MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Tuesday, November 16, 2004
10:43 a.m.*

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
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DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

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P R O C E E D I N G S

MR. HACKBARTH: Welcome to our guests in the audience and I apologize for the temperature in here. It actually feels like it is getting a little bit warmer. It's been quite cold.

Our first item for today is a presentation on what is basically our context chapter and each of our March reports. Rachel?

DR. SCHMIDT: Good morning. Today I'm going to walk you through some information that, with your input, we will turn into the introductory chapter of the March report to Congress. Since that report will include your recommendations for payment updates we tried to use that first chapter to put those recommendations within the broader economic context as you begin to consider -- in which the Medicare program operates. By describing the overall spending context as you begin to consider update recommendations, we're also trying to be responsive to a mandate within the MMA for MedPAC to consider the budget consequences of its recommendations.

when MedPAC reviews payment rates for each sector of providers we try to keep in mind what would be adequate

payment for efficient and effective providers that are providing appropriate care. We do that because part of the Commission's role is to get the best value for Medicare's resources, which are really the resources of taxpayers and beneficiaries.

We aim to walk a line between ensuring good access to quality care for Medicare's enrollees while using the program's resources efficiently and effectively. In recent years you have taken a particular interest in exploring how Medicare might link payment to quality.

Part of the reason for doing this is to better serve the clinical needs of beneficiaries. But another reason may be that in some cases paying more for better outcomes or higher quality could improve the efficiency of how care is provided. This is not always the case but it may be at times. This draft chapter tries to describe the economic landscape for Medicare and some of the trade-offs and goals for the program.

Now let's take a look at some of the forces affecting health care spending in general and the Medicare program in particular.

This slide summarizes the most important trend to

focus on, the fact that health care spending has been a growing part of our economy, and all indications suggest that it will continue to grow faster than national income for the foreseeable future. The United States spent about $1.4 trillion on personal health care in 2003 or about 13 percent of our gross domestic product. This includes health care services funded by all payers. So private health insurance, public programs like Medicare, and out-of-pocket spending. The Medicare program spent about $281 billion that same year, or about 2.6 percent of GDP.

This chart shows you that over the longer term there's been a steady upward trend in the share of our nation's resources devoted to health care. Notice that there was a period in the 1990s when these lines were fairly flat, a time when managed care was introduced and plans were able to bargain successfully with providers over payment rates and, to some extent, to control the uses of services. Also, the Balanced Budget Act of 1997 put constraints in place on the growth in Medicare spending.

However, the lines have begun rising again and many analysts believe that the flat period of the 1990s was an anomaly. There was a subsequent backlash against managed

care. Consumers demanded broader networks of providers, and providers exerted more bargaining power in negotiations over payment rates.

So now spending is on its upward trajectory again. There are some important effects that result from this. On the one hand, health care industries are a growing part of our economy, creating jobs and providing new technologies that can improve our lives. On the other hand, health care costs have grown to the point that some businesses say it is affecting their ability to compete in the global marketplace and some workers are deciding that they cannot afford health insurance premiums.

The relative market power of plans versus providers is an example of a short-term factor that affects growth in health care spending. So let's talk about the factors that affect growth over the longer term.

Most economists have concluded that innovation is the biggest driver of spending. Some new health technologies spend money, for example by helping to avoid hospitalizations or reducing lengths of stay. However, in some cases, innovations may not be worth their costs, and even in a few cases might have been harmful in unexpected

ways.

Many innovations lead to higher spending because they increase the demand for health care. Providers and their patients become aware of how to use those technologies more broadly. And since many innovations reduce the invasiveness or pain of treatments, more people want the therapy.

Other characteristics of the U.S. health care system interact with new technologies to increase the demand for health care. For example, while insurance is good for limiting the potential out-of-pocket liability of beneficiaries, it can also lead people to use more care than they would otherwise if they paid for it all themselves directly at the point of service.

Likewise, providers may not be sensitive to the cost of care when deciding among treatment options. Many people's expectations about how long they will live and what the quality of their lives should be is changing. And as our standard of living increases, so does our demand for health care services.

Of course, the Medicare program is affected by demographics, specifically the coming retirement of the baby

boom population. Our country's lifestyle has become more sedentary than before. That fact, in combination with our high fat diets, has led to a higher prevalence of obesity and more of the chronic conditions that are associated with it.

And last but not least, some analysts point to Medicare's payment systems as providing little incentive to control spending since, in many cases, providers are paid more for doing more.

So there are a lot of upward pressures on health care spending in general and on the Medicare program in particular. It's also important to bear in mind for the context of Medicare that the federal government is facing a sizable budget deficit. This chart shows the latest baselines from the Office of Management and Budget and the Congressional Budget Office. Both organizations estimated that for fiscal year 2004 the deficit was about $415 billion or 3.6 percent of GDP, about where the vertical line is on this chart. That's the largest it's been since the early to mid-1990s when Congress passed the Budget Enforcement Act which included pay-as-you-go rules for constraining growth in spending associated with entitlements and tax changes.

The Congress has been considering readopting pay-go rules but has not yet done so formally. In any event, there may be considerable pressure to limit Medicare's program spending in order to reduce the deficit, but at the same time there are a lots of upward pressures on program spending.

I just want to remind you briefly about the sources and uses of the Medicare program's resources. We tend to focus on things like trust fund balances when we talk about Medicare's financing. This chart combines all types of funding and benefit spending together without making distinctions between Parts A and B.

The pie chart on the left-hand side shows you that in 2003 just over half of Medicare's total financing came from payroll taxes that active workers and their employers pay into the Part A Trust Fund. Another 30% came from general tax revenues. That's the taxes we all pay that aren't dedicated to a specific use like the payroll taxes. Beneficiary premiums, mostly for premiums on Part B, made up just 10 percent while interest on trust fund balances and other small sources made up the rest.

The pie chart on the right-hand side shows how

Medicare used its resources on 2003. The majority, 45 percent, were paid for hospital care with 17 percent going for services on the physician fee schedule. 13 percent went to managed care plans, 5 percent went to skilled nursing facilities, 3 percent for home health, 2 percent for CMS's administrative expenses and 14 percent for other services that include hospice, clinical lab, DME and other things.

I'm showing you a chart that was put together by CMS's Office of the Actuary for the 2004 Trustees Report. This shows you their long-term projections of Medicare program spending, which is the height of the top line of these stacked layers, along with the expected sources of funding which are the layers themselves except for interest.

We're sitting at the point shown by the vertical line, with Medicare making up just under 3 percent of GDP. Note the bump-up in 2006, when the new prescription drug benefit begins, which will bring Medicare up to about 3.4 percent of GDP. Over time, the trustees expect that share to grow to about 8 percent of GDP by 2036 and about 14 percent by 2078. That growth is driven by the things we talked about, medical innovation, the retirement of the baby boomers, and so on.

The scare part of this chart is the layers. First off, note the yellow layer at the bottom, payroll taxes on active workers. That makes up about half of the financing today but look how it's flat and becomes a smaller share of the total picture over time. That's because the payroll tax is a fixed percentage of earnings and there will be fewer workers supporting each beneficiary in the years to come. Today there are about four workers paying taxes for each enrollee in Part A. But that ratio will fall to about 2.4 workers per beneficiary in 2030 and 2.0 in 2078.

Note that premiums from beneficiaries are expected to grow over time, both for Part B and the new Part D. However, most of the funding will come from general tax revenues, the dark blue area. Today, general tax revenues make up about 30 percent of all funding, but that share is growing.

The MMA put in place a trip wire to make policymakers consider changes in Medicare program financing, when general revenues are projected to reach 45 percent of program outlays. This wire could be tripped in just a few years from now. That means that the president would have to propose and the Congress would have to consider legislative

changes to reduce the share of financing from general revenues.

Also note the red area at the top. I'm sure you know that this year the Trustees projected that the Part A Trust Fund will be exhausted in 2019. The red area shows you how much revenue the Medicare program will need to make up to keep Part A benefits as they are today. Under the law, the Medicare program cannot pay for benefits once the trust fund is exhausted, so policymakers will need to make changes to address this shortfall.

So clearly, there's a lot to be concerned about in terms of Medicare's long-term financing, not to mention the overall health care spending in our economy. Which raises the issue of how much do we value health care services and how much do we want to spend on it?

It seems that our society values health care a lot. Our health care spending has led to improvements in public health and medical innovations that have lengthened our lives and kept us healthier than before. But that's not to say that all new technologies have been worth their expense. Some have not. And it's not always clear that every use of a new technology is worth its cost.

The body of research by Elliott Fisher and the Wennbergs has shown that a lot of our health care resources aren't used very efficiently or effectively. They found that higher spending areas of the country do not necessarily have better outcomes or higher quality or satisfaction, and often it's lower.

This is a famous body of research that suggests that the Medicare program could save as much as 30 percent if higher spending areas adopted the practice patterns of lower spending ones.

So we're in a situation where we value health care a lot but we don't necessarily use the resources we have very well and we're beginning to face some very real pain in terms of financing that health care. Some analysts have begun to say that the upward trend in the share of our national income that we devote to health care is too much. Others disagree. So it may be useful to start talking about how much we, as a society, want to spend on health care.

Basically that involves looking at trade-offs, spending resources on health care just up to the point where the value that we get out of that spending is just worth the value of what we're giving up in terms of the other ways

could use those resources.

This isn't just a theoretical discussion. The budget deficit situation may mean that we are reaching a crossroads where society will need to consider more explicitly some of the trade-offs and what it values and what it wants to do with its scarce resources, for example trade-offs between health care, education, homeland security, defense, that sort of thing.

Even within Medicare program spending by itself policymakers will have to make trade-offs. Some analysts believe that initiatives such as effective use of information technology, adopting pay-for-performance strategies and limiting growth and supply induced demand will help Medicare make the most of its resources. It seems pretty important to move Medicare towards value-based purchasing.

The final part of the draft chapter reviews the various categories and policy options that decisionmakers have been considering and they are listed on this slide. Given the magnitude of Medicare's long-term financing problems, it's likely that policymakers will need to use a combination of approaches. All of the options are pretty

difficult but in general it seems that if policymakers wait longer to realign Medicare spending and financing the changes that they would need to make would be more drastic.

The list of categories here is intended primarily to motivate discussion about what sorts of changes the Medicare program could face and the chapter discusses some of the available literature on their likely affects on quality of care, access and Medicare spending.

This concludes my presentation. I welcome your comments on the content and tone of the chapter and any further research that you think is necessary.

MR. HACKBARTH: Good job, Rachel.

Let me start with a comment and question. The title is At a Crossroads in Medicare Financing: Assessing Payment Adequacy and Moving Toward Value-Based Purchasing. I wonder if we should be even a little stronger than the draft in terms of saying that it's our view -- and I think this is our collective view -- that faced with the sort of financial trouble that you describe in the chapter and is captured in that one graph, number six, that trying to deal with the problem through across-the-board spending constraint, treating all providers equally as though they

are the same, is a dangerous approach. That has been Medicare's traditional approach to trying to achieve budget savings. We just squeeze everybody equally.

But under these circumstances we need to change our game. And as difficult as it may be across the whole range of providers, Medicare needs to be more careful and discriminating, if you will, among providers on various types of care. We need to send clearer signals that this is good and we want to reward it, and this is bad and we want to discourage it.

That's a major change in direction for Medicare but I think it's a theme that consistently is emerging out of our work and I would like to see it more prominent in the chapter. There's a question mark at the end of that. Do other commissioners to agree with that? Does that make sense?

DR. CROSSON: Yes, I think I do. And I think I had a similar comment. I really like the paper. I think the breakdown of the last five methodologies to try to resolve the problem is a good one.

When I looked at the space of that each one of them occupies, I think I would have wished for perhaps more

discussion around the payment rate issue and then the management and use of services, only because I think -- and I think other discussions have suggested this, that we have had here -- is that these may very well be the two areas where most change is possible and the most leverage exists.

So for example, I think some of the issues around how services are paid for, physician services and hospitals are paid for, what potential changes could or would not be wise to change would be useful just in general.

And then secondly, in terms of the management and use of services, maybe expanding that section a little bit to indicate some potential areas that might be fruitful, realizing that they are going to be discussed in later chapters, might strengthen the paper.

DR. SCHMIDT: I certainly take that point but let's reiterate that there will be another chapter that is evolving as we speak, one or maybe more, that goes into particularly the management of use of services in greater detail.

DR. CROSSON: Thank you.

DR. SCANLON: I thought this was an excellent piece of work and really does lay out the issues, as grim as

they are, extremely well and comprehensively. I think we are probably at a point where we need to think about fundamental changes in order to try and deal with this for the future.

The idea that Medicare is going to be a value purchaser is the one that I think we really need to emphasize. And emphasizing that, which to me means that Medicare is trying to efficiently purchase access to quality services for its beneficiaries. The use of the term efficiency in that sentence is, I think, the appropriate place for efficiency because one of the things that has been a premise behind much of the payment policy that we have had, at least in the minds of many, is that the prospective payment system is recognize efficiency and reward efficiency. The reality is that they recognize low cost. The two don't necessarily equate.

I think we need to consider how to move away from the idea of always rewarding the low cost and perhaps inordinately rewarding low cost. We need to think about what is it we're buying, have a greater variation in the rates in terms of what we pay for a particular service based upon quality, maybe also based on market factors.

This may end up being an incredibly important aspect of trying to maintain access throughout the country while trying to be an efficient purchaser. So I think we want to make sure that we emphasize efficiency in the right place, and that's from the program's perspective as a purchaser. We're really relatively ignorant of exactly how efficient providers are but we need the program to be efficient.

MR. HACKBARTH: I agree and I would add the point that right now we don't even necessarily reward low cost. We do it for relatively small bundles of services, but sometimes rewarding low cost for a narrow range of service may lead to higher cost in overall management of the patient looked at on a grander scale.

MR. DURENBERGER: Obviously, I agree with everything that's been said, particularly the title. It's so challenging. And then there's so much material after it that what I did is reorganize your material, just as an outline form. And I'll send it back to you because the content is absolutely terrific and you got it all on PowerPoint, which is like a miracle.

But I wanted to suggest one addition, and I don't

know exactly whether this is our purview. One of the ways in which this could start is by a comment that says that the histories of this commission is really the history of the policy changes and financing access to health care service over the last 20 years. This morning we've already talked a little bit about was that the right direction to go. I think pointing out to the reader -- and my tendency is always to think about who's going to read this. And I would like to target somebody other than Bill Thomas and the staff of the Finance Committee, and try to get more people who are in the Congress to get interested in the challenges that they face in supplementing the work of leadership.

So reminding people that the history of these commissions or commission traces the history of efforts to try to change the financing, I thought, was a great way to start.

But at the end of it, and maybe this is coming in the future, is the Medicare Modernization Act as the future. It just feels to me as though it would be important for MedPAC to point out and to stress the importance of the effort to privatize the Medicare program using the experiences of the past, including the predecessors to

Medicare+Choice, now Medicare Advantage, and perhaps a little more emphasis on "health insurance" side of the paper.

Like many of you, I was probably taken by the current issue of Health Affairs and the lead articles on health insurance which they haven't updated for five years. But there's a lot of really good information, some of which you already touch on.

The commitment to consumer driven health care and what does that actually mean in the context of integrating and care coordination versus something else? Again, to the extent that we can ground that in the realities of what research tells us, the commitment or lack thereof to universal coverage. What does that actually mean in the context of the issues that were discussed earlier regarding hospital margins and is it our obligation versus somebody else's obligation? Certainly, this commission would have a concern about commitments in the MMA policy and the related things that came into it towards universal coverage.

And then finally, on perhaps -- at least from my standpoint -- a more positive context, the issues around regionalization and all of the quality demos and the care

coordination demos and those kinds of what are very positive in the context of what we're looking at, parts of the Medicare Modernization Act.

But again, particular emphasis on regionalization because regionalization they weren't quite sure -- it feels like they weren't quite sure of it. First it's going to be prescription drugs, then it's going to be PPOs. And then there was this battle over what happens in 2010. I, for one, given the conversation we had earlier on, feel fairly strongly to say something positively about regionalization in the Medicare program, in the same way that I feel that perhaps the work that we all engaged in over the last 20 years of treating all doctors alike, all hospitals alike may not have been the wisest course of action in some parts of the country.

So bottom line, adding to Medicare at a crossroads should be the reality that besides that big budget deficit graph, we need some kind of a narrative graph about the potential impact, insofar as health service research can help us understand it, of the current policy track that the majority in the Congress is on right now.

MS. BURKE: To start with, it's a terrific piece.

I just have a couple of comments, one or two small technical things and then one is just a broader context.

The two small technical things, on page 29 of the document you very effectively talk about the extraordinary impact that the decline in a number of workers per retiree will have. In the first instance you cite what the alternatives will be to an increase in the payroll tax of 2.9 percent to 6.2 percent. And then alternatively, you could cut HI expenditures by 48 percent.

In the second instance, you talk about the delay until 2019, the message being if we don't start dealing with this now, the impact will be far greater. And you've chosen to show what the increase in the payroll tax would be to 7.1 percent but you don't talk about what the cuts would be in the program.

So I would again, in both instances, use those examples because I think they are a positive message.

The second relatively small thing is there's no reference, and I kind of understand it, but there's no reference in the entire document to Medicaid. Particularly in the context of page 32 and page 33, where you talk about cost-sharing and changes that might be paid with respect to

the beneficiary's participation, there's no reference to the potential impact that would have on the Medicaid program and the number of people who are duals.

So I would, again, at some point reference essentially the impact would not only be here but it might well be on not only their tendency to buy wraparound but also the impact on the state Medicaid programs in terms of the duals.

The final thing is really an overall question. An extraordinary job of talking about the context of Medicare and the structural issues around financing and alternatives. What is here, but only briefly and only at the very end, is who the Medicare beneficiary is. There is a brief reference in the course of the discussion around cost-sharing that references Marilyn Moon's work and some others about who this population is.

I think we might benefit from reminding people once again early on who is this person? This sense that it is a 68-year-old living in Palm Beach that has the capacity to bear all of these changes is a false impression. And I think an up front clear indication of who these people are, essentially the female dominance over time, particularly in

the old-old, the fact that there are a large percent of them who are relatively low income, many of them with comorbidities. They're not all playing golf full-time.

I think that helps create the context as well, not only about the structure of the program, but as we alter the program what the impact would be on this, in many cases, very fragile population. And I think it would benefit us to remind people because, as Dave suggests, I'm not worried about Bill Thomas. But I am worried about the large number of people who have this false impression of what the Medicare program is today, as compared to what it was in 1965. Because it is a different program, not only because of the way we pay for services and deliver them, because the population is different than it was.

And I think we need to remind people of that because how we design it going forward will have a huge impact in terms of who these people are. Many of them are in Palm Beach playing golf, reading Fortunate Magazine. But there's a whole heck of them that are not, and I think we need to make sure that they understand that.

So I'd put that in the context, as well, up front.

DR. BERTKO: I also want to commend Rachel for

doing an excellent job of stressing many of these things. I guess I would only suggest perhaps considering a tone of even greater urgency for two reasons.

I'll point out that the assumptions used in the chart shown are from the intermediate assumptions of the trustees under current law. The 2004 reporting facts cites the SGR, in particular, as being one of the things that might be, in fact, something that needs to be considered as how it changes with the probable reaction that it would accelerate the trigger for that 45 percent rule.

The second reason for urgency, which is apparent from the graph of course, that the HI Trust Fund revenue from payroll taxes will now be exceeded by outgoes within the next year or so. And so while the trust fund itself isn't technically exhausted until 2019, this outgo over income is going to have an effect on budgets very, very soon.

MR. SMITH: Rachel, this is terrific work, as many of the other commissioners have said.

I had thought as I read the last part of the chapter along the lines that Jay and Glenn talked about earlier. It seems to me we ought to reverse the order in

part because more leverage, more capacity on the last two points, both the payment rate point and the management of services point. That is also more our area of competence, rather than talking about taxes or even eligibility.

I do think it's important to leaven the eligibility discussion a little bit with -- we are living longer. We are gradually ratcheting up the Social Security retirement age. But folks who fall into that pre-Medicare eligible hole are very vulnerable. You say that but I think it needs a bit more emphasis.

So I think about reordering the five. I think the five are fine. But I would say more about chapter three in the management of service provision. That that's the thematic, as Glenn said, that I think we want to drive everywhere we can here.

Just one point, building on Sheila's point about the material on page 29, it's all true. But it's also true that the fewer workers supporting each beneficiary are going to be much richer than their predecessors were. And so increasing the payroll tax, not an option that it seems to me we want to jump up and down and say we are for, but increasing the payroll tax is still going to leave the

supporters of tomorrow's beneficiaries with higher real incomes than their predecessors had.

This is scary stuff. I don't want to try to minimize how scary it is. But it's important not to be scarier than we have to be.

MR. HACKBARTH: Any others? Okay, thank you, Rachel.

Next is the mandated report on eliminating physician referrals for physical therapy

MS. CARTER: Last month you reviewed and provided comments on a draft of this report. We've tried to reflect your comments in this draft and would like to get your last thoughts on it.

Briefly, this report was included in Section 647 of the MMA and is due January 1. It requires MedPAC to study the feasibility and advisability of allowing Medicare fee-for-service beneficiaries to have direct access to outpatient physical therapy services.

Under current Medicare coverage rules, a beneficiary must be referred by and under the care of a physician for outpatient physical therapy services to be covered. These requirements are listed in the next slide.

First, a patient must be referred by a physician. A written plan of care must be reviewed every 30 days by a physician. And for longer-term treatment the patient must be reevaluated by a physician. Direct access refers to eliminating these requirements.

Medicare's coverage is limited to services that match a patient's condition and are provided with reasonable frequency. Note that services must be restorative. Local carriers and fiscal intermediaries are key to how these coverage policies are implemented and to the determination of whether services provided were medically necessary.

The Office of the Inspector General has concluded that some of the services provided that are medically unnecessary are due to a poor understanding of these coverage guidelines.

At the last meeting, you concluded that there was no reason to change the current physician requirements but you raised several specific concerns that we've tried to address.

The first argument for retaining requirements is that many beneficiaries have multiple and chronic health care conditions. In 1999 about 78 percent of beneficiaries

had at least one chronic condition and 63 percent had two ore more. The physician requirements are in place so that beneficiaries' often complex health care needs are correctly diagnosed and considered in treatment decisions. You noted that many beneficiaries seeking physician referrals are also having their other health care needs addressed during the same visit.

The second argument is that the current requirements do not appear to impair access for most beneficiaries. In 2003, 85 percent of beneficiaries report no problem in getting therapy services.

Third, lifting the referral requirements for physical therapy services would set a precedent for other services with similar coverage requirements.

And last, the program uses the requirements as a way to curb unnecessary utilization. The private sector uses a combination of strategies. When physician referrals are not required, service limits are commonly used to control service provision.

Your discussion last month noted that while Medicare's physician requirements are necessary, they are not as effective as they might be and that additional steps

need to be taken. These next steps might include increasing provider education about coverage rules for physicians making the referrals and for physical therapists furnishing the services.

The Office of the Inspector General has repeatedly recommended that Medicare's claims contractors, the facilities where physical therapists practice, and the professional associations step up their efforts at increasing provider knowledge about Medicare's coverage rules.

At the last meeting you noted that research is needed to develop a body of evidence indicating when and how much therapy services benefit older patients. This evidence could then be used to establish practice guidelines that could be used to educate physical therapists and physicians about physical therapy service provision that is likely to be effective for beneficiaries.

At this point, I would like to gather your last comments on this draft and if you have specific edits you can give them to either me or Sarah.

MR. HACKBARTH: Comments?

I think you did a very good job of capturing the

comments at the last meeting.

Okay. We are racing ahead of schedule, which is actually a good thing because I think we've got some topics in the afternoon that may run a little bit long. And so what we're going to do is move up our scheduled lunch and shoot for 11:45 on that, and maybe even a few minutes earlier.

We will now have a public comment period. Let me reiterate, as I always do, the rules, which are brief comments, very brief comments. And if somebody before you in line has made your comment, please don't feel the need to repeat it in its entirety.

Goodness gracious, we are setting new records for speed here.

Hearing none, we will reconvene at 12:30. So 12:30 is when we'll reconvene. Thank you.

[Whereupon, at 11:23 a.m., the meeting was recessed, to reconvene at 12:30 p.m. this same day.]

AFTERNOON SESSION [12:37 p.m.]

MR. HACKBARTH: Good afternoon. I meant to acknowledge this morning before we started the fact that Bob Reischauer, the vice chairman isn't here. That's because he has a board conflict. The Urban Institute board is long scheduled to meet on these dates and when we shifted our schedule it created an unavoidable conflict for him.

So let's turn to the next item on the agenda which is physician pay for performance. Karen?

MS. MILGATE: In this session we will be discussing whether it's feasible, given the status of physician quality measures and measurement activities, for Medicare to base a small portion of physician payment on quality. This is the third in a series of discussions on pay for performance in various settings. As you recall, we talked about home health agencies in September, hospitals in October, but this is the first discussion on physicians.

We're not suggesting that at the end of this discussion the Commission identify a specific set of measures, but really more to give us some guidance on whether a sufficient number and type are available to do pay for performance.

To assist us in this analysis we spoke with and collected sets of measures from accreditors and certification bodies, CMS, purchasers, plans, specialty societies, including the AMA's consortium, and others. This analysis is based on staff research on the measures and discussions with those experts.

Again, the purpose of the analysis is to really answer the key question of whether it's feasible to base a small portion of physician payment on quality.

There are a couple of different consideration when we're looking at this question. One is, as we looked about in the other settings, the criteria that the Commission developed back in the first discussions on moving towards pay for performance. And the second is, as you've stated in past meetings, the cost of not moving forward, which may be particularly important in the physician setting because of the central role that physicians play in the health care system pay for performance may be less effective without their participation.

In addition, there's increasing awareness of the need for incentives for physicians to adopt and use information technology in their practices, and using

information technology as one measure in pay for performance may in fact strengthen the business case for physicians to adopt IT.

I am not going to go through each of these criteria. We have talked about them several times in the past few months, but these are the criteria the Commission developed for determining whether in fact the measurement activities were sufficient in different settings to apply pay for performance.

We looked at four types of measures, just as we did in the hospital and home health setting. That would be process measures, outcomes measures, structural measures, and then patient experience of care.

Process measures are used in the physician setting to really try to answer the question of whether physicians are providing care that is known to improve outcomes. The strength of these measures are a couple. One is they both measure the quality of care and at the same time identify specific steps that physicians can take to improve quality. They are also well-trusted by clinicians because they're often based on research that shows that these processes are associated with good results for the patient.

Examples of process measures in the physician setting include, for diabetic patients, whether eye exams or HgbA1c tests are given at appropriate intervals; for patients with coronary artery disease whether lipid profiles are done again at appropriate intervals; whether immunizations are done for patients, either pneumococcal immunizations or influenza immunizations.

Then the last one is a slightly different type that we're going to be talking about in this setting, and that is looking at physician care within a setting of care. A lot of measures look at physician care only in their office, and we have included in the analysis some ability to look at physician care within its setting. So for example, you could look at a process measure in a hospital, such as for patients who had acute myocardial infarction or a heart attack, whether they received aspirin on arrival and discharge and then hold the physician at least partly responsible for that.

So who uses process measures and how are they used? The National Committee for Quality Assurance uses process measures in their accreditation process for health plans, so that's not at an individual physician level. They

also have two recognition programs which rely heavily on process measures, one targeted at diabetes and the other at heart/stroke where in fact the physician can voluntarily come forward and give their own data to the NCQA on particular measures and if they meet a certain level then be recognized as a high quality provider of diabetes care.

CMS uses process measures in the QIO program. Specialty societies and the AMA's consortium also have developed and used process measures for confidential feedback for individual physicians. And health plans and purchasers use these in a variety of different ways. You can see that RAND, for example, uses them for research and then MedPAC uses them for monitoring purposes. So we've used some of these process measures ourselves.

The measures on a few conditions such as heart or diabetes are used very often and those are the examples that you will often see. But there are also measures available in many other conditions.

So are there process measures that meet our criteria? Many process measures are well-accepted and evidence-based. The burden of data collection really depends upon the measure. If we were just to use measures

that were based on claims, were derived from claims there would be less burden. The physician would not have to collect information. However, the set would be a smaller set and possibly not as accurate as if we had more information in addition to claims.

If the information came from direct reporting from the physician, such as from flow sheets where information could be collected right at the time the patient is seen or through medical record abstraction it would be more burdensome for the physician but probably more accurate and would have a larger set of measures to use. Of course, the use of electronic health records would greatly decrease this burden of collecting information on process measures.

In general, risk adjustment is not necessary on most process measures. And clearly physicians do have it within their control to improve on these measures. Many of these measures do need improvement. The one issue that we may have on process measures is it is unclear if there are measures available for all types of physicians. That would take a little bit further analysis.

Outcomes measures try to answer the question of how the physician care actually affected the patient, and it

can capture information on both clinical effectiveness and an important concern, safety, which some of the measures don't look at quite as directly.

Here we looked at three types of outcomes measures for physicians, and they are actually fairly different so I want to take each of them in turn to try to define and give an example of them. First we looked at intermediate outcomes, which is something that goes between being a process measure and outcome measure. There's no need to be too pure about the definitions but we've called it an intermediate outcomes.

An example here is where a process measures would be whether the HgbA1c test was performed. The intermediate outcome is considered, what was the level of control that was actually achieved for the patient. Were levels within the normal range or the healthy range for patients?

Potentially avoidable admissions are a longer-term outcome and perhaps one that you are really trying to avoid an admission, an acute event in a person's life. These are admissions that have been associated with what are termed ambulatory care sensitive conditions, where it's been shown through research that in fact high quality ambulatory care

will prevent some of these admissions. So one example here would be the percent of patients who are admitted to a hospital with complications of diabetes.

The other type of outcome that we looked at was to look at physician outcomes within a setting of care. For example, you could look at the percentage of patients who died, such as CABG mortality, those who develop infections or experience complications in a hospital. You could also look at other types of settings where you would not be looking necessarily at adverse events, which are what all these are on your slide here, such as in the home health setting you could look at functional improvements, for example, as one outcome, or in dialysis you could look at the adequacy of hemodialysis.

So who uses outcome measures and how are they used? The intermediate outcomes are really used fairly similarly to process measures so I won't go into detail there on how they're used. It is really the same way in which many process measures are used. They are used both at the individual physician level but also at the group level or the health plan level.

Potentially avoidable admissions are generally not

used at the individual physician level. AHRQ has used them, MedPAC, as well as disease management organizations to look broadly at the quality and access to ambulatory care for an overall population. Then outcomes and settings are used by specialty societies and by some feedback initiatives. They're usually used in a confidential manner for quality improvement purposes with physicians. However, there are a couple example where there's some reporting on individual surgeons; the most famous is probably the New York CABG mortality which is done at an individual surgeon level.

So are there outcomes measures that meet our criteria? Some are well-accepted. For example, intermediate outcomes are quite well used. Potentially avoidable admissions are accepted at the population level so they could be useful if the unit of analysis were groups. Then setting-specific measures are used primarily for confidential feedback at this point, so those we would need to look at a little further to use them for accountability purposes.

There is some increased burden for data collection but there are strategies to lessen this burden. The intermediate outcomes pretty much you would need to require

some level of records abstraction or flow sheets. Again, the EHR would make that a little bit less. Potentially avoidable admissions you could look at through claims, so that would be a low burden on the physicians. Setting-specific measures you could actually look at the facility reports and then assign them to physicians, so perhaps the physician wouldn't have to actually do the data collection.

Risk adjustment is available for intermediate outcomes but we would need to look in more detail to evaluate whether outcomes are appropriately risk-adjusted for the in-setting types of measures. Improvement is definitely something that people have called for in this type of measure. For example, it could help address safety issues in hospitals as well as some of the management of chronic conditions with the potentially avoidable admissions. However, because they are outcomes there are a lot of different factors that affect the scores on these so it would be important to do a further evaluation of how much effect, for example, beneficiaries might play on the outcomes measures.

Structural measures help to ensure that physicians are capable of delivering quality care. Some examples here

include certification and education. Board certification might by one thing you could look at, but there might be other types of certification programs. You could look at continuing medical education that would be particularly targeted at quality improvement, for example, as one structural measure. There is also an increasing interest in looking at physician's care management and patient education functions in their offices.

But probably the most central to this discussion and the most well-used at this point is physician use of clinical information technology. There are really three different ways that this is looked at. One is just the simple adoption. We could look at simply, do you have an electronic health record? But that doesn't get you necessarily into knowing whether the physician actually used the electronic health record for quality improvement. So another step would be to say, does the electronic health record have the functions that you need? For example, you could say, do you have a patient registry and do you actually keep track of your patients within that registry?

But then an even further step to make sure that the EHR would be used for quality improvement would be to

look at the results of that use. So you say you have a patient registry. Do you actually track patients with certain chronic conditions, and then do you follow up on that information? So then also give them reminders, for example, to come to the office for a particular preventive service or diagnostic test.

Increasing awareness of the importance of electronic health records in physicians' offices and the need for incentives to encourage physician adoption make this a central piece of any structural measures that you would want to apply.

So who uses structural measures and how are they used? NCQA also has a recognition program called Physician Practice Connections similar to their other recognition programs that are specific to conditions. These could be applied to all types of physician offices. There they ask physicians to basically document on three different types of measures. They have measures in clinical information technology, a set that is geared toward care management, and the other set is geared toward patient education, all within one recognition program. It's designed so that basically it's easier to actually meet the care management and patient

education standards if in fact you use a clinical information technology system. So the way it's designed is actually as an incentive to, over time, encourage physicians to about information technology.

CMS is considering using these types of measures in a demonstration project called the Docket Project. And large purchasers, Bridges to Excellence being the one group that is most well known for this, does rely on the NCQA recognition program as one piece in their pay for performance initiative. Plans and consumers also have been known to use board certification as one measure of whether physicians are delivering good care.

So are there structural measures that meet our criteria? Certification and education are well-accepted as measures of quality. Information technology, while strongly supported by many, is not as well-accepted simply because the measures are newer, but it is clearly an area that is growing in importance.

The burden is really pretty low for data collection for certification and education. I would really be just informing, yes, no, I am certified, I have a certain level of education. The measures would need to be developed

but the data reporting would be fairly straightforward. There is some burden for reporting on the use of IT. Simply, there would have to be some type of survey or some data reporting form created for that. Risk adjustment isn't necessary. They apply to all physicians, which is nice because you know you have measures that will apply broadly. And there is a growing recognition that physician use of information technology is critical for significant improvements in quality.

Patient experience is the last type of measure we looked at. Here the question is really whether the care met the goals of the patient. These types of measures can ensure that patients are involved in their care and that they also understand their role. These also apply broadly to all patients and types of physicians.

I'm not going to go through each of these examples but these come from the Consumer Assessment of Health Plan Survey which has been used by CMS to look at health plan quality and access. But many of these questions are the same types of questions you would want to look at individual physicians as well.

These are used really to look at broad populations

generally, and because there is no particular tool now, no standard tool, but AHRQ is developing a tool -- in the United Kingdom where they also do not have a standardized tool they simply ask whether the physician is using a survey and don't look at the levels or the response.

Are there patient experiences measures that meet our criteria? Clearly, the concept is well-accepted. There is no standardized tool, but again, the burden would be low if simply the question was whether the physician used a survey. Risk adjustment may not be necessary but this is something that AHRQ should really research as they develop one. As I said, it does apply broadly and improvement is possible.

So even though our analysis thus far focuses on quality measures, pay for performance raises other issues as well. I think we talked about a couple of these even in our discussion this morning. The first is how you would actually assign responsibility for an individual patient to a physician. Medicare beneficiaries often see more than one physician, so there's some question about who would actually be responsible.

Two methods that we found in the private sector

were, one, simply evaluating claims to look at whether there was a certain minimum threshold, either dollar-wise or utilization of visits, that could be assigned to a particular physician and then you would consider that physician, or perhaps several physicians that take care of the patient would be responsible for their care.

Another way to do it is to let physicians self-identify or identify the patients who have particular conditions. Clearly this would need to be audited to make sure that they were not choosing just their healthier patients, but that's the method that NCQA uses in their recognition programs.

Another issue as I've mentioned going through the presentation, is whether there are process and/or outcomes measures that are available for all types of physicians. It is unclear so further analysis would be needed on that. Using IT or patient experience would apply broadly so that wouldn't be an issue for those types of measures.

Another issue is the unit of analysis, whether it would be individual physicians or groups of physicians. We would particularly like some Commission feedback on this one. Many issues can be addressed by groups. For example,

sample size would be larger if you looked at groups rather than individual physicians. It may be easier to attribute patient care to a group rather than to an individual physician. In addition, groups often will have better feedback loops so it might be more useful for quality improvement purposes. And there may be economies of scale in reporting at the group level rather than individual physicians having to collect data. Of course, not all physicians practice in groups so that's an issue that would need to be dealt with.

This last slide tries to be a picture summary of what we found in our analysis. It is really a potential strategy to help us prioritize options. The initiative could really be phased in in several different ways. What we present here is a left-to-right look at where we think it might be possible to start. For example, you might start with structures and have a few process and then move on out as we became more comfortable with measures, or as it was determined really what the important priorities in the physician setting were.

The other way to do it is also to think about ways to use the information differently. So some of the

information might be used in the beginning for confidential feedback. For example, that's often how information about physician care in a setting is used currently. That might be a place to start with that type of information rather than actually paying on the basis of it right away.

Thirdly, you could weight measures differently based on their importance or your level of trust in the measures. For example, in the U.K. example on patient experience they have very few points assigned to patient experience but many more points to the areas where they feel more comfortable with the measurement, for example, clinical indicators.

Just to summarize quickly. Information technology clearly has a central role in making it possible for physicians to assess and report on the quality of their care. IT use also applies broadly to all types of physicians and has the potential to improve quality of health care. Therefore, this type of structural measure could be very useful initially, along with certification and education.

Process measures, either claims-based or those derived from flow sheets or records abstraction could also

be used initially on physicians where those measures exist. The same would be true of outcomes measures. Patient experience of care is clearly an important dimension but until there's a standardized tool we wouldn't suggest that you would want to do anything other than ask the physician if in fact they did survey their patient.

That concludes my presentation. I would be interested in your comments on the direction of the analysis and again whether there are important concepts or measure sets that we may have missed in our evaluation.

DR. MILSTEIN: That was a wonderful summary. One of the facets of performance that we have not yet looked at but I think is something we may want to look at is what the Institute of Medicine in categorizing dimensions of quality referred to as efficiency. Right now in California I am on the steering committee of what I think is today the largest of the pay for performance programs at the physician level in the U.S. It's a program operated by the Integrated Healthcare Association California-wide across many managed care plans that will in 2004 pay out approximately $100 million in bonus pay to California physician groups. We are now about three years into it and we're looking back and

saying, what changes do we want to make. Having gotten our toe in the water maybe I can just briefly tell you what the pioneers are thinking anyway.

First, I think we're tilting in the direction of more measures even if less perfect. We started out focusing on a very narrow list of very methodologically pristine measures and now our self-criticism is, we measured what could be measured with great precision but we maybe missed what was clinically important. And we now are tilting in the direction of the U.K. which has literally hundreds of performance measures, something maybe in between those two extremes. But our feeling is that 10 or 15 were not enough.

Secondly, we are in the interim tilting a little bit more of the reward on actual uptake and use of robust clinical IT systems since that eventually creates very low measurement burden if the measurement is being fed by electronic health records. We're adding efficiency measures because we feel that was an important dimension of quality that we missed the first time around. We are also moving measurement from measuring only physician groups to measuring groups and individual physicians, as challenging as that might be.

Lastly, I think taking a cue both from the U.K. and from Mark McClellan's recent comments, we feel that the percentage of total physician pay that needs to be on the table for physicians to very heavily prioritize performance improvement needs to be a lot more than the 5 percent to 10 percent we currently have on the table. We believe it needs to be considerably north of 10 percent if performance improvement is going to be a very high priority among physicians. So those are just some lessons or learnings from some early adopters.

MR. HACKBARTH: A couple of questions about that, Arnie. What percentage currently is on the table for the program that you're describing?

DR. MILSTEIN: It varies somewhat by health plan but it is 5 percent to 10 percent. There's some variation across the plans.

MR. HACKBARTH: You've emphasized including efficiency as one of the measures. Can you say for what you mean by that. What kind of the efficiency measures are you talking about?

DR. MILSTEIN: I think something that would be more analogous to what economists call total cost of

ownership. That is average cost per patient of all health care resources utilized in taking care of either an episode of acute illness or a year's worth of chronic illness and preventive care. So it's total health care cost associated with a particular physician or a physician group being primarily, or as Karen was describing, substantially responsible for the care of that condition or that patient over that time period. So it would take into account things like propensity of a physician to use a brand drug rather than a generic drug. It would take into account propensity of that physician's asthma patients to end up in the emergency room. It would take into account propensity of a physician to order a lot of follow-up visits by specialists for a chronic condition. All that would be wrapped up into a total cost of ownership rating.

There are seven or eight brands of commercial software on the market that many health plans and capitated delivery systems use in order to quantify or attach a rating to a physician with respect to total cost of ownership or what the folks at Dartmouth would call longitudinal cost efficiency.

MR. MULLER: Let me add my compliments to you on

this chapter. It both builds on previous work and does it very powerfully.

In terms of things to emphasize, I think the fact that we are starting to use a common language here of structure, process, outcomes, patient experience, I urge us to keep going in that direction. One of the things we discussed last month is over the last three or four years there's been some kind of coming together across the various groupings for measuring quality. And the more that we move in that direction so that we are speaking in a common language with common categories and common terms I think is of critical importance. Obviously the extent to which both MedPAC and CMS go in that direction I think that helps the general cause.

Secondly, I want to speak to the unit of accountability. We have come to that before and Arnie just touched on it too. Having larger group practices and integrated groups -- we had some estimates this morning as to what proportion of the nation's physicians fall into those categories. But one of the collective setting that is well-established is the hospital medical staff. Not always organized to operate as one, but the Joint Commission

evaluates it, state health departments review it. So as you think about collectivity – and I think we all are moving towards that -- it has to be bigger than one doctor here and three doctors there. So when we think about what collective institutions do we already have within the American health care system, the fact that the national regulators and the state regulators use the hospital medical staff I think is something we should keep thinking about, whether that can be one of the collective units that take some kind of accountability.

So I think the issues both raised in the paper, and of the issues that Arnie and others have brought up indicate how distributed care -- all the Wennberg stuff -- is just one more bit of evidence about the enormous diffusion of the way in which practice proceeds in the American health care system. So the more we can start thinking about accountable units -- we had some discussion this morning whether that can happen on a national geographic basis. My guess is that is a little bit too hard to figure out exactly how to implement. But states are a big part of the health care structure of the country so thinking about accountable units and local regions I think

makes a lot of sense.

I also agree that we should put more of the payment at risk. Last year when we encouraged CMS to put some of the update at risk, so roughly we put more than 10 percent of the update at risk last year, went with 0.4 against 3.5 or whatever. So I think that's the right direction to be going into. I know 1 percent, 2 percent, 3 percent I agree is just too small a number. You cannot jump up to an extreme number that quickly, but having some sense that in a multi-year period, maybe three, four, five years, we're going to move that up every year for the payment risk and whether you go to 10 percent, 20 percent, 30 percent. But we have now seen 30 years of evidence that the payment system drives behavior more powerfully than almost everything else. So if you want quality to be as big a part of the agenda as we are suggesting that it should be than more and more of the payment system has to be tied to quality.

Fourth, I would just suggest that I do think that we have to be able to work off existing information and systems, and therefore with all the defects and limits of going off claims systems I would still urge us to go off

systems that are already being created for other purposes. I think to have to go back and do chart abstractions and so forth, to really add more cost to implementing a system of quality I think is going to put a big burden on it.

So again, there's a lot of movement towards putting more emphasis on the EMR and more computerization of the health record. The extent to which we can use existing systems as they more and more get put into the American health care scene, not just payment systems, as opposed to coming up with separate systems for the purpose of evaluating quality, I think we should err on the side of using existing systems rather than trying to implement any new systems.

That obviously then puts pressure on your payment system, your EMR and so forth, to be developed in such a way that it can be used for quality measurement purposes. I think we want to keep some incentive out there for both the vendors and the other people who are creating these systems to have quality measurement built into the basic system, rather than thinking about creating a whole new set of tools just to measure quality.

But again, I thought it was a superb chapter.

DR. NELSON: Obviously I support the notions that are in this, and I found particularly helpful the description of the U.K.'s efforts in this area. I am really glad you included that.

I just want to make the point that we have to be aware as we proceed with this of unintended consequences that could end up in worse patient care rather than better patient care. I don't think that that is the dominant theme running through this, but I will give you two examples where it could in actual fact happen.

One would be in the potentially avoidable admissions, understanding that oftentimes the decision whether or not to hospitalize the patient is the toughest decision the clinician makes. The patient with congestive heart failure that you probably can take care of at home but you are not exactly sure, the patient with asthma, or -- oftentimes that was the toughest decision I had to make as a clinician. Once I made the decision to put the patient in the hospital then it was very clear-cut what to do. It was how far I could go in managing them successfully at home, whether they are diabetic in mild acidosis and I decided to talk to them on the phone every six hours and adjust their

insulin and try and bail them out without putting them in hospital. Oftentimes that is what I did.

If we get brownie points for potentially avoidable hospitalizations according to certain categories and err on the side of not putting the patient in the hospital and impose a greater risk on the patient as a consequence, that obviously would be a bad thing. I don't know exactly how you build safeguards into that but one way to protect against that is on the iffy kinds of factors, let's not put them in right away. Let's do some more research and work before they are included with either rewards or penalties.

Another example is the possibility of physicians avoiding certain patients because they might make their profile look bad. The patient who won't quit smoking. They still need medical care even if they can't quit smoking. If, for example, a physician's performance was paid differently according to some factors that relate to patient compliance that they can't control and it resulted in harm to the patient, that would be a bad thing.

DR. CROSSON: On the issue of the unit of measurement, group versus individual, whatever group means in this context, and I think Karen laid out nicely there are

a lot of attractive aspects to doing it at the group level. The issue of sample size, for example, would expand the number of measures you could use because you would have enough experiences and a greater number of diagnoses in that regard. There are economies of scale. Certainly measuring at the group level begins to address the issue of attribution. It also begins to address the issue of care coordination or integration that in the absence of it being provided by a group tends to fall to the patient, sometimes to a vulnerable, sick individual to do, which is an important issue.

I think also measuring at the group level, at least in some context, is helpful to the extent that it drives peer pressure, peer support and pressure which in our setting and others is a useful tool, which would not be present measuring at the individual physician level. Certainly I was interested in Ralph's suggestion about expanding the idea if there is a value here, expanding the idea of what a group would be. Perhaps this could be something that in some settings a medical staff could do, I would agree with that.

Another value of measuring at the group level is

that in fact, at least at the moment, this is where the IT systems are being used and put in place, and therefore from the perspective of a vanguard you would be getting the better information for a while anyway from those groups. There are two big problems with doing this. The first is that most physicians aren't in groups. That's a small problem. But as Ralph said, there are other ways to think about this and to address this. On another issue this morning we talked a little bit about that. Certainly the medical staff, county medical societies, there are ideas, some of which are difficult to imagine but yet possible.

The second problem I think is that even in the group setting you are going to have outliers. I think one of the objections that is raised to measuring a group level, are you saying you don't have anybody in your group who's not performing in the way he or she should be performing, and that's problematic. My sense of that is that that can be addressed and probably should be addressed as part of an overall evaluation by making sure that if the measurement takes place at the group level that there is a process in place to deal with that problem. Of course, many groups have that and I would probably suggest that many don't and

depending on the definition of groups you might not have such a mechanism.

As opposed to moving towards a measurement process which focuses only on the individual and therefore rolls back all those advantages to measuring at the group level. A couple thoughts.

MR. HACKBARTH: If I understand this correctly, it's not clear to me that it needs to be all individual or all group. There are instances of existing well-defined groups that have the internal controls and processes in place, even bill Medicare as a group as opposed to individual clinicians, and they could be accountable at the group. But for the individual physician who wishes to be independent of that, then you would have individual accountability. You could have a blend of the two.

Just by virtue of my experience, I guess I'm where you are, Jay, in terms of seeing some advantages in terms of the group process and improving quality. If there is truly accountability at the group for the overall result I think clinicians working with other clinicians can often accomplish things that a distant government, even with more refined tools cannot, because physicians respond to their

peers. So I'd be uneasy about ruling out systematically group influence in improving performance.

DR. WOLTER: I was somewhat responding to a little bit of a theme in here about how important it might be to find measures for all physicians. Is that the tack we want to take or would it be important to identify the high use, high dollar, high likelihood of areas for improvement in quality and focused an initial wave of pay for performance with a bit of a focus rather than trying to just find something for everybody? I don't know, Arnie, how you have addressed that but I would think you probably asked those questions in one way or another. So that is a question more than anything.

Then on the structures of care, in my experience as we have tackled quality it really has involved -- really a lot of nursing has been our success, finding clinical nurse specialist in quality who support teams led by physicians to take on diabetics, congestive heart failure, et cetera. There's a fair amount of expense to that when you do that which really is not reimbursed. The It tools, as important as they are going to be, are tools around which teams like I've just described have to organize the care.

So I don't know how we would include that in our thinking but that is a structural issue.

I was interested in the U.K. list also. I noticed they had something about organization of care as one of their pay for performance criteria. I don't know what that is but I'm wondering if they're trying to incent something along those lines.

You have heard me say this before, if you look at the areas where there seems to be great opportunity to improve quality and possibly at the same time deal with efficiency, they are congestive heart failure, diabetes, some of these big chronic disease areas. If we were to be patient-centered in our thinking we would follow the patient's quality experience and cost over the course of a year and longer. That really does mean we'd been looking at inpatient and outpatient care, and ultimately we are.

So how do we chart a course where we are really trying to look at the patient's experience through the system and how the Part A and Part B systems really have to be looked at in a coordinated so that the incentives for physicians and hospitals to work together across the settings start to come into play? I think that is, from my

standpoint, certainly an important theme.

MS. BURKE: Just following on that for a second and reflecting back on our discussion early this morning, I wonder, Karen, as you identify the four questions at the outset that we're trying to look, I wonder if we ought not add to those questions in the vein that we were just discussing which is whether or not in the course of looking at each of these issues whether their application ought to vary. The whole question of whether you do it by specialty, by geographic location.

It is not only a question of confirming whether the evidence is well-based, whether or not it can be collected is a standardized way, whether they have risk adjustments. The other question it seems to me is an application issue. As we challenge ourselves to figure out what can be applied generally there is also the question that we have asked, which is whether or not that ought to be, at the outset, the first place we go. So one might ask whether an application issue, that is how one might begin to do this, ought not in and of itself be a question as well as the factors that would make up the decision as to which of these we would apply, how relevant they are, how accurate

they are.

MS. MILGATE: Are you referring to the unit of accountability, because of the examples you gave --

MS. BURKE: No, I'm talking about to whom they should be applied. For example, we might decide that our primary concern as we move towards pay for performance is around certain kinds of behaviors among certain physicians and it might be related to certain practices, certain specialties, certain services. While I am not arguing against a broad application when we moved towards a pay for performance system, one of the questions we have to struggle with is, will we be ready to do everybody all at once in all cases? Or are we more likely to be focused on the areas where there seems to be the highest need?

MS. MILGATE: Which is somewhat what Nick was saying.

MS. BURKE: I'm saying, following up on Nick's point. The questions that you've identified at the outset are presumptive of a broad application. When I think in fact there is a question to be asked as to narrowing that application and phasing it in over time, narrowing it for a variety of reasons. I don't know that I would know which of

those categories to choose, but following Nick's point maybe a question ought to be asked. Maybe that's one of the things that we continue to pursue as we go forward.

DR. MILSTEIN: Just following up on Sheila's question. In order to target, we need some reasonable baseline information on which we might target. I think probably our best and most precisely calculated inventory of the epidemiology of quality of care problems in the U.S. was the study that RAND finished a year and-a-half ago and published in the New England Journal of Medicine. Thought they didn't break it down across an infinite number of frames, I think RAND's conclusion was that in terms of using compliance rates with evidence-based medicine, excluding any contraindications, that the opportunity for performance lift in American health care was very widely distributed across multiple specialties and settings.

Unfortunately, if one were to say, weren't there some sterling examples of either settings or physician specialties where performance is so good that we really can say that is a lower priority, I think if the RAND folks were here they would say no. Unfortunately, though there were some specialties and settings where the rate of compliance

with evidence-based guidelines was higher rather than lower, but in general I don't think there was any setting or specialty group that they examined in which there wasn't at least a 30 percentage point opportunity for gap closure.

MR. HACKBARTH: I'd like to go back to some of the issues that have been raised and try to generate some specific discussion just so we have a better understanding of where commissioners are. One issue that Arnie has raised is the notion of longitudinal efficiency and not just looking at short periods of time, but the bigger package, longer periods of time and the full range of services. Now I assume that's being done in your project in the context of still fee-for-service payment system. So this is an overlay on top of fee-for-service payment; is that right?

DR. MILSTEIN: Yes, the California project is focused on managed care plans, and the managed care plans vary in how they pay the doctors. I think probably because there's been a rollback in capitation, probably most of the medical groups that are participating are currently being paid fee-for-service, but there are some capitated groups.

MR. HACKBARTH: So the flow of dollars out of this quality pool, so to speak, are to the plan and then it's up

to the plan to distribute them among the individual providers?

DR. MILSTEIN: The flow of dollars is from the plans to the medical groups. The medical groups are in some cases of IPAs, very loosely organized, and in some cases they're very well organized multi-specialty groups analogous to Permanente. There's a blend.

MR. HACKBARTH: So what I'm struggling with is, although I certainly agree with the concept of we ought to be rewarding high quality with some consideration of the efficiency, what I'm struggling with is how you graft that onto what is still basically a fee-for-service payment system in Medicare, and how that would actually play out.

DR. MILSTEIN: Let me illustrate. Irrespective of whether the physician payment system were capitated/risk-based or fee-for-service based, it would still be possible to take that payment and increase it or decrease it based on some weighted combination of quality of care measurement and longitudinal cost efficiency measurement.

MR. MULLER: That whole discussion about accountability comes right back and hits you in the fact because you're just miniaturizing the SGR argument, which is

when you have -- as soon as you start having three, four, five physicians or settings, dialysis, ambulatory surgery, hospital, et cetera, involved in the care, how do you make the allocation among them? In some ways if you just had one doctor and one setting for a course of a year then you could deal with this issue. But that is not the way the care is delivered. Therefore the unit of accountability needs to be decided upon before one can -- Arnie, I don't know how you do it except if you just allocate the issue to medical groups, that is not 100 percent of your population, so I'm not quite sure how you do it.

DR. MILSTEIN: The folks who have been working on it would say that at this point it's an art form based on scientific methods in which you -- there is, for example, kind of a consensus exercise occurring in the private sector now being administratively managed by a combination of the Leapfrog Group and Bridges to Excellence which includes participation by provider organizations, health plans, and consumer organizations. Essentially saying, how do we deal with issues of either quality or cost efficiency attribution in situations where there is more than one physician or more than one medical groups, or a medical group and a hospital's

performance are both at play?

I think the good news is multiple stakeholders in thinking through the challenges are saying the answer is not to back away from the challenge but rather to come up with something that multiple parties agree is reasonable. So there is a variety of so-called attribution methods that are currently likely to be deemed equally reasonable as long as at least one of them is used.

MR. HACKBARTH: Let me move on to the issue of what is the data used for the adjustment, claims versus new data collection. I'd like to hear some more thoughts on that issue.

MR. BERTKO: I am always one for being on the practical side without increasing expense and I believe Ralph was one to say -- chart pulls in my own experience are very expensive. I do know that the RAND people have taken their chart methodology, summarized it down to fewer indicators, and then are trying to roll that out in terms of piloting it. That would seem to be a very practical way to run it across the Medicare Part A, Part B data. Ideally, there are a number of them that I know on the commercial side work with what will become Part D in prescription

drugs.

So going in that direction strikes me as possible for some subset today and even better starting in 2006 when we have that data stream flowing through, and avoids perhaps -- I clearly agree with Karen's comment that the individual stuff where you go to charts is more robust, but this might be something that is good enough to get us started and eminently practicable.

MR. HACKBARTH: As I understand it, there are people trying to develop another option, not go to raw charts and pull out data anew, but rather have concurrent collection of data through flow sheets and other mechanisms so that maybe the costs on lessened and you still get a more robust set of data.

MS. MILGATE: Alan could maybe talk about it more than I can. In fact the AMA's consortium for performance improvement has really been the leader in this and they have developed for each condition that they've looked at both measures and then a data collection tool which they call a flow sheet where it basically has different -- it has a history. It is one page which is unique to look at it -- history of patient visits over time and you can check off

preventive test, diagnostic test, blood pressure, so that the physician is managing the patient's care at the same time as being able to check what happened over time and it's also the data collection tool.

And actually having talked to several different medical groups, their comment is it really isn't that helpful for quality improvement often to be going back into records. But if you are doing this at that point in time -- Alan probably should comment on whether it's an increased burden or not. It would seem to me it would replace some note-taking now, but it may be an additional step.

MR. HACKBARTH: So the concept -- and I'd like to hear from clinicians about whether this might be realizable, but the concept is that you do it concurrently and potentially there is the benefit of not just collecting data but also saying, here is what we're looking for. You're telling the clinician, this is what you're being measured on.

MS. MILGATE: Right, and becomes a checklist for them for their own care management as well.

MR. MULLER: The early evidence on putting the computerized provider order entry when it's physician order

entry that came out of the Brigham is there's about a 15 percent to 20 percent decline in efficiency in the first period. That period can be three to six months. So if you're asking in a difficult environment to have a decline in efficiency of 15 percent, 20 percent to put CPOE in, and then you think of this as an extra form of CPOE, I think you can think of it that way, you're really putting on more. It's hard enough to get -- a lot of us have been urging for years that we move more towards the physician order entry. It's still I think less then 15 percent of the order entry is done through that. If you have the sense it's a real slowdown in efficiency I just think you're putting too many strikes in the way of getting this done.

MS. MILGATE: This wouldn't necessarily be electronic. It could be.

MR. MULLER: If it's not electronic it makes it even worse.

MS. MILGATE: It could be built into an EHR but it would basically just be a replacement for whatever the physician would use not to record. But maybe it might slow down, it's true.

DR. NELSON: I agree with avoiding the unfunded

mandates on data collection if we can possibly do it. If we can get it from administrative data while we're starting, that's fine. And checklists would be better than nothing but I don't think that they would be greeted with open arms by a clinician who is also facing the possibility of reduced fees anyway.

So I think a lot of it depends on whether or not there is some consideration of the administrative burden in terms of paying for it. If you can calculate how much additional time is taken in patient care through the use of checklists and submitting these quality data and build that into the reimbursement formula in some fashion then I think that would be acceptable because most clinicians want to do a good job. They want to improve if they can.

But I think to tell the clinicians that from now on you will use this checklist and you will turn it in with some regularity, and don't worry we will make it as easy as possible on you, if they've got their choice between two patients, one Medicare and one not Medicare and they only have one appointment open, you know which one they're going to take.

MR. HACKBARTH: Yes, the burden is a very real,

very important issue. On the other hand, we don't want to, in keeping with your earlier theme of unintended consequences, we wouldn't want to pay people to do things in an inefficient way, pay for collection. Ultimately what we want them to do is move into the 21st century and use computers for these things. If you pay them for the old way, the incentive for them to move towards better systems is diluted. So it's a tough balance to strike.

DR. CROSSON: Perhaps the same point. I just want to make the obvious point that the value of the clinical system approach is that you are actually having the clinician record the information that is necessary for patient care, and then electronically it extracts the information that's needed for quality and other things. So you are not actually having extra work.

That is not to say that taking physicians from paper to a computerized medical record is easy. It is not. We are in the middle of it. We just had a rollout in Colorado of 500 physicians in the last couple of weeks. It does have a short-term impact on productivity, but in all of the settings where we have put it in place, including Portland, Oregon and Colorado and Hawaii, we have really not

experienced a sustained reduction in productivity. In some specialties, in internal medicine which is the most complex administratively and clinically, it has added some. But in most specialties it has not, and the recovery time of productivity is measured in weeks.

DR. MILSTEIN: I certainly support Glenn's notion that we build a better information base sooner rather than later than issues of how imperfect are the performance we'll drop off quickly. Karen and I actually attended a meeting sponsored by RWJ and Commonwealth Foundation about three weeks ago in which Shelley Greenfield reported on fresh research that asked the question, if you rank physicians with respect to quality of care performance using claims data, which is obviously the least perfect, and compare it to how physicians rank using medical record abstracted data he reported that the correlations now are running quite favorable. Not perfect, but quite favorable. Adam Dudley has done research on hospital inpatient performance for AHRQ reporting a very similar results. That is the correlation in rankings either way is quite good.

I think at the end of the day what we're talking about here is what kind of physician or hospital

misclassification error are we prepared to tolerate as we move forward in pay for performance? And as Karen was saying, what's the opportunity cost of not proceeding, given what we know about current quality levels? Dana Saffron in Boston has actually looked very carefully at this question of physician misclassification error. That is, giving a physician a B rating when actually his or her performance might be an A- or a C+. Her point is that if you do a statistical analysis, as long as you're not trying to very carefully separate by deciles and instead are separating by above and below average or top or bottom tertile, that claims data has relatively low risk of misclassification error.

MR. HACKBARTH: It would be helpful, Karen, if we could learn more about that research, because I think that goes right to the heart of the issue. You are trying to optimize and if you use claims data you have a lower cost of collection. Potentially I gather also a broader set of measures that you can do quickly, but the risk is accuracy, and if in fact there is research showing that that cost in terms of accuracy is not very large, that's potentially very important information.

DR. MILLER: Before we move on to other issues here, the other thing I want to say about -- something just to put in your minds. If we think that we are going to go down a claims approach, either alone or in conjunction with something else, another thing we might want to think about is enriching the claims process. So having test reports reported on the claims, so that over time if that's the path, the data set becomes richer. I just wanted to put that thought, and I think people have said that in other settings.

Can I ask one thing? So is it that you do get a richer set of measures out of a claims stream than from --

DR. MILSTEIN: It's not a richer set of measures. It's a richer set of affordable measures. You could get that same richness of measures out of medical record review but it would cost a lot of money or a lot of physician time in collecting.

MR. BERTKO: I would only add that the set of measures for RAND is quite substantial. It is over 100 measures. It's is much less than the 450 or so in the New England Journal article and it covers a broad range of specialties, which I think is another important part.

MR. HACKBARTH: So perhaps a better way to put the point I was making, Mark -- I think I did misstate it -- is for any given level of investment you can have a broader set of measures if you use claims because of the lower cost of collection than you could if you tried to extract clinical data from records or flow sheets or something else.

DR. NELSON: Karen, you may have referenced this and I didn't see it. One of the considerations that we haven't touched on is whether we pay for performance that meets a certain standard level, for whatever condition, or whether we pay for improvement even though it may start at a lower level and show substantial improvement. Whether or not those who have been in this business and are performing at a 95-percent level and can only go up 1 percent are disadvantaged with respect to those who go from 30 to 50, or some combination thereof. I think the article in Health Affairs goes into this in some detail in terms of what the private sector is doing on this.

MS. MILGATE: We didn't talk about it in great detail in the paper. I think it's is referenced, but we did discuss that when we were talking about whether to apply these pay for performance for health plans in Medicare as

well as dialysis facilities and physicians, and the Commission at that time said that it should be a mix. So we have kept that in mind. I think that is probably referenced, but it isn't developed in the paper, which it could be a little bit more if you think that is an important point to make a little stronger.

DR. MILLER: I would just say a little bit stronger than that. We're operating under the assumption that that is one of the principles the Commission has agreed to and as we crank through these differences that we are assuming, until we hear differently, that is a principle we're going to carry forward.

MR. HACKBARTH: Karen, I'm sorry, I cut you off a minute ago and then didn't come back to you.

MS. MILGATE: There was just one point on the RAND data. One of the reasons they had so many is that they had prescription drug data. So it would be really important in the Medicare program to be able to use the prescription data if we are going to rely on claims, along with Mark's point on making the claims as useful as possible. I don't know if they also included lab values in the claims. I don't think they did, but that is another improvement that would be very

useful, because then you could get not just whether an HgbA1c test was done, which is currently all Medicare can get out of claims data, but look at the actual levels that a patient achieves, which in and of itself is more useful. But as you said, there may be a broader set you could do initially with just claims.

MR. HACKBARTH: The last issue I wanted to go back over is the amount, how much the potential quality payment is. What we've been saying is take an amount equal to 1 percent or 2 percent and then redistribute that based on quality performance. Ralph and Arnie and maybe some other commissioners as well have said, that seems awful small relative to what we want to accomplish. I just wanted to go through that a little bit further.

First of all, my understanding of what we've been saying is that the 1 percent or 2 percent is a starting point not necessarily an end point. I think the spirit of the conversation there has been we need to be wary of unintended consequences, and by initially attaching a lower level of payment perhaps we diminish the risk of having unintended consequences while we're ramping up and learning in the early stages of the effort.

I think the circumstance in Medicare is perhaps a bit different, Arnie, than the circumstance in a private project in a couple ways. One, obviously, is the political process that one needs to go through to get approval. But beyond that, Medicare is much larger than even usually a band of major private purchasers in terms of dollar volume and the potential impact. So 1 percent or 2 percent on Medicare may be in dollar value equal to or greatly larger than 15 percent or 20 percent from a local purchaser consortium.

I think given the magnitudes and given the policy process I guess I still feel comfortable that we ought to start small as we are learning but keep the door open to a progressively larger amount as we become more confident. That is just my take and I wanted to get other people to react to it.

MR. SMITH: You are right about the potential size of a 1 percent or 2 percent pot. But of course the universe across which you would distribute it is correspondingly large. So I think if we are concerned, and I share Arnie's concern that 1 percent or 2 percent is very unlikely to have the kind of impact that we are looking for here, that we

ought not to think about just total dollars. Medicare is the biggest payer in the game but it also pays more doctors than anybody else. So it's both sides of that equation.

MR. HACKBARTH: But let me just push on that for a second. My point is that Medicare has a larger average share of the typical physician practice than any individual private payer, and even in most cases, aggregations of private payers. So the influence, the power of Medicare is potentially greater both for good and for ill. I am just saying that as we ramp up and are learning that the power of that statement warrants some caution that maybe others wouldn't be required to exert.

MR. SMITH: Caution is appropriate and I do agree, Glenn, that this ought to ramp up. Whatever the departure point is we ought to be headed on an upward slope. I think we have learned not to try to do arithmetic in your head, but 1 percent of 20 percent of my practice is a very small number. And if that is both the up and downside of doing something which otherwise I would not do, it is hard for me to imagine at least that that gets the powerful -- we have got a lot riding on making the pay for performance stuff work, as we talked about this morning and last month. We

ought to use not a risky big stick but a big enough stick to think it has got some capacity to change behavior.

DR. SCANLON: I think that the numbers are magnified some by the amount of redistribution that we think we're going to accomplish. If we set the bar so low that everybody succeeds then there's not going to be any redistribution. But if the bar is high enough than the 2 percent maybe becomes 4 percent for some and only a half-percent for others, so that does reinforce it.

One of the issues related to this that I feel we need to talk about is, what's the pool going to be that we're going to be taking this 2 percent out of? Because it became clear as I went through the paper that all physicians in some respects don't have the same opportunity to perform, given current measures. So it is not necessarily 2 percent of physician payments. But then once we've said that, where do we draw the boundaries in terms of identifying what the appropriate pool is and how it is going to be redistributed among the people that are eligible for that tool.

DR. MILLER: I think it is a question and to date the way we have dealt with it is we have said 1 percent or 2 percent from existing payment. So you go through the

process of setting whatever payments are going to occur. So you go through an update process. You say, these are the dollars that are available and you take a percentage or so off of that and you redistribute on the two bases that you've talked about, attainment and improvement.

Part of the reason that we have thought and tried to work so hard about thinking about how comprehensive you can be here is because of this very issue. Nick's point is well taken. You could zero in and take a set of conditions, providers or however you wanted to do it, but then you would have to get into the idea of drawing the boundaries of the dollars that are associated for them.

One of the things that was unsaid but implicit in the strategy moving from left to right on that picture is that the first set of measures are in fact trying to pertain to all physicians. Then you go to the second set of measures, and then probably the process measures don't reach across the entire spectrum. There the do-no-harm issues does become an issue when you probably do want to stay small. But I can also say that if you begin to say this is a direction that Medicare is going to move in, the necessity of specialties and providers to bring process measures

forward and say, here is my set to be measured on, you begin to get some kind of pressure to do that. But I don't need to minimize this point. This is a judgment.

DR. MILSTEIN: I think this is a great moment for what some would term evidence-based policymaking. If you look at Meredith Rosenthal's summary in Health Affairs last spring of pay for performance programs where she summarizes about 50 of them, many of them at the physician level, she makes the observation which has been reinforced by AHRQ and other health service researchers is that we actually have yet to have a single pay-for-performance program in the United States, whether it's at the physician or hospital level in which the dosage level was adequate to pull forth a significant detectable performance improvement.

So I like this line of reasoning of saying, we know what Medicare is as an average percentage of physician income. We multiply that times whatever percent pool we have in mind. It seems to me we at least ought to make sure that the dosage that we apply is above the dosage at which we know, based on others who have gone before us, has not been effective. So we have an evidence base of 30 or 40 physician pay for performance where we know when you

multiple the amount of the size of the pool times the amount that that payer represented to a physician we have yet to get a therapeutic effect.

So I would hope as we go forward we would use evidence to make sure we don't start out at a dose we already know to be sub-therapeutic based on others who have gone before us. I think it's probably not insignificant that the U.K. looking at the evidence said, start out with 18 percent of total comp and go to 30. That was their intuition.

They obviously had to struggle with the issue of unintended consequences as well. I think into their logic -- I had a chance to talk to the folks who put it together. Underneath their logic was, one has to be careful about unintended consequences partly in proportion to how good your baseline is. If you have a great baseline of performance then be very cautious about messing with it. But when you start out with a baseline of 55 percent compliance with evidence-based medicine, it does tend to encourage putting a little bit more money on the table because it isn't like our current baseline is that precious and worth preserving necessarily.

MR. MULLER: Using different metaphors but along the same line of argument, is basically that the powerful incentive drive powerful innovation, and that's is core to economic theory. We have seen in all our work that we'd done last year or so there's powerful incentives out there for imaging, there's powerful incentives out there for diffusion of technology. And there's not powerful incentives out there for diffusion of quality. So what don't we understand here? The overarching incentives inside the system right now take us in a different direction.

So if we want there to be a powerful incentive towards quality then have one, rather than keep tweaking around at the margin with it. Again, everybody will get upset about how one gets from here to there, but I do in the paper saw the average G.P. in the U.K. has income of under $100,000 a year, and you're saying they can make up to $77,000 in incentives for quality. That is beyond 18 percent to 30 percent. That is not what the expected value is likely to be, but still it gives you a sense of how much they are putting the economic incentive behind the quality initiative.

So I think one has to think in those kind of

powerful terms. Again one can think in a phase-in basis. You can't just -- we don't have a political system like the U.K. where you can just put it in in one year, so you need a segue into it. But unless we think in those terms -- and then what we learn in the rest of the economy, having incentives -- this is not just a static model. The incentives then drive the innovation that you want. So a lot of the questions that we're trying to answer today really have to be answered down the road as a result of the innovation that goes forth. This is something where having the 50 states try to figure it out in different ways or the regions figure it out in different ways is not a bad idea. So I think let's think about, whether you use Arnie's metaphor or this one, moving in a more powerful direction.

MS. MILGATE: Just one comment on that. One of the reasons in the beginning we had thought it would be small that is unique from the U.K. example is just the consideration would be that it would be budget neutral, so it would be money taken out of a base and then redistributed. The U.K. example, they actually had an analysis done that showed that their system was underfunded and uniquely said, we're going to put some more money in to

make sure that we are adequately funding this system, and then decided this was probably the best bang for their buck to spend those dollars.

That doesn't mean that we still might want that level to be higher, but I think that the comparison is not quite apples to apples, just for that reason.

DR. CROSSON: I just want to recognize that Bob is not here so some of us have the responsibility for the runaway metaphor. I just want to make sure that we know whether we're talking about the biopsy or the pill, the dose that gets administered. Because it seems to me that we're talking about a 2 percent biopsy from the Medicare payment corpus. But then that doesn't necessarily mean that the dose that gets administered is only 2 percent, because that is a function of the design of the incentive system. So the dose that gets administered could be a good deal larger than that. Make it too large and then you don't have enough people winners. I understand that.

But I just think that it strikes me that maybe the size of the biopsy really is the political problem more than the size of the dose that gets administered. And depending on some clever design we might be able to get more impact

than with other designs.

MR. HACKBARTH: We may put you permanently in charge of metaphors.

We are going to have to move ahead in a second.

DR. WOLTER: I was thinking about the return on investment piece and the budget neutrality piece. You might imagine over time that fewer avoidable admissions and improvements in quality in chronic disease might save some money, but you would almost certainly decide that might not show up in 12 months. Or you might imagine that connecting this effort to profiling over time, as people are participating in data streams, might allow other decisions to be made that would get patients in the hands of more value-oriented providers. But that's also not going to happen probably in 12 months.

So I think the question is, at what point do we try to look at something that is a little bolder, but it's going to have a longer time frame? I don't know what the appetite for that is, probably not very high in this next 12 months. But really that is what would be a bolder approach, would be to think over three, four, and five years, try to put some things in place that really could create the

ability to profile, could create the ability to measure improvements in quality, and some reduction in cost in some areas. I think it's almost impossible to do it in a 12-month budget neutrality set of principles.

MR. HACKBARTH: Thank you very much, Karen. Well done as always.

MR. HACKBARTH: Next is the mandated report on physician volume.

DR. HAYES: Good afternoon. Dana, Ariel and I are here to review a draft report on growth in the volume of physician services. Congress asked for this report in the Medicare Modernization Act.

Recall that we presented parts of this report at the October meeting. We're here today to present the rest of the report. Based on your discussion, we will revise the report and prepare it for submission. It is due on December 8th.

Let me take just a few minutes to review the requirements for the study and give you a progress report on where we are and what we'll cover today. The specific requirements are shown on this slide. They begin with a request that we address the extent to which the volume of

physician services results in improvements in beneficiary health and well-being.

The MMA then goes on to list five factors that are believed to help explain volume growth. They are listed here. The first one is really three topics in one. It's growth in the components of spending that are included in CMS's definition of physician services. They include the physician fee schedule, outpatient laboratory services and Part B drugs. These are drugs that are usually administered in physician offices.

The other factors listed here are a little bit easier to explain, but a lot harder to address it turns out. We were asked to look at the extent to which changes in the demographic characteristics of the beneficiary population affect volume growth. Also to contrast the volume growth for Medicare beneficiaries and other populations, the effects of coverage decisions and new technology on volume growth, and finally shifts in the site of care.

Just as an added bonus, so to speak, we were asked also to look at the impacts of law and regulation on the sustainable growth rate. Recall that the sustainable growth rate is part of the formula that's used to update payments

for physician services and control spending for those services.

At the October meeting we presented results on the first two factors listed here. We will today cover the remaining topics in the report. They are shown in bold on this slide.

Dana will begin with a brief recap of what we covered at last month's meeting and then she will begin our presentation of new material for this meeting.

MS. KELLY: I will quickly review the findings from last time. We found that Medicare expenditures for physician and lab services and Part B drugs combined have increased on average 8.4 percent since 1999. Per fee-for-service beneficiary spending for Part B drugs has grown disproportionately over the period, averaging almost 23 percent per year. So as a result, Part B drugs now account for almost 12 percent of the total expenditures considered by the SGR, up from about 7 percent in 1999. Nevertheless, physician expenditures remain the most important driver of growth in spending for SGR services.

You saw this chart last time. It demonstrates the importance of physician spending to overall growth. The

bars represent the annual increase in per fee-for-service spending for the three components, physician, lab services and Part B drugs. The first bar, for example, represents an increase of 10.7 percent between 1999 and 2000. Growth in spending for physician services, shown in green, accounted for 82 percent of the total increase in that year.

Since 1999 the only point at which growth in physician expenditures did not account for the lion's share of spending growth for the SGR components is between 2001 and 2002. During that period, of course, we had the negative update for physician services, combined with a jump in drug spending.

The bar at the far right represents the change in spending between 2003 and projected spending for 2004. As you can see, CMS expects changes to Medicare's payment for Part B drugs to significantly slow drug spending. No such slow down is projected for physician spending growth.

As the mandate asked us to, we also talked about factors that might explain growth in expenditures last time. We first looked at the aging of the Medicare population. This is important, as you know, because older beneficiaries are more costly to the program. But we found that the

proportion of beneficiaries aged 75 to 84 and those 85 and older increased just slightly.

We also found an increase in the proportion of disabled beneficiaries, a very slight increase in the proportion of male beneficiaries, and a small decrease in the proportion of fee-for-service beneficiaries who died. Since beneficiaries in the last year of their life tend to be more expensive than other beneficiaries, a decline in the death rate would tend to decrease expenditures in that given year.

Taken together, our analysis found that changes in beneficiary age, disability status, sex and rate of death cannot explain the growth in physician volume in spending. The net effect on spending per beneficiary during the time period was actually negative, minus 1.1 percent per year.

In addition to demographics, we also considered shifts in the geographic distribution of fee-for-service beneficiaries because some states have been shown to have higher utilization patterns than others. We looked at each state's proportion of total fee-for-service enrollment in 1999 and in 2002. We found that states that gained in their fee-for-service enrollment shares had higher use relative to

those with reductions in their fee-for-service enrollment shares but the effect was very small. Because of these shifts, we would expect per beneficiary spending to go up about 0.2 percent per year.

We've shown that the physician component is the important driver of growth in services covered by the SGR and that the growth is not due to demographic changes or shifts in the geographic distribution of beneficiaries. We attempted to isolate the effects of price and volume and found that volume and intensity increases accounted for more than 80 percent of the growth in physician expenditures between 1999 and 2002.

As you know, previous analyses that the Commission has done looking at the growth in physician services found a particularly high rate of increase in use of imaging services and diagnostic tests. These types of tests also vary widely across geographic areas, raising questions about whether they are value added services. It's of concern not only because of its effect on Medicare spending but also because greater use of services is not associated with improved outcomes.

Now I'll turn to our analysis of a factor that

many believe explains the growth that we've seen in service volume and intensity, new technology. As you know, some new technologies have been extremely expensive, involving hospital stays that cost tens of thousands or even hundreds of thousands of dollars. In many cases, new technologies have indirect effects, creating new demands for physician office visits and other physician services and costly pharmaceuticals. Even where medical advances reduced per-service spending, they may raise total spending by making it possible to treat more beneficiaries, including those who were previously too frail or ill to be suitable candidates.

Many new technologies enter the Medicare system informally, through the back door so speak. Technological change can occur within an existing code without increasing a physician's work, and therefore the relative value of the code. This type of change may increase volume, for example by expanding the number of beneficiaries who can safely and appropriately receive certain types of services.

New technologies also can enter the Medicare system formally, sometimes through CMS's national coverage determinations, but far more frequently via decisions made by local carriers and intermediaries.

Congress asked us to examine the impact of new technology on recent growth in physician volume and expenditures. It's very difficult to sort out the impact of new technology. The purest way is to look at new codes. Our contractor, the Urban Institute, found that 372 new codes were introduced in 1999 through 2002. Overall, almost a third of the volume associated with these codes was for oncology-related radiation therapy while about 8 percent was for imaging services. But newly introduced codes had only a small effect on overall volume growth, on average 0.33 percent of total expenditures for physician services furnished each year was associated with the new codes.

The mandate also asked us to consider technology introduced through national coverage determinations or NCDs. Between January 1, 1999 and December 31, 2002 CMS issued 18 NCDs related to coverage for physician and lab services and Part B drugs. The vast majority of coverage determinations, as I said, are made by local carriers.

It's difficult to determine the impact of these coverage determinations and of the national coverage determinations. NCDs generally do not introduce new technologies to the Medicare system. Instead, they

formalize or clarify decisions that have already been made by local carriers.

In addition, NCDs don't always expand coverage. Sometimes they restrict coverage by nullifying local carrier decisions or by specifying that certain technologies will be covered only if provided to patients meeting specific criteria.

This estimate of new technology is obviously very conservative, the effect of new technology. It does not account for technology change with existing codes or diffusion of technologies to new populations. It also does not account for the indirect effects of technological advances. These types of effects generally increase costs but quantifying them is quite difficult.

Technological advances, of course, can also reduce costs by improving productivity. The work of Susan Foote, et al, demonstrates that simply identifying what constitutes new technology can be difficult. They asked two physician consultants to review local carrier coverage policies and identify which ones related to new technologies. One consultant thought that 8.5 percent were related to new technology. The other thought almost twice as many were

related to new technology.

So that concludes our presentation on technological change and Ariel will talk about shifts in site of service.

MR. WINTER: Thank you. I'll be talking about our analysis of the impact of shifts in setting on the growth of physician fee schedule services and will be addressing two questions as part of that, which are in the slide.

The first one is have services shifted between facility and non-facility settings? Facilities include hospitals, skilled nursing facilities and ambulatory surgical centers. Non-facilities are primarily physician offices, but also include dialysis centers, clinical labs and patient homes. We will be using physician offices as a shorthand for all non-facility settings during the presentation.

The second question is whether shifts in setting have affected growth in the volume and intensity of physician services. We measure volume and intensity using relative value units or RVUs. Each service is assigned an RVU that determines how much it is paid. We consider non-imaging and imaging services separately because there are

differences in how the equipment, supply and overhead costs are billed for each type of service. We will be discussing this more further on.

Our contractor, the Urban Institute, examined the share of non-imaging fee schedule services provided in physician offices in 1999 and 2002. The setting for each service is derived from the place of service variable on the physician claim. This table shows the share of services provided in physician offices in each year. The services are weighted by their RVUs.

Let me draw your attention to the top right cell on the table. This shows that the share of non-imaging services provided in physician offices declined by 1.4 percentage points between 1999 and 2002. This is somewhat surprising, given changes in technology that have made it easier to offer procedures in physician offices.

You'll notice that the portion of major procedures done in offices declined steeply from almost 8 percent to 4.5 percent. This category includes cardiovascular, orthopedic and surgical procedures that are generally not performed outside of hospitals. We were surprised to see a number as high as 8 percent in 1999. We don't have a

definitive explanation for why the number is so high but it could be due to errors in how the place of service on the claims was coded.

I'd like to mention one caveat. We were looking at a relatively short time frame and there could have been a migration of services to physician offices that occurred in earlier years. We started with 1999 because in that year Medicare began to pay different practice expense rates based on the site of service which we thought would lead to more accurate coding of the place of service on the claim.

Next, we will examine whether the shifts in setting that we observed had an impact of growth in RVUs. We will first review the structure of the physician fee schedule so that you can better understand our analysis.

Fee schedule rates have three parts. The first is the work component, which covers the physician's time and expertise. There is the practice expense part, which covers the equipment, supply and administrative overhead costs. And finally, is the part that reimburses for professional liability insurance.

As I just mentioned, CMS pays higher practice expense rates for some services when they are provided in a

physician office rather than a facility. This is because when a service is delivered in a facility Medicare pays the facility a fee to cover its equipment and overhead costs. Thus, the practice expense payment for the physician should be lower than if the service was provided in a physician office.

If services were to migrate from facilities to physician offices, practice expense RVUs would increase for those services with higher practice expense rates in the office. Although we found that there was no overall shift of services to offices, it is possible that some discrete procedures with high practice expense rates for the office may have moved to the office setting. The migration of such services could have caused an increase in overall RVUs.

Here are the results. We found that total RVUs and practice expense RVUs for non-imaging services grew by 19 percent between 1999 and 2002. This is a conservative number because we controlled for changes in RVU values between these years and we excluded new codes that were introduced after 1999. But we do not adjust for enrollment growth. Movement of services to the office setting do not appear to account for any of the RVU growth, which is what

we had expected, given that there was a slight decline in the share of services provided in physician offices.

There are a couple things I'd like to note here. One is to repeat the caveat I mentioned earlier, which is that we measured a fairly short time frame. And second, there were some procedures that moved from facilities to offices and other procedures moved in the reverse direction, but there was no net effect on RVU growth. For example, there were two urological procedures that shifted dramatically from facilities to offices. On the other hand, there were several endoscopic procedures that moved from offices to facilities. By the way, those could include ambulatory surgical centers.

I'll move on now to a discussion of our methodology for imaging services. There are three types of imaging claims. Professional component claims cover the time of the physician to interpret test results and write the reports. These are paid regardless of whether the study is performed in an office or facility.

The technical component claims, those cover the cost of performing the study, such as the equipment, supply and technician time. These are only paid if the study is

done in a physician office. If the study is done at a facility, Medicare pays the facility a fee that covers these costs.

The third type of claim is when one physician does both of these components, they submit a global claim. If two physicians provide each component separately, they bill separately for each. This is in contrast to non-imaging services in which the same physician bills for both the professional and nonprofessional cost.

If imaging services are performed more frequently in physician offices, there will be an increase in the share of imaging claims that are either technical components or global. So we looked at whether the share changed over time, which is the next slide.

Here is what we found. The proportion of imaging services that were billed as technical components or global claims, indicating that they were performed in physician offices, increased from about 63 percent in 1999 to 66 percent in 2002. The services are weighted by RVUs.

Among different imaging categories, nuclear medicine grew the most, from 75 to 81 percent. This shift toward physician offices reinforces our rationale for

exploring ways to manage the growth and quality of the imaging services provided in physician offices.

Now we will examine the impact of this shift in setting for imaging services on growth of total imaging RVUs. If more imaging services are performed in the office setting, this leads to more technical component or global claims, which in turn leads to additional practice expense payments. We found that total imaging RVUs grew by 39 percent between 1999 and 2002. As with our estimate of the growth of non-imaging services, this is a relatively conservative number.

Practice expense RVUs increased by 47 percent. Movement of imaging procedures to physician offices led to additional practice expense payments that accounted for 18 percent of total RVU growth. To estimate this number we simulated RVUs in 2002 based on the 1999 distribution of types of imaging claims.

What if we were to combine the impact of shifts in setting for imaging services with non-imaging services? The net effect is that 3 percent of the growth in total RVUs is related to shifts in setting. So even when we factor in imaging there is a very small net impact on all services.

Now we will move on to Kevin.

DR. HAYES: Our next and final factor that we were asked to look at concerning growth in volume has to do with comparing Medicare beneficiaries and other populations. For several reasons, we would expect that volume growth would be higher for Medicare beneficiaries than for others. The first has to do with a disparity in coverage. Medicare beneficiaries, of course, by definition, have health insurance coverage while many of those under the age of 65 and in the non-disabled population do not.

Second, Medicare beneficiaries have greater protection from cost-sharing because in a lot of cases they have supplemental coverage. By contrast, those with private insurance are often paying cost-sharing out-of-pocket.

Third is the matter of technological innovation. Because of the greater burden of illness experienced by Medicare beneficiaries, it's quite possible that more technological innovation is directed toward them.

We found however, in looking at a variety of different data with the help of Chris Hogan, our contractor, that we were just unable to reach a definitive conclusion about whether there is a difference in volume growth between

Medicare beneficiaries and others.

Let me just make several points about this. First, we did find some data that -- and research by others -- which showed that looking service by service that there is some evidence of higher volume growth for Medicare beneficiaries than for others.

A problem with this kind of work, however, is that it doesn't allow us to aggregate up and to reach conclusions overall about volume growth for Medicare beneficiaries compared to others. What I would ask you to recall is work that we have done for the payment adequacy chapter in the March report, where we recall that we've looked at volume growth for Medicare beneficiaries over time and tried to reach some conclusions about payment adequacy based on that.

So we have come up with figures like on a per beneficiary basis volume growth has gone up by -- going back to 1999 -- it's been in a range of 4 to 5 percent per year. So what we were striving for in this kind of a comparison was a number like that that we could compare with the Medicare population. And clearly, looking service by service, we were unable to do that.

That prompted us then to try and look at some

alternative data sources. The first one that we turned to was the database of private insurer claims that we've been working with for the past few years. As you know, we've used that database previously to compare Medicare's payment rate for physician services with private insurer's rates. The thought was that we could tap that database and use it also to look at volume growth. But it turned out to be an exercise really in frustration. One of our data sources changed the data reporting methods midstream, which had a big impact on how subscriber enrollment was reported. So that made it difficult for us to adjust the volume growth numbers for growth in the number of enrollees.

The other problem that we encountered from our other data source is that coverages, benefit packages, benefit designs that were used for enrollees were all changing over time, even within year. So there again, it became difficult to try and adjust the volume numbers that we were getting with the private insurer claims for growth in the number of enrollees.

So that was kind of, if you will, a bottom-up way of trying to assess volume growth by looking at use of specific services in the privately insured population. So

we then tried a different, more top-down approach, and looked at data on aggregate spending for physician services spending on the part of private insurers. We encountered some difficulties there, as well.

Part of it just had to do with the need to adjust for inconsistencies in the benefit packages between the privately insured and Medicare beneficiaries coverage. The other just had to do with cost-sharing differences between the two types of populations. So we ended up abandoning that effort, as well. And as I say, reached the conclusion that we were just unable to come up with stable measures of volume growth for Medicare beneficiaries and others.

We turn now to the last topic for the report, having to do with the estimates of the effects of law and regulation that are in the sustainable growth rate.

With this part of the report we did not feel that we were capable of looking at the effects of specific changes in law and regulation in trying to assess whether CMS had evaluated those adequately. Instead, we focused on a process that CMS is using to come up with these estimates. At the end of the section in the report, we have some suggestions for how they might improve that process.

Let me first talk about some of the issues that CMS confronts in trying to do this work. The first just has to do with the limited data that are available. Really, by definition, we're talking here about limited experience with changes in spending due to law and regulation. In a lot of cases we're talking about new benefits that Medicare beneficiaries have not had previously, the effects of regulations and how they affect the operation of the program and so on.

CMS attempts to address these data limitations by consultation with a variety of entities. The work for this is done by the Office of the actuary in CMS. Staff there consult with staff in other parts of the agency, physicians working in the agency, physician organizations outside CMS, previous research that's been done that might be relevant to the topic, whatever it is.

The other thing that they try to do in this kind of an environment is to consider not just the primary effects of a change in law and regulation, say in the case of a new benefit the use of that benefit itself, but also the secondary effects of a change in law and regulation. Any sort of associated services that might be used in

addition to the new benefit itself.

The other issue that's important in considering changes in spending due to law and regulation just has to do with the need to revise the estimates as better data become available. By law CMS is allowed to revise a sustainable growth rate for a particular year twice over the course of subsequent two years. So there is a potential here for changes in these estimates to occur as better data become available.

Let me just come back to the issue of how CMS estimates the secondary effects of law and regulation. Two examples illustrate this. If we start with a new screening benefit, that's a relatively straightforward case where we're talking about use of the screening benefit itself as well as associated tests and procedures. The latter would be the secondary effects.

Things get a bit more complicated when we're talking about a preventative benefit, however. There is, of course, the primary effect of the benefit itself. But there's also secondary effects, which could be positive or they could be negative. In other words, the benefit could result in greater use of some services but less use of

others. And so where the Office of the Actuary often ends up from a secondary effect standpoint, the net effect is zero.

Of course, as better data become available over time, there is the potential for such an estimate to change.

We concluded the section of the report on this with some thoughts about transparency. Clearly, we're operating here in an environment, CMS is, in an environment of limited information. And so it would certainly be prudent for the agency to look for opportunities to lay out the assumptions that have to be made in making these estimates.

In addition, this is a case where what qualifies as a change in law and regulation and what does not is important. Are local coverage decisions included in the definition? What about administrative actions such as new billing codes? Here again, it would be useful for greater transparency to occur, for there to be perhaps a onetime explanation of what's included in the definition and what is not.

That concludes our presentation on the report and we look forward to your comments.

MR. HACKBARTH: Let me begin with a question and a comment about how we frame the report. The statutory mandate has as the basic question to what extent do increases in volume result in care that improves the health and well-being of Medicare beneficiaries? That's sort of the mega question. And then it asks us to respond to a specific series of factors that you've just gone through in the presentation, change in site of service and so on.

As I read the report, we sort of jump over the mega question, to what extent are changes in volume improving the health and well-being of Medicare beneficiaries? And obviously that is not a question that lends itself to simple response. But it does seem to me to be an opportunity to make what is one of our basic points recently, some of the increase in volume is good. Some of the increase in is not so good. In fact, the same can be said about what's in the base. Forget the growth. The base is a mixture of good and bad.

It's a very basic point but I think a critical point. It leads to our policy recommendations that we need to start being more discriminating in the tools that we apply, not just in Part B but in the whole program in

general. So I think this is one more opportunity to toot that horn and we ought not to pass it up.

I also had just one narrow question about the process of revision of estimates for new benefits and the like. In the paper it says that the estimates are subject to revision for one year. But I thought I heard you say that they have two chances to revise. Could you reconcile that?

DR. HAYES: The draft is incorrect on that point. It is for two years.

MR. HACKBARTH: We were telling Hill staff yesterday that it was one, so we need to go back.

DR. MILLER: So we need to change the law and make it one. I think that's what Glenn is saying.

[Laughter.]

MR. HACKBARTH: Right, that's what I'm saying.

Other comments or questions about the report?

MS. BURKE: I guess just to underscore your comment, Glenn. I thought the report was useful in helping us understand what we did and didn't know about increases in volume. But I could not find the answer to the central question, which is the question of whether it contributed or

not. So I felt that I was better informed as to what we knew about, why, and what we didn't know. But I've really didn't ever come to understand the answer to the central question.

DR. HAYES: And it is a very difficult thing to try and pin down. What we probably need to do in the intro to the report is to make that point clearly.

MS. BURKE: Yes, or not. If we don't know the answer, then we ought to just say we don't know. Because it wasn't a question of hard to pin down. There was no answer to that question, that I found. And if, in fact, answer is that there is no answer, that we cannot determine that, then we ought to just say that outright.

I think one of the challenges that I think we always find in the course of these reports, which are enormously helpful, is sometimes we ought to just state the obvious at the outset and then spend the next 25 pages getting to where we started. But I think we ought not wait for someone to try and figure that out, 20 pages in, that we couldn't answer that question. If we can't answer it, then we ought to just outright state that and then explain what the challenges were in trying to derive that.

So I think we ought to just say that.

DR. MILLER: Based on comments in discussion with Glenn, the way we were thinking about going at it was at the beginning of the report to review sort of the Cutler and Fisher arguments as a way to frame this question, reach the conclusion that Glenn was making, and then say now we'll proceed with the other parts of the mandate and kind of march through the rest of the report.

DR. MILSTEIN: It may not be feasible, but in view of some of the insights that all of us have gained over the last five years based on the research continuously flowing out of the Dartmouth Group, it would be for me useful in interpreting these growth numbers to understand whether there are any differences in these growth numbers in what I'll call the North Central geographies where care has historically, as a matter of who knows what, been much more conservative versus areas where that conservatism -- at least in service volume -- has been lacking.

For example, if we were able to do some kind of a geographic segregation along that line and we were to see, for example, that service growth rates are quite modest in the geographies that are known to be conservative in their

service use and getting equal or better outcomes and doing well on quality measures, and that the bulk of the growth rate was in areas in which historically there has been and continues to be a lot of high-volume service use without associated evidence of either quality numbers going up or health benefit, at least for me that might be useful in offering a judgment about what this means.

MR. HACKBARTH: I vaguely recall that in our initial cuts at why volume is going that we did some geographic looks at it. Kevin, do you want to summarize that?

DR. HAYES: Yes. Yes, we looked at volume growth for the 50 largest metropolitan statistical areas. We were not in a position of looking at the specific areas and identifying what the areas were, so much as we were focusing on this matter of growth in use of more versus less discretionary services.

What we found was that in the areas with the highest volume growth, the highest -- hold on a second.

That the greatest variation in volume growth among geographic areas was in the most discretionary services, imaging services and tests and least variation with respect

to major surgical procedures.

MR. HACKBARTH: The same is true of the growth rates as is true of the base, that the variation is in the discretionary and not in the less discretionary. And there is variation in the growth rates.

DR. MILSTEIN: Resources permitting, it would be useful to see the analysis in which we would, for example, of the 50 geographies for which we've already cut the data, maybe apportion them by the Dartmouth quintiles and then see what growth rate analysis shows in areas that are relatively conservative versus relatively less conservative in their volume of service use.

MR. HACKBARTH: This particular report, as I recall, is due very soon, like December 8 or something like that. So maybe what we can do is look at some of that previous analysis and see what we can import into this very quickly. Then, if we so desire, we can do some more in-depth analysis in the future.

Anybody? I have one more.

In Rachel's paper this morning, she included a table that was done by Ken Thorpe and others. This is not Medicare-specific analysis but it analyzes the rate of

growth for specific conditions and breaks it into component parts, how much is due to price increase, how much is due to increased intensity of service, and how much as due to population growth.

When I first looked at that table I found it very striking how much variability there is among conditions. In some cases, it's the treated prevalence of the disease that is driving the growth. For example, in the case of diabetes, I think was one where we've had a rapid growth in the number of diabetics. Other conditions, the treated prevalence is not growing much at all and it's just that we're treating each existing case much more intensively than we did in the past.

That slice at the growth is really not in the report as written. I know Thorpe's data are not Medicare-specific and I'm not suggesting that we go back and try to look at the Medicare data, but I think that's an observation worth including, that some of the volume growth is not really attributable to physicians or the health care system, but maybe to how we live our lives and our behavior. It's just an important point for completeness, I think, to be included.

Any other questions, comments? Okay, thank you very much.

Next on our agenda is a report on a survey that we did on retiree health benefits. Jon Gabel, one of the presenters, is not yet here. So we're going to shift the order and move ahead to the home health update and outlier policy. Then after that, we'll come back to the survey results.

MS. CHENG: I have two topics to discuss with the group this afternoon. One, you need to put your payment adequacy hats back on. A lot of our sectors began their payment adequacy review in our last meeting and I'm the oddball out here. So just put that on real briefly.

The other topic that I'd like to discuss with you is some research that I've done on the home health outlier provision, and I'll give you a little bit of background and get you started on some research that we have there.

First, to payment adequacy. I've got four of the factors from our framework that I've got some information on for you today. The first is going to be beneficiaries access to care. The second is quality of care in home health. I've also got some information on the entry of new

home health agencies and access to capital for this sector.

MedPAC has acknowledged several times in the past that this benefit itself has always had some ambiguities. A lack of definition of the benefit makes it difficult to determine whether the appropriate beneficiaries are getting the appropriate care. Also, how does the spell of illness concept apply to this benefit, that covers both skilled and custodial care for patients whose conditions are not expected to improve?

These ambiguities have complicated our analysis of this particular prospective payment system really since we've begun our analysis of it. MedPAC has, in the past, recommended that definitive eligibility and coverage guidelines be developed and that research be done to develop clinical guidelines to enhance our understanding of who ought to be getting what in this benefit. Until those changes are made, however, any analysis of this benefit is going to face some limitations.

This is a quick review of home health. I've got a picture here of the spending for this benefit. In the first half of the 1990s spending and use of home health grew quite rapidly. The care was increasingly resembling long-term

care and not so much the medical services of other post-acute benefits. Nearly half of the visits in the early '90s were the non-medical home health aide visits. And one third of all visits were delivered to patients who, on average, received at least one visit nearly every day for the entire year.

These growth trends and other trends led to changes in the enforcement of program integrity, eligibility and changes very basically to the payment system itself. The payment system was changed from a cost-based system to a cost-based system with limits in 1997. Spending fell by about half from 1997 to 1999.

In October of 2000, CMS implemented the current prospective payment system. Payments began to grow again. The Office of the Actuary predicts 8 percent growth in spending in 2005 and 4.7 percent growth annually over the next 10 years.

For our payment framework factors, the first one is beneficiaries access to care. I've taken this down into three different questions, the first one being do beneficiaries have providers in their community? Can beneficiaries obtain care from those providers? And when

they do, are they obtaining appropriate care?

In examining answers to our first question we found that 99 percent of all beneficiaries live in an area that was served by at least one agency in 2004, according to our research and CMS's Home Health Compare database of service areas for home health agencies. 97 percent of Medicare beneficiaries live in an area that was served by two or more agencies. Many of the unserved areas on this map are also unpopulated. If we look at the state that has some of the lightest shading, such as Montana, we find a coverage rate of 93 percent.

Now this estimate may overstate coverage because willingness to serve one portion of a ZIP code that is either very large or not homogenous may not be a true indication of the willingness to serve the entire area that we are describing. However, it may also understate the coverage because of two elements in this analysis. We have P.O. boxes for a number of beneficiaries, so we can't accurately put them in the place where they reside. So those beneficiaries actually show up, in our analysis, as unserved.

Also, because this service area is driven by the

actual presence of a served beneficiary, if there was a number of beneficiaries in an area and they did not ask for service in the time period, it may mean that there's an agency willing to serve that area, there just was no call for service in our time frame.

Looking at our second access question of whether or not then beneficiaries can access the providers that are in their community, we found that nearly 90 percent of beneficiaries who responded to the CAHPS survey about their home health experiences in 2003 reported that they had no problem or a small problem in accessing the home health services when they sought them. The percentage of beneficiaries who did not have a problem was slightly but statistically significantly higher in 2003 than in 2002 and the percentage of beneficiaries who had a small problem was significantly lower in 2003 than in 2002, again slightly but statistically significantly. The number of beneficiaries who reported a big problem is statistically unchanged between these two periods.

For our third access question of whether once the beneficiaries get in the door do they get the services that they need, we turned to quality and outcome measurements. I

haven't put each of the 11 national outcomes on this slide. A more complete set of these measures is available in your mailing materials on page seven.

This evidence suggests that beneficiaries access to appropriate care has not decreased because the measures of quality recently rose. The share of patients who achieve a positive outcome has increased in the most recent time period over the previous period. This could be the result of more home health patients receiving appropriate care and thus enabling good outcomes. However, this evidence does not allow us to conclude that all care that patients receive is appropriate care. If inappropriate care doesn't have an impact on this measure, then we can't pick that up.

It also focuses on functional improvement and these functional improvement measures may not reflect the goals of patients with chronic condition whose care is more oriented towards stabilization than improvement.

These quality indicators are risk-adjusted, so they account for diagnoses, comorbidities and other patient characteristics from time period one to time period two. So to the extent that we are able to adequately risk-adjusted this, we are looking at differences in quality rather than

differences in the patient mix from the first period to the second period.

DR. NELSON: Sharon, are these data reported by the agencies?

MS. CHENG: This data is driven from the OASIS assessment that every agency has to do on each patient when they are admitted to care and then again when they're discharged.

On another one of our framework factors, we are looking at the supply of home health agencies and we note that it has recently increased. Over 500 home health agencies began to participate in Medicare over the last 12 months. Over the same time period about 100 agencies exited the program, making the net gain about 400 agencies, which is a 9 percent increase in one year in the number of agencies participating in the program.

All the newly participating agencies that we're picking up in this analysis, however, are not necessarily brand-new. CMS is continuing its efforts to assign ID numbers to entities that formerly conducted business as branches of other agencies. So some of these new participants might have been branches of existing agencies

before they received their own Medicare ID.

The final indicator that I will discuss from our payment adequacy framework is access to capital. As I've noted a couple of times before, access to capital is not a particularly strong indicator in this sector. It seems to be determined more by the size of the industry compared to other health care industries. And also, it is influenced by perceptions of risk on the part of the investors but not necessarily going to be reflective of the adequacy of Medicare's payments in any given year.

We also note that most home health agencies don't use the kinds of access that we can measure. They are not publicly traded and they don't access bonds or other forms of capital that we could get some measurements on.

That said, the market analysts that do look at the publicly traded companies in this sector are generally positive about the companies in this sector. One company that specializes in buying and selling home health agencies predicts that the upcoming year will be "breakout" and that access to debt appears to be improving. They note that the value of invested capital at one fairly large publicly traded home health agency grew 355 percent over the last 12

months. In most of the analyses that we have, Medicare is still noted as the highest margin payer in the sector.

The second topic I'd like to discuss this afternoon, moving out of our payment adequacy framework, is the outlier provision of the home health PPS. The outlier provision was an optional feature when CMS designed this PPS in 2000 and it was implemented in 2000 and has been a part of the system since it was implemented.

Through the outlier provision, Medicare shares the losses on particularly high cost patients with the agencies. It covers 80 percent of the losses incurred on patient services. Not all high cost episodes will qualify for outliers. The costs have to exceed the payment by a threshold amount, which would be about $2,600 in calendar year 2005.

CMS anticipated that the outlier payments would be about 5 percent of total spending on home health. The base payment when they designed this system was lowered to accommodate the outlier payments and still remain budget neutral. In 2002 2.6 percent of episodes qualified for outlier payments and those outlier payments were about 2.7 percent of total payments. In their most recent rule, CMS

has proposed a reduction of the fixed loss amount and this change is designed to increase the number of outlier episodes and outlier payments.

Again to say, we have not reached a decision point on our analysis of the outlier. Today's information is really provided to you as an early step in a project to answer your questions about whether this PPS is working in a broader sense. So we hope as you look at some of these results you can point the staff in a direction about how we can best proceed with questions on the outlier specifically but also if they raise questions in your mind about things to look at in the PPS more broadly.

In looking at this provision, the conclusion that we come to is that the initial results are mixed. The payment system does meet the criteria that we suggested for an outlier provision that we proposed in this analysis. However, we also note that there other provisions in this payment system that fulfill many of the outlier functions. There is an adjustment called the LUPA, the low utilization payment adjustment. And what that does is provide an outlier for especially low cost episodes.

There's also a provision in this payment system

that's called the significant change in condition or SCIC adjustment which if, during the course of a 60-day episode, a patient's health deteriorates to the point where they would qualify for a different payment group, then they can be switched to that payment group and then the balance of days will be paid at the additional payment group. So though that might cause a patient to be a high cost compared to their original payment group, then they can adjust the payment group for the balance of the days.

The other provision in the system that works somewhat like an outlier is also the fact that our episodes are 60 days long. So if you have a patient with a particularly long stay, there's a new episode payment every 60 days. So that source of cost variation is also cared for in another way in this payment system.

We also note that the way that the outlier provision is formulated can be manipulated. And we note that the issues that we identified in our analysis, you could try to address them with refinements to the outlier provision or you could look elsewhere in the PPS for refinements to address some of the issues.

So as we thought about the role that an outlier

payment could pay, we came up with this list of criteria. An outlier payment could be appropriate if there's a particularly wide variability in the cost per episode within the payment groups that we've designed. In a prospective payment system, payment will rarely be exactly the same as the cost per unit of service. But the system is designed to pay appropriately on average. However, if especially costly episodes are not particularly rare events, it may be necessary to offset the losses incurred by the providers who care for those particularly expensive patients.

An outlier provision might also be appropriate if some providers treat a greater proportion of high cost patients than others. This outlier payment could then provide some equity among providers by increasing payments for those who care for especially costly patients.

A third criteria that we proposed would be that an outlier policy would be appropriate if beneficiaries who are likely to be high cost could be identified in advance. An outlier payment could then maintain access for those patients who can be identified as high cost by mitigating the losses that the provider is likely to incur if they decide to admit them. Similarly, an outlier payment could

reduce the incentive to limit care after a high cost patient has been admitted.

To look at our first criteria, we estimated variation in costs by measuring the variation in the number of minutes of service that are delivered in an episode. And we used the coefficient of variation to describe this variation. The coefficient of variation is a statistic that measures the standard deviation in the number of minutes and divides by the average number of minutes for that case-mix group. It thus produces an index that allows us to compare the variability in case-mix group with the sense of the meaningfulness of the variation.

Let me take you through a quick example using this picture. On this graph you see the 80 case-mix groups that are used in the home health PPS. I've drawn a heavy line at the value cv of one. So in the case-mix group that's the first to hit that line at one, the average number of minutes of care is 1,300. The cv of one for that case-mix group tells you that the dispersion around that average is, in fact, quite large as measured by standard deviation. In fact, it's also 1,300 minutes. So for most of the episodes in that case-mix group the average number of minutes is

1,300, give or take 1,300 minutes.

Out of 80 case-mix groups, 42 had coefficients of variation equal to one or greater than one. Those 42 widely variable case mix group account for 58 percent of all payments in the system in 2002. Even below that heavy line that I've drawn at one, a cv of 0.9, 0.8 or 0.7 indicates fairly wide dispersion compared to the average number of minutes in those case-mix groups. Some of the cv's above that line at one indicate very wide dispersion.

So from this we know there's plenty of variation in minutes within almost all of the case-mix groups. We do not know from this analysis exactly how variation in minutes relates to variation in cost, but it does suggest that costs probably vary a great deal as well.

The presence of this wide variation suggest that there is work for an outlier policy to do. However, it might also suggest a more fundamental approach, namely an examination of the case-mix system. The red bars that I've included on this picture are the five case-mix groups with the highest amount of outlier payments. Together, the outlier payments in those five case-mix groups represent 60 percent of all outlier payments made in 2002. As you can

see, four out of the five do cluster at the right-hand side of this graph, which does suggest that most of our outlier payments are going to case-mix groups where there is a fairly large amount of variability.

Considering our second criteria, we did find evidence that high cost outlier episodes are not distributed randomly among agencies. We found differences by type of control of the agency -- voluntary, proprietary or government -- as shown on this slide. We also found differences between freestanding and hospital-based agencies. We also found a wide variation among agencies generally.

In considering our third criteria, because home health is delivered in patient's homes, the availability of informal care that's unpaid or is perhaps paid separately by the patient but is not provided by the home health agency is going to affect the amount of care that the home health agency has to provide to that patient.

Payments however, do not vary based on the availability of these other sources of informal care. Not surprisingly, the availability of caregivers in addition to those provided by the home health agency does appear to be

related to a significant difference between outlier and non-outlier cases. This pattern suggests that an agency may be able to identify patients with high cost relative to payments if the agency can ascertain the ability of caregivers in advance of admitting a patient. Patients with very frequent care from caregivers, the ones at the top whose caregivers are available multiple times during the day or night or multiple times during the day have a statistically significantly lower average frequency of outlier episodes. Conversely, patients with infrequent care or no caregiver have a higher than average frequency of outliers.

In your mailing materials, there was also an additional table of 16 other patient characteristics such as obesity, ventilator use or heavy smoking that are also significantly related to the frequency of outliers. These patterns suggest that patients who are likely to be high cost outliers could be ascertained in advance by a fairly simple screen and potentially avoided by home health agencies. Such behavior would lead to an access problem for beneficiaries with these characteristics. An outlier policy can mitigate the impact of these high cost cases and could

play a role in maintaining access for those beneficiaries. However, this information, too, could point to the need for re-examination of the case-mix system.

We then compared the average minutes per outlier episode to average minutes in non-outlier episodes to get a sense of where the cost of high cost episodes were coming from. We found the greatest difference between the amount of skilled nursing minutes in outlier episodes and those of non-outlier episodes.

Again, because we do not have standards of care, we cannot determine whether these additional services are medically necessary to meet the needs of the patients who receive them. However, this does suggest that there is a substantial opportunity to limit services or differentiate between high cost and low-cost patients once they are admitted.

This amount of nursing service also points to the possibility that the outlier provision could be manipulated by some agencies. A back of the envelope calculation suggests that the average skilled nursing minutes of 2,400 are equivalent to a skilled nursing visit every weekday for the entire 60 day episode. The fact that agencies max out

the number of visits in an outlier episode could suggest that there is an incentive to maximize the number of visits. If an agency's marginal cost of additional skilled nursing visits is below the per visit payment that they receive, then agencies could have an incentive to provide the maximum number of visits once they've qualified for an outlier episode.

Our experience under the cost-based payment system pre-1997 suggests that this can be a powerful incentive to provide additional visits.

In summary, this is again very preliminary research but we think it has a couple of suggestions that appear to tell us several things. There does appear to be wide variability in the minutes and perhaps the costs of care within payment groups. The proportion of outlier episodes does vary between agencies. And beneficiaries likely to be high cost do seem to be able to be identified in advance based on patient characteristics.

We also note that many agencies in this sector are small, so a handful of expensive outliers could have an impact on their financial stability.

We also note that other provisions in this payment

system do much of the work of outliers, so perhaps outliers are somewhat of a belt and suspenders approach to payment system. Outliers might not correlate with high variability in costs if our estimate in the minutes doesn't correlate very well with the true cost of episodes. And there seems to be a question of whether outliers can be manipulated, and that question should probably be examined.

MR. HACKBARTH: Could you put up the graph again with the yellow bars? I think we need to just reflect for a minute what this means, with the acknowledgment that this is based on minutes as opposed to costs. But to me that's a very striking picture, I think with ramifications beyond outlier policy. It goes to the heart of the case-mix system.

Last year we included in our report some language expressing concern that the current case-mix system may not be appropriately capturing all of the variation and therefore there was some risk that we were mispaying for certain types of patients. This graph and the amount of variation documented augments that concern, at least in my mind.

I want to think for a second about other possible

explanations of this. Part of it is that the case-mix poorly defines homogeneous classes of patients. But I can think of at least one other possible explanation, and that is that the product is so poorly defined, so flexibly defined, that we are really not talking about a fixed product, let alone fixed category of patients.

I don't know if there other possible explanations of what that means, as well.

MS. BURKE: Glenn, what would you have expected?

MR. HACKBARTH: That's a good question. I wonder if we had a comparable graph for the hospital DRG system. I'm not sure that the coefficient of variation is on this scale. I may be wrong, but it's much smaller.

MS. CHENG: I'd love to be able to do apples to apples and I did sit down with our hospital team and asked them if they've look at something similar.

The hospital measurement has the advantage of really being able to look at cost variation within DRGs. This is minutes, which is not going to be one-for-one for cost. But the DRG system has cost variations with cv's around 0.6. And that's the starting point for the variation of minutes that you see here.

MR. HACKBARTH: We're going up from there.

DR. SCANLON: I expected this. Partly it goes back to when we were paying on the basis of cost and we saw the variation that existed in agencies across the country in terms of the amount of services that were being provided.

At that point, no one was complaining about underservice. The issue would be then in a world where we create an incentive to reduce services, people are not going to complain about underservice because they don't recognize what services they should be getting. I think the hospital comparison is totally different because there was an expectation about the services you were going to receive. Physicians are there to ensure that you receive those kinds of services. And in this area it's completely different. The problem starts at the very beginning of the paper where it says we have no coverage guidelines, we have no clinical guidelines as to what this service involves.

The solution is never going to be -- until we get those, which I think may be impossible -- the solution is not going to be in fixing the case-mix measures. We're not going to define groups that are going to be so well-defined that we know what services the people within that group are

going to need to receive.

That's what's critical to protecting patients. So I think it's a more fundamental issue. We talk about an outlier policy that if we designed one that was well enough to protect the patients, we suddenly would discover the outlier policy was the payment policy.

MS. RAPHAEL: The only thing I would say to that is, first of all, I think there actually is progress in clinical guidelines. I think one of the reasons we have some improvement in outcomes is because we now do have guidelines for how we deal with diabetics and congestive heart failure and wound care patients. And while I'm not saying if any way there's a systematic approach here, I think that this has crept into practice.

Secondarily, there is an assertion throughout this, starting with page one, that there are no clinical guidelines. And home health care isn't meant to cure illness. It's meant to treat illness. And how do we know when a spell of illnesses over?

But then, for many chronic conditions, if someone enters a nursing home, if they see a physician, do we have clinical guidelines in those cases? Do we know when the

spell of illness is over? I think we face the same thing in dealing with chronic illness in a number of settings.

So why single out home health care? Because no matter how you slice it, even when you look at the improvements, this is still a chronically ill population. We're hoping now 36 percent of the people can improve walking. Basically that's our improvement level for this group, are those who are confused less often. We've gone to 42 percent are now confused less often. So it's still basically a very chronically ill population, even though we've narrowed the benefit to much more skilled and post-acute kinds of services.

DR. SCANLON: That is, in part, why I wouldn't propose that we move completely to having clinical guidelines to govern whether or not we bought the right services. I think we have a chronically ill population and we have very great difficulty in defining what we want in terms of the maintenance of that chronically ill population.

There are some that would react to the word maintenance and say that's not going to be a Medicare-covered service at all. And I think that's not where we are today. We've moved beyond the point where we say you have

to be able to demonstrate that you're going to improve or we're not going to cover you. I think we are now into caring for the chronically ill. We don't have a good outcome for what that care should produce. So therefore, I wouldn't want to hold it against home health agencies because they didn't achieve the kinds of outcomes that are associated with people that do improve because, as you said, you've got 60 percent of people who are not improving on that kind of a measure. And that may be appropriate for the vast majority of them.

The probably we have now is we're paying and those people are not necessarily being served. That graph, if you had a hypothesis that the number of minutes was zero, you can't reject it on the basis of that graph. The confidence intervals overlap zero in every case. That's believable.

So I think we have a fundamental problem with the structure of the payment system that goes to taking something that is totally undefined, an episode of care, and making a very large payment for it.

I'm somewhat concerned about the fact that even though Wall Street's not that involved, that Wall Street seems to have said that there may be a breakout year coming.

would invest, too, on the basis of this graph.

It's too bad that the CMS data do not allow us to know exactly what's happening with respect to the number of agencies. But there is this issue of what we saw before was when we identified that there was considerable profits in home health services, we had an explosion in terms of the number of agencies. And they tended to be proprietary. And they tended to have very different patterns of services than did the traditional non-profits that were providing these kinds of services, almost double the members of visits as the traditional agencies.

I keep asking myself why haven't we've seen that yet, given the system?

MS. RAPHAEL: I don't want to make this a dialogue here, but I do think this is a very segmented industry. You have some sort of pure Medicare players who are almost 90 percent dependent on Medicare. And whither Medicare goest, they will go. And you have other organizations where they are very Medicaid dependent, where they do a lot of charitable care, they are working with managed-care plans.

And I think you have an industry that is really very bifurcated. Yet, we are trying to have a unitary

payment policy. That is something that really, I think, is very, very difficult to do.

And you're right, the outlier policy, when you look at it, the proprietaries had a 3.3 percent outlier rate which is much higher. I think it's fascinating, 60 percent of home care agencies provide 1,000 or less episodes a year. This is an industry with a lot of very, very small entities. And then you have this cluster of really large entities who could manipulate. I think a lot of the small agencies wouldn't even know how to manipulate. They're having a hard enough time just surviving.

So for me the larger question is how do you make a payment policy that preserves access for those who really are smaller and more fragile and vital in their communities, at the same time that there is equity here?

MR. HACKBARTH: Other comments?

We have danced around this issue of how well the product is defined, and then last year how good the case-mix adjustment is. And now we're looking at the outlier and whether it's needed and how accurate it is.

I guess I have a growing feeling that we are not going to the real issue. We're not even particularly close

with this payment system. And it's not just a matter of refining it around the edges. I think we are missing the mark by a substantial amount, although don't ask me what exactly the alternative is that we put in place tomorrow. I think that requires some thought. But we may want to change the tenor of our recommendations and make it clearer how far off the mark we think this system is.

DR. MILSTEIN: Do we know very much about performance variation among home health care agencies in the same geography on these or any other measures of change in patient functional status? Is this an industry where all the home health agencies are pretty much getting the same results? Or is there a lot of performance variation within the industry in say holding geography constant?

MS. RAPHAEL: My impression, and Sharon can probably modify it, this is impressionistic, is there's not much difference in the outcomes between the agencies.

MR. HACKBARTH: As you will recall, we're just now at the point of trying to say what's our basically quality measure set that is sufficiently robust that we can make meaningful comparisons of performance?

MS. RAPHAEL: But Sharon, do you see much

variation? I don't.

DR. WAKEFIELD: Has anyone looked at that data set for variation?

MS. RAPHAEL: Yes. And if you look at Home Health Compare in any geographic area, if I were a consumer I would find it hard based on that data right now to differentiate.

DR. MILSTEIN: Addressing my own ignorance, what do we know about the impact on these or any other measures of patient functional status of home health agency intervention versus no intervention?

MS. CHENG: Versus no intervention? We really have a pretty different dataset. Because we have such good measurement of people who are under the care of a home health agency, we know a whole lot more about them. We could get very different measurements, though, and compare perhaps folks that were discharged from a hospital to different post-acute care settings or no post acute-care setting. But then you don't get information on their functional improvement 60 days later because they sort of drop off our measurements.

DR. NELSON: When I was checking the publicly reported data on the Web for Utah for home care and for

SNFs, I certainly wouldn't have a clue of which were the better ones or the less good ones as a consumer. I didn't have a clue as a practitioner from which ones were how I would choose.

MS. RAPHAEL: I think a lot of what causes variation in costs have to do with informal caregivers because unlike other parts of health care we know there are 54 million informal caregivers in our nation. On average, they spend 18 hours a week. And they really bear a lot of the brunt of this care. There's no doubt about it. If you have someone 89 with no informal caregiver, that's a whole different situation than someone 66 with a spouse.

Also, we find that dually eligibles, if you think of Medicaid, if in anyway that's a proxy for social and economic problems, they cost us a lot more in resource consumption than a Medicare-only case.

So there are other things that enter into this variation that are very hard to capture when you try to move toward clinical guidelines.

DR. NELSON: Can I make another point? There are there some lessons in this discussion we've just had with respect also to other publicly reported data, for example

hospital quality data as that's becoming gathered to the point that you can look at it and try and draw some conclusions.

I saw some data on use of aspirin, prescribing aspirin for patients who had a myocardial infarction. There were a number of the hospitals that I was looking at in this cohort that were reporting 100 percent compliance. Well, let's see, a good hospital shouldn't have 100 percent compliance with that. You've got some patients for whom aspirin are contraindicated.

The point that I'm making is that we are having self-reported data. And whether it's collected on OASIS or whatever, there isn't any external validation or verification at this point.

So I don't know how useful it's going to be.

DR. MILLER: Sharon, I'm going to need some help here. Of the measurement and quality issue for just a second and back to the structure of the program, I think we recognized coming into the room that this wasn't a narrow conversation about outliers. And I think some of the references throughout this that there are other parts of the system that might be addressing this and there are other

issues to look at.

A couple of things to keep in mind. We have a mandated report that talks about case-mix and profitability coming online at some point, which I can't remember right at the moment.

And also we have discussed -- and Sharon this is where I want to be clear -- a longer-term agenda of looking at the elements of the payment system more broadly.

And then also, the notion of if you were going to step back from the payment system and think about it what are some of the issues or what are some of the other ways to think about this? That's all fair, Sharon? That's on our agenda for the June cycle? I can't remember; is that right?

MS. CHENG: The mandated report on whether or not there is a relationship between case-mix at an agency and that agency's financial performance is due to the Congress in November of 2005.

DR. MILLER: And then for June we had talked about looking at some of the other elements of the payment system?

MS. CHENG: That's right.

DR. MILLER: So in a sense, I think some of these other issues and potential broader problems with the payment

systems can be implicated and discussed. But it is this issue that we do kind of return to time and time again, what is the benefit? And what do we think this benefit should be for Medicare? And that's a little harder to analyze, but I just want the commissioners to know that we will go through the pieces of the system and talk about are there ways to improve it? But I do believe we will always either back in or run into, whichever way you want to think about this, issue at some level or another.

Carol, I just want you to know, we have not forgotten the point about the informal caregiving and the dual eligibles that you brought up. Part of our cranking through some of this is to see whether those issues do apply.

MR. HACKBARTH: Any other comments on home health? Thank you, Sharon.

Now we'll go back to the survey results. Welcome, Jon.

MR. GABEL: Thank you.

MR. HACKBARTH: Jill, you will do the formal introduction?

DR. BERNSTEIN: Earlier this year, MedPAC

sponsored a supplement to the Kaiser Family Foundation/HRET survey of employer health benefits. We designed a supplement to look at some questions about retiree coverage now and where it's going in the future.

Jon Gabel, who is a vice president at HRET, is going to walk you through the main findings from that survey.

MR. GABEL: Thank you for allowing me to present the results of the survey about post-retirement benefits. Just a little bit of background to begin with, let me back up a second.

Please, as I give the presentation, if you have any presentations please ask the questions as we go along.

Just a little background about retiree health benefits. Slightly more than one-third of all Medicare elderly beneficiaries rely on retiree health benefits for their supplemental coverage. This coverage is generally recognized as the most complete coverage for the Medicare population. It is historically a continuation of the same benefit package that retirees had as active workers.

Research shows that these beneficiaries tend to be younger and wealthier, and other factors held constant they

use about 25 percent more services than other beneficiaries.

MedPAC commissioned a special supplement of the 2004 Kaiser Family Foundation/HRET survey to study retiree health benefits. MedPAC, in commissioning the study, wished to collect data not available from other surveys.

Specifically, MedPAC wanted to examine the employee share for retiree health benefits, the status of active workers with regard to their future retiree health benefits, and also look at an early indication about how MMA, the Medicare Modernization Act, was likely to affect retiree health benefits.

Just a little background. I think most people here are familiar with the Kaiser Family Foundation survey. It is a national survey, a random sample of American employers, public and private, three or more workers. In the 2004 survey we completed interviews with 1,925 employee benefit managers. Of those firms, 634 offered retiree benefits and 509 offered retiree benefits to the Medicare-eligible population.

Let's look at some results. This first graphic shows since approximately 1993, when FASB went into effect, that there have been relatively little change in the

percentage of firms offering retiree health benefits. But this is misleading because, in fact, what happened in the 1990s was when the economy was expanding, when employer-based health coverage was expanding in the latter half of the decade, there was an erosion in retiree health benefits. This erosion took the form of restricted eligibility and increased cost-sharing on the part of retirees.

The vast majority of Medicare-aged retirees are retirees who formerly worked for a firm with 5,000 or more workers. In other words, it is 81 percent of the retirees.

We note that these same firms constitute just one-tenth of 1 percent of the nation's firms and cover approximately 40 percent of the active workers who are covered by job-based health insurance.

In fact, during this period of time, again in the 1990s, and since 1999, there has been relatively little change in the percentage of firms offering health benefits to early retirees and to the Medicare-eligible retirees. About 95 percent of all firms that offered retiree health benefits will offer them to early retirees. The figure for the Medicare-eligible population is lower at about 75 percent. Again, we see no discernible trends over the last

couple of years. Again, this is misleading, as we'll show in subsequent graphics.

MS. BURKE: Can I confirm what I assume I know to be the case, that these numbers do not include the federal or state government as an employer?

MR. GABEL: They do include state government. They do not include the federal government. They include local.

MS. BURKE: Military?

MR. GABEL: No, they would not include military.

Among the firms that offer retiree health benefits to the Medicare-eligible population, the so-called jumbo firms are far more likely to offer retiree health benefits if they offer retiree health benefits at all.

Some firms have already terminated coverage. Let me back up. Some firms that currently offer health retiree health benefits have already terminated coverage to some of their active workers. Based on our survey, we find that about two-thirds of the workers from firms offering coverage will be eligible for retiree benefits when they retire. Restated, about 25 percent of the current workers will be offered -- some of the workers will be offered benefits.

And then we have about another 8 percent of the workers who work for a firm that will not offer retiree health benefits to any one of these active workers when they retire.

State and local governments are far more likely to offer coverage in the future.

MS. BURKE: I'm trying to equate what you just said to the chart. Do I read this chart to suggest that 91 percent --

MR. GABEL: That's state and local government.

MS. BURKE: That's state and local, and 67 percent of large firms will offer?

MR. GABEL: Are currently planning to offer, yes. This is weighted by workers. So we're talking about workers who work for firms who currently offer retiree health benefits.

MS. BURKE: I'm trying to understand your passing comment about 25 percent. 25 percent will not?

MR. GABEL: It's going down to the second group of bars. It's about 25 percent of the active workers that work for firms that currently offer retiree health benefits work at a firm where some of the workers will be covered.

MS. BURKE: I'm slow. I'm trying to understand

that with the first case.

DR. BERTKO: Sheila, let me try. I used to work in this area.

The some worker bar says out of a group of current active employees there may be a newly hired group who have none and people with five or more years of coverage -- and I think you have some of these -- after a certain date won't have coverage. And that's that 25 percent.

MS. BURKE: The second set isn't a subset of the first set?

DR. BERTKO: No.

MS. BURKE: So the first set suggests that of workers in firms of 200 or more, 67 percent will be offered coverage.

MR. GABEL: Yes, all workers.

MS. BURKE: Now who are the some workers?

MR. GABEL: I think if we go to the next graphic, it will explain it.

So for those firms which will be terminating eligibility for future retirees, what is the criteria they are using? The most common criteria is the date of hire, affecting about 60 percent of the active workers. The

second most common -- and more than one criteria can apply -- will be a collective bargaining agreement. Other firms will use the date of retirement as a criteria or criterion for determining who will receive retiree health benefits and who will not receive retiree health benefits.

State and local governments, again, are more likely than those in the private sector to offer coverage.

Here is a glimpse into the future. For those firms currently offering coverage to retiree and active workers, about 27 percent of those active workers are working at a firm that plans to eliminate Medicare-age retiree health benefits for new hires in the next two years. Now 17 percent very likely, 10 percent somewhat likely.

And about 13 percent of the active workers in these firms work for a firm that plans to eliminate Medicare-age health benefits for active workers who have not yet retired.

MR. SMITH: So that 13 percent is a subset of the 60 percent?

MR. GABEL: Yes, of the 67 percent.

MR. SMITH: So today 67 percent of folks in firms with over 200 employees will be offered or are in a firm

where 100 percent of employees will be offered retiree health insurance? And of that number, 13 percent is likely.

MR. GABEL: Yes. For the new hires the figures are larger, 27 percent.

Retiree health benefits are highly valued by retirees. Compared to active workers, retirees are much more likely to take up coverage. For the retirees, of those who are eligible for retiree health benefits, 93 percent will take up coverage. Compare that to 83 percent or so for active workers. In all, about 77 percent of the retirees will be covered by the retiree health plan.

Medicare retirees have higher enrollee premiums than active workers. This is true for early retirees, as well as the Medicare-eligible retirees. On average, they contribute about $68 a month. They pay about one-fourth of the cost for single coverage. The average cost for a Medicare retiree is $276. About half of the claims expenses not seen here are for prescription drug expenses. Premiums for retirees who work for smaller firms are higher and retirees pay a higher percentage of those premiums.

DR. MILLER: Jon, when we reviewed this one of the questions was what the percentage was relative to active

workers. And the answer to that was 15; as I recall?

MR. GABEL: That's correct.

DR. MILLER: And then there was another question of for other retirees, non-Medicare age, and you were going to look into that.

MR. GABEL: I confess, I wasn't able to access that. We have not asked that question in recent years. John, maybe you can help me. Is it higher or lower than -- I think it's lower for the Medicare eligibles.

DR. BERTKO: Can you rephrase the question, Mark?

DR. MILLER: The reference points that I think we need to keep in mind as we go through this are we're talking about what's happening to Medicare-aged retirees. But there's also a phenomenon that's happening to the work force and other retirees.

So the question I'm just trying to draw a bead on is when we see these things can we put them in the context of relative to other groups? The question I was asking specifically, I know for the active worker population -- in fact, we were talking about it a little bit at lunch, 15 percent.

When we went through the review, you were going to

look at what it was for non-Medicare-aged retirees to see how this figure compares the other retirees.

MR. GABEL: Mark, let me get back. I will send it to you. I apologize. I will send you that figure.

The last graphic looked at central tendency. This one looks at the distribution. You'll note that still about one-third of all Medicare-eligible retirees receive their retiree coverage free, about one-third. And of 5 percent have to pay 100 percent of the bill. Retirees from firms with 1,000 to 4,999 workers, you will note, are more likely to have to pay the full fare than for other sized firms. You will also note that union workers are slightly likely to receive full premium payment

Medicare-age retirees are less likely than active workers, slightly less likely than active workers, to face incentives not quite as strong to purchase the preferred drug, whether generic or brand-name drug. You'll note from this graphic that about 65 percent among firms with 200 or more workers work for a firm with either a three-tier or a four-tier cost-sharing. That figure is 52 percent for the retirees. Also, please note that the numbers for two-tier are relatively the same.

In the next two years we have some more bad news. It's true for both active workers and it is true for retirees. When we asked employers were they planning to increase the share of the health benefit premium in the next two years, you can see overall for large firms about 65 percent of large firms said yes, they were very likely to do so, 8 percent somewhat likely to do so. In fact, these numbers are even slightly higher for active workers than they are for the retirees.

Just an aside, having asked these kinds of questions about active workers for many years in the survey, employee benefit managers tend to underestimate what they actually do. The answer is why is this? Because we ask them the question in January and February. And then in September and October they receive a 20 percent increase. At that point, they start buying down in different forms or other.

DR. BERTKO: Jon, can I interrupt here because I think this is mostly an answer but there are really two things that are hidden in here, I think, and I'll ask you to confirm it. The first, I think, is what you alluded to most directly which is as premiums rise not only is the

percentage going to lead to bigger absolute dollars but perhaps the percentage will be changed bigger.

MR. GABEL: Yes.

DR. BERTKO: But for retirees in particular, I'm at least aware of a number of large jumbo employees who have firm lids or caps on the contribution. I was wondering if that is also probably embedded in those 48, 63, and 67 percent numbers?

MR. GABEL: We didn't specifically ask that this year. We have asked that in the past and, of course, we have observed that many employers are putting some types of caps on contributions and lifetime benefits and other such measures.

DR. MILLER: Can I get one other clarification? You said it was slightly higher for active workers? But 72 percent are someone and very likely. And if you add up the numbers for the active, it's 90 percent.

MR. GABEL: Correct.

the survey was fielded only a few months after the passage of the MMA. Over the last two months I have given a number of seminars to employers in about 15 different cities in the United States. So let me just relate what I've

learned on firsthand exchange.

When I've asked at these seminars, which say typically have 50 employers at them, I ask them what are you planning to do with regard to the MMA? Most of them say I don't know. We asked the question last spring. I think, therefore, you should put a great deal of uncertainty about the results that I'm about to show you. That's your caveat. Now let's go to the results.

We asked them how they were going to respond to the MMA. About 1 percent said they were going to totally drop coverage. Less than 10 percent said that they would buy into a Medicare Part B, either in full or partially. We have about 14 percent who said they don't know. And now of the remaining firms, by about two to one, the firms say that they will offer a Medicare qualified plan. The other group says that they will wrap around the Medicare Part D benefit. They will offer a wraparound type package.

So the conclusion therefore is that very few will drop coverage. There's a great deal of uncertainty. Perhaps not as many, but it's very uncertain will offer any Medicare Part D coverage as had been originally envisioned. Again, a great deal of uncertainty.

At this point, let me try to summarize what I see as the conclusions from the survey. I believe we are witnessing an acceleration of past trends. The erosion of retiree health benefits which took place during a period of a strong economy in the late 1990s is accelerating during the period when the economy is not nearly as strong. We're not witnessing wholesale dropping of health plans. Instead, what we're seeing is restrictions on eligibility, so current and new hires, for those firms currently offering retiree health benefits are less likely to have retiree health benefits when they retire.

If you're going to ask me what is the principal reason why we are seeing this erosion? I would say it is simply the fact that the cost of retiree health insurance has increased 56 percent since the year 2000.

Let me also add the burden of retiree health benefits. We don't have any graphics here, but when we looked at those firms offering retiree health benefits one-third of these retirees received their health benefits from a firm which has more retirees than active workers. 27 percent of the Medicare-eligible retirees receive their retiree health benefits from a firm which has more Medicare-

eligible retirees than active workers.

MR. SMITH: A 56 percent increase in costs in four years. Is that because of drugs? And what will be the impact of -- if it is, that's totally off the charts with respect to other health care cost increases --

MR. GABEL: No, it's not. It's very comparable.

MR. SMITH: Really?

MR. GABEL: Yes.

MR. SMITH: How much of it is drugs?

MR. GABEL: Well, 50 percent of the claims expenses in any given year. I would say that the underlying claims expenses -- I'm doing this from memory. Up to about 2001, retiree health benefits on private insurance, not just for retiree, for active workers and retirees, prescription drugs were the fastest increasing component of claims expenses.

Claims for inpatient health expenses have gone up. They are still less. Right now the fastest increasing component on the private side is for outpatient hospital services. That includes the way the data are calculated. It includes ambulatory surgery centers. And it also includes emergency rooms. That's in double digits. It

continues to be in double digits. I think that's driven heavily by the volume of services.

Lastly, if you were going to ask me what has been the impact of the MMA on retire health benefits? I would say it's really too early to say. I think most employers at this time have not made a decision. Again, talking to my employer groups I note that their big hesitancy is the thought of having to qualify each year to be a Medicare plan. That certainly is a constraining factor.

I thank you again, very much.

DR. BERTKO: Let me only add a slight update. Jon talked to people earlier in the year. We had an informal meeting with employer representatives, consultants from a variety of things. This was only a month ago and they said basically the same thing. Wait and see. We'll do whatever makes most sense. We're keeping everything in place, which somewhat implies that they will accept the 28 percent subsidy, provided that they qualify for it, with some indication that in a couple of years they might go to the wraparound option.

Again, I think that's almost along the lines of what you said.

MR. GABEL: Yes.

MR. DURENBERGER: I guess this is out of curiosity more than anything else. It seemed to me, watching from afar, that one of the most difficult provisions to put together in the Medicare Modernization Act was the application of employee retiree benefits. I don't know what the difficulties were.

Secondly, when you look at the amounts of money that were budgeted over 10 years for this particular provision, they seem quite large.

Which gets me to the third question, which is at what point do we understand what kind of recommendation, if any, we should be making to the Congress if we don't get any reaction or feedback from a lot of employers because they're waiting for something else? Or maybe I'm missing something here but can I ask John that?

DR. BERTKO: I would ask Bill to chime in. Bill and I have, as part of the Trustees Technical Advisory Panel, sat through six weeks or eight weeks of which this was one of the key questions. Among the things we think about very seriously is as no one knows. It's unknowable today. And that we need to really wait, not only until

2006, when these are out there, but more likely to 2007 or 2008 before the employers actually have their time. They have a very long lead time, in terms of making changes.

So the 1/1/06 benefit cycle begins in January for most of these jumbo employers. And they won't know what to do because the bids won't be in until June 2005 for those. So they may not do much of anything in year one, other than play along, which would be to see if they qualify for the 28 percent subsidy.

I guess my personal advice to the Commission at the moment is let's wait and gather data before we say much about it because I'm not sure what else we can say today.

DR. SCANLON: I would agree with John. I think one of the things that came out of that session was the unfortunate situation the Actuary is in in having to make an estimate of how the employers are going to respond. And really, that there are no data that can guide this.

The Congress has created incentive that is intended to try and maintain some of that coverage, to preserve or to reduce somewhat federal spending. But the question is going to be whether it works out to be that way. And we won't know for maybe two or three years.

People really need to get some feel as to how this is going to work out over time and then they will be making their decisions. A lot probably will depend on where the economy is at the given points in time. We may not see the reaction immediately if the economy is doing well. But if we are in the period of somewhat higher unemployment, more may tend to react sooner.

MR. DURENBERGER: Then a related question because there are other programs out there that supplement the Medicare benefit package, Medicaid being a very large one. We did a whole section on this in our June report some time ago. Does the same thing apply to all of these other areas of financial supplementation? Do we really need to wait until somewhere after 1/1/06 to see what is happening, particularly to prescription drug, in order to get a reaction back from others?

MR. HACKBARTH: I think the other circumstances are little bit different.

DR. MILLER: Some of what I would say about what was said here, and I'll come back over to you here, is I think part of what you and John and Bill were just saying is part of the reason to return to the caveats here. We're

talking about people speculating what they're going to do about in a couple of years. There's a very small number of firms that drive these numbers and they're working in an environment that they don't understand at this point. So I think you have to take this with several grains of salt.

I think it's absolutely true on the employer piece, we really are going to have to wait to see what's going on. The reason that we did this is there's two agendas that this could potentially link up to. One is our direction on monitoring the impact of the drug benefit and seeing how that is going. And that could pull in some of these other payer issues. That's a little bit different issue than the employer piece, which I think will play out over a longer period.

And then the general agenda of looking at out-of-pocket costs and supplemental coverage and how the beneficiary is carrying that. And some of what we were trying to do with this was to see whether there was places that we needed to be looking on that agenda. So I see this hooking up to those two agendas, but I think your point on the employer piece specifically is probably a little bit further out.

DR. NELSON: And volume. It works into volume.

MR. HACKBARTH: With regard to Medigap, as I understand the process, they're now going to be redesigning the standard plans to accommodate the Medicare drug benefit; are they not, John?

DR. BERTKO: Even more complex than that. First of all, they have 10 major options, three of which have the drug benefit. As of 1/1/06 those are frozen. You can stay in or you can leave. The new ones will not have a drug benefit and you would pick that up from a stand-alone drug plan. PDPs is our shorthand for that.

MS. RAPHAEL: I had an accounting question. Are there issues about this liability that employers are facing comparable to the pension liability and being underfunded that could affect future patterns here?

MR. GABEL: I would say the immediate dark cloud on the crisis is with state and local governments. They did not have to comply -- FASB didn't apply to them. Now there's a new one, GASB, is that what it's called?

Now that will be applying to state and local governments. So they will have to go on an accrual basis for their future retiree benefits. They have many, many

retirees relative to the number of active workers. So I would think if I were to come back and talk to you in two years I would see we've seen a real change among state and local governments in their offering of future retiree health benefits.

DR. BERTKO: For Carol, and let me just offer that unlike defined-benefit pension plans, there is no PBGC organization. Some folks, like United Airlines, just through bankruptcy terminated their plans, at which point nothing is there. The last point is for a whole variety of reasons, some of which are linked to FAS 106, there is very little prefunding on this. Most of it is on a pay-as-you-go basis. As John said, there are companies that have 120,000 retirees and now 30,000 active supporting that kind of a benefit.

DR. WAKEFIELD: PBGC is there.

DR. BERTKO: There is no PBGC for retiree health benefits.

DR. WAKEFIELD: For the rest of their income plans.

DR. BERTKO: For their income pension plans, yes. Except of course, you read in today's paper about their own

separate problems.

MR. SMITH: Folks have a property value in their pension but there is no property value associated with the promise of --

MR. HACKBARTH: Anybody else?

Thank you, Jon. Thanks, Jill.

We are now to the last item of the day, which is actually two separate items, the mandated reports on cardiac surgeons practice expense and then the first assistant study.

MR. GLASS: Thank you. We're talking about two studies, as Glenn said. The Commission has draft letter reports, and you, as a Commission, have discussed each of these once and given us your comments. We've put these in the draft reports on we're hoping that we'll get your last thoughts today and wrap these up.

The first is the certified registered nurse first assistant study, again mandated in the MMA. We discussed this in September. What we were asked to do is study the feasibility and advisability of paying certified registered nurse first assistants directly from Part B. Currently some groups are paid for first assisting under Part B, physician

assistants, clinical nurse specialists and nurse practitioners. Others are not, including the certified registered nurse, first assistants and surgical technologists.

The scope of this issue is that the total payments for first assistants have been going down. The physician part has been going down. The non-physician practitioner part has been going up.

It was $54 million for non-physician practitioners in 2002 and $104 million for physicians. So that's the scope of this. Of 74 million surgeries, 5 million of those use first assistants.

There also about 1,700 certified registered nurse first assistants. If they replace physicians or others who are currently being paid for these services, paying them as a total effect on Medicare payment wouldn't be very large. We went into that somewhat in the paper, what might happen in the future.

This is due January 1.

Now we've attempted to incorporate September's discussion and subsequent comments from the commissioners in the letter report. To start off with, there are no Medicare

criteria for paying non-physician practitioners separately. So there's no clear criteria that you could say this group should be paid and this group should not be paid. So you have to either imply it or otherwise figure it out.

From what we found, CRNFAs are not automatically disqualified by licensure, as were some other groups that the Commission has looked at in the past. And they are similar in education and training to some of the groups. But because duplicate payments are still a concern, we feel if Congress chooses to pay CRNFAs separately the whole payment issue should be budget issue.

In the paper we also mention the conceptual appeal of combining payments and how that would support the Commission's goals of quality and care coordination and relieve the Congress of having to revisit who's eligible to separately bill repeatedly and leave the decision of should assist to the clinical experts. We believe this reflects your comments on the paper.

The second study we discussed last month, again mandated in the MMA, on cardiothoracic surgeon practice expenses for bringing clinical staff to the hospital. Here we were to determine if the practice expense relative value

units for thoracic and cardiac surgeons adequately take into account the cost of surgeons providing clinical staff in the hospital. Also due January 1.

We also may want to remember the broader practice expense study Nancy briefed last month. That was on phasing in resource-based relative value units.

To review, the IG report found that surgeons bring staff with them, cardiothoracic surgeons bring staff with them, about 75 percent of the time to the hospital. The other 25 percent of the time hospital staff members would be doing the things the clinical staff does. So the clinical staff may assist in the operating room, they can provide pre- and postoperative care, and they could be physician's assistants, surgical technologists, CRNFAs and others. Some of those people can bill separately and some of them can't. And according to CMS, the Society of Thoracic Surgeons reported that about half the time that the clinical staff are brought they can bill separately. The IG also pointed out that about 19 percent of the time hospitals reimburse the surgeons for bringing clinical staff.

So in total, about 30 percent of the cases where staff are brought there is no direct reimbursing. The other

70 percent of the time there are.

In our new draft of the letter report we've incorporated your comments and the views you expressed last month or attempted to. We conclude that the current practice expense relative value units exclude the cost of clinical staff brought to the hospital. So if you took a narrow perspective and said where the definition as adequate and includes everything, then clearly it does not. This is true for all specialties, not just cardiothoracic surgeons.

However, there other factors that need to be taken into account. Note that revenues may offset the cost in some cases, for example, separately payable clinical staff. Beyond the separately payable and other offsetting revenues, the issue of payment duplicating some hospital PPS payments or perhaps physician work payments and GME payments still remains. Improperly accounting for all the offsetting revenues and duplicate payments would be quite complex and touch payment systems.

As you recognized last month in our practice expense report, a lot of data and other issues is going to be addressed in CMS's five-year review of practice expense RVUs and our work plan for that study mentions several

issues. Basically we're saying that this should probably be part of that larger effort of practice expense review, not its own project. So that's what we're saying we should address as part of the larger practice expense review.

Again, we mention the conceptual appeal of combined payments.

In the case of cardiothoracic, it's interesting because there was the heart bypass demonstration where payments were combined for the Part A and Part B. People in those demonstrations felt it improve quality and it did seem to save money. So the appeal may be greater here. It also gets to the government out of the decision of what clinical staff to use when and that sort of thing.

That's about it. We want to know if we properly reflected your comments in the draft report and if there's anything else you want us to touch on?

MR. HACKBARTH: Any questions, comments?

Okay, everybody's read their materials. We're ready to go. Thank you.

Now I need to get credit for the next time I'm running late. I've got an hour plus in the bank. Just so everybody knows.

We'll have a public comment period.

MR. MEYER: Good afternoon. My name is John Meyer. I'm a cardiothoracic surgeon from the Children's Hospital in Boston. That's my day job. My other job is to be the Chair of the Health Policy Council for the Society of Thoracic Surgeons, which is a profession association that represents essentially all of the cardiothoracic surgeons in the United States.

I appreciate the opportunity to address the Commission on this issue of Medicare reimbursement for practice expenses of cardiothoracic surgeons, particularly around the clinical staff issue.

I have to admit, this is a pretty arcane technical issue and I have to confess that I didn't really figure this out until I read the GAO report that Mr. Scanlon prepared in 1999, which includes this two-page diagram with boxes and arrows all over the place. Then I finally understood it.

The basic problem is that the practice expense methodology that CMS has adopted, including their edits, results in a phenomenon that they term euphemistically pool leakage. This pool leakage basically amounts to a transfer of funds from the cardiothoracic surgery practice expense

pool to all of the rest of medicine. The consequences, which we fervently hope are unintended but are real, are the following: the Congressional intent that CMS recognize all staff, equipment, supplies and expenses -- not just those which can be tied to specific procedures -- is not being fulfilled. Cardiothoracic surgery practices our incurring these costs. The data come from the AMA/SMS survey of all practicing physicians which is the basis for the whole practice expense reimbursement.

When these costs are not recognized because of administrative and, we believe, methodologic errors, the law is not being followed. The policy of recognizing and reimbursing physicians based on the typical situation is not being followed.

The HHS OIG study independently found and verified results that were almost identical of what we did from an internal survey from our own members, that 74 percent of cardiothoracic surgeons bring clinical staff that are employed by the practice to the hospital as part of their team of caregivers. Over 80 percent of the hospitals where cardiac surgery is performed indicated in the same OIG study that they do not reimburse the cardiothoracic surgeons for

any of the costs of the clinical staff that they bring with them to the hospital setting. This is the equity issue which the staff have appropriately outlined in their draft report.

We understand that there are some concerns among the commissioners and the staff about Medicare paying twice for the same service. We contend that the large majority of these costs are not even been paid once. With the current CMS methodology, the same total amounts of money are being spent by Medicare for physician services. This is budget neutral.

We estimate that this pool leakage phenomenon amounts to $50 million to $60 million a year. This may not seem like a lot of money in the grand scheme of Medicare physician spending, but when you realize that there are only 2,000 practicing heart surgeons in the United States the net result is a $25,000 to $30,000 hit per year per surgeon. This has been going on since 1999.

We estimate, conversely, that the increase in E&M payments, which is where all of the practice expenses get loaded using the current CMS methodology, we estimate that the increase in E&M payments due to this pool leakage

phenomenon is less than 25 cents on $100 E&M service.

How could this problem be fixed? There are at least three different solutions to this problem, and all three are relatively simple and, I repeat, all are budget neutral.

One way is to simply mandate specialty specific evaluation and management codes for office visits and consultations. This eliminates much of the pool leakage problem and at least keeps the practice expense pool of money within each specialty.

A second option is to require hospitals to reimburse cardiothoracic surgeons for the cost of the clinical staff that are employed by the practices and are brought to the hospital as part of their surgical team. The HHS OIG study, I remind you again, found that over 80 percent of the hospitals where heart surgery is performed do not reimburse surgeons for these costs.

The third and perhaps the simplest option is to have CMS restore the direct input data that they had and used in the first year of paying under a resource-based practice expense system, just restore that data. If that occurs, then that solves the problem because the basic

problem with this pool leakage thing is that there is a misallocation of the practice expense dollars from the cardiothoracic surgery pool into the E&M services.

All we're asking is that they be reallocated what we believe is more correctly. And by the way, by doing so you don't have the occurrence of what is happening now, which is that an office visit for a cardiothoracic surgeon -- according to CMS's own data -- is six times the practice expense of what it is for an internist. That's sort of a patently absurd result.

We believe that this problem, combined with a whole series of other reimbursement changes, is having an effect. For the last four years there been fewer American medical school graduates applying for training in cardiothoracic surgery than there are available positions. This year there were only 92 American medical school graduates applying for the 138 available positions.

We have read the draft report of the staff and, with all due respect, we request that the Commission adopt any one of the three alternatives that I have outlined. We respectfully request that you not meet the Congressional intent by recommending another study three years from now,

perpetuating the current inequities.

There are copies of our more detailed comments on the table behind Mr. Hackbarth. I appreciate your attention and willingness to consider this issue. I'm happy to answer any questions. Thank you.

MR. HACKBARTH: We don't normally engage, in fact, never engage in exchange during these. So we appreciate your comments.

Any other public comments on this or any subject that we've covered today?

MS. McILRATH: I just wanted to make a couple of comments about the pay-for-performance and to just say that I hope you would talk about the environment in which you think it would be possible to do this. You're talking about a 2 percent withhold. Out of what? A negative 5 percent update? Or a freeze or those who do adopt whatever kind of pay-for-performance measures that you think are possible, they get negative 4.5 instead of negative 5 percent?

The other thing is that I think you should think about can you do pay for performance and quality measures in a system like the SGR because depending upon which measures you choose, you may very well be increasing physician care,

at least in the early years with the savings occurring over on the hospital side.

So long as you have the SGR, you may be making that problem worse when you have quality improvement. I think it would be a good thing to address.

I also wanted to say on the volume report that I hope you would put some caveats in there about the new technology. If you only look at new codes, and I acknowledge that it's very difficult to look at -- it's probably impossible to look at the whole realm of what is happening. But to just give you an example: for photodynamic therapy for macular degeneration, the treatment is $311. The drug that they use as part of the treatment, which is also in the SGR, is $1,322. You also normally have three visits and three -- I don't know if I can even pronounce this -- fluorescein angiograms and three fundus photographies that are done before and after the treatment. The costs of the visits comes out to $229. The cost of the scans is $543. The scans are required as part of the coverage decision. So basically, if you were looking for new code, you would have picked up $311 out of a $2,406 bill.

So I'm just saying, there are a lot of other things that go along with a new procedure or a new code sometimes.

MR. HACKBARTH: Any others?

MR. HOGAN: Hi, my name is Mike Hogan and I just have two quick corrections hopefully to again the issue, the pesky issue of cardiothoracic practice expense.

The staff said that these PAs and other staff can bill separately half the time. The data showed that it's about a third of the time that they can bill separately. And that amount is easily known and excludable from what you pay in practice expenses. So it's easy to calculate.

And he said that 30 percent of the time physicians receive no payment for this. The data show that it's over 60 percent of the time physicians receive no payment for this from any source.

MR. HACKBARTH: Any other comments?

Thank you. We reconvene at 9:00 a.m. tomorrow.

[Whereupon, at 4:17 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Wednesday, November 17, 2004.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Wednesday, November 17, 2004
9:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
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.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

P R O C E E D I N G S

MR. HACKBARTH: Good morning. We have two items on the agenda for this morning. First is another installment in the analysis of specialty hospitals, and then we will have a session on variation in hospital financial performance.

MR. PETTENGILL: Good morning. As you know, the Medicare Modernization Act requires MedPAC to study physician-owned specialty hospitals and report to the Congress in March of next year. Under this mandate we have been asked to compare the cost of care in physician-owned specialty hospitals and full-service community hospitals, the extent to which each type of hospital treats patients in specific DRGs, and the mix of payers in each type of hospital. We have also been asked to analyze the financial impact of specialty hospitals on community hospitals, and how the DRG payment system should be updated to better reflect the cost of care in an inpatient setting.

At the last two meetings this fall we have presented preliminary information on many of these topics, including those listed on the slide, and we have covered the applicable federal laws governing physician ownership or

investment in hospitals or other health care facilities, characteristics of physician-owned specialty hospitals in the markets in which they are located. We have provided preliminary findings on our analysis of payer mix, and findings from our site visits to three markets that have specialty hospitals. We also provided preliminary evidence on differences in relative profitability across and within DRGs, and on patient selection in specialty hospitals.

This morning we are going to turn to four additional questions. Carol will lead off with preliminary evidence on whether physician-owned specialty hospitals patient transfers are different than those in other hospitals. I will follow with preliminary findings on whether Medicare inpatient cost per discharge differ between physician-owned specialty and comparison hospitals. And then Jeff will give his preliminary results on two issues. The first of these is whether physician-owned heart hospitals affect Medicare per capita use of heart procedures for beneficiaries living in their local markets. The second is whether these specialty hospitals affect the financial performance of local community hospitals.

With that brief introduction, Carol take over on

transfers.

MS. CARTER: Many hospitals transfer a small number of cases to other acute care hospitals. In some cases, hospitals that lack certain equipment or lack of staff expertise transfers patients who need services that they do not offer. Such transfers are likely to improve the quality of care the patients might otherwise receive at the transferring facility. In other cases hospitals respond to the incentives of the prospective payment system to lower their own cost by discharging patients to other hospitals or post-acute settings. A disproportionate share of transfers raises concerns that the hospitals are inappropriately transferring patients for financial gain or that their quality of care may be in jeopardy.

In September we reported on our site visits to specialty hospital markets. During those visits we heard a range of opinions about transfers. Specialty hospitals told us that they transferred out cases that they did not have the services to treat appropriately. Community hospitals told us that they thought that some of the transfers might be financially motivated.

Last month we presented information about the

relative profitability of different types of cases. We presented evidence that in general lower severity and surgical cases were relatively more profitable than high severity cases and medical cases.

Our analysis of the patterns of transferring cases out of specialty hospitals focused on two questions. Do specialty hospitals transfer cases more frequently than other hospitals? And second, do specialty hospitals transfer their costly and severely ill patients more frequently than other hospitals? To study this issue we analyzed Medicare discharge data for 2002 using the same comparison groups we've used for other analyses. Because physician-owned orthopedic and surgical hospitals transfer very few cases we did not analyze their transfer patterns.

We first compared the transfer rates of physician-owned heart hospitals to those of their peers and competitors. I will remind you that peer hospitals meet all the specialty hospital criteria but they are not physician-owned. Competitors are located in the same market and provide similar services but are not nearly as concentrated.

We found that physician-owned specialty heart hospitals transferred 2 percent of their cases. This was a

higher share of the cases than the percent transferred from peers, which you can see is 0.9 percent and competitor hospitals at 1.3 percent of their cases. Looking at the type of cases transferred, specialty heart hospitals transferred 1.6 percent of their heart cases compared with 0.7 percent of the heart cases at peer hospitals. This difference was statistically significant.

The difference in the percent of cases transferred was larger for non-heart cases. Specialty heart hospitals transferred 3.7 percent of their non-heart cases while peer hospitals transferred 1.1 percent. For the non-heart cases, the differences between specialty heart hospitals and their peers and competitors was also statistically significant.

Looking at the transfers from specialty heart hospitals for different types of cases we found that non-heart cases were transferred more than twice as often as cardiac cases. That is the 3.7 percent compared with 1.6 percent. This reflects their specialization. Yet because specialty hospitals have much higher volume of heart cases, in terms of the number of cases the typical heart specialty hospitals transferred 27 heart cases and 16 non-cardiac cases a year.

We also wanted to know what kinds of cases physician-owned specialty hospitals transferred. Are the transfer cases more complex and would be expected to have high cost? Are they low or high-severity patients? To evaluate the complexity of their transfer cases we calculated the national average relative costliness of Medicare cases in each of the severity classes of the all-patient refined, APRDRGs. Then we used these national averages to compare the mix of cases transferred and those retained by physician-owned specialty hospitals and comparison hospitals.

If the hospitals had the national average relative costliness for each APRDRG severity class the index would tell us whether the cases they transferred were expected to be relatively more or less costly than the cases that they retained. The expected relative costliness of heart cases transferred from specialty hospitals was higher than the index of the heart cases transferred from peer and competitor hospitals. This is the 2.2 percent compared to the 1.8 percent for peers and 1.1 percent for competitors. The difference between specialty hospitals and competitors was statistically significant. The difference between

specialty and peer hospitals was not.

Heart cases that were not transferred from specialty and peer hospitals had similar indexes. You can see this is 1.5, 1.4 up there. Both of these indexes of costliness were higher than the index of the cases that remained at competitor hospitals, and those differences were statistically significant.

Looking just at the heart specialty row you can see the expected relative costliness of the heart cases that specialty heart hospitals transferred was considerably higher than the index of the cases that they kept. That is the 2.2 percent compared to the 1.5 percent. We know that a hospital's expected relative costliness captures two factors. One is the severity of the patients within a given illness or condition. The other is the relative costliness of the patients across the illnesses or conditions.

For example, one hospital may treat low severity cases from case mix groups with higher relative costs, while another may treat higher severity cases from less costly groups. These two hospitals would have the same index. Therefore, we also compared the share of cases in the highest severity class. This is class 4 of the APRDRG

classification system. We looked at the cases that were transferred compared to those that were not. Nationwide, I should just say that 7 percent of Medicare discharges are assigned to this highest severity class.

We found that 8 percent of the APRDRG class four severity cases were transferred from specialty hospitals compared with 2 percent transferred from peer hospitals and 3 percent transferred from competitors. The differences between hospital groups were larger for non-heart cases, 13 percent of the class four non-heart cases were transferred from specialty hospitals compared with 2 percent from peer and competitor hospitals.

In conclusion, specialty hospitals appear to transfer cases more frequently than peer and competitor hospitals. Compared to peer and competitor hospitals specialty hospitals appear to transfer cases with higher expected relative costs, and they transferred a higher share of severely ill patients. We do not know if the transfers were done to provide more appropriate medical care, or financially motivated, or both.

Now Julian is going to talk about the analysis of the cost differences.

MR. PETTENGILL: Now we come to the question of whether the costs differ between physician-owned specialty hospitals and traditional hospitals. Ideally, if costs are different we'd like to be able to identify at least some of the major sources of those differences.

Hospitals' Medicare inpatient cost per discharge might differ for three reasons. First, hospitals' costs reflect what they do. This includes differences in the kinds of patients they treat. Physician-owned specialty hospitals' costs might differ simply because they treat patients that have higher resource requirements. In addition, hospitals' costs reflect the other activities that they engage in. These include the extent to which they operate medical education programs or serve disproportionate share of poor patients. Generally, physician-owned specialty hospitals don't train residents, nor do they generally serve a disproportionate share of low income patients. But many of the hospitals that we're comparing them to do engage in those activities.

Second, market conditions, particularly input prices for labor and other inputs, differ across markets. So physician-owned specialty hospitals' costs might differ

because of where they are located. They are not everywhere in the country.

Third, hospitals may perform with different levels of efficiencies as indicated by differences in length of stay, differences in size as reflected in opportunities or the lack thereof for economies of scale and scope, differences in staffing patterns or compensation for employees.

To examine the cost differences we compared Medicare inpatient costs per discharge in physician-owned specialty hospitals and our comparison groups. We used much the same comparison groups we've been using, in particular the peer specialty hospitals, competitors within the same markets, and all community hospitals. We used data from hospitals' fiscal year 2002 Medicare cost reports. But to make the comparisons fair we standardized the cost per case to control for differences in factors that affect cost but are largely outside of hospitals' control, at least in the short run. These include case mix, input prices, and the extent to which hospitals train residents or serve poor patients.

We also examined length of stay. We did that

because length of stay might be one controllable factor that accounts for differences in costs. Here we compared each hospitals' actual length of stay with it's expected length of stay, taking into account its mix of Medicare cases. The expected length of stay for each hospital is based on its mix of cases by APRDRG and severity class and the regional average length of stay in each of those categories in its region. That is, given a hospitals' mix of cases this measure tells us what it's length of stay would look like if it had the same length of stay as the region in which it's located for each of the APRDRG severity classes. The ratio of actual to expected length of stay then tells us whether their stays are longer, shorter, or about the same as what you would expect. Other things being equal, shorter than expected lengths of stay are normally associated with lower cost per discharge.

Now let's look at the results. This table shows the standardized Medicare inpatient cost per discharge for physician-owned specialty hospitals and selected comparison groups. Standardized costs here are expressed as relatives. That is, we divided the value for any hospital group by the overall national value. The bottom row for community

hospitals is 100 percent and anything else is relative to that.

The amounts compared are expressed as percentages of the national amount, and the last two columns show the means and medians for each group. For example, in the middle column you can see that the average cost for physician-owned heart hospitals are 8 percent higher than they are for peer heart hospitals or for all community hospitals. Average costs in orthopedic and surgical hospitals are still higher at 117 percent and 133 percent of the national average. The averages for peer orthopedic and surgical hospitals lie in between. They are higher than those of all community hospitals but they are not as high as those for physician-owned specialty hospitals.

You might think that these large differences would be statistically significant, but in fact they are not. The explanation for that is that these are very small groups of hospitals we're comparing here, at least the physician-owned and the peer hospitals, and the cost per discharge vary a lot across the hospitals within these groups. So it's hard under these circumstances to achieve statistical significance. In our preliminary data the physician-owned

specialty hospitals appear to have somewhat higher costs than the comparison hospitals but the differences are not statistically significant.

The length of stay data show a different story. The middle column of this table shows the ratio of actual to expected length of stay where the expected length of stay accounts for the hospitals' mix of cases and is based on the regional average length of stay in each APRDRG severity class. Physician-owned specialty hospitals appear to have shorter than expected lengths of stay and these differences are generally statistically significant.

For example, heart specialty hospitals have significantly shorter length of stay relative to the expected value than peer heart hospitals. That is the 83 percent at the top of the middle column. Physician-owned orthopedic hospitals have shorter than expected lengths of stay and these are significantly shorter both than either the peer orthopedic hospitals or all community hospitals. Surgical specialty hospitals, the 69 percent in the middle column also have shorter than expected lengths of stay and these are significantly shorter than those for all community hospitals. They are not shorter than those for the peer

hospitals, although the difference has to be close to being significant.

So our tentative findings are, physician-owned specialty hospitals appear to have higher costs than other hospitals but the differences are not statistically significant. They also appear to have shorter than expected stays, given their case mix and regional length of stay patterns. Something else must be going on here to explain this difference, but at the moment we do not know what it is.

Now Jeff will talk about findings from his studies.

DR. STENSLAND: Today I'm going to address two questions. First, is a Medicare beneficiary more likely to receive cardiac surgery if a physician-owned heart hospital operates in that beneficiary's market? Second, did the relative profitability of community hospitals decline when heart hospitals entered their markets?

We investigate the impact of physician-owned specialty hospitals on utilization and hospital profits by focusing on physician-owned heart hospitals. We focus on heart hospitals because they are larger, 52 beds on average,

than orthopedic or surgical hospitals which have 15 beds on average. If physician-owned specialty hospitals cause an increase in utilization or a strain on the financial performance of community hospitals it will be easier to detect the impact of physician-owned specialty hospitals by examining the case of heart hospitals rather than smaller orthopedic and surgical hospitals.

We compare the rate of change in cardiac surgeries in 10 markets that gained a physician-owned heart hospital to the rate of change in cardiac surgeries in markets without physician-owned heart hospitals. This is known as a difference in differences approach. The year 1996 represents a year before any of the heart hospitals opened. By 2002, our heart hospital had been operating in each of these 10 markets for more than one full year.

By comparing the rate of change in cardiac surgeries in these 10 markets that gained a heart hospital to the rate of change in 295 markets without a heart hospital we can control for national trends in cardiac surgery utilization. To define market areas for cardiac surgery we used the Dartmouth atlas of health care hospital referral regions. These markets were created in part by

examining travel patterns for Medicare patients receiving cardiac surgery.

Second, we will examine the financial impact of physician-owned heart hospitals on local, full-service community hospitals. We use the same difference in differences approach, but financial data was only readily available for 1997 through 2002. Due to the loss of 1996 data we're limited to examining the impact of physician-owned heart hospitals in eight markets.

Before we get into the data let's spend a minute thinking about the financial incentives facing physician investors in heart hospitals. Physicians who invest in heart hospitals share in their hospitals' profits. Once the physician-owned heart hospital opens these physicians have an incentive to recommend patients for cardiac surgery; an increased incentive. As we told you last month, low severity cases tend to have higher profits than high severity cases. Therefore, cardiologists and cardiac surgeons who own heart hospitals have a financial incentive to increase the ratio of low severity admissions to high severity admissions.

In addition, certain types of DRGs are expected to

have higher marginal profits. For example, CABG surgeries may have had a higher marginal profit in 2002 due to having a fairly high DRG payment and relatively low supply and device costs. It contrast, defibrillator implantation is believed to have had a relatively low marginal profit in 2002 due to high device cost and relatively low DRG payment in that year. Hence, heart hospital investors may have had a stronger incentive to increase CABG surgeries at their heart hospital in 2002 than they had to increase defibrillator implantation in 2002. It should be noted in 2003 CMS significantly increased the average payment for defibrillator implantation.

While the financial incentives to increase the number of cardiac surgeries are there, it is not clear that all physicians alter their clinical decisions due to these incentives. Some cardiologists could change their practice patterns. Others may not change their practice patterns at all. We do not attempt to evaluate whether specific individual physicians are changing their practice patterns. This study is limited to examining whether the introduction of a heart hospital is followed by either a shift upward in the total number of cardiac surgeries or a shift toward

higher profit cardiac surgeries.

Now let's look at the data. From this slide we see that both types of markets experienced an increase in the volume of cardiac surgeries, which include angioplasties, from 1996 to 2002. While the rate of increase is higher for markets with heart hospitals, the difference is not statistically significant. In our site visits we found that some community hospitals responded to the loss of cardiac surgery volume by recruiting cardiologists and cardiac surgeons into their community. These would be new cardiologists and new cardiac surgeons to replace those that are primarily practicing at the physician-owned heart hospital. It may be too soon to evaluate whether this recruitment will have an effect on the volume of cardiac surgeries in these markets.

Next we want to examine whether physician-owned heart hospitals see unusual rates of increase in the more profitable categories of cardiac surgery. From 1996 to 2002, the number of coronary artery bypass surgeries declined resulting in 0.5 fewer bypass surgeries for every 1,000 beneficiaries in heart hospital markets, and by approximately 0.9 fewer CABG surgeries for every 1,000

beneficiaries in other markets. The literature attributes this nationwide decline to be the substitution of angioplasties for CABG. However, the decline was smaller in markets with physician-owned heart hospitals, which is consist with the financial incentives we discussed earlier.

Angioplasties increased in all markets. The growth rate in markets with physician-owned heart hospitals is not statistically differently from the growth rate in markets without physician-owned heart hospitals. Defibrillator implantation increased in all markets. The differences in rates of increase was not statistically significant. This is consistent with our assumption that marginal profits on defibrillator implantation were small in 2002 and did not create a significant incentive to increase admissions.

Most interestingly, the ratio of low severity surgeries to high severity surgeries is increasing in all markets. Low severity cases are defined as those with APRDRG severity level one or two. High severity cases are defined with an APRDRG severity level of three or four. The ratio of low severity cases to high severity cases in markets with physician-owned heart hospitals is not

statistically different from the growth rate in other markets. The difference is not statistically significant.

We can summarize by saying, if the opening of physician-owned heart hospital did introduce an increase in cardiac surgeries through 2002, the magnitude of that increase is too small to be detected with most of our tests for statistical significance. In September we told you that physician-owned heart hospitals conduct over 25 percent of the Medicare cardiovascular surgeries in their markets. Because the impact of physician-owned heart hospitals on utilization is very small relative to these hospitals 25 percent market share, we know that physician-owned heart hospitals are primarily obtaining patients by taking market share from community hospitals. This raises the question of whether community hospitals' profit margins fall significantly when they lose these patients.

In this slide we compare community hospitals in markets with heart hospitals to community hospitals in markets without heart hospitals. First of all, we notice that heart hospitals form in areas where hospitals are receiving more Medicare revenue per bed. This could be due to heart hospitals choosing to locate in markets with less

excess capacity and in markets where the patients are disproportionately elderly. The 11.3 percent change in Medicare revenue per bed at community hospitals in heart hospital markets was slightly lower than the 13.7 percent change in other markets.

Our preliminary results from a multivariate model indicate that there is a statistically significant reduction in Medicare inpatient revenue at community hospitals that compete with physician-owned hospitals. In other words, we found that the difference between the 11.3 percent and the 13.7 percent growth rates shown in this slide is probably not purely due to chance.

While heart hospitals appear to take Medicare patients from competitor community hospitals, these competitor community hospitals do not appear to have below average levels of overall profitability. This implies that most community hospitals were able to compensate for the revenue they lost to heart hospitals. On our site visits we found that community hospitals responded to competition from physician-owned heart hospitals with measures such as cost reductions, expansions in other surgeries, rehabilitation, pain management, neurosurgery, and aggressive price

negotiations with private payers, and in some cases recruiting new surgeons into the community.

In summary, our findings are first that it appears that heart hospitals are capturing market share from community hospitals. Second, despite competition from heart hospitals, full-service community hospitals that competed with heart hospitals continued to have profits that were in line with national averages through 2002. During the timeframe of our study, 1997 to 2002 we do not have any evidence suggesting that the introduction of physician-owned heart hospitals has caused a significant reduction in community hospitals all-payer margins.

We are available for questions.

MR. MULLER: If I understand the summary of the information correctly, the model here of the specialty hospital was that, whether one uses the words a focused factory, but the sense that the care would be better, the costs would be better, it would be more efficient. What we're saying here is the costs are no better, they may be higher. There's not evidence of more efficiency.

There is evidence that we are avoiding case selection in the payment system that pays on averages

because there's an incentive to do the less severe cases, even though the payment is based on an average payment, so therefore basically there's the advantage of -- and you showed that last month -- shows a great reward for case selection, which is one of our concerns always is we don't want to pay -- we want the payment system to reward providing better care rather than selectivity in taking care of less ill people in an average payment system. And by the fact that they transfer more cases, that is probably a proxy or a marker that they have less medical capacity because they have to transfer more cases out.

So it seems to me that the case that this is a more efficient way of practice is not only not made but it's counter-proved. So they are more costly, less efficient, and they don't have the medical capacity of other hospitals.

MR. HACKBARTH: To totally judge efficiency we would also need to be able to control for quality differences, and that is a big missing piece of the puzzle. So it could be that the increased costs are associated with increases in quality. We do not know that and I'm not -- is there any way we can address that question?

MR. MULLER: That would be an interesting finding

in the program in general.

DR. MILLER: I would just say, as you went through the results I think you summarized everything pretty well. The one thing that I would have put just a few degrees differently, I think our evidence on efficiency, to the extent that we can measure it, which we can't because quality is not present, is mixed. We have the cost per case, there's no difference, but the length of stay was statistically shorter.

MR. MULLER: But in some ways if you have a lower severity with a higher cost, that should be a proxy for efficiency.

DR. MILLER: I admit that your point is taken on that. On the quality stuff, I just want to remind people, we aren't going to be able to grind through that in any detail. We have tried a couple of things. The transfer was one was to very indirectly look at it. We have tried some other methods to look at quality data but we're not going to be able to get any deeper on that point.

MR. MULLER: In terms of measuring the effect when the heart hospital is there and its effect on the costs or the margins at the other hospitals, there is a question of

scale. Obviously, if there's a lot of hospitals in a community, one hospital by itself is not going to dramatically change the average of 10 or 20 hospitals in a community. If there's one heart hospital and one community hospital, you could see a big effect on that. So the fact that they may not be as big an effect, that could also be the result of the number of hospitals in the community, there's enough of them that even one very successful competitor, successful in the sense of moving cases over, may not have a big effect.

So do we have a sense of what's roughly the number of hospitals that were in the sample of the communities that we took? Are we talking about comparing one community hospital, five community hospitals, 10 community hospitals?

DR. STENSLAND: The sample of community hospitals is 35, and there's 10 markets, so it's an average of 3.5 community hospitals that are doing cardiac surgery in each one of those markets.

In terms of being able to detect the influence of these hospitals, that's why we focused on the heart hospitals and not these little surgical and orthopedic hospitals. Then we did it in stages first saying, what

these heart hospitals do primarily is inpatient Medicare surgeries, so most of their patients are Medicare and most of their revenue comes from the inpatient side. So we decided to look at, are these community hospitals losing Medicare inpatient revenue, because that's probably where they get hit the most when these heart hospitals come into the community. And we were able to detect a significant drop-off in Medicare inpatient revenue.

But then when we get to the larger picture of saying the overall profit margin, which is much harder to detect because now we're looking at the influence of these heart hospitals on a much bigger pool of revenue and expenses and we weren't able to detect any statistical significance difference there.

MR. MULLER: You would expect these hospitals, if they are struggling to reshape their programs, to take adaptive steps to accommodate over a five, six-year period. Obviously, if they didn't change their conduct at all you'd wonder about what they were doing. So the fact that they were able to accommodate in part is useful information to have.

My concern in part is if we look at the set of

patients that we are concerned about here who are treated for heart care, the findings of they're taking patients of lower severity without getting lower cost, without evidence of -- as you say, we're silent on quality but I take lower severity and at best equal cost, perhaps higher cost, as a sign that the quality may not be there either. So one of my concerns is in the group of patients that we're looking at, to have the payment system be advantaged so that there is a clear signal to take care of less ill patients and then have the community hospital be there as a backup by showing the rate of higher transfer. That doesn't strike me as good social policy for Medicare to be engaged in.

MR. HACKBARTH: I am with you on a lot of that, Ralph, in particular what we discussed last time, we don't want people to profit from taking advantage of errors, if you will, in the pricing system. But going to the issue of the competitive effect, I would hope that if a new entrant comes into market, whether it is a specialty hospital or a general hospital, that it tends to reduce the profitability of the other competitors in the market. That is the way markets work. That is the impetus to change.

To the extent that we find that that doesn't

happen, that is a cause for concern on my part. You can just add new entrants into markets and the system produces more money so everybody is held harmless. That is a bad thing. That is not a good thing.

MR. MULLER: That goes back to the discussion we had yesterday. Those were all-payer margins or were those Medicare margins? Those were all-payer margins, right?

DR. STENSLAND: Yes, all payer.

MR. MULLER: So obviously what else is going on in the health care economy in the last four or five years, we went through some of those numbers yesterday in terms of the payment rates from private payers going up in this last four or five-year period. So that's probably more a function of what wasn't happening in terms of cost control in the private payer market in the last five years compared to other parts of the cycle. But the way we discussed that in the past, it is hard for us to use Medicare policy to try to shape the private payer market.

MR. HACKBARTH: But my basic point, you would hope that competition has some effect on the margins of the other participants, otherwise the system is even more broken. So if you find an effect of specialty hospital entry on

community hospitals, I'm not sure that that is a sign of something bad going on. I think that might be a sign of a small ray of hope that in fact there's some market dynamic left in the system.

MR. SMITH: It would depend in part on what the adaptive strategies were. If the community hospital cut capacity, that would raise a different set of concerns than if they be increased efficiency.

Jeff, you talked a little bit about, as I understood the written material and last month's presentation, no clear pattern. In some cases they became more aggressive competitors, in some cases they did cut capacity. Do we have enough information, either statistically or from your site visits, to think about what the modal adaptation was? Because I think trying to understand that tells us whether or not this is a good or a bad thing. If people in response to a shift in volume to the specialty competitor simply squeezed everything and became less available to play the backup role that the community hospital is still responsible for, that would be a cause of concern regardless of what happened in the relative margins. I am wondering what we know about that.

Julian, a question for you and then I'll stop. What is on your suspect list to explain the anomaly of shorter length of stay and increased cost? Where are you headed to try to --

MR. PETTENGILL: I think that is a time and resources question. As Mark pointed out the other day, we are really cranking a lot of things, particularly the policy options for next month, and that doesn't leave much in the way of resources to follow up on this immediately. Time and resources permitting, we will try to take advantage of some of the other work that others on the staff have been doing with the cost report data to look at components of hospitals' costs and see if we can't pick up what's accounting for the difference. But again, that needs some time and effort to focus on it.

MR. SMITH: Would that include a look at the impact of both ownership structure and capital structure on costs?

MR. PETTENGILL: Part of it would have to do with capital for sure. I don't know that we had in mind just looking at ownership structure in particular, but that is a possibility.

DR. MILLER: Let me set some expectations here a little bit. We have a very tight timeline to put this together. Our next step in December is to bring sets of recommendations on what we have. This has been a very resource-intensive project, both in staff time and in computing time.

I also want, just as a broader caveat as we talk about what conclusions we are reaching here, we are sampling in a sense on a number of hospitals and a time period. The staff were very careful in caveating their results, but we are saying we are not discerning statistically significant effects so far in the time period and the sample of hospitals that we have. I get a little nervous if we start to drill down into smaller and smaller units, do you see effect on these types of hospitals or this type of a cost structure? I think we're going to continue to encounter insignificant results.

So I don't want to build up a lot of pressure behind that because I don't know that we will have the resources to slog through it. Plus I just think given our sample size, I think that is going to be hard to reach down into. If you don't agree you should say so, but I just see

us coming back with results saying, didn't see an effect as we drilled down.

DR. STENSLAND: The question on how do they respond, what's the modal behavior, I think in most cases in the site visits we saw their reaction was more, we've lost a profit center. Let's find a new profit center. I thought one of the most interesting things is we asked them what you do. In one case a hospital was willing to actually outline, we lost X amount of money. We got this much from here, here, here, here and we ended up at the same spot in the end.

So we asked them, where did they get that money from? What were these new profit centers? It was these things like rehabilitation, pain management, expanding the cardiac lab, certain price increases. But the interesting thing is that in the survey we asked specialty hospitals, what are you specializing in. In some cases they would say, we also do pain management and we also do rehabilitation. So there's this one playbook and they're both playing off the same playbook of what profit centers are there for you to expand and make the money off of.

DR. SCANLON: This is in some respects is a very

similar to what David was saying. I will qualify it with time and resources conditional, that what is happening on the cost side I think is important. Maybe this will assuage your concern about the lack of the competitive effect. I think for the hospitals to remain in the market they need to keep those margins at some level. Some of the good response to competition can be a change in cost structure. If we can learn a little bit more about that, that would actually be helpful. But I recognize that we have learned a lot about specialty hospitals from this whole process and that we've got many other things to do at the same time.

DR. MILSTEIN: As others have already commented, it is distressing to have to make a recommendation here without any information on the numerator of the value equation that is quality. I think the staff has done a terrific job of trying to ferret out available quality comparisons. I also respect the fact that we are in the eighth inning and we have limited resources.

I wanted to say that as I've thought it through I think there's probably one other avenue of approach that might allow us to make this decision with the benefit of some quality information that is credible in the scientific

community. And that is, as staff is previously aware of and has pursued, roughly two-thirds of the hospitals doing bypass graft surgery in the United States do participate in a gold standard risk-adjusted outcomes reporting system operated by the Society for Thoracic Surgeons.

Staff, at my suggestion, went to the STS and said, would you be willing to run an aggregate profile of these hospitals as a group versus hospitals in their communities so we can see how they are doing on risk-adjusted outcomes. And as I understand it, the Society for Thoracic Surgery said, maybe but this is a policy and we can't deliver it within your timeframe.

I want to suggest a second avenue of approach that would be not time-consuming or resource-consuming, and that is, every hospital that participates in the STS system gets a report every quarter that tells the hospital, relative to risk-adjusted national norms, how they are doing on risk-adjusted mortality. Could we not go to these same hospitals who have cooperative with us in these markets, both the specialty heart hospitals and the hospitals that have given us information who are their competitors and say, would you voluntarily be willing to give us your risk-adjusted

mortality score as reported to you by the STS, which is an actual to expected ratio, we might combine it into a market-specific, de-identified comparison so we can get at least a clue using a gold standards outcomes system, how these hospitals are doing on the numerator of the value equation?

MS. CARTER: I just wanted to note, when I did talk about the specific requirements that we were asking about for, about half of our specialty hospitals were in the STS database. So that is going to limit the markets that we can look into.

MR. HACKBARTH: But it's something.

MS. DePARLE: Arnie and I were talking about, one, how much we have learned, but also that the case that the specialty hospitals had been making that has given me at least pause is that they have data showing that the outcomes are better. We all care about that. So if that data exists I would like to see it. I understand the limitations we have on getting it, but this is a place where I think these hospitals could help us get that data. So if we can get it in a reasonable timeframe it would help me at least in thinking about this.

DR. STENSLAND: We may not have made this clear

but when they are allocating duties in the MMA of who's doing what with regard to specialty hospitals, we can look at quality. But CMS was specifically given the responsibility of comparing community hospital quality versus specialty hospital quality in their report that's due in March.

DR. MILLER: Which was one point that I was going to make. But to also say, we can try to go follow up on this. I think what you want here, if I understand the suggestion, we want to get for a given marketplace the specialty hospitals that would voluntarily give us these reports, and also I assume we need some community hospitals. We will pursue this idea but there is always the issue of, in a situation like that who's willing to provide it may in some ways bias what you actually get.

DR. MILSTEIN: I agree with that comment. That said, what's nice about the STS reports is that it tells you for any given hospital how they're doing on a risk-adjusted basis of a national comparison. So I think it would shed some light on our decision if all specialty hospitals that are participating in STS were to voluntarily give us their reports and they were to show us that compared to national

risk-adjusted norms they were either no different, favorable, or unfavorable. That would, at least for me, be a partial light in an otherwise dark room.

DR. SCANLON: For me I think Mark's comment is very important, the issue of self-selection into this would need to be examined. If only half the hospitals are participating we need to know are they different than the other half, because we don't want to have an impression that is misleading on the basis of this self-selection process. And then you used a very important word, if all of them are willing to provide the information, because if there's a further selection in terms of the ones that are willing to provide, the information becomes more suspect.

DR. MILLER: We will pursue this.

DR. CROSSON: Looking forward to the recommendations in December, throughout the analysis there have been two issues here, two elements that have been interwoven all throughout it. One is the phenomenon of the specialty hospitals itself, and the other one is the issue of physician ownership. Most of the analysis that we've had have had those two elements in there.

Each one of those two elements has a political

issue attached to it. In the case of the phenomenon of the hospitals themselves there's the moratorium. Then with respect to physician ownership there is the question that may evolve around closing or not closing the whole hospital exception to Stark.

I realize that we have specific questions that we've been asked but what I'm basically asking is, as we moved towards recommendations it seems like there are three possible areas they could be in. One would be some recommendations about having some direct change to the market dynamics. The moratorium is an example of that.

Another one would be a recommendation to deal with this perhaps indirectly by fixing the problem that appears to exist in the distortions in the pricing, and parenthetically I would favor that. I think that probably is the most sensible.

But the third issue has to do with the element of physician ownership per se, and particularly I think the issue of the percentage or the degree of physician ownership, and the potential impact based on that, on the perception of conflict or of concerns in that area, which has been a traditional issue in the profession to at least

look at and examine. There's plenty of difference of opinion about where that exists and what might or might not be done.

So the question is, on that third issue, are we going to try to take a look at that?

MR. HACKBARTH: Yes. What we have been doing here now over the course of several months is addressing component parts of this, trying to build some analytic foundation. Next month, December, as I understand it, is now when we will begin to go back and look at these issues in terms of recommendations for policy. Certainly that is one of the component parts that we will address as well as the pricing and so on. So the fact that we haven't talked about it for a couple months doesn't mean that we've forgotten about it.

DR. NELSON: You reported last month about the previous growth of these hospitals. Of course there is a moratorium now so the growth is flat now. But is there any information from the business plans of Medpath and national surgical hospitals, or from CON, or are there ways to infer what the projected growth might be, given the similar circumstances to what we've had in the previous few years,

which of course might change? What I wanted to get a feel for is whether we're just at the beginning of a real steep curve in development of these facilities, or whether it is a more shallow curve, or whether perhaps it's flattening. Any way to infer that?

DR. STENSLAND: I think what we mentioned before is they have approximately doubled in number from 2002 to 2004. So when we have our sample, which is things that were active in 2002, and then there's the other sample out that we get from industry and other sources saying, this has been formed or this is under construction, so that difference is approximately a doubling from 2002 to 2004. A lot of where they're going is in a lot of the same states where they already are. So it's not so much that a lot more communities will have one specialty hospital. It's that the community that already has one is now going to have two. That is the direction things are going from what we've seen.

MR. HACKBARTH: I think it's important to keep reminding ourselves that we and the Congress have a difficult task here. We are trying to evaluate a phenomenon in the relatively early stages of it, and because we need data to do analysis we have to reach even further back and

we end up with small samples that compromise our ability to reach definitive judgments. This whole phenomenon, if it were left to run, might look very different five years from now, maybe for better or for ill, I don't know which. But trying to do it at this point in time is very challenging.

DR. WOLTER: This is a question on the competitive response. Jeff, you said that some of the community hospitals responded with price increases as one of their strategies. I was just wondering if it would be possible for us to look at charges, cost-to-charge ratios? Is there any difference in what has happened in these communities from other communities, and would there be a possibility we might see a trend toward higher charges? I don't know -- the sample size is small but that might not be too difficult to look at.

DR. STENSLAND: That's a good idea. We can do that without too much difficulty.

MR. HACKBARTH: I had just a couple things that I didn't quite understand. On number 21, the bottom row, the growth in low severity surgeries divided by growth in high severity surgeries, it suggests that for both the heart hospital markets and the other markets that there is more

rapid growth in the low severity than the high, and the difference between the two I think you said was not statistically significant. That runs counter -- I thought the way these things worked is that as we got experience with them, we started applying them to more and more difficult patients. That was the pattern of diffusion, they started to go and be applied to older patients. It just struck me that there was such rapid growth in the low severity cases in both types of markets. What am I missing here?

DR. STENSLAND: I guess there are a couple things that it could be. One is, this is absolute changes. So if there were 10 more low severity cases and five more high severity cases, we would say the ratio was two. But I could rerun this and look at what is the percentage growth in low severity growth versus the percentage growth in high severity cases. So it might be that there is a bigger base of low severity cases to start with.

MR. HACKBARTH: That is probably why it looks like this.

DR. STENSLAND: There is related literature on this in that when they looked at what happened in New York

and Pennsylvania after they started having report cards and they asked, what's happening to the high severity cases in those states, the found out the high severity cases did decline after they started offering report cards, which would be a similar incentive there. You don't want a high severity case because you have a worse report. And this would be, if you have high severity case, there's less profit.

MR. HACKBARTH: Then on number seven, the right-hand column, the heart cases not transferred. You are saying the average expected relative costliness of the not transferred cases is higher in the specialty hospitals than in the peer and competitor. How is this consistent with the selection hypothesis that they are taking the lower-cost cases, the cases you would expect to have lower cost?

MR. MULLER: It makes the case. They transfer –

MR. HACKBARTH: No, the not transferred column I'm looking at. So the ones they're not transferring have a higher average expected cost if I'm reading this correctly, but I can't square that with what we were told.

MS. CARTER: I think that is because it measures both the costliness of the DRG and the complexity, so that

this measure captures both of those. So for example, peer and competitor hospitals have higher weighted DRGs, if you will, but they could still be taking the low severity cases. Like the specialty heart hospitals are mostly, something like two-thirds of their cases are heart cases and two-thirds of those are surgical cases, and those are higher-weighted cases. That's how I would interpret that.

MR. HACKBARTH: So this doesn't control for the fact that they are taking --

MS. CARTER: The measure reflects both of those, which is why I went to the next slide and looked at just the severity measure.

MR. HACKBARTH: Any other questions or comments?

MS. DePARLE: Is it possible to look at readmissions? Would that tell us anything about quality?

MS. CARTER: It's possible, but I don't know, given the time constraints on our programmers whether it is.

MR. HACKBARTH: Thank you.

Next is a variation in hospital financial performance.

MR. LISK: Good morning. Today Jack and I will be reviewing results of an analysis we conducted that examines

the performance of hospitals with consistently negative and consistently positive overall Medicare margins. In this analysis we are trying to understand the role different cost factors might have in explaining variation in hospitals' financial performance. We hope that this analysis will help inform our discussion of payment adequacy for hospitals that will take place in December.

As you may recall, the Commission included an analysis in our June 2003 report that examined factors that help explain variation in hospitals' financial performance. The study, which is 1998 data on hospital performance under the acute care inpatient perspective payment system, found that a quarter of the total variation in inpatient margins was attributable to components of the payment formula, particularly the IME and DSH adjustments and rural hospital specific rates paid to sole committee hospitals and Medicare dependent hospitals.

Some of the in financial performance was also attributable to the area wage index and case-mix adjustments but the individual influences of these factors was smaller than that of the policy adjustments I just mentioned.

About a fifth of the variation was found to be

attributable to hospital operating characteristics thought to be at least partially under hospitals' management and control, such as occupancy rates and length of stay.

Market characteristics such as population demographics, provider supply and local competition were not found to be important sources of variation. About half the variation in financial performance remained unexplained.

Now the analysis I just reviewed examined one year of data from 1998 for Medicare inpatient margins. The Commission though, in its payment adequacy framework when we've looked at hospital financial performance, has focused on the overall Medicare margins which incorporates payments and costs for most patient care services provided to Medicare patients by hospitals, including inpatient, outpatient, skilled nursing, home health, rehabilitation care and psychiatric services for fee-for-service Medicare beneficiaries.

The overall Medicare margin, however, varies substantially from one year to the next. For half of all hospitals it differs by 4 percentage points or more from one year to the next. And for a quarter it differs by 8 percentage points or more.

There are a variety of reasons why the margin can vary from year-to-year but it may also mean that a single year margin may not provide the best representation of providers' performance. So to avoid the pitfalls of single year data, we decided to examine performance of hospitals with consistently good or poor financial performance over a four-year period.

We might expect to see different results in this analysis compared to the earlier results also, because we are looking at different Medicare margin measures for one, the overall Medicare margin instead of the inpatient margin. And we are looking at performance over four years rather than one year. Just keep that in mind.

I want to briefly review the methods. Our analysis examined overall Medicare margin data for 1999 through 2002. We required that hospitals have overall Medicare margin data and total all-payer margin data in all four years of the analysis. Consistent performers had to have negative overall margins or positive overall margins in all four years of the analysis.

Our final analysis included more than 80 percent of hospitals covered by the Medicare acute care inpatient

PPS. The analysis excluded critical access hospitals.

Our final analysis included almost 3,000 hospitals and what we find is that about 29 percent had consistently negative overall Medicare margins. But over two-thirds had either consistent positive margins or margins that were intermittently positive and negative over the period. The largest fraction of hospitals, 37 percent, consistently had positive overall Medicare margins over the period.

Of note is the small share of hospitals, less than 2 percent, that had both negative Medicare and negative total all-payer margins.

Our presentation today will focus on the costliness measures. I did want to mention, however, that we also looked at some basic provider payment system characteristics that were like in the previous analysis and found the results to be consistent with our earlier study. So we will not be presenting those findings today.

So let's move on to some of our findings and look at factors influencing costs. The first set of cost-influencing factors we examined are annual changes in length of stay. Here we go back to 1994 to help capture some of the shift in care that occurred to post acute care in the

'90s. As a reminder, length of stay dropped substantially during the '90s as hospitals began discharging patients earlier, at earlier points in their stays, to various forms of post-acute care.

The drop in length of stay was larger for Medicare patients than for privately insured. At least this is in part possibly due to the financial incentives of the inpatient PPS, in terms of the per-discharge payment system.

It does not appear the negative margin group had any difference in length of stay compared to that of all hospitals. But hospitals with consistently positive Medicare margins had a median decline in Medicare length of stay of three-tenths of a percentage point larger than the national median. That translates to about 3 percentage points over this period, which could translate into savings in variable cost for these providers.

The positive margin group also had slightly larger drop in length of stay across all payers and the negative margin group had a slightly smaller drop.

Next we can look at occupancy rates where we see the median value for the positive Medicare margin group is higher than for the negative margin group. Higher occupancy

should translate into lower unit costs as fixed costs are spread over unit output. We can see that there's differences in Medicare share of patient days, some small differences in Medicare patient days.

Another factor to consider is also the average age of plant. We often hear that dealing with an aging plant potentially reduces provider profitability. However, we see here very small differences in average age with the positive margin group having slightly older plant and equipment and the negative group having slightly younger plant and equipment.

MS. BURKE: Craig, can I ask a clarification? On the occupancy rate, is that of all patients or just Medicare?

MR. LISK: That's of all outpatients.

Moving on to Jack now.

MR. ASHBY: Moving on to the next slide, in addition to looking at specific factors that affect costliness, we also compared the negative and positive margin hospitals directly using a measure that standardizes for differences in case-mix using the Medicare DRGs and input prices using the Medicare wage index. As we can see

on this chart, the negative margin group has above-average costs in the absolute and the positive margin group has below average costs. More specifically, the negative group's median cost per discharge is about 12 percent above the national median and about 24 percent above the median for the positive margin group.

What's more, the positive margin hospitals have continued to have their costs increase more slowly over the last four years so that it does appear that the gap between the two groups is continuing to grow.

Next, we compared the negative and positive margin groups to their competitors, which we defined as a hospital covered by the inpatient PPS that's located within 15 miles of the subject hospital. Both groups do have competitors but the median positive margin hospital has three competitors, the closest of which is about four miles away, while the median negative margin hospital has one competitor about 12 miles away. The negative margin group does tend to, on average, be located in more sparsely populated areas. And in some of the cases, there is also a critical access hospital within that 15 mile radius.

Looking at the results of this analysis, first let

me say that we brought in a third comparison group for this part of the analysis, the small group that Craig referenced earlier that has negative Medicare and negative total margin hospitals.

DR. WAKEFIELD: Jack, on your previously slide, distance to areas -- I'm sorry, I just answered my own question. Never mind.

We were looking at the statistical period and wondering if the distance was to any hospital, CAH or PPS?

MR. ASHBY: No, it's only to a PPS hospital. We just defined CAHs as outside this analysis. But I did want to make note of the fact that there are some CAHs in these communities. So in some sense, the distance is a little bit less than would appear here.

At any rate, we brought in a third group into this comparison, those with negative Medicare and negative total margins. You'll notice first, looking left to right here, that this new group has even lower occupancy, 42 percent versus 46 percent for all of the hospitals with negative Medicare margins, and even higher costs, about $6,000 per case compared to $5,900 for all of the negative margin hospitals.

Second, looking up and down in this chart, both the negative margin groups have considerably lower occupancy and higher costs than their competitors. And those with negative Medicare and negative total margins are the furthest behind their competitors on these measures. The positive margin hospitals, on the other hand, have close to the same occupancy as their competitors and they have lower costs than those competitors.

We conclude from this analysis first, that higher costs and higher cost growth play a major role in explaining differences in financial performance under Medicare. Of course, the payment system also plays a role but the implication of this particular analysis is that hospitals do indeed have substantial influence over their own performance under Medicare.

Second, we would conclude that hospitals with consistently negative Medicare margins have generally a poor competitive stance in their markets. They are not doing as good a job in attracting patients, which then contributes to higher unit costs and ultimately to lower Medicare margins.

But a negative Medicare margin usually does not mean a negative total margin. As we've talked about several

times in previous sessions, there's very little relationship between Medicare and total margins. But for the small subset of hospitals that does have both a negative Medicare margin and a negative total margin consistently over our several years, this group has the same problems as the larger group with negative Medicare alone but to the even a greater proportion. So in the end, they are even less competitive in their own market areas.

Any questions?

MS. BURKE: Jack, tell me what we know about the payer mix in these hospitals?

MR. ASHBY: We did look at Medicaid and found that there was just virtually no difference on average between the groups. So the leftover group, kind of an all other, mostly private, is essentially about the same.

MS. BURKE: So the presence of either uncompensated care or Medicaid as a payer doesn't have any influence on the margin?

MR. LISK: Actually, Medicaid in the positive group was 12 percent of the cases, compared to 10 percent for the negative margin group and the all hospital group. So there is a small difference there.

MS. BURKE: It contributes positively, not negatively?

MR. LISK: Right.

MS. BURKE: And uncompensated care?

MR. ASHBY: Uncompensated care, unfortunately we don't have a measure available at the moment to look at that directly.

MS. BURKE: In the mix among size of hospital or the nature of the hospital, for example teaching hospitals as compared to community hospitals, privately owned as compared to community owned?

MR. LISK: Teaching hospitals tend to be in the positive group. Rural hospitals tend to be in the negative group.

MR. ASHBY: But perhaps a qualifier on that latter one. This is data through 2002 in this analysis so it does not reflect the benefit of the MMA provisions that will markedly raise the bar for rural hospitals.

MR. LISK: Ownership really, on the negative Medicare, it was really the positive Medicare was more likely to be proprietary, for instance. In the negative, it really wasn't anything to say who was more likely to be

there in terms of hospital characteristics.

MS. BURKE: So if you were to try to put into a sentence or two the characteristics of hospitals who have a tendency to be negative in terms of Medicare margins, what would be the quick summary? Like low occupancy, high cost, rural –

MR. LISK: A little more likely to be rural. A little more likely to not receive IME or DSH payment adjustments.

MS. BURKE: Relatively small.

MR. LISK: Smaller than average.

MR. SMITH: And likely not to have as much competition.

MS. BURKE: And more likely to be relatively isolated.

MR. ASHBY: Relatively, but again on average, you do have a hospital within a 15 mile radius, which means that by any real standard they're not isolated.

DR. MILLER: Did you say that relative to their competitors they tend to also -- when you were going through yours. They tend to have lower occupancy.

MR. LISK: And considerably lower occupancy rates

than their competitors.

MR. MULLER: Along those lines, in the work earlier this morning we were pointing out that surgical DRGs tend to be more profitable than the medical. Can you comment as to whether there's any, as far as we know, any big difference between the proportion of medical DRGs versus surgical DRGs in the profitable versus the unprofitable?

MR. LISK: Don't know that. We know that there's some slight -- the negative hospitals have slightly lower CMI on average then the consistently positive group in terms of CMI, which is consistent with the earlier analysis that was done. A small CMI effect, not a huge. The differences aren't big. I don't know about the medical/surgical split.

MR. MULLER: It's probably not enough to explain all the variation that Jack and Craig have come up with but since one of the things we've noticed over the years is both a difference in payment but also the likelihood of the costs going up in these kind of complex medical cases. Now whether you have those complex medical cases in small hospital that tend to be more rural is probably not as much the case. But I think to the extent to which our payment system and some of its weaknesses has some affect on this,

if we could just look at that as well without an inordinate amount of extra work.

MS. RAPHAEL: I thought this was very useful, kind of not looking at one year and really trying to get a sense of some of the trends. Could you review what's been happening in terms of the trends in the Medicare share of patient days for hospitals overall? Because clearly for these less profitable hospitals, they have a higher share of Medicare patient days. But what's been the trends in that area?

MR. ASHBY: I don't know that we have data on the tip of our tongues to look at that. My sense is that it's been relatively stable. We have not noticed that being a major dynamic in the industry. But it's something we would really have to go back and measure to be certain.

DR. MILLER: You have it in this dataset; right?

MR. ASHBY: Yes.

DR. MILLER: I think the answer is we'll look at.

MR. ASHBY: We can certainly get that. It's easy to do.

DR. CROSSON: Just a question. As Sheila was painting the picture of the hospitals that are negative

Medicare margin hospitals, thinking about it it sounds to me like a failure of governance, actually. You can say failure of management or failure of governance.

In other words, the question for me would be what are the people who run those hospitals doing? Or actually, what are the boards of those hospitals doing or not doing? I just wonder whether there has been any thought given to looking at the characteristics of or the effectiveness of governance between those two groups of hospitals.

MR. LISK: I think that's what we're trying to do. I guess the governance, you're talking about in terms of some of the ownership and some of those types of structures.

DR. CROSSON: I'm talking about the role of the hospital or the management but ultimately the role of the hospital board to have a hospital that year after year, at least in Medicare, is losing money. When you look at the cost structure differences there, they're pretty significant. And those things generally are different because of management activities. But often those management activities are directed by the governance of the hospital.

And I just wonder whether we actually have

evolving differences in hospital governance that is, in some ways, accountable for some of those differences. That's the question.

MR. HACKBARTH: I think the governance variable is very difficult to get a grip on and measure in this sort of analytic way. What we're trying to do here is get a grip on the management variables, the things that you think management might be able to influence. And the general pattern is consistent in the sense that the costs are higher, occupancy lower in the losing hospitals. So I think it's consistent --

MR. ASHBY: It certainly implies a lot about the management.

MR. HACKBARTH: -- about the management. It's consistent with that hypothesis. It's probably too limited data to say it proves that the problem is management.

But are there other variables that we could look at that would go to the management hypothesis? Wage increases. If we could spend 15 minutes we might be able to think of a number of other variables that could be explored.

MR. LISK: That's right.

In terms of the total facility though, what's

surprising is you see these low occupancy rates for this group of consistently negative Medicare margin hospitals. But as Jack said at the end, if you look at the total margin, it's very similar to the other hospitals in terms of other hospitals on average.

So something else is happening there, as well, in terms of management. They are able to manage the bottom line. And it may be that they're in less competitive markets and so the cost pressures from the private sector aren't there and the private sector payments are increasing but the pressures aren't there to control Medicare costs. I think that may be one of the things that's happening here.

MR. ASHBY: Just to elaborate one point on that and that is, as we've said, the cost increases in recent years continued to be higher despite the fact they had higher underlying costs.

But if you focus more specifically on the group that had negative total margins as well as negative Medicare margins, then you see that the cost growth was beginning to come down in recent years. There was extreme pressure to do so and some evidence that they had acted. But in the absence of that bottom line pressure there didn't seem to be

any indication that management was making moves to do anything about this situation.

DR. NELSON: Know anything about the bad debt factor between these groups? It seems to me that a hospital is struggling because it's in an urban area that has a large amount of uncompensated care and has to write off a lot of bad debt.

If its bad debt amount was similar to what a more affluent community hospital's bad debt was, then one could infer that there were management factors rather than catchment, demographic factors that were reflected in their performance. But you're saying no, you don't know anything about bad debt?

MR. ASHBY: We don't have a measure at the moment to put into this analysis.

MR. HACKBARTH: That would have a more limited affect on the Medicare financial performance because you don't have uninsured patients. People could be failing to pay their deductible if they don't have supplemental coverage.

MR. ASHBY: But Medicare is covering 70 percent of that by policy anyway, so we wouldn't expect great

differences there.

MR. HACKBARTH: Other questions?

MS. BURKE: I think it would be enormously useful to tease out the urban/rural mix of these three groups, particularly the group with the negative margins. I would guess, based on just instinct and probably a little in the way of fact, that we would see a pattern of rural.

I mean, the question of governance is a good question but it wouldn't surprise me in the least if these weren't community hospitals, relatively small, low-volume. I think of the state of Kansas that at one point had more than 50 percent of the hospitals had fewer than 50 beds. And I suspect that's higher now. I can see those hospitals and I wouldn't be in the least bit surprised if they weren't, in fact, these hospitals that are struggling along in these communities.

It would be interesting to know how many of them are urban because I think that is a different nature of question. But I think understanding the rural versus urban, urban even sort of community within 15 or 20 miles of a large metropolitan area, would be helpful in understanding or at least appreciating what some of the issues might be

with some of these hospitals.

Not to suggest that it's good or bad but I think that would help our understanding to understand where they were.

MR. HACKBARTH: Although the smallest have, in very large numbers opted for CAH status.

MS. BURKE: That's why I'm asking whether or not that calculation has changed that. It may, in fact, have changed that group dramatically and they may, in fact, not be largely rural.

MR. ASHBY: In the MMA provisions you would say the same thing.

MS. BURKE: It would be interesting to understand that because I think there is a legitimate question about how long they are carrying on and what the point is and what the dynamics are in that particular community because that contributes to a lot of decisions about whether or not it's the only physician in town and it's the largest employer.

There are a lot of dynamics like that that don't make the right case but at least it would help us understand who they are. But just an understanding of what the urban/rural mix might be useful, particularly if the

critical access guys are pulled out, what remains in that group would be useful to know.

MR. HACKBARTH: Refresh my recollection about last year's financial analysis. My recollection is that the affect of MMA was large enough that we were projecting that once MMA is implemented that the average margin for rural hospitals would actually exceed the average margin for urban hospitals.

MR. ASHBY: Yes, we were projecting that one year ago. We will have new information on that, that again reflects the MMA provisions, at our next meeting.

MS. BURKE: That would be helpful because this is pre-MMA. So this might be a radical change.

MS. DePARLE: I forgotten, I think you reported on this at last meeting, too. How many hospitals have now been designated as committee access hospitals as a result of the new standards in the legislation?

MR. LISK: It's getting close to 1,000.

MR. ASHBY: 984, I believe.

MS. DePARLE: What's the universe? Is it 6,000 or 5,000?

MR. LISK: We're down to less than 4,000 PPS

hospitals now. I'm not sure exactly what the number is going to be, but it is now less than 4,000.

MR. ASHBY: But keep in mind that we did exclude critical access hospitals from this analysis, including ones that became critical access later than the data. We still excluded them to have the cleanest look that we could.

MS. BURKE: That's why it would be interesting to know what's left in that little pocket.

MR. MULLER: Just anticipating some of the work we'll be doing in December and January, especially when we go to payment adequacy. In the past when we've looked at that, we've looked at the annual numbers and the framework and then said in light of our best estimates of margins in that year we make a determination of whether the base is adequate and then we look at the updates.

I wanted to think aloud a little bit about when one has a multiple year perspective how that changes, if at all, the payment adequacy analysis. And also I wanted to tie it to a discussion we had yesterday and the prior month on pay for performance, how we tie these things together.

I think some of the import of today's analysis is that the hospitals with consistently negative margins are

just having a harder time competing in the marketplace in terms of lower occupancy, higher costs. And some of the higher costs may be a function of lower occupancy because as we all know there's a high fixed cost to hospitals. If your occupancy is low, your costs go up quite a bit. So those things are probably highly correlated in terms of performance.

But if we're thinking about then what we do as a result of this, in the past analysis we have indicated if there were a lot of consistent negative margins we would have to think about how to -- what we do about that in terms of payment adequacy. One of the concerns you had, Glenn, is the update is a broad brush way of dealing with the payments. Part of what we're trying to think about is are there more targeted ways of using our dollars.

So I think part of what I'd like to see as we go through our recommendations in December and January is how to bring together some of the targeted thinking on pay for performance with the adequacy framework so that we try to mesh those things together.

I think it's also realistic, given Sheila's line of query about the rural hospitals, we've seen there have

been consistent policy efforts to try to redress that. The act last year went in that direction, as well. So some of the problem of the margins in those hospitals, if indeed your hypothesis -- and it's a hypothesis -- comes through, then some of the negative margins in these hospitals may, by that stroke of the pen, have gone away.

But I think we should try to put the pay-for-performance together into the adequacy framework.

And I think if we're going to start looking at multiple years, as I've argued in the past, we have to think of it across various sectors and obviously the inpatient hospital being, the hospital in all, being 45 percent of the Medicare payment obviously always gets the most attention. We have to think about if we're going to look at it over a multiple year basis, what's the import of that for the nursing home and dialysis, et cetera, and so forth.

So if we could be thinking in those directions, I think that would be helpful.

MR. HACKBARTH: Any others? Thank you.

Okay, we'll have a brief public comment and we'll have the usual ground rules.

MR. FENIGER: Randy Feniger, the American Surgical

Hospital Association. I apparently am the one who has to apologize for forcing you to work in the dark. Normally I like to shed light on government activities but lean to the left and -- whether that's a political statement or not, I'll leave to you.

Just a couple of points I'd like to make and I will be as brief as possible. First of all, again commendations to both the staff and the commissioners. The quality of the analysis, its depth in a very short time with a very limited sample to work with, and the incisiveness of the questions and discussion points that have been brought up throughout this debate, I think on a very touching political issue lend credibility to everything that you've done.

Quality measures, I can't speak for the heart hospitals. We have very few cardiovascular members. Unfortunately, most surgical hospitals or most areas of surgery do not have the advantages of the STS database, which is a very good one. We have tried to look at proxy measures such as nurse/patient ratios, postoperative infection. That data has been shared with your staff in aggregate. And we would be more than happy to make that

available in greater detail from our own internal surveys. It is self-reported and I understand the limitations of that. But to the extent that it sheds any light on quality questions as proxies, we are more than happy to share that with the staff in greater detail if it is appropriate.

Your discussion at the last meeting, I think, on DRGs I think really was reinforced by comments today. At the heart of this is what is happening to the inpatient hospital payment system in Medicare over time and what incentives does it provide or not provide all of the hospitals in a system, irrespective of their ownership.

Our organization feels that this would be an area we what certainly encourage a very hard look by the Commission and by the Congress. Obviously, you're not going to get it done between now and your report. It's a large task. But we think that this is an area that would be very, very productive for analysis.

Finally, the bottom line of the slides suggested, at least in the analysis you've been able to do so far, no real difference, no harm, no foul. I recognize that you have been working with small samples and that limits your ability to really -- and we are sort of on the upward slope

perhaps of the new development. That limits your ability to really determine what might be happening in the future.

However, I think the fact that the conclusions that your own staff reached and presented to you, the small samples that you have so far which you've acknowledged in your conversations, suggest that recommendations that come from the Commission be very cautious. I think it would be unfortunate to have recommendations that send a signal that we wish to preserve the hospital system as it exists today, and we wish to discourage new entrants to the market irrespective of their ownership or shape or form.

I think that, in fact, we probably need lots of new innovation and experiment to deal with some of the issues in health care and in the Medicare system. And I would just, on behalf of our association, urge caution based on what you have been able to look at with all the hard work, very cautious recommendations coming from the Commission.

Thank you.

MR. HACKBARTH: Okay, thank you very much.

[Whereupon, at 10:45 a.m., the meeting was adjourned.]