to keep that mechanism in some fashion. That will be

in the text and we will talk, as was suggested at the last meeting by Bob, I think that there are different paths that you might take and no specific recommendation at this point.

So I urge people to look at that chapter and provide us comments on that. So just as a reminder, the way I envision that passage in the report is to say our fundamental concern -- we had a number of concerns about SGR. But the single biggest one was its inequity in treating all physicians alike and, as a result of that, it really doesn't have a power to reward good behavior and discourage bad behavior. And there are ways that you might try to address that issue within the context of a volume cap without endorsement of specific proposals.

Then we'll see what sort of reaction we get from Congress, and whether there is interest in that. To the extent that there is interest in it, then we can invest resources in developing the ideas and get to deciding whether we want affirmatively recommend that or not. So we are a step short of that.

MS. DePARLE: I was disappointed we didn't get to see anymore animated slides from Joan, first of all. I was

waiting for them.

But also, I had hoped we could discuss the removal of drugs from the SGR. I guess we're not going to have an opportunity to talk about that here. But I made my point about it the last time.

DR. NELSON: I wanted to see if in the morning we could -- you've got that half hour carved out.

I had some issues with the SGR alternative models and the degree to which they have been discussed enough that we want to put them out in prime time where they may be misinterpreted by some of our audience.

So for your consideration, is there a possibility of us spending a half-hour or so on the SGR subject in the morning, either in executive session or whatever? We had a half hour that was allocated in case we needed one.

MR. HACKBARTH: The proposal is to start at nine, and at that point we could talk about the SGR variations or whatever the appropriate term is and the issue of the drugs in the SGR baseline.

So nine o'clock tomorrow, everybody make a note of that.

Anything else before I go back to specialty

hospitals and the whole hospital exception?

Having talked to some of you about this, and based on the discussion the morning, what I'm proposing it that we change the recommendation here from a one-year extension to 18 months. So what we're talking about is two years, roughly, from today is when the moratorium would expire. Let me just stop there and open that for discussion. Dave, I know you had some thoughts.

MR. SMITH: Glenn, there has been a lot of conversation, both with you and among the rest of us. And I could live with this. I would prefer that it had the unless language in it. Not because I actually think it will change behavior, but it will reinforce the message that the reason that we want to extend the moratorium is not to bar the door but to get other work done, to get the DRG adjustment work done, to get the Secretary the authority to establish gainsharing.

I think including those, they are in the other recommendations we will be making. But I think referencing them in this recommendation would send the message that the Commission wants to send.

MR. HACKBARTH: Thanks for that, Dave. I

absolutely agree that we went to be clear about the message here. It's not extend protection from competition for another couple of years. The message is make room, time for the necessary work to be done that's in our other recommendations.

What I would suggest is that we say that in the text right after -- in fact, let me read what Dave had written out as a possible boldface recommendation. Dave's language was if the Secretary completes the SGR revisions called for in recommendation one and Congress provides the Secretary with the authority called for in recommendations two and five, Congress should consider ending the moratorium prior to January 1, 2007.

So what I would say, as opposed to making this boldface, just basically put this in the text right after that recommendation, just to keep the recommendation language as simple as possible but with this language in the text convey the point that you're talking about, which I concur with.

So that is my proposal. Any other comments or discussion of it?

Okay, lets go ahead and vote. All in favor of the

recommendation?

Abstentions?

Opposed?

Okay. Before we go to the public comment period let me just add one note. We have not, during this meeting, talked about the Medicare Advantage program. This is a comment directed for our audience. As was discussed at the last meeting, the reason for that is not based on policy but rather on logistics. We have had so many issues that we have had to deal with in the Commission, we haven't had the time, the staff resources or the commissioner time, to go back and revisit Medicare Advantage in the wake of the changes made by the MMA. We plan to do that. In fact, we will begin doing that in the March and April meetings, potentially leading to recommendations for inclusion in our June report.

People should not infer from the omission in our agenda in recent weeks or in the March report that MedPAC has changed its position. Our position, briefly put, has been that we strongly favor the option of enrolling in a private plan for Medicare beneficiaries, but we think that it ought to be a neutral choice. That is, that the

government ought to pay an equal amount, as best we can, regardless of whether the beneficiary elects a private plan or traditional fee-for-service. But there are many new and interesting and important issues raised by MMA and we will be taking those up in March and April.

So now on to the public comment period, with the usual ground rules. Thank you for waiting.

MR. MERTZ: Thank you. I am Alan Mertz. I'm the president of the American Clinical Laboratory Association, and I am commenting on recommendation six under strategies to improve care, pay for performance, specifically the requirement that lab values be reported with all claims. I just wanted to make a couple comments.

First, we certainly, the labs understand and agree with the value of lab values and we want to work with the Commission. We have a couple of concerns though that we wanted to raise.

First of all, I think there's a perception that there is complete uniformity in standards and how these values can be reported. While there is some standardization that's currently being used with versions of LOINC and HL7, we are a long way from having any kind of uniform codes or

messaging system that can be used. This is something we're actually working very hard on and we are working with outside groups to develop that and with the government. But we have a long ways to go, and that's why we appreciate some of the comments earlier by Dr. Nelson that this needs to be a precursor before you move ahead with this recommendation. We are probably several years off before we have standardized data reporting systems.

Secondly, there is a tremendous, as Dr. Nelson pointed out, tremendous cost involved in retooling all of our systems to do this. I think there might be the perception that you have some large labs out there and then physician labs. But there also thousands of community labs, smaller labs, there are hospital labs. Many of these small labs use outside billing, clearinghouses and so forth. They do not have the capacity to report lab values.

Thirdly, not all lab results are numerical or reference values. They're often narratives that the physician or pathologist adds on for things like flow cytometry, microbiology, cytopathology. So there are not always numbers that can be reported.

Lastly, there are privacy issues with HIPAA that

need to be looked at. Labs currently do not routinely or do not typically report lab values to payers. We get paid through claims that we make through billing departments but we don't typically report lab values, which is an entirely different area.

So for these issues we would like to work with you. However, we would urge that until we have the standardization that we're working toward a couple years down the road, before -- we need to figure out how to deal with the additional costs and burdens. We have been frozen 19 out of the last 20 years under the lab fee schedule. We would have to find some way that we could find the resources to do this, and also the privacy concerns need to be addressed.

Thank you.

MS. COYLE: Carmela Coyle with the American Hospital Association. Mr. Chairman, if I might ask a question and make a comment.

The question is, I think it might be important to the public to know today whether and how the market basket recommendation for hospitals interacts with current law. There's been some confusion I think among some of us in the

public seats. It's because current law is market basket minus 0.4 percentage points unless a hospital submits data on a specific set of quality measures, and I think there's just some confusion about whether and how there is interaction.

DR. MILLER: There has been discussions in the Commission about that proposal, and the direction that we took on pay for performance is different than that. We would see our recommendation replacing the current law recommendation.

MS. COYLE: Thank you, that is very helpful. And then the comment.

America's hospitals are very disappointed in the decision that was made by this commission today to cut Medicare payments to hospitals by way of recommending less than a full market basket update. I think hospitals are challenged to understand the decision made by this commission, in part because of the data that your own staff put in front of you that shows that Medicare hospital financial performance is the worst it has been since the inception of this commission. Medicare payments are lower than Medicare costs, and in the aggregate that means that

hospitals are losing money treating Medicare patients.

I think we're also challenged to understand the decision, given the really important earlier discussion around pay for performance. This commission talked about the importance of providing incentives to hospitals to improve their clinical performance. I think even Arnie Milstein pointed out the increased costs that would be associated with that. Things like IT. Things like implementing rapid response teams. Things like the staff needed to extract the data from patient records to collect and report it to the public. Yet just two discussions later, rising costs were used as a rationale to cut payments to hospitals. I think that is of concern.

I think we are challenged in part because commissioners suggest, at least as one argument and one rationale for making this cut, that hospitals that are in a financially poor position are there because their costs are high, and because perhaps they are poorly managed. Yet if that is a rationale, we do not understand why a recommendation to provide less than a full market basket update would be made for all hospitals, regardless of their situation.

Finally, and with all due respect to the chairman and to the commissioners, I think hospitals are challenged, and perhaps we're joined by some others in these public seats, who with great respect follow this process, to understand how a commission that is established to deliberate and make policy decisions in an open and public process can one month ago put a recommendation on the table for a full market basket update for hospitals, and after thorough discussion without a single objection raised by a commissioner, without any concerns expressed, 30 days later come back with a recommendation for less than a full market basket update, without a thorough understanding or explanation as to from where. From where market basket minus 0.4. Why not 0.3? Why not 0.2? Why not 0.5? And any commissioner who requests a separate vote on an alternative that seemed to have some interest is denied the opportunity of that vote.

Thank you.

DR. HEITHOFF: I'm Ken Heithoff. I'm a physician and a radiologist. I'm the national medical director for Center for Diagnostic Imaging in Senator Durenberger's great state of Minnesota. I come here to speak on behalf of

NCQDIS, which is an organization comprised of 2,400 outpatient imaging centers and departments in the United States.

Basically I would like to commend the Commission for taking on this important topic, and NCQDIS supports the MedPAC recommendations. We believe these recommendations take very important strides in improving patient care and protecting Medicare trust fund dollars. And especially are congratulatory and supportive that appropriate training is a particularly important aspect of your recommendations, and applaud the recommended standards for imaging quality. Your work is an important first step in addressing rising costs and quality of care concerns in diagnostic imaging. As you look at this issue further we urge you to consider privileging policies that address the technical as well as the professional components of diagnostic imaging services.

Speaking for myself as a physician, I think one of the things as I look forward that is most difficult about the current situation, and this puts me in concert with all of my clinical colleagues, and I understand that as reimbursements for the services that they are trained to do decrease, they look for ways to augment their incomes, and

this has been particularly an area and a concern in diagnostic imaging services.

However, since the facilities tend not to be competitive, and they tend to be installed in smaller practices, the equipment tends to be, and usually in my experience has been of lower quality, lower cost, and I'm concerned -- and they get reimbursed the same as a full-fledged imaging center. I am concerned about the quality issues going forward. So I think if you ignore the technical aspect of this, you lose the ability to try to control costs, if in fact it is proven that self-referral by physicians owning equipment is an issue that has to do with rising costs and utilization.

Thank you very much.

MS. BONTA: Hello I'm Camille Bonta. I'm with the American College of Cardiology. Speaking with respect to the discussion on imaging as well.

In today's discussion, I think in response to a question that was asked by Dr. Reischauer regarding the accreditation of facilities Mr. Winter cited two studies, and we are somewhat familiar with those studies. The first is a BlueCross-BlueShield Massachusetts study, and I would

like to add that that study found that the failure rate was highest among podiatrists and chiropractors when compared to specialty physicians and surgical physicians.

The other study, if it's the same study that we're familiar with, excluded looking at the CT, MR, and nuclear and looked just at x-rays. If this commission is going to make recommendations that affect these other types of imaging modalities we think that you should look at studies that also look at these modalities and not just x-rays.

Furthermore, that study hand-picked five radiology practices and hand-picked 95 non-radiology practices as the samples in their study, and I hardly think that that is a scientific study.

Thank you.

MS. McELRATH: I have a question. I don't know whether because what I would like to speak about is what you just decided not to talk about, so I will keep it brief.

MR. HACKBARTH: Is it the SGR baseline?

MS. McELRATH: Yes. It's the SGR baseline but I'd also like to talk about the other alternatives that were suggested.

MR. HACKBARTH: We are going to add that to the

agenda tomorrow morning.

MS. McELRATH: So that will be a public session?

MR. HACKBARTH: Yes, at 9:00 o'clock.

MS. LaBELLE: I will hold my comments till then as well. Thank you.

MR. HACKBARTH: We are adjourned and we will reconvene at 9:00 o'clock.

[Whereupon at 5:19 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Thursday, January 13, 2005.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, January 13, 2005
9:11 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
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

P R O C E E D I N G S

MR. HACKBARTH: Would you take your seats, please.

Let me talk for just a second about our agenda this morning. Last night we agreed to add an item, a discussion of both the portion of the chapter related to alternative ways to structure an SGR-like mechanism and to discuss the SGR baseline issue and whether it would be appropriate to take drugs out of the baseline.

We're going to have that discussion. But rather than leading off with it, as I said yesterday, I think I'll put that in the second slot. Nancy-Ann wants to participate in that discussion and she's going to be a few minutes late. So we'll do Dan's discussion on Medicare+Choice payment rates and then probably turn to the SGR-related issues and then move on to the agenda from there. Dan?

MR. ZABINSKI: I hope my voice lasts through this today. At the September meeting we presented results from work on a study mandated by the MMA that analyzes issues related to the payment system in the Medicare Advantage program. Today I'm going to discuss additional work that builds on our earlier analysis.

The MMA study actually has seven parts but today

I'm going to focus on one specific part, identifying appropriate payment areas for MA local plans.

You likely know that counties currently serve as the payment area for MA local plans. But we have found that using counties as the payment area does create some problems. First, many counties have large year-to-year changes in per capital fee-for-service spending. Using four year moving averages, we found substantial changes in fee-for-service spending from 2001 to 2002 for many counties, especially those with relatively small Medicare populations.

Large year-to-year changes in fee-for-service spending are important because the Commission has recommended paying equally between the fee-for-service and the MA sectors. But if you can't get accurate estimates of local fee-for-service spending, there's some uncertainty as to whether you can be confident of paying equally in the two sectors.

Also, we found that adjacent counties often had very different levels of per capita fee-for-service spending. payment rates often depend on local fee-for-service spending, so if adjacent counties have very different levels of fee-for-service spending, plans may end

up offering less generous benefits in the county with the lower rate, or may avoid it all together, which may create appearances of inequity between adjacent counties.

We did some empirical work that showed that using larger payment areas would help mitigate these two problems presented by counties. that is, larger payment areas would reduce year-to-year changes in per capita fee-for-service spending and there would be fewer adjacent counties with large differences in payment rates.

However, simply making payment areas larger is not necessarily better. As you consider alternatives to counties, we must be aware of two issues. First, payment areas must not be so large that the costs of serving beneficiaries varies widely by geography. Extremely large payment areas can create problems for MA plans because the plans are required to serve the entire payment area. In very large areas they may find they are profitable in some parts of the payment area and unprofitable in others, which may cause them to avoid the payment area all together.

We should also be attentive to whether payment areas accurately reflect plan market areas. If a payment area does not match a plan's market area, the plan may again

find they are profitable in some parts of the payment area and unprofitable in other parts.

We actually considered three alternative payment area definitions that are larger than the county. In one we collected urban county into metropolitan statistical areas or MSAs, and within each state we collected the non-urban counties into a single statewide non-MSA area.

In a second alternative, we collected all counties into health service areas or HSAs as defined by Diane May Cook and colleagues at the National Center for Health Statistics. These HSAs are collections of counties that are relatively self-contained with respect to short-term hospital stays among Medicare beneficiaries.

In the third alternative, we collected urban counties into MSAs and non-urban counties into the HSAs I just mentioned. A feature of all three of these alternatives that I want to point out is that if an MSA or HSA lies entirely within a state's border the portion in each state -- I'm sorry, the MSA or HSAs serves as a payment area. But if an MSA or HSA crosses a state border, the portion in each state is a separate payment area. For example, the Philadelphia MSA lies both in Pennsylvania and

New Jersey, so the part that is in Pennsylvania is one payment area and the part that is in New Jersey is a separate payment area.

Our reason for splitting MSAs and HSAs that cross state borders is that states typically have different insurance laws, rules and guidelines which may cause insurance to behave differently in different states.

The next three slides illustrate these three alternatives using the state of Texas as an example. First, we considered the MSA statewide non-MSA definition of payment areas. The striped colored areas represent the MSAs in Texas with each being a separate payment area. The entire white region is the statewide non-MSA area for Texas and would be a single payment area.

As you can see, there's a lot of white area on the map, meaning that this payment area is quite large, which is a concern we have about this definition because the cost of providing care can vary widely in such a large payment area. This definition reduces the number of payment areas in Texas from 254 counties to 28 MSA statewide non-MSA areas. Nationally, it reduces the number of payment areas from over 3100 counties to just over 400 MSA statewide non-MSA areas.

In this diagram we have the HSA definitions for the State of Texas. Each colored set of counties is a HSA or health service area that would act as a separate payment area. It's clear that the non-urban counties are in payment areas that are much smaller than the statewide non-MSA area from the previous slide. However, one problem that we view as a possibility is that the HSAs do split up split up some MSAs. We view that as a possible problem because MSAs often act as accurate representations of plan market areas for urban counties -- I'm sorry, for plan market areas, sorry. Under this definition there would be 61 payment areas in Texas and 935 payment areas in the country.

In this diagram we considered the MSA/HSA definition of payment areas. This is a hybrid of the definitions on the previous two slides and is an attempt to address the problems associated with those two definitions. Our method is to first collect all urban counties into MSAs, then we collect the remaining non-urban counties into HSAs. Under this definition there would be 84 payment areas in Texas and just under 1200 nationwide.

Then, to give a better sense of how these three payment areas relate to one another, on the next three

slides we hone in on a smaller area than the state of Texas, that being the Texas Panhandle area around the city of Amarillo. This slide shows how the MSA statewide non-MSA definition looks around Amarillo. The orange striped areas are the two counties that make up the Amarillo MSA which acts a separate payment area under this definition. The white area that you see is simply the state non-MSA area in that part of the state of Texas.

When you switch the HSA definition, the two orange striped counties then become part of this larger red area which is the HSA for Amarillo and serves as a single payment area under this definition.

Finally, when you consider the MSA/HSA definition, the two counties making up the Amarillo MSA again become orange striped areas and become a single payment area on their own again. The remaining counties from the Amarillo MSA remain red and act as a distinct payment area on their own.

You may have noticed that all three alternatives use the county as their building block. One reason we did this is that the county is the smallest geographic unit on which national health statistics are maintained. Therefore,

it's very convenient for us to use the county as a building block to make larger payment areas. In addition, using counties as a building block would present no additional burden to CMS or plans for collecting the data necessary for determining plan payments. However, some counties, especially those in the western United States, are quite large. In those situations, we must take care to avoid making payment areas that are too large.

We used three tools to assess the desirability of the three alternatives that we considered. In one we asked does the payment area provide enough Medicare beneficiaries to obtain reliable estimates of per capita fee-for-service spending? In a second tool, we asked how well does the payment area match Medicare Advantage in private sector plan market areas? If payment areas do not accurately match plan market areas, plans may be in situations where payments are well above costs in some parts of the payment area and well below cost in other parts.

We actually used two measures to analyze how well a payment area matches plan market areas. First, among payment areas that are served by at least one plan, we determine the percentage that have the entire payment areas

served by plans. Second, among plans that serve at least part of a payment area, we determine the percent that serve the entire payment area.

Finally, we asked how much geographic variation is there within payment areas in terms of the costs of serving beneficiaries. If the costs of serving beneficiaries varies widely within a payment area, payments may be well below plan costs in the high cost areas and well above plan costs in the low cost areas.

We measure the variation within a payment area as the difference between the per capita spending in the highest cost county and the per capita spending in the lowest-cost county in the payment area.

When we analyze how well each of these alternatives measures up to the three analytic tools on the previous slide, we found the following results. First, the MSA/statewide non-MSA definition provides the largest beneficiary populations and likely the most stable estimates of per capita local fee-for-service spending. In fact, the MSA/statewide non-MSA definition provides the largest population by a wide margin over the other two alternatives. The reason this definition performs better than the other

two alternatives on this measure is the large statewide non-MSA areas that exist in many states.

We also found that the MSA/HSA definition is the best match to the plan market areas with the MSA/statewide non-MSA definition being a close second. And then we also found that the MSA/HSA definition has the smallest variation in terms of the costs of serving beneficiaries but the HSA definition is a close second on that measure.

This concludes my discussion of payment areas but I want to close by discussing our next steps that we want to take to complete our study. At the beginning of my presentation I said that this analysis of payment areas is only one part of a larger study mandated by the MMA. One of our next steps is to complete all parts of the mandated study which includes the following.

First of all, the analysis of MA payment areas, which we discuss today. The second, we are to analyze the adjusted average per capita costs or AAPCC rates. The importance of studying AAPCC rates is that the MMA has reestablished use of those rates in determining plan payments. The AAPCC rates depend directly on local per capita fee-for-service spending which can vary substantially

among counties. We have identified the factors that affect variation in the AAPCC rates and presented those results at the meeting last September.

In addition my colleague, Scott Harrison, wants to examine how well AAPCC rates reflect plan costs. This will help indicate how well plan payments match their costs of providing care.

A final thing we are to do is to assess the predictive accuracy of the new system used to risk adjust payments for MA local plans, that being the CMS-HCC risk adjustment model. The importance of this issue is that the CMS-HCC substantially increases the use of beneficiaries' conditions to predict their costliness and has the potential to have a strong effect on plan payments. This analysis is largely complete and we presented the results at the September meeting

Then in addition to the work mandated by the MMA, this spring we intend to do a broader analysis of payment issues in the MA program and add that additional work to the study mandated by the MMA. This combined study will then become a chapter in the June report.

That's all I have and we're looking for comments

on mostly content and methods.

MR. HACKBARTH: Dan, I noticed that you, in an excellent presentation, missed an animation opportunity. When you switched to the Amarillo thing, you could have just nicely made that move.

MR. ZABINSKI: We looked into it, but we couldn't quite get it to work.

DR. BERTKO: Given that this is something I spend a good portion of my life on the other side of the fence, let me make a couple of comments here.

First of all, understand that the goal of reducing variation is appealing in a theoretical sense. Dan correctly said in one of his slides a key component is matching costs to revenues here, this being looking at the revenue side for the most part, although I think the goal was to look at cost or matching costs a little bit later.

Going beyond counties presents real problems. For example, there are some counties in California where a single hospital might be not quite but close to a sole community provider and very, very difficult to contract with. That's the most tactful term I can think of.

In other places, in a large MSA, one side of a bay

has got a very well run cooperative system of hospitals and physicians. The other side has got one that is much, much more costly, for almost inexplicable reasons, but also difficult to contract with.

A third point to think about, at least going into 1/1/06, and I'm not sure our recommendations have as much urgency, is that the bidding system which we talked about very briefly yesterday introduces a whole new round of uncertainty to folks like me. I do stay up late at night and wake up in the middle of the night figuring out how our bids are going to be for the A/B version, which is going to change a bit, and for the Part D part, which is going to change dramatically, and then the link of the two together.

The next thing I would actually introduce is, as Dan correctly says, that counties are the basic building block for these. But to look at counties alone and how you group them together is difficult for two reasons. First of all, I live in a county now in Arizona that is bigger than I think three New England states put together, and some California counties are like that.

Secondly, in the Bay Area, where I sometimes live, it's not only the size of the county but it's actually the

commute distance. So no one in southern Alameda county would go outside of there, towards San Jose, because it might be 10 miles but it might take you an hour to transit that time. And so, all those things, I think, need to be mixed together.

The last complicating factor I will add -- and I apologize, Dan, we haven't had a chance to talk about this -- is snowbirds. In Florida, at least, the snowbird retiree population is as much as 10 percent of the whole universe down there. And the way that I think it's done is that people are recorded in the county of residence on July 1st where they get their Social Security check. And so you have Wisconsin people who show up with some claim activity down in Florida for a significant portion of the year. And some work I did 10 years ago or eight years ago shows that's not insignificant.

Hopefully, I've just added a little bit more to your complexity.

MR. HACKBARTH: On the last issue, do you have a proposed solution dealing with the snowbird problem?

DR. BERTKO: I think there could be possibly -- I don't have a solution to it. But I'm just throwing that out

as a potential additional effect that for say Arizona and maybe some of the other Southwest states and for Florida in particular and possibly the Carolinas, that you might need to think about as you assess some of this.

DR. REISCHAUER: Just on that point, it's very difficult to separate that issue from the person who goes from Boston to the Mayo Clinic to get care on a one-time basis.

DR. BERTKO: My recollection on this is when I looked at it years ago we actually took the look at the hospital stats for out of state admits and that give us some clue to it. But it's not especially precise, along the lines of what you're saying.

DR. REISCHAUER: You know, on this stuff, I have a hard time thinking of why it would be good to break HSAs and metropolitan areas into the metro area versus the balance when what the HSA is telling us is that people in this red area more or less use the same facilities. Some of them might drive a long distance or not.

And then, when you chop it up the way you do, you say well, there's a huge difference in the per beneficiary expenditures in these two units. But the non-metropolitan

area within the HSA is an area with a pretty small population. I think we can get agitated about the gaps without looking at the numbers of people that are in these. Humana might be more desirous not to include them in the same group but how much of a burden really is it if it's 4 percent or 5 percent of the total population in the HSA that's there?

And then the question is, I think when you're thinking about this, do you have the same set of rules for providing services to people in this area throughout the area? I think there's a good reason not to have the same kind of requirements in lightly populated areas for the definition of serving the people.

I would opt for more flexibility on that front.

MR. ZABINSKI: Just one comment on the HSA. As a payment area, like I said, it's got some definitely attractive features as sort of a self-contained hospital service area or market area type of idea. I guess the one drawback we see, it does often split apart metropolitan statistical areas. Like in the state of Texas I know the Dallas MSA is partly in one HSA and partly in another.

DR. REISCHAUER: What John is telling you is a MSA

might be an interesting concept. But if the people in the southern Bay Area never go to a facility in the Northern Marin County, why do we think it makes any kind of sense for health care?

MR. ZABINSKI: In a lot of cases MSAs do.

DR. REISCHAUER: Sometimes they do and sometimes they don't.

MR. ZABINSKI: None of these measures is perfect. I think we just have to go through and look at what are the drawbacks of each and what are the positive attributes of each.

MR. HACKBARTH: John, so the thrust of what you were arguing for is smaller areas, basically. And that gives plans the flexibility to say that we're going to serve the areas where we think the contracting opportunities are reasonable and not serve monopoly provider markets. So you're looking for smaller, even at the expense of dividing MSAs? I'm just making sure I'm following your arguments.

DR. BERTKO: That's correct. And what I didn't add there that I should is that we now are going to be in a new world with local plans, both HMOs and a few PPOs, that follow exactly that rule, and then regional PPOs which could

conceivably be argued a little bit differently and applied to the broader ones.

It's not so much lack of service but it might be that the cost structure crossing counties -- let's take San Francisco County. The moment that you go across the border, to where my in-laws lived in San Mateo County, the AAPCC drops by I think $100 a month. And that blend there is not quite as obvious.

But yes, it's more of a can we match what appear to be the cost structures in those counties to the revenue?

MR. HACKBARTH: From your perspective as you go smaller the risk, has Dan pointed out, is potential instability in the rates and sharper boundaries as you move across the rate areas. You don't see those as problems?

DR. BERTKO: The answer there is there is some instability. But in addition to have a geographical stability you can also have longitudinal stability.

MR. HACKBARTH: We already do that, as I recall. We use a five-year moving average for these calculations.

MR. ZABINSKI: Right. The rates that I talked about typically are five-year rates.

DR. BERTKO: So how instable are they? They're

different and the question of stability is perhaps -- I'm just thinking. I guess I personally have not worried about time instability of the rates for the last couple of years. There have been too many other factors involved.

DR. MILLER: Can I get one of you to talk about one other thing? Dan, when we were going through this there was a couple of times when we were talking about which one of these configurations approximate what private plans are doing? My recollection is it's the MSA/HSA combination. And I'm sort of asking John if maybe you could comment on that statement. Maybe not so true, kind of true, because you're sort of saying no, we need to go down to smaller atoms. And if I'm interpreting this right, this suggests that private plan areas might be -- the MSA/HSA combination might approximate the private plant areas.

DR. REISCHAUER: Can I ask the question of what we mean by private plan? We're talking about non-Medicare populations. If we're talking about the employer-sponsored thing, it's making a price deal with each person. So the only thing that's offered generally for geographic area is the individual one; right?

DR. BERTKO: No.

DR. REISCHAUER: You have one price that you offer to all employers, adjusted for --

DR. BERTKO: Let me be specific and say, for example, in the small group market, which uses what I would call manual rates and don't vary by individual employer experience, we have rating areas. So pick a state like California, and I helped create the HIPC rating areas by doing these things.

We had six areas which covered five of the large Metro areas plus an all other, much like the non-HSA/MSA. And each of those would have a separate rating.

For example, hospital competition in Southern California, you probably read about in CalPERS, is much more intense and the rates are significantly lower than they are in Northern Cal, either the Bay Area or Sacramento. And those are reflected in those things. And the rating areas tend to be one to a few counties, usually more than a few counties, the nine county Bay Area, the four county Sacramento area, three counties in San Diego, et cetera. So that's part of that answer.

I interpreted Mark's question as being how do private Medicare Advantage plans look and if I can I'll

answer that question today, which is perhaps a little different than -- I don't know what the period for Dan's is, but over the last few years what has devolved is, I believe, the Med Advantage industry has gone to more and more ACR filings by county, although a plan might cover 10 counties in Southern California. It may have now 10 filings and 10 different premiums, benefit structures, et cetera, to better match the cost parts there and the revenue.

DR. REISCHAUER: But I think the answer to the question that I heard Mark asking is that you actually have larger units than you're arguing for in the non-MA area?

DR. BERTKO: In private sector, to the extent we have, we have larger areas that are generally groupings of counties for the under-65 population.

DR. REISCHAUER: Do we plan to do any kind of analysis on what's behind the variation? I remember when I was dabbling around in this area I always used to use the example of Prince George's versus Fairfax County and you look across the river. And there's like a $2000 difference per year, or something like that, in the payment. This is supposedly adjusted for demographics and risk factors and things like that.

Understanding why these, averaged over five years, what these exist might answer the question on whether we should design systems that preserve these differences, as opposed to force more uniformity.

MR. HACKBARTH: Jack Wennberg has some ideas about why they exist. You can try to homogenize and that makes sense to me. As you say, provided that you can assure that, in fact, plans are going to serve equally the whole, complete larger area and not take advantage of the blended rates and say well, we're going to more people over here from the low-cost piece of the new revised district.

I'm not sure how you do that.

DR. REISCHAUER: There are regulations on marketing and things like that. When you think of a metropolitan area or Prince George's and Fairfax County, they all watch the same television shows and listen to the same radio.

MR. HACKBARTH: The marketing, I think, is maybe the crudest tool for selecting where you want to get your enrollees from. There are a lot more sophisticated tools than that and you can regulate marketing but the other stuff is more difficult to regulate. The network that you build

and whatnot.

DR. BERTKO: One of the biggest problems today, at least in Med Advantage, and to a large degree in commercial is networks. And while you say it would be nice to create a network, it's really the other way around. The network creates your product. And to the extent that you have a good contract with hospital A on one side of the river and a terrible contract or no contract with hospital B on the other side of the river, it's going to drive things because that's the way it is. And an employer, small group, who's got everybody concentrated, will buy on side A and not buy from you on side B.

DR. SCANLON: I was going to comment on the point that you brought up about the bigger area and the fact that that, in some respects, is an independent policy objective. In the MMA with the regional plans we have designed them with the idea that we'd like to expand MA participation. But those are very big areas compared to what we're talking about here. And I can understand John's rationale for why smaller areas are a lot more easy to deal with. But this is, in some respects, the intermediate option.

I don't know if it would be something where we

actually did generate a whole lot more participation, or if whatever rise in terms of the differences within these areas to the need as we have in the MMA for the regional plans, to think about geographic adjustment. The fact that depending upon where your enrollees come from, you may need to sort of have some kind of an adjustment of payments, which I know is a nightmare to think about. But it's theoretically an option to consider because there is no perfect geographic mapping that is ever going to be designed. There's a conflict of objectives here. The question is where does this fit, in terms of the balance. Thanks.

DR. MILLER: I want to make sure I got the point. So you could have 10 counties and a rate for each of the 10 counties, or you could say this is an area and then an adjustment, which presumably wouldn't recognize the complete difference across counties, that says if you travel from this county your payment is a little bit up or down? Is that what you're driving it, Bill? Or John?

DR. BERTKO: Let me say it a little differently. Let's say that you have a 10 county area that you bid upon, whenever it is, commercial or otherwise. But you get a preponderance of people in counties that you didn't expect.

What Bill is suggesting, and in fact I believe CMS is thinking about today for regional PPOs, is how do you make some adjustment for actual enrollment over projected enrollment? And they could be quite different.

DR. CROSSON: I realize we're a long way from recommendations and there's still more work to be done, but I just would reiterate one point. That is that there's more than one stability issue that we have to deal with. And with all of the moving pieces now in the payment for MA plans, the entry of regional plans, the competitive bidding process and the drug plan, I guess I would urge probably later on that we consider carefully before we add yet another fourth moving part, until some of those other pieces are a little bit clearer.

DR. REISCHAUER: In answering the question that Mark asked John, would it be useful to look at the areas that the FEHBP HMOs offer services in as sort of some indication of what the private market is willing to do? And then also to answer the question what about the FEHBP national plans? How do they do this?

MR. ZABINSKI: Scott, did you get into anything like that?

DR. HARRISON: I'm pretty sure the FEHBP areas are bigger than -- I think they're at the metro area.

MR. ZABINSKI: I think it's something we can look at.

DR. BERTKO: Let me only add to that that Scott is correct in theory once again but the plans that are local plans tend to be HMOs and tend to define their service areas. So for example, Jay's company probably serves the following four counties in Atlanta but a different plan might serve 10 counties as a local plan. Then the BlueCross-BlueShield national serves the whole state.

DR. MILLER: I think this is about to be a stupid question so if it is let's move on. I think what we're talking about --

MR. HACKBARTH: He wants me to ask it.

DR. MILLER: But you see, he's really picked up on it and it's not working.

Some of the thread of your argument seems to be -- I want to stay at a more microlevel because different plans that I'll be competing against will be going to different areas. But I thought the point of this is to say that all local plans would have to compete on the same area? So

maybe it wasn't such a stupid question?

DR. BERTKO: No, that is not a stupid question. I always am a little askance when somebody has that as a preface.

A, all local plans will not compete at the same local area. They can't. Again Jay, I'm going to use your company because you're a little bit more structured in terms of physical facilities and stuff. If you said compete in all of 20 counties in Northern California, I believe he physically can't do that. We are a different model and generally we can do that. But again, we have places where we just can't compete and we don't. And so you could say do 20 counties, but you might not get people. And if you required 20 counties, you would get fewer bidders, which I think is a perverse consequence.

MR. SMITH: John, in general, the reason that you can't compete is because of local market conditions and contracting issues for you?

DR. BERTKO: Yes. The scale on membership billing and enrollment and stuff doesn't matter. I mean, more is better. But we just can't compete in some areas against some plans. And it varies market by market. It is subject

to -- you know, all health care is local, absolutely is the case here.

MS. BURKE: But if we could go to Bob's point, and to Bill's as well, and that is what are the policy directions we are trying to achieve here? And they are, in some cases, competing. I mean, to the extent that we believe that yes, historically there been these enormous differences by county, by area geographically that we want to begin to reduce that variance because we don't believe all of it is appropriate.

The extent to which you began to purchase at a broader and broader network of activities you begin to compress those differences. Arguably, that's one of our policy objectives is not to have these small units that have enormously different costs that we can't truly account for as being appropriate.

So my concern is that to the extent to which you continue to endorse these teeny units and allow huge variances to continue to exist, it is at odds with arguably what we are trying to achieve.

MR. HACKBARTH: I think that's absolutely right. The challenge is using what is a voluntary program for both

plans and beneficiaries to force that change. People ultimately have the option to say I don't want to play, these areas don't make sense to me economically, they don't match my business model. So I just won't play at all.

Whereas, in the traditional fee-for-service program we've got much more power to shift things around. There's a very different dynamic in the private plan option, I think.

MS. BURKE: And I absolutely agree with you. And the goal is also to try to get as many people competing as you can and tolerate a certain amount of that to exist.

The example of Kaiser's structure is such that it really can only literally service a certain area, and other plans similarly, because of the network construction and everything else.

But I worry, to the extent that we continue to endorse these very small calculations, that we will continue to encourage or allow to go forward these enormous -- and the question is just how at the margin you begin to compress that and still keep the market competitive and keep people in the game, particularly in a rural areas. There's no question.

MR. HACKBARTH: As Bill was saying, this is a problem to which there isn't a right answer. This is an optimization problem. You're trading off different variables.

DR. BERTKO: May I respond partly to Sheila by saying many of the things we talked about yesterday, pay for performance, resource use measurement, address what I think is the underlying root of the problem. Costs are actually very different. To the extent that fee-for-service costs go more towards the mean, that works.

The BBA actually is, in my opinion, a failed experiment on using revenue constraints to do this. And what we saw was a shrinkage of service areas.

MR. HACKBARTH: Arnie, last comment and then we're going to have to move ahead.

DR. MILSTEIN: It's not clear to me how expanding the areas on which the plans bid addresses the underlying problem. All it does is the problem can go on. It's just that as the plan is putting together a rate, it's taking into account these big variations that are occurring within a given area.

So I think if we want to get at the problem of

large variation, we have to attack it via solutions other than expanding boundaries for Medicare Advantage plan bidding.

MR. HACKBARTH: Okay, Dan. Thank you very much.

Next we'll turn to the SGR discussion. Joan is going to have a brief presentation about what is in the text of the report, or what we're developing for the text of the report, which is assuming Congress wants to keep some sort of an aggregate limit, how might that be restructured? And different paths that might be taken for doing that.

We are not making any recommendations here. This is a conceptual discussion.

And then I don't think there's anything prepared on the SGR baseline issue, but we'll also talk about that in this segment.

MS. SOKOLOVSKY: I want to apologize, first of all, for having no formal presentation. I didn't expect to be facing you all this morning.

I'm just going to briefly discuss the segment of the physician payment issue chapter that was not presented yesterday that's on modifying the SGR.

The Commission has long been on record as favoring

the repeal of the SGR, and there's nothing in this section that goes against that. We have, among many problems with the SGR that we've identified, the one that we focus most on is the fact that the national target does nothing to create incentives for individual physicians to reduce inappropriate volume.

What we said here is that if the Congress nevertheless finds it necessary to maintain some sort of target, are there ways that we can modify the SGR that would increase the likelihood that targets would create individual incentives?

Nothing in this chapter is an actual proposal. These are four ideas that came from the discussion among the commissioners last month. Let me just say very briefly, the four ideas have many design and implementation issues attached to them. If the Commission wishes to go further with them, those are things that we would have to analyze and deal with.

The four ideas that we discussed, one is to create a separate target for organized groups that meet certain criteria. That's the one that we discussed most fully last month.

The second idea is to have regional targets where the volume of services in one region, however defined, would be compared to a benchmark or the national volume increases and payment changes or conversion rate would be affected by whether the region was above or below that target.

The third idea is based on the hospital medical staff, and that would start with services provided by physicians within hospitals and look again, as with the regional model, it would look at the sense to which hospital medical staffs go above or below some benchmark in terms of the volume of services that they produce for different conditions.

And finally, the last one is service-specific target, which looks at things like imaging and says what is the volume of services here, with the idea that if one kind of service like imaging was growing much more rapidly than others, and if the conversion rate depended upon that rate, there would be an incentive for those people who provide imaging services to work harder or work on guidelines in order to control that.

So those are the four ideas, and now I leave it open for discussion.

MR. HACKBARTH: Let me just make a couple of additional comments.

I, for one, am not prepared to endorse any of these ideas. I just want to make that clear. This is very much brainstorming, if you will. And my notion is that if there's interest by Congress in one of these, then we could invest resources in developing it further. And after we do that, we may reach the conclusion that this can't work. The problems outweigh the benefits. So no commitment is implied here.

The other thing I want to emphasize is that I don't see any of these ideas as being a solution for the SGR hole, the fact that we've got this big baseline problem. As I've said before, I think the set of reasonable policy options that would solve that problem is zero. It's beyond policy at this point. So in thinking about these things, we shouldn't have as a constraint that they have to fill the hole that's been created by the SGR.

MR. MULLER: I think running through a lot of our discussions, both yesterday and the prior moths, whether it's around the pay for performance, around variation of cost just in the MA geographic definition areas, whether

it's on the imaging discussions and so forth, is this theme of both diffusion of technology, utilization controls, and I think they kind of come together.

I think it's important as a hypothesis here to see whether any of these groupings that you've just suggested have any possibility, have a greater likelihood of allowing some organized effort towards utilization control and diffusion of technology. And so one of the criterias that I would evaluate these against is those four groupings, how do they compare at least on that measure in going forward?

DR. STOWERS: I think these really have a lot of possibility in looking into that. I think the only question I had, and some of us had kind of mentioned this, if this is really something or the kind of brainstorming we want to put on the Hill? In other words, have we discussed these enough, looked into them enough? Is there a risk of someone taking one of these ideas and running with it before we get a chance to really put some time in it? Rather than just be mentioning them at this point, we really go into some detail here.

So I'd just open it up for that thought process, if the Commission has really looked at these enough to be

identified with these ideas on the Hill.

MR. HACKBARTH: Again, I think we can write it so it's absolutely clear that there's no endorsement implied. Some of these ideas have been around for at least 15 years, that I know firsthand. So it's not like we're giving them an absolute new thought that they might dangerously run off with.

So I think at the end of the day, Ray, I think that risk is manageable.

MS. DePARLE: Well, speaking of dangerously running of with, I think that's probably true, Glenn. But one thing I would argue for is I think these ideas are interesting. I especially like the high-cost medical staffs one, or whatever we're calling that. And I do think that's one that there's been some research done on.

But I hope that whatever we do, we don't start something again without having at least tried to do a demonstration of it. You and I have discussed how, with the RBRVS system, it was taken sort of from the bench to wall-to-wall across the country. And the parts of it that have not worked that well should have been pretty obvious.

Actually, I don't know whether the researchers at

Harvard thought that setting a national target would control individual physician behavior. Surely, they did not. Perhaps that's just what happened when the thing got implemented. But in any event, it's my understanding there was never any real demonstration of it. At least with DRGs there was a demonstration that went on.

So that first. I know some of us talked about whether there were things going on at CMS -- I think you and I talked about this -- some demonstrations that they were already doing where perhaps they could look at some of these ideas.

MR. HACKBARTH: You use the term demonstration. Another interesting concept is the one included in the MMA for disease management of much larger scale pilots with the opportunity to move towards broader implementation without going back to Congress.

When I think demonstration, unfortunately it doesn't conjure up good things for me. The process is painfully slow and often doesn't yield definitive results. But a pilot has a whole different --

MS. DePARLE: I accept that and I think you're right. Actually, I think what we've seen with some other

changes that have been made, you can argue welfare reform and other things, is that it does need to be broader scale in order to really see how it's going to work. But I guess I'm just saying I'd like to see if there are some opportunities to try some of these things out.

That said, and saying I like these ideas, I remain skeptical about the use of targets for volume control and the idea that with one subsector of the health economy, one payer, that we will say you guys have a target that's linked to some external factor, growth in GDP. That's a very elegant idea. I could see us adopting it for the whole country. People have talked about that. But that isn't where we are.

It makes no sense to me to put physicians under that when we don't do it for anyone else. And of course, that's the position MedPAC has had. So I would say that.

And on the issue of whether there are policy options to help solve the problem with the doughnut -- this is a different hole, not the doughnut hole. The SGR hole, the Grand Canyon hole. This is not a doughnut hole. I'm mixing my various holes here, I guess.

But anyway, I do think I have seen, and I raised

this at the last meeting, some analysis around the proposal to remove drugs from the SGR. And when I first heard about this 18 months ago, I kind of rolled my eyes, honestly. Because I thought well, why do we need to do that?

And then when I looked at it more, and I looked at the legal analysis that was done, I actually found it persuasive. And I don't know whether the mathematical analysis of how it works is correct or not. But if it is, it does seem to help solve some of the problem.

And I also think that from a policy perspective it isn't really fair or it didn't make policy sense to have drugs included in the SGR, and therefore, in a sense, counted against physicians when there was no link between that and the way we paid for drugs, which was the Part B payment, which has been part of the problem.

You and I have discussed the extent to which the physicians are responsible for the spending on drugs, or for prescribing them. That's a place where reasonable minds can differ. But I do think that would be something that should be considered.

So I just make that point.

DR. NELSON: With respect to the multiple spending

target issues, some people will read this and immediately extrapolate it to multiple payment systems. And I think it's one thing to set a target. I think at the very least we ought to indicate that the natural consequence of targets would be some differential payment systems. And that among the variable impacts that we have yet to explore is what those might imply for access and other things.

In other words, someone would read this and say we're going to have geographic targets. That means there will be geographic payment differences that are greater than would have been the case. That if I have to choose an area where payments are higher or payments are lower in which to practice, I probably will give some weight to those where payments are higher.

So an exploration of these concepts, in terms of targets, is fine. I think that we need to acknowledge at least that the second step in this process would be to examine the impact on payments and how that might affect the system as a whole.

Having said that, I agree with including consideration of these different models.

Back to the chasm, the Grand Canyon, the elephant

in the room, I think we are obliged in fulfilling our duties to the Congress to try and help them deal with this problem. And the only way that I can see to do that would be to remove Part B drugs, going back to the base year, and at least ameliorate the difficulty that they have.

The notion that those payment went, by and large, to physicians is refuted by some studies that the AMA did that shows that 80 percent of those payments went to the pharmaceutical industry. Some portion, obviously, represented physician payments and could arguably be placed within Part B, but not the whole thing. But it seems to me that that consideration can be easily ignored as a trade-off from the benefit that would come from us recommending to the Congress a way to deal with this enormous gap, and not just keep ignoring it, pretending it isn't there without us offering some advice on how to deal with it.

MR. BERTKO: Just a quick suggestion here on one of these four options to Joan. It's my recollection that in Dave's great state once again BHCAG, the Buyer's Health Care Action Group -- if I've got the acronym right -- actually did a health care system-based program where they actually looked and afterwards changed the payment unit cost levels

depending on the activities of the group. The successful ones that kept a cost target down got paid more per unit of service and vice versa.

So a good place to start to see how did it work. I will tell you, my consulting firm at the time bid on it. It was unbelievably complex. That's number one.

Number two, there's a reward and penalty phase on this one, and we should consider if we go in this direction paying more than the base Medicare payment rate or less on this kind of thing.

And thirdly, again my recollection was there could be a connection to what beneficiaries pay. In this model, a beneficiary who chose a more efficient system, I believe, got a reduction in their out-of-pocket premiums, which in this world translates into Part B premiums or cost-sharing, yes.

So I would just suggest there's a lot of other connections here that we probably want to think about for a minute, and I'm just adding that to the complexity of Joan's research.

DR. MILSTEIN: My comments are very much aligned with John's. I think step one, as exemplified by BHCAG, is

we need to help Congress pick the right target. The right target is total spending per beneficiary. That's what's affecting the federal budget.

Frankly, it may take more physician services to opt to bring total spending down. I'm not sure that we need less, particularly of primary care. I'd like to maybe throw more primary care services at the Medicare population if I want to reduce total spending.

So I hope one of the things we'll consider is what's the right target we ought to be focused on? I don't think it's physician services. I think it's total spending per beneficiary.

Secondly, I think it's obvious we have to, the next time around, incentivize the right -- the meaningful unit of analysis. I'm sorry, meaningful unit of intervention. BHCAG came up with an imaginative way of linking together physicians who were not in any kind of group along the lines of Jay's. But they put them together and found a way of achieving a degree of accountability for total spending, and then also got their agreement to rewards and penalties based on whether they did or did not meet the targets.

John's comment about beneficiary -- I don't know whether it's in our purview or not. It's not really provider payment, but it's obviously a critical lever if we're trying to control total spending.

In terms of can we work our way out of the hole, I think I'll echo some of my comments yesterday. I just asked Bob for an order of magnitude estimate of what percentage of total Medicare spending is in the form of physician fees?

DR. MILLER: 20 percent.

DR. REISCHAUER: I gave you the right answer.

DR. MILSTEIN: Think about what implies. Think about how important physicians are in determining total stream of spending. There's nobody with higher leverage in total spending than physicians. In thinking about it, it's a tremendous opportunity to incentivize physicians, whether it's with SGR relief or some other means, to be more active partners in controlling total Medicare spending.

As Jack Wennberg, we keep referring to, he's documented that there's a lot of what is generally referred to as flat of the curve medicine going on in the Medicare population. Is there some way we can help Congress use this crisis creatively to begin engaging the most powerful levers

on total spending -- i.e., physicians -- in a task that the Congress desperately needs help with.

DR. CROSSON: I support going forward with the analysis of these, obviously.

In terms of framing, I think even though these ideas are connected to the SGR, I mean I think they're connected to the SGR conundrum because the update process offers an opportunity to create not differential payment systems but differential payment rates.

But in terms of how we frame it, I think it really fits more with the pay for performance concepts that we're developing, because when we talked about pay for performance yesterday remember we really -- and the chapter I think outlines that at least in some places -- that the performance we're talking about is not just quality but it's also efficiency. And really, what these ideas do, if they are able to be done, what they will do is provide a second arm to the pay for performance direction which is to provide opportunities for differential payment, not for quality in this case but for efficiency.

So just in terms of how we frame this, I think it's possible for it to get all tied up in the SGR issue,

which has a lot of emotional content and substantive content to it, as opposed to what it really is which is just simply using the update methodology as an entry point to try to deal with the pay for performance concepts around efficiency.

So that framing issue I think might be helpful.

With respect to the SGR conundrum itself, I know we've got a lot of work coming, but I would also support taking a look at the zero sum game, or however you put it, the null set to see whether or not there is something, whether it's the issue of drugs or part of the drug thing coming out of there. I think the problem we face is that I think on another level everybody realizes something has to be done. And one year fixes create further problems and the like.

So I would at least enjoy this year some further discussion on that also.

DR. SCANLON: I'd like to talk about getting ourselves out of the hole. And I agree with you, Glenn, that there is no policy option that gets us out of the hole.

I am interested in this issue of removing the drugs, not so much from the perspective of did physicians --

are they responsible for it? Did they benefit from it? That kind of discussion, because as Nancy-Ann indicated, reasonable minds can differ on those particular points.

But the fact that we're in this hole because of the unintended consequences of a set of laws, and if there's a legal way out, maybe it's the best thing to do to take that and to start from a fresh point and move forward.

The unintended consequences, in part they go to the SGR statute itself, which allowed for no revision. The problems began in 2002 when GDP grew slower than the estimates and there was no way to go back and say wait a minute, we overestimated.

There was also an issue with respect to the information that was available in terms of prior year's growth information and the claims flowing through HCFA at the time. And so therefore, the amount of spending in the past has been underestimated.

The net result was that physicians had been paid more than they would have been in 2000 and 2001, and you end up with the reduction in 2002. There was no way to -- what reasonable people might do -- go and correct that because it wasn't within the statute at that point in time. You create

a hole and then you suddenly come up against the budget law, which we talked about yesterday, and the fact that this is going to be scored and you can't dig your way out of that scoring hole. But it's not clear that the budget, while that law has very great value in terms of the discipline it imposes, anticipates this kind of a circumstance where we're trying to deal with error that we didn't anticipate happening.

So I'm very favorably disposed towards let's find a way out of here sort of imaginative use of law, since it was use of law that got us into the hole in the first place.

DR. MILLER: I think this is clear, but I just want to say this so that there's no misunderstanding. You remember yesterday there were some of the arcane conversations about scoring and that type of thing. This is not to dispute your point but everybody understands that it doesn't change the spending stream at all. That's the point I just wanted to make sure people understand.

MR. HACKBARTH: Let me just pick up on that because I was going to go back to this a little bit later.

This is a scoring issue, as opposed to a budget issue. And that worries me, for MedPAC to become involved

in scoring issues as opposed to budget issues. We're talking now not about policy but about process, and a highly politicized process at that.

The reason this is an issue is because it is a scoring issue and from Congress' perspective it looks one way, and from the Administration's perspective it looks very different. And that's why there's sort of a stalemate on this.

I worry about getting involved in strictly scoring issues as opposed to budget policy issues.

MS. BURKE: Glenn, to that point, because I think that's a critical point.

I think what I'm hearing Bill say, which I absolutely agree with, is at the end of the day our position has been straightforward, which is that we are focused on appropriately issues related to the long-term strategy for the program. And the issue about how one appropriately decides what the right mix of services is and how to make sense out of a system that spends an enormous amount of money and there are a variety of pressures on the system.

And so I absolutely agree with you. I think we ought not get in the middle of a scoring fight. I think we

ought to continue to focus on what we think makes sense for our long-term program strategy, which is how do you incentivize physicians? How do you make sure there's quality of care being delivered? How do you make sure that it's the right mix of things?

And we have had a variety of tools available to us, some of which have made no sense. I think the Commission has been very clear from the outset about how stupid the SGR is. There's nothing that's going to redefine this pig for anything other than what it is. There's no dressing it up. It is what it is.

And so I think the question for us is let's acknowledge that it's a -- sorry, maybe the pig isn't the right reference.

I think our priority ought to be to look at what do we think makes sense from a policy perspective for how we ought to reimburse physicians and how we ought to incentivize them. I think it will fall out as to how we manage or how we acknowledge the fact that it's going to create an issue in scoring and a budget issue for both reasons.

But I'd really like to focus on the question that

Nancy-Ann has asked, and that is one, what do we think about the way this base was calculated? But the longer term question is how do we really think physicians ought to be reimbursed? How do we really think we ought to incentivize them?

And I think these four options are interesting. They are a fundamental question about whether we think there ought to be caps, if that's the right tool or not. I'd like to have the Commission spend some time on what do we think that is? Is it these four options? Is it something else? Is there some way to trigger physicians sense of their ability to capture lots of resources and distribute them?

But I think you're absolutely right. It is what it is, no ignoring it. But I think we've been fairly consistent about saying this is a stupid way to control a big problem. And whatever we're going to do is going to complicate it further. But it is what it is.

MR. SMITH: Sheila made my point, better than I would have.

DR. WOLTER: My point has been made, too, but just to emphasize, I think it would be best if this discussion were not framed as SGR but were framed as options that could

lead us to improvement coordination of care, integration of care, efficiency incentives. Because I think if it gets caught up in the SGR option framework, it might not lead us to the place we want to go.

MR. HACKBARTH: Let me just pick up on that. The idea of modifying the SGR and trying to target it geographically or to organize groups makes me nervous for reasons that Bill alluded to. The potential for unintended consequences is very great. Trying to control things by formula, as we've learned through the SGR, is a hazardous business. And even if we have narrower groups, many of the same hazards still exist.

The reason that I think this is worth thinking about, my own personal objective would be to take what is a real problem and use it as a lever to get the system moving more towards organized care that integrates care. And I wouldn't want it just to be physicians. I'd like to create opportunities that span some of our traditional lines. And I agree with Jay, it ought to be about a combination of quality, performance and cost.

I'm trying to take a lemon and make lemonade and use it as a constructive force for rewarding the way I think

the system needs to go to deliver better care. But it's very hazardous to try to use this sort of tool, even for a worthy purpose. And so that's why I'm reluctant to endorse anything at this point.

But on the policy, I'm with Nick 100 percent, on the objective I'm with him.

MR. MULLER: I think that's why, in the spirit of the last few comments, I mean the SGR was a very flawed effort to try to hold physicians, as a collective, accountable for spending. And that's why I think the way Joan poses it, I think we need to be thinking about what are the accountable units? Capitation, in some ways, in the late nineties, was also a failed effort because it was too naive, we thought that just kind of aggregating physicians together would all of a sudden magically make them able to do the kind of comparison of costs and program that Arnie and others have referred to.

So I would encourage us, whether it's evaluating -- not evaluated but looking at this effort in Minnesota and the other efforts like that, to keep understanding which accountable units, which kind of collectivities do a good job of this.

Because I do feel that part of what we skip over fairly consistently in some of these analyses is who's actually going to do this and where's the evidence that groupings know how to do this and have demonstrated they know how to do this. And there are certain examples around the country. The obvious ones are the organized medical groups that have been around for 100 years or 70 years or whatever.

But there has to be some hope in this medical world beyond just those organized groups because they're not 100 percent of the population nor will they be 100 percent of the population of physicians in this country.

So I both agree with Arnie's sense that a critical part of this is the right signals to physicians. But I also think that a very important part of it is to look at what kind of units can, in fact -- and not just theoretically but go look around the country at what the evidence is -- what kind of units can in fact perform this kind of role.

And I would also, as Nick and Arnie and others, look more not just at physician spending but look at the kind of macro spending inside the system and get the sense of what are the organizations that, in fact, can achieve

this kind of performance.

DR. STOWERS: I really agree with what's being said here. I still think there's a fine line between the policy issues and the scoring and getting involved in that and making a commitment right now. But this issue of whether drugs ought to be included in physician payment, and that sort of thing, is not going to go away. Even if the SGR were to be gone tomorrow, that's still going to be an existing question out there.

So even though the AMA did a preliminary study that showed 80 percent didn't go to the physicians, I think we would be helping Congress and others, whether we took a commitment one way or another on the scoring issue, to go ahead and look into this policy issue and maybe get some more validated data and that kind of thing over time.

Because this is going to be something that's coming back and it would be timely, I think, for everybody to continue to look into that.

DR. NELSON: I think in wrestling with the volume growth issue we need to acknowledge the fact that some of that reflects the continued payment inaccuracies or -- let's see -- that it reflects the fact that some services are

still valued, for payment purposes, higher than they perhaps ought to be and are stimulating growth thereby.

Just as some dentists did an x-ray on me every time I went to get my check, the potential is for groups of neurologists to do an MRI on every patient that they see because it might contribute something. Or ear, nose, throat specialists do an MRI of the sinuses on everybody that comes in with a sinus complaint. And it's hard to argue against that on clinical grounds until you see how the profiles work out.

Ultimately, we're going to have to examine whether or not we are overpaying for some of those imaging services and fix that part of it so that the services that are truly valued highly by patients and are not currently being reimbursed, like telephone services and e-mail consultations and so forth, are properly valued and those that are being overpaid have that fixed as well.

DR. REISCHAUER: It strikes me the reason we're in this is because Congress, first with the VPS and then with the SGR, said we need a mechanism to moderate the growth of spending on physician services so that it remains affordable, in some sense, for our economy. And we have to

ask ourselves is that an objective that we think is worthy of maintaining in the system? Or should it be defined more broadly, is Arnie suggests, to the total growth of Medicare spending? And of course, the MMA has something in there on that.

And we have summarily concluded several years in a row that the SGR is a failed mechanism for doing this. And I thought the reason we were putting this discussion in here is to answer that question well, if you don't like this but the goal is okay what are you suggesting? And what we're just sketching out in a broad kind of way is here are four other approaches. They all have complexities. They all have inequities. They all have questions about how effective they would be.

We don't have to go much further than that, it strikes me. We're moving off in a different direction with varying payments by quality. And presumably quality has a utilization dimension to it. And if you did it all right somehow, that would take care of, I think, a lot of this. But we're sort of betwixt and between here because I think we're shifting tracks and saying the emphasis that we're really making is down this, let's try and affect things by

quality.

Just with respect to what difference does this make, and this is not a MedPAC issue but sort of a larger public policy issue, I think it's unquestionably true that total spending on physician services would be a lot higher now if it weren't for the SGR. First of all, the 5 percent cut never would've occurred.

MR. HACKBARTH: But we also gave them a big increase driven by the SGR, above MEI.

DR. REISCHAUER: It was driven by lots of other things, too, one of them being the fact that we had a huge budget surplus so people really didn't care about a lot of these things as much as they care about them now. And just draconian threat out there has allowed 1.5 percent increases for the last few years, 1 percent the year before. Whether that's good or bad is a different question. And how much of it's been offset by volume increases, we really don't know.

But for the purpose that this was put into effect, in a perverse kind of way, it sort of worked.

MR. HACKBARTH: We're going to need to move ahead in just a second but let me just talk about the baseline issue. One of my concerns, as I've already stated, about

entering into what is a scoring dispute as opposed to budget issue.

The second issue that I've raised is whether we could reconcile endorsement of taking drugs out retroactively with previous MedPAC positions. My concern there is that the burden of our analysis about overpayment for drugs is that the money wasn't all going to the drug companies. A significant portion was going to physicians.

I know AMA has produced an analysis saying that 80 percent went to drug companies and 20 percent to physicians. That may be right, that may be wrong, I don't know.

Some things about it are unclear to me. I have questions about whether it includes rebates, discounts, and that sort of stuff. But at the end of the day that's sort of a technical battle.

So that's about the income in the past. Were these dollars, back to '96, income to physicians? I think a significant piece of it was. Then, if we look forward, okay we've fixed, at least to some degree, the payment for drugs going forward so there's not the same degree of overpayment. But we need to remember that as part of that deal there was a big increase in the administration payments to physicians,

and done with new money.

And so to say the drugs ought to be out going forward and we don't need to worry about the fact that we've recycled some of those dollars in a new form and higher payments for administration, I'm not sure that that hangs together all that well, either.

So there are a number of counting issues that I have about this, but at the end of the day the single biggest concern I have about entering this debate is it's a scoring battle. It is not about policy. It's not about the real dollars going out of the Treasury. It's about scoring. I just don't think that's where MedPAC belongs. I think that's very hazardous terrain.

I think we do need to move ahead. I keep forgetting that we've added another session here and I know people have planes to catch.

So thank you, Joan and Kevin.

MS. DePARLE: Thanks for changing the agenda so we could have a discussion of this.

MR. HACKBARTH: Next up is the use of comparative clinical information by Medicare.

MS. RAY: Good morning. At today's session we'll

be discussing the potential of Medicare to consider three types of information when making coverage and payment decisions, information from practical clinical trials, comparative clinical effectiveness information and cost-effectiveness information.

As with most issues there are many points of view about whether Medicare should collect and consider clinical information about the effectiveness of technologies among Medicare beneficiaries, whether Medicare should consider cost-effectiveness when making coverage decisions and in the ratesetting process, and whether Medicare should consider clinical information in the ratesetting process. Proponents contend that conducting these analyses could be used to promote beneficiaries access to high-quality care and help Medicare act as a prudent purchaser.

Others are concerned that such analyses could delay beneficiaries' access to new technologies, the lack of standards for conducting these studies, and the cost of conducting such studies and the implications that such studies could dampen the innovation of future technologies.

Just a little background here, now that we've gone through, I think, the broad policy issues involved. Since

1999 CMS has used an evidence-based approach when making national coverage decisions. This is based upon using the best clinical evidence available. Recently, the Agency has linked several national coverage decisions with collecting clinical information in order for the Agency to learn more about the effectiveness of certain technologies for Medicare beneficiaries.

By contrast, cost information is not explicitly considered when making national coverage decisions although there was one exception to that, a colorectal cancer screening test which we talked about in your briefing materials.

In contrast to the coverage process, clinical information is not usually considered in the ratesetting process. One exception was in 2003 when CMS set the payment rate for a new biologic at the same rate as an existing biologic after concluding that both were functionally equivalent. The MMA, however, limits the use of functional equivalent standard in the hospital outpatient setting.

I'd like to take the opportunity here to review relevant MedPAC work in this area. Most recently, in the June 2004 report on implementing Medicare's drug benefit, we

discussed the need for drug comparison studies. We stated that physicians and beneficiaries would benefit from having an independent resource for drug-to-drug comparisons. We raised as an issue but did not reach any conclusion about who should conduct these studies and who should pay for them.

In our March 2003 report, in our chapter on paying for technologies in Medicare's prospective payment systems, we stated that it may be appropriate to limit payment to technologies that provide additional benefit commensurate with their cost.

That same report also included an appendix that provided an overview of Medicare's local and national coverage process.

Now I'd like to get into a little bit more specific information about what we mean about practical or it's also called pragmatic clinical trials. Their goal is to assess the risks, benefits and costs of technologies as they are used in routine clinical practice. In contrast to FDA approval trials, practical clinical trials assess the effectiveness of technologies among broad populations in real-world settings. Although information from FDA approval

trials is available for new technologies, it typically provides information about efficacy among a limited study population. There's usually restricted eligibility criteria involved, such as excluding patients with multiple comorbidities. FDA approval trials are typically conducted under strict clinical conditions, not real-world use.

Practical clinical trials usually include multiple comparison groups and multiple outcomes, including functional, quality-of-life and economic end points. Once collected, information from practical clinical trials could potentially be used by CMS to reassess their coverage decisions.

Recent decisions linking national coverage with collecting clinical information includes these technologies listed on this slide. What do these technologies have in common? They are costly and they have the potential for high use.

There is increasing interest by the Congress to develop sources and methods that can provide valid and reliable information about what works best in health care. MMA authorized the Agency for Health Care Research and Quality, AHRQ, to conduct and support research studying the

outcomes, comparative clinical effectiveness and appropriateness of health care services. However, the MMA does not permit the Secretary to use this data to withhold coverage of prescription drugs, although other organizations such as prescription drug plans can do so.

The MMA authorized up to $50 million in 2004 and additional funds as needed in later years. The Congress appropriated $15 million for AHRQ to conduct this research.

AHRQ recently announced its intent to conduct systematic reviews of the effectiveness of information, including prescription drugs, for top 10 conditions affecting Medicare beneficiaries. These conditions include diabetes, cancer and dementia, including Alzheimer's disease.

Looking at considering cost-effectiveness analysis, the goal of this is to relate the clinical effectiveness and health outcomes of technologies to their net resource costs. It's central function is to show the relative value of alternative interventions, including drugs, for improving patients' health. Cost-effectiveness analysis builds on information on both the technologies clinical effectiveness and costs.

As noted in your briefing materials, CMS's previous efforts to try to consider information about the cost-effectiveness of technologies in the coverage process did not succeed primarily because of concerns that beneficiaries' access to new services might be impaired.

This brings us to our next steps and we would particularly like your guidance on our next steps that we've proposed here. First, to interview CMS policymakers, manufactures and patient groups. To investigate how comparative and cost-effectiveness information is being used by other public payers and private payers. To review methodological issues surrounding such analyses, and any other issues that commissioners suggest.

We believe that this will lead to a June report chapter with potential recommendations that might include, for example, how to facilitate head-to-head comparative trials and the possible use of cost-effectiveness information in Medicare's coverage and payment process.

That's it.

MR. MULLER: Just going back to the discussion a few minutes ago, I would add to this the people who actually have to do this, the doctors. So medical groups, medical

staffs, organized units like that I think are critical because you have all of these evaluators doing it but then you actually have to talk to people who are expected to implement this.

MS. BURKE: I just had a question really that's related not specifically on point, but would you remind me again what the current Medicare policy is with respect to participation generally, in terms of research, and how we separate out those activities that we will fund from those, for example, with respect to NCI patients and others, people that in the midst of clinical trials? Just remind me of what our coverage is.

MS. RAY: Let we see if I can get this straight. Medicare will pay for the routine costs of patients participating in a clinical trial. So if the patient has to go to the doctor, Medicare will pay for that. My understanding, however, if it's an experimental device that that's not included in Medicare's payment.

MS. BURKE: If there are events that occur in the context of that research, for example someone becomes ill, I presume that it would be covered in the normal course? Or not? It is.

So it's only the actual either the device or the pharmaceutical that might be involved that would not be covered; correct?

MS. DePARLE: That's correct and that was a policy that we changed in late '99 or early 2000.

However, the four example that you put up on the page earlier, the practical clinical trials, it's my understanding that in those, at least with respect to the cancer drugs, I haven't had discussions about the other two, but with respect to those cancer drugs they are paying for the drugs even though they are experimental and considered to be part of a clinical trial.

MS. BURKE: Is that under a specific authority or is that just a break with the current policy?

MS. DePARLE: I don't know.

MS. BURKE: I'm trying to remind myself of how we divide this up in terms of current policy.

MS. DePARLE: The idea was that you didn't pay for the device or the drug because it was "experimental" in a clinical trial. This, being a hybrid, I guess they've just taken a position that we are covering them. It's coverage with conditions, is another way to put it, which is what we

did for lung volume reduction surgery, too.

So I suppose under that theory, they're covering them.

MS. BURKE: And the admissions are covered.

MS. DePARLE: That was always covered because if you're a Medicare beneficiary and you go to the hospital -- the issue was whether or not you had additional visits because of the clinical trial and we made the decision that, in order to encourage clinical trials to have participation by beneficiaries, not to separate it.

MS. BURKE: Great, thanks.

MS. RAY: I just wanted to add with reference to the anticancer drugs, those drugs are FDA approved. And like other injectable drugs, unless there is a specific national coverage decision, Medicare will pay for the off-label use.

In this case, they are making this distinction here that we want to study their effectiveness. And that's where we're getting into the practical clinical trial.

DR. NELSON: I think this is very good, Nancy. I think it's as important as our chapters on quality. I would like some consideration to be given to have a small expert

panel attend of our meetings. There are some folks who have really done a lot of research on effectiveness. Hal Sox edited a journal for the College of Physicians and has done a lot of research, and folks of that kind, as when we had Brent James and Don Berwick and so forth, to really tell us where the field is going and where the value in those of research lie.

I think also we ought not to focus just on emerging technology but some attention ought to be given to that technology that's still being used that's outdated or no longer of value, has been perhaps superseded, in some cases redundancies are occurring. We need clearer understanding of when to get a CAT scan, when to get an MRI.

So some of the modalities that are in common practice still need to be examined from the standpoint of effectiveness.

DR. MILSTEIN: Just a suggestion that with respect to the third bullet point about review methodological issues, I wanted to suggest that that include a consideration of the advantages and disadvantages of refining the unit of cost-effectiveness analysis to specific treatment indications or patient subgroups, because the

emerging evidence is that there are vast -- the population is receiving it and then you subdivide the cost-effectiveness analysis by different subgroups, you get very different answers both with respect to effectiveness and cost-effectiveness.

I expect our ability to achieve more value for Medicare spend would likely be higher if the unit of cost-effectiveness analysis was more refined than simply the treatment as one chunk applied to everybody that's currently getting it.

DR. MILLER: I'll just comment quickly on that. When Nancy and I and others were talking to CMS about this, and Nancy I'll get this wrong, they divide things into patient registries and practical clinical trials. And one of those -- and I can't remember which label -- is directed towards that kind of thing.

We know a defibrillator works but do you want to put it in everybody or does it work best for this segment of the population? They are definitely contemplating that. And as part of this exercise, we assumed we would be contemplating that.

DR. MILSTEIN: One way of thinking about it is

treatment indication dyads. That's really the unit of analysis that yields most information and opportunity for improving value.

Cost-effectiveness, I think, in the technical term, refers to how much money you spend in order to prevent a death. And the question is are we using that term in a more generic sense to refer to how much we're spending to get a certain amount of health gain? Are we talking about utility adjusted health gain?

In the analysis, there are a number of pivotal variables that affect the validity and also the opportunity for using such analysis to improve the value of Medicare spending.

DR. BERTKO: I wanted to add to Nancy's second bullet here and maybe be more explicit because she may have this planned. Some investigation onto I'll call it under the umbrella of transparency, the uses of this kind of information by both beneficiaries and members under private plans or other public payers and by the physicians themselves, as I think Ralph indicated here.

There is a group of people doing I think what's called shared decisionmaking on treatment alternatives and

it would be useful to see how well this plays out and what future there might be along these lines if the research was done and available.

MR. HACKBARTH: In fact, that's long been an area of personal interest to me because in a lot of cases what it comes down to is the proper choice is based on beneficiary or patient preferences and how they value different outcomes and what kind of attitudes they have towards risk, et cetera.

So even if you've got all of the economics worked out at one level, it doesn't answer all of the questions about what appropriate treatment is. We've got to find more effective ways to engage the patient in that decisionmaking process.

DR. REISCHAUER: This might be absolutely impossible, but it would be nice to have some idea of what the costs of these analyses are. We've thrown $15 billion out on the table and some people think that that's a step forward. My view is this is inconsequential chump change for what really is required.

And also, some kind of idea about what is going on in the private sector, among plans, among insurers, among

others. I mean, in a real sense, this is an international public good and it's crazy that Humana's doing some of it and Atena's doing some of it and BlueCross is doing some of it. It really should be done in some coordinated fashion. They could be part of this.

The other thing that I would think we would want to put a plug in here for is the importance of electronic health records and IT to doing this in an efficient kind of way. And also, the information that is going to be hopefully gathered by the drug benefit in MMA, if done appropriately, is going to provide a lot of good information when combined with other claims data to do these types of analyses.

MS. BURKE: Can I follow up on that very quickly? Nancy, one of the things you may want to do, the IOM has had some discussions around this question of how you convene people around the table who are interested in sharing this information. It may well be worth talking them to them, as well. This whole question of it's a common good to the extent that we determine what is and what isn't effective.

This issue of how much money is needed to do the research and how one gets people to engage and avoid issues

of restraint of trade and a whole variety of other things.

DR. REISCHAUER: And the HIPAA complications.

MS. BURKE: And the HIPAA complications. But I know they have spent some time on this, so you might want to talk with the folks at the IOM and figure out where they are in moving that conversation forward.

MR. HACKBARTH: Anyone else?

MR. MULLER: If I could follow up on Bob's point about a public good. In some ways when the Humanas and the Aetnas do it, it's also a private good and they do it for a real reason. I think one of the challenges for us is we want to use that -- the metaphor we want more groupings that considers this to be enough of a good that it's willing to invest in it. Obviously, if it were available in some kind of public way, in terms of information, through CMS and so forth, that's valuable.

But also, as I've argued consistently, you need institutional settings, whether it's plans like Humana and Aetna. Part of the problems of integrated delivery systems, much of which has not yet come through for reasons we've discussed here, we'd like to see integrated delivery systems try to have that as a good, as well, if they had some

incentive to move in that direction.

So I think one of the challenges for us is to keep understanding are there entities somewhere between the individual physician and individual hospital, and not just the health plans, that are organized to do these kind of efforts? And I think a lot of the themes we discussed, whether it's Bob's point just now about the MRI, the whole pay for performance discussion, these things do coalesce in certain ways.

And I think understanding more fully why it's just the health plans at the moment that seem to have an economic return for making these kind of investments, very few providers have that. Again, the Kaisers, the Mayos do it as part of their culture. But there isn't enough of an incentive yet for many of other players in the system to make these kind of investments.

I think one of the things we're struggling with is how do we get those incentives into the delivery system for more our players, not just the health plans. Because I think the health plans have learned they can't do it themselves because they're not the doctors, they're not the hospitals, they're not the nursing homes, et cetera.

So I would like us to keep paying some attention to how we get institutional players to invest in these private goods so that by the coalescence of a lot of private goods it becomes a really big public good.

MR. HACKBARTH: Coming from an organization that had the Kaiser-like culture and a great interest in trying to figure out how to practice better with fewer resources, one of the problems that we faced was that our physicians bought into that premise as sort of a matter of entry. They didn't come into the system unless they believed in that principle.

On the other hand, they practice in a world where not everybody else shares the same objective. And that imposes a real constraint on what they can do. When you spend your life at the Brigham as a specialist surgeon or an oncologist or whatever, you may have certain convictions. But if you try to implement them and they're not bought into by the broader community in the hospital, it's difficult, very difficult.

And for me that adds up to a case that would be a whole lot better for organizations like my old one or Kaiser if everybody were pushing in the same direction, we had

broader public investment in these tools.

DR. REISCHAUER: You know, when Humana discovers through a proprietary analysis that procedure X is ineffective for condition B, and it says we won't do it, it becomes denial of care and rationing. When an objective international body says this doesn't work, it becomes something different.

You should not be competing on those grounds, I don't think.

MR. HACKBARTH: Thank you very much, Nancy.

Our last item is another upcoming mandated report on handling costs for drugs trucks delivered in hospital outpatient departments.

DR. WORZALA: Everything dealing with outpatient takes about three minutes just to say.

Good morning. I'm here to give you background and describe our approach for this mandated study we were given in the MMA, which is on the handling costs hospitals incur when they deliver certain drugs, biologicals and radio pharmaceuticals in their outpatient departments. For the rest of the report I'll call those products unless I need to differentiate between one or the other.

The report is due on July 1, 2005 although we expect to include it in the June report. Rachel Schmidt and Sarah Kwon are also working on this project.

The MMA changed the way hospitals will be paid for these products and the set of products are those that had been on the pass-through list in December 2002.

To refresh your memory, the pass-through mechanism provides additional payment for certain new technologies for a period of two to three years. And as you'll recall, a large number of products were moved from the pass-through list to regular payment groups in January 2003. So the study is really addressing that large group of new technologies that flowed into the payment system then.

Beginning in 2006, the MMA requires CMS to pay for these products using acquisition costs. GAO has been asked to estimate those acquisition costs. We have been asked to determine whether or not the payment system needs an adjustment to cover the handling costs hospitals incur for storing, preparing and disposing of the products. And if so, how should it work.

The idea behind the study question is that previously the handling costs for these products were

included in the payment for the product itself. Arguably then, these handling costs are already incorporated in the payment pool.

However, when you move from paying this larger amount to the acquisition costs how exactly will the payment system treat those handling costs?

So there are many pieces to answering this question. I just want to address the most basic ones, which is what products are we talking about? And what costs are we talking about?

This slide comes from our analysis of the 2002 hospital outpatient claims and lists the pass-through products with the highest payments in that year. We've split it into two columns, drugs and biologicals, and radiopharmaceuticals. For the drugs, we've included their brand names in parentheses.

The drugs and biologicals include a number of products used in cancer treatments, including treatments for anemia, number one on the list, as well as chemotherapy agents. One of the top five, Remicade, is for treating rheumatoid arthritis and Crohn's disease.

The radiopharmaceuticals include many products

that are for diagnostic nuclear imaging procedures. Some are also used for treatment purposes. FDG is used for PET scanning.

In total, our study applies to products in about 250 APCs. Within those APCs, there are over 1000 national drugs codes or NDCs.

Now that we have a sense of the products we're looking at, what are the costs we need to study? First, we're looking at both hospital pharmacies and their nuclear medicine departments, due to the inclusion of radiopharmaceuticals. Second, we're looking at handling costs. So what do these departments do to store, prepare and dispose of the products? This can include things like complying with safety requirements, conducting quality improvement activities as well as staff time, storage space, equipment, supplies and disposal fees.

It might also help to understand what we're not looking at, which includes the actual acquisition costs as well as the costs associated with administering the product to the patient. So for example, we are looking at the cost of preparing a chemotherapy infusion in the pharmacy but we're not looking at the costs incurred in the infusion

suite to administer the IV and monitor the patient.

This slide puts our study in the context of the flow of payments for these products. Of course, all payments are made to the hospital, not the manufacturer. In the pink box at the top -- it's a little purple, but it was pink in the office -- is GAO's study on acquisition costs. That is one payment. In the middle box is our study, looking at the handling costs. And the policy question, again, is whether the OPPS needs a payment adjustment to cover these. At the bottom is the existing separate payment for the cost of administering the drug to the patient.

So we've had a number of consultations with providers and trade associations about this study. We've also reviewed the literature. And surprisingly, we found very little data on the costs we're discussing. This is primarily because they are generally covered as part of the payment for the products itself. In addition, there's really no common definition for what these costs are, nor a methodology for measuring them.

So we concluded that we wouldn't be able to conduct consistent data through a survey. Instead, working with a consultant, we plan to develop a framework for

defining and measuring the costs and to have that framework reviewed by a set of experts in hospital pharmacy, nuclear medicine, cost accounting and finance. We'll then conduct a case study in four hospitals to assess the feasibility of actually using the framework to measure the costs. And of course, with only four hospitals, we won't have any representative cost estimate.

We'll also look at other sources of information on these costs, such as data from Maryland hospitals and the Medicare cost reports. But we're not optimistic that they'll be detailed or consistent enough to answer the question.

So that's our study and it is very narrow in scope. But we think it may raise other questions about how the outpatient PPS is paying for drugs, biologicals and radiopharmaceuticals.

So I'll take your questions.

MR. HACKBARTH: Well, other than all of those caveats, we've got this nailed. We know how to get a handle on this. This is going to be a challenge.

Questions, suggestions?

MR. WOLTER: I'm sure this is impossible, but

would there be any chance we could try to create some parity between what happens in hospital and physician offices in terms of how payment works? Probably the answer to that is no, I'm guessing, based on what we just heard.

MR. HACKBARTH: Yes, hard to figure.

MR. MULLER: I think Chantal hit it on the head, trying to get a representative sample here and so forth, obviously we're not going to have that. But the standard caveats that we would make, in terms of regulatory requirements in certain settings being different than others. For example, all the hospitals now are pretty regulated. It's almost like pharmas in terms of clean rooms and air filters and so forth.

So I think whether we can get some sense of the different regulatory environments in which some of these settings live, and therefore the kind of cost consequence of that. We also, in other settings, talk about overheads and just talk about it as accounting issues. There's obviously real costs behind some of these overheads. And trying to get a sense of what some of those might be in some of the more complex settings, I think would be useful just to see the data on this.

I don't know where this goes either. I have some suppositions on it. But I think I'd definitely like to get a sense of at least one complex setting in our four sites to see how the requirements have ratcheted up. Obviously, we're all aware of the whole biotech revolution in the last 15 or 20 years. My sense is, having been in one part of this, is the requirements on us to handle the biologics is much more of an investment in people, facilities, et cetera than it was 10 or 20 years ago.

DR. REISCHAUER: My condolences to you, Chantal. I can't imagine how you're going to do this.

You're looking at a subset of all the stuff, as David Cutler calls this, that Medicare uses. But that's a subset of everything in the hospital is doing. So what are we looking at, the average cost or the margin cost here? Because an awful lot of it -- I mean, this isn't like an experimental lab that has a monkey room and a rat room and a fish room and you can divide it up. It's all mixed together, the Medicare stuff and the non-Medicare stuff. Or are you going to do the total and then sort of say how much of this is Medicare business?

DR. WORZALA: We'll bring our framework to you in

March, but I can give you a little more detail about what we're thinking. The notion is first to actually define what costs we're looking at, so that when we go to these hospitals we can say we want you to look at this.

And then where we're headed, although I can't say that this is definitely what we'll do, is asking the hospitals to do some microcosting. So take a few products and have them microcost those products and not actually look at the costs themselves but look at relatives to see if there's any way of grouping the products by relative resource use.

So that's the kinds of things that we're thinking about.

DR. MILLER: A different way to think about what we're doing here is after we evaluated the environment and data, could you even survey -- if you went out and sent a survey, would people even understand what you were asking for? And would there be common definitions? Is to come back to the environment and say all right, if you need to understand this information and identify this information, this is how you go about doing it. And then there would presumably be some cycle that would follow from that in

which they would gather the information and then have it.

Is that kind of what we're thinking?

DR. WORZALA: Yes, that's a step back from what I was saying. Thank you, Mark.

MR. MULLER: That's point two, isn't it? Were you just rephrasing point two?

DR. MILLER: Exactly.

MR. MULLER: Thank you.

DR. WORZALA: I just want to say, Ralph, to your point, we are talking with hospitals about their willingness to participate in this. And our goal is to have representation of teaching, large urban, as well as smaller community hospitals. We don't know that we'll reach to urban, since we clearly can't be representative and we need facilities that have enough volume in these areas and also sophisticated cost accounting systems in order to help us out.

MR. HACKBARTH: Anyone else? Okay thanks, Chantal. Good luck.

DR. REISCHAUER: Don't come back until you find the answer.

[Laughter.]

MR. MULLER: And fix SGR on the way.

[Laughter.]

MR. HACKBARTH: Okay, we will now have our public comment period.

Okay, thank you all very much and see you in March.

[Whereupon, at 11:08 a.m., the meeting was adjourned.]