MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Wednesday, November 8, 2006
10:10 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
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WILLIAM J. SCANLON, Ph.D.
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* November 9 proceedings begin on page 279

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: This morning we begin with two sessions on the SGR mandated report, which incidentally will be followed by two more SGR-related sessions tomorrow morning.

The first SGR item is on multi-specialty group practice in the U.S. Cristina, are you going to lead the way?

MS. BOCCUTI: Yes, thank you.

Good morning. As Glenn just mentioned, the Congress asked MedPAC to analyze alternatives to the SGR, including policies that might adjust payments based on physicians participation in group practices. So this we're going to present some information and data analyses on the topic.

I'm going to go through the background information pretty quickly because our panelists last month reviewed this material. On this slide here you can see that for the most part physicians tend to work in small practices. Half of all office-based physicians worked in practices with only one or two physicians. And single-specialty group practices are more common than multi-specialty ones.

In the last decade single-specialty groups have grown in number, while we see little to no growth in multi-specialty group practices. Researchers have attributed this growth in single-specialty practices to several factors such as the continued financial profitability of solo and single-specialty practice styles, particularly under fee-for-service revenue models which reward procedure volume growth.

Also, negotiating leverage can be gained at relatively small sizes compared to multi-specialty groups. And third, health plans retreat from tightly managed care have led to growth in single-specialty practices.

So we attained some insight on the perceived benefits and barriers to forming large group practices through the site visit portion of the Community Tracking Survey, which is conducted by the Center for Studying Health Systems Change. This survey interviews physicians and executives from health plans and hospitals. Interviewees most frequently cited gaining leverage with health plans as the most frequent benefit, and second gaining economies of scale as a benefit for forming group practice.

Other benefits are listed on the slide but I'm not going to go through them.

Interviewees also cited several barriers to group practice formation with the desire for autonomy and difficulty cooperating with other physicians as the most frequently cited barriers.

Other research lends some further insight into the lack of growth in large multi-specialty group practices. For instance, several studies have indicated that patients show some preference for solo and small group practices, and consequently physicians may be responding to consumer demand.

Some observers note that physicians' desire for autonomy and independence from medical groups stems, to some degree, from medical school education which seeks to train all physicians to make independent decisions. Physicians' preference for autonomy often makes them uneasy assuming the role of followers who bestow leadership positions onto others in their practice.

Although in the past decade we see little to no growth in multi-specialty group practice, there are some opportunities for growth in the future. Younger physicians are more likely than older physicians to practice in medium and large groups due, in part, to lifestyle practices such

as less on-call hours.

Additionally, some large groups report many more physician applications than they can accept from certain specialties. So another opportunity may lie in medical school training. Fostering teamwork and quality measurement through medical school training may increase physicians' preferences for group practice.

Reliable and valid analyses comparing group practice to solo or very small group practice is relatively scarce but I'm going to review what's been published on three topics, namely quality and patient satisfaction, use of IT, and cost and efficiency.

A meta-analysis of published research did not find conclusive systematic differences in quality and outcomes of care between multi-specialty medical groups and solo, smaller single-specialty physician practices. However, some recent studies suggest that group practices outperform on selected measures. Some studies have found that large multi-specialty group practices and groups affiliated with or owned by HMOs or hospitals were significantly more likely to use recommended care management processes, or CMPs, such as disease registries, reminder systems, clinical

guidelines. And this is in comparison with groups that were more loosely organized.

Nonetheless, even in large groups the use of CMPs was not widespread.

A very recent analysis found that health plans with a greater reliance on physicians in group practices scored higher on several HEDIS measures than plans relying on more fragmented physician care systems. Despite these quality differences, research has generally found that solo practices and practices based on fee-for-service revenue have higher patient satisfaction rates than prepaid group practices or group model HMOs.

Greater use of electronic medical records has the potential to improve the quality of the medical care. According to the National Ambulatory Medical Care Survey, or NAMCS, 24 percent of physicians reported use of EMRs in 2005, and this is up from 18 percent in 2001. This study found that as medical groups increase in size their use of EMR also increases. Also, multi-specialty practices were more likely to use EMR.

While physicians in larger practices are more likely to have IT, many large groups still lack clinical IT.

They don't use it for key clinical activities such as ordering prescriptions or public health reporting.

So there really is no comprehensive research comparing resource use between multi-specialty group practice and solo smaller single-specialty practices. Several studies have found that the pre-paid groups are associated with lower resource use and patient costs. Note, however, that we can't determine whether differences in patient costs can be attributed to group practice treatment patterns or to revenue incentives inherent in capitated group practice. In fact, some studies have shown that fee-for-service practices are more likely to compensate physician employees based on volume production.

Studies have also shown that delivery systems that include hospitals and physicians have been found to have lower overall costs than more decentralized and independent systems and networks.

Using clinical vignettes from the CTS physician survey one study found that for ambulatory symptoms or conditions that do not have a clear consensus on the best clinical response, solo practice physicians were more likely to treat or refer rather than recommend no immediate action.

So considering the dearth of information directly comparing resource use by practice type, we embarked on a claims analysis in geographic areas for which we have 100 percent of beneficiary claims, namely Boston, Minneapolis, Greenville, South Carolina and Orange County. Our analysis compares spending and utilization of beneficiaries whose main physicians are in multi-specialty or hospital-affiliated groups with those who are not.

In addition to the claims files we also used CMS files that link physicians to medical groups by group name and tax number. We identified beneficiaries' main physicians as the physician who accounted for the highest share of the beneficiary spending on evaluation and management services between 2001 and 2003 and had at least 25 percent of the beneficiary's total E&M spending during that time.

We identified physicians who were part of a multi-specialty group or a hospital-affiliated group, such as a faculty practice group, through these files and through an examination of the physicians in the group.

And finally, we standardized payments across all areas to control for input price differences and payment

policies as we've done with spending comparisons in our episode grouper work.

So before I go through these results I want to note that this analysis is a first step and should be interpreted with caution as there are many limitations, which I'll described in the next slide. So on to the findings.

Similar to well-documented previous research examining geographic differences in spending and utilization, we too saw variation in spending and in the number of physicians in practices among the four areas that beneficiaries saw. The share of beneficiaries whose main physicians were part of a multi-specialty or hospital group varied from 17 percent in Greenville to 42 percent in Minneapolis.

Despite this variation, this slide shows that for all areas average total payments -- that's the third column -- is lower for beneficiaries whose main physician was in a multi-specialty group. Also, the last two columns show that the number of physicians and the number of practices seen by these beneficiaries is also lower.

You see draft written on this slide because

further analysis to address the data limitations, which I'm going to go through in the next slide, may change the results. So we'll keep working on it.

The first of these limitations is that spending and utilization comparisons are not adjusted for health risk. However, we did examine the average age of beneficiaries in the cohorts and found that beneficiaries whose main physician was in a multi-specialty group practice were slightly older in three out of the four MSAs, indicating that health status, to the extent that it correlates with age, was not a factor.

A second limitation is that although we show spending differences by geographic area and practice type, there are many other factors that may contribute to these differences. For example, area market characteristics such as managed care penetration may influence practice patterns and spending.

A third limitation concerns physician services provided in teaching hospitals. Residents who see patients in teaching hostels do not always bill Medicare for the services they provide, so consequently payments for patients in faculty practices may be lower because resident surfaces

were not billed. However, attending physicians may bill Medicare for services provided by a resident when the attending physician is directly supervising the service.

Another limitation we must attach to our preliminary analysis stems from the challenge of classifying physicians as part of a multi-specialty group. Physicians may be affiliated with multiple practices and therefore bill multiple tax numbers. For physicians like this we attributed them to the practice where they saw the most beneficiaries.

Also, a single practice may have multiple tax numbers for business purposes, masking the true size and specialty mix of the entire practice.

In future analyses with private data we may be able to refine this practice classification. We may also begin to examine patterns of care through the Commission's ongoing work with episode groupers.

Another source of data on medical group practice will come from CMS's current demonstration project. I'm going to turn it over to Jennifer to discuss some of the details for this.

MS. PODULKA: Before we concluded, we wanted to

briefly describe CMS's payment model that offers an opportunity to capitalize on any potential differences between multi-disciplinary groups and other delivery systems.

As data from CMS's Physician Group Practice demonstration become available, they will inform our understanding of how these kind of organizations compare to others in terms of quality and efficiency. The demo is designed to study the effects of providing financial incentives for Parts A and B coordination, infrastructure investment, and quality improvements.

The 10 participating groups include various multi-disciplinary group models that range in size from about 200 to 500 physicians. In total, the groups comprise 5,000 physicians and more than 20,000 Medicare beneficiaries. The demo will use a total 32 quality measures that focus on diabetes, CHF, CAD and general preventive care.

Participating physician groups can earn bonuses through a shared savings model that incorporates these quality measures if Medicare spends less for the group's beneficiaries than for comparison beneficiaries living in the same service area. Participating groups must achieve

cost savings that exceed 2 percent of their expenditure target to be eligible for bonus payments. If a group does this, 80 percent of their cost savings goes into an individual group's bonus pool, as shown on the second line of the slide. Medicare retains the remaining 20 percent of savings.

On the third line you see that of the group's bonus pool, a portion is paid based solely on the cost savings. And on the fourth line you see that the remaining portion of the bonus pool, 30 percent in the first year and rising to 50 percent by the third year, is tied to the physician group's performance on the quality targets that I mentioned earlier. So that the group that meets all quality targets will receive their maximum quality bonus and match Medicare also retains any bonus set aside for quality performance that is not earned by the participating groups.

MS. BOCCUTI: So now, on this final slide, I'm going to bring us really to the task at hand, namely the SGR report. So considering the large share of physicians in multi-specialty groups and that some multi-specialty groups do not engage in activities that improve quality and manage costs, payment policies that focus simply on group status

per se may not effectively elicit desired practice activities.

Rather, it might be more fruitful to focus on rewarding the activities that are desirable. In doing so it might provide physicians with incentives to organize into the types of groups that best perform them. I've listed some of these activities on the slide and you may want to add or delete some.

This focus on rewarding activities or criteria rather than simply group status is akin to the Commission's previous recommendation to develop policies to encourage the use of IT functions rather than simply the ownership of it.

Medicare could require such activities among a set of criteria for favorable payment under or outside of the SGR. If physicians organize into the types of practices that can best perform these activities or criteria, we may see a growth in multi-specialty group practices as care coordination and team-based care may indeed be the key to efficient health care delivery.

Thank you. We'll be happy to take your questions.

MS. BURKE: A terrific job. I had really just a couple of questions.

One, is there any opportunity to get any preliminary information on the demonstrations? I notice that the report indicates 2008. Is there any midpoint or information that we might have access to in the interim that would give us any directional guidance?

MS. PODULKA: We're exploring right now the possibility of including some very preliminary data, especially in the SGR report. So we can certainly get back to you about that.

MS. BURKE: My second question is on the data that indicates preferences for physicians in terms of their choice of going into practices. I notice the data was from a survey done between 1996 and 2001. I'm not assuming that there's been a radical change, but do we feel fairly comfortable that that's still largely representative of people's views? That's 10 years difference.

MS. BOCCUTI: When I look at the recent publications they're always citing those studies. I'll look into seeing and talk with other experts and see if they can uncover anything that's more recent. It's not really a challenge so much.

I think Larry Casalino, when he was here last

time, did mention that the satisfaction rates for very large and well-established groups were higher than all of the groups at large. So I think I might have mentioned that in the mailing materials, but I'll make sure that comes through.

MS. BURKE: And then the last question was just simply there's a reference to antitrust in the course of the paper, sort of around page eight or nine. And I wondered if we had a better information about where specifically that is encumbering the sort of grouping together of physicians? How big a challenge is that in reality?

MS. BOCCUTI: Lawton Burns has been an FTC. He was here last time. And he has actually consulted for the FTC on that kind of question, and I have some FTC reports. So perhaps I'll get that a little clearer and give some indication of what's happened in the past.

MS. BURKE: Thank you.

MR. HACKBARTH: The antitrust issue would be more a single-specialty group issue than a multi-specialty?

MS. BOCCUTI: I'll speak from what I vaguely know. The law has to do with the number of doctors in the area. So single-specialty is able to skirt -- the denominator

being all docs in the area.

But the single-specialty can kind of do well when they're just all the specialists in the area. So when they're the numerator -- they should be part of the denominator, too.

MR. HACKBARTH: So you're saying they don't segment the market, look at market for cardiology services? They just look at all physician services?

MS. BOCCUTI: I risk going a little too far on my knowledge base in addressing this.

MR. HACKBARTH: That doesn't quite ring true for me.

DR. REISCHAUER: I have, first of all, a clarifying question and then a comment on the group practice demo. The clarifying question is are these Part B or Part A and B expenditures?

MS. BOCCUTI: For the data analysis that we did?

DR. REISCHAUER: Yes.

MS. BOCCUTI: It's all spending, A and B.

DR. REISCHAUER: It seems so low, even at standardized U.S. rates, to be $2,000. Really?

MS. BOCCUTI: I was thinking about that, too, when

I was comparing it to Dartmouth Atlas.

DR. REISCHAUER: I thought we were talking about a number like $7,000.

MS. BOCCUTI: One thing that's different is this: the numbers get a little bit higher when we include the beneficiaries that were not attributed to a physician. These beneficiaries had higher spending. They saw more doctors, which interfered with our ability to assign them to a physician because they saw so many you couldn't get the 25 percent threshold. So the numbers on mean spending do increase a bit if we included them.

And perhaps it might be helpful to include those means. I think there may have been some of it, but your point is well taken.

DR. REISCHAUER: My comment about the group practice demo is a question of its relevance. Just looking at the information here, we see multi-specialty group practice seems to be at a significantly lower level. So the problem is really everybody else. And so what we're testing in the group practice demo is how much better than being already better can they get?

Which is an important question. There's no

question that that's true, but it doesn't strike me as going to the real challenge here which is how do you either get the small practices to operate more efficiently or how do you get them to transform themselves into multi-specialty practices?

MR. HACKBARTH: Although the group practice demo, as I understand it, encompasses more than just multi-specialty groups. We heard from the CEO of Middlesex.

DR. REISCHAUER: But that was a virtual --

MR. HACKBARTH: Yes, but the idea would be that perhaps, if you can develop a payment mechanism that rewards integration and coordination through shared savings that physicians in a variety of individual practice settings might align themselves together to take advantage of that. So it's not just a payment system potentially for large multi-specialty groups which are inherently limited in number.

DR. REISCHAUER: But of course there's an inherent problem with the group practice demo, which is it's performance is compared to what's left or a panel. And if everybody's in the game there's nobody to compare it to. Wish that we had that problem.

DR. CROSSON: Thanks very much. I'd like to compliment Cristina and Jennifer on their report. I've always found it gratifying when facts support one's prejudice.

But this is a point of that, of course, I have a lot of interest in. I've spent my entire professional career essentially in a prepaid group practice and believe in it.

But it's really only more recently, as I reached out a little bit beyond my own organization, that I came to understand that actually some of the qualities that I had attributed to prepaid group practice existed in group practices which were predominately fee-for-service. So when Jack Wennberg and Elliott Fisher, a year or so ago, look at the resource utilization, for example, for Medicare beneficiaries in the last six months of life in dollars and in numbers of physicians seen, similar to this -- and among the name institutions in the United States in fee-for-service Medicare -- they found somewhat surprisingly that one of the most efficient was the Mayo Clinic.

You might think and intuit that the Mayo Clinic could essentially charge anything they wanted to anybody

because of their well-deserved reputation. But in fact, they didn't. And that's predominately fee-for-service practice.

So what is going on there? I think that's a key issue for us. And this report begins to get at it. I'm not sure I fully know.

I think one observation that I've had is that it's a simple one. And even before clinical information technology, physicians in multi-specialty group practices share a common medical record, for the most part. In other words, all of the specialists, primary care doctors, are recording the information and their decision-making and their justifications in one record, which is then reviewed over the course of time in the course of care for the patient by everyone else.

That does a couple of things. Number one, it tends to help reduce duplication because subsequent physicians know, in fact, what was done and what the rationale for decision-making was. That's sort of obvious. But there's also human phenomenon, which I think everyone shares, physician or not. And that is that we tend to think differently when we know our peers are looking at the

decisions that we make.

And I believe that, whether you want to call that culture or professionalism or whatever, has always been present in group practice and is going to be and is being augmented by the use of clinical information technology where the information is even more accessible.

When you add to that what I would call organizing the science, which is really providing for independent-minded physicians, nevertheless providing an organization to the science, the standards that exist in terms of care, and providing that to physicians in an easily acceptable way, even for independent-minded individuals it tends to propel practice in a better direction.

So I think that exists irrespective of payment mechanism and is a function of multi-specialty group practice, and we saw that little bit of that in the analysis that was done here today.

I tend to view this as potential because I think actually, when you then take the payment system and organize that in a way that augments that potential and those capabilities, then I think you have something that should form the basis for a long-term improvement in the health

care system.

So I do think that the issue, as Bob outlined it, is really what are the implications of this? And for me there are both ways we can go. We can say what can we do to improve the current system for practices that cannot organize in this way? And I think that is useful.

I also think that over a long term, a Medicare policy that is directed towards, in the way that was designed here, facilitating and incenting these kinds of activities will then lead some, not all, physicians and some hospitals, I believe, to rethink the idea about the organization of care into integrated systems. And I think in the long term that's a good thing.

DR. WOLTER: I think the issue that really underlies the potential for group practices to be units of accountability around quality and efficiency has to do with system approaches to value. And that's really the driver.

In addition to IT, I think group practices are more likely to invest in mid-level providers and create connections into the community for care in between individual patient visits and to work more closely with their hospital if there's not a hospital in the

organization.

I do like the comment, though, that we should create incentives around behavior and results, not just being a group, that makes a lot of sense to me. And the Middlesex presentation last month is a very, very good example of that and it would then create incentives for other physicians and hospitals to create some approach to coordinating how they tackle care.

I would put a pitch in that in these incentives that we might put in place we put some focus around high-volume, high-cost disease, because I think there's so much potential there to both improve quality and take some cost out of the system. That would be a very logical place to try to get doctors and hospitals working together. And I think that's also a key. It's about more organized approaches to care, but it's also about how the physician group, whatever that is, connects to the hospital care for these high-cost, high-quality patients.

And so that's really back to the theme of where do we find ways to put Part A and Part B together, particularly in fee-for-service environments because it's obviously done in the prepaid setting.

In that regard, in my view, the alternatives to the SGR are not just about physicians in Part B but there about tactics across the entire Medicare program that can help us create more value. And I'm kind of hoping we can position our conversation about alternatives to the SGR as something about appropriate resource utilization across the entire program because many of the things we're now starting to put on our list really to go beyond the physician community.

And in fact, if you look at volume drivers there are many things hospitals do to drive volume in terms of how they recruit, how they invest, where they're really trying to create their market growth. In fact I'd say there are huge forces in that area in terms of driving volume. And yet all of the focus right now is on the physician side, which is maybe not serving us well, although we have a mandate to do this report.

I mentioned the role of mid-levels. I think that's really critical in all of this in terms of how we tackle these issues.

There are some underlying incentives in the current reimbursement system that are counter, I think, to

things that create incentives to create more coordination of care, more organization of care. There's so much disparity between what some specialists can make versus what some primary care physicians can make. And there's even disparities between what one specialist makes versus another that sometimes I have a hard time understanding.

And a lot of these things are drivers for people to want to stay in a smaller practice or a single-specialty practice. Certainly, the ability to own certain facility aspects, and that's much more likely in certain specialties than others. All of these things create incentives that want to keep people in their own atomized units. And I don't think that the cottage industry is going to serve us as well in the next decades as it maybe has in recent ones.

So I think some of those existing incentives also need attention.

And then on the PGP demo, if I could just mention, I think I've mentioned this in the past, I think there's a flaw in the financial design in that the first 2 percent of savings can't be shared. It may be fine to have that as a cliff before any sharing occurs. I meant to check our projections in our group as to what we think might happen.

But I think there's no way we will do as well in the demo as we would have under just plain old fee-for-service, primarily because the first 2 percent is carved out.

So that could be a value of the demo, Bob. We might learn some of the things that would tweak how we apply this in the future.

Also, on the data, we didn't get our baseline data, which is the date about our patients for the year, before the demo started until three-quarters of the way into the first year of the actual demo. I'm sorry Sheila's not here. And I don't think we've seen any feedback yet, in terms of our performance, and we're about a year-and-a-half into the demo.

So that's another issue because I think most excellent performance improvement does better when there's much more timely feedback so you can kind of adjust course and make changes to what you're doing.

MR. HACKBARTH: Nick could I just go back to the first part of your comment and playback what I heard? I just want to make sure that I got it right.

What I hear you saying is that within an SGR option you may wish to have an opportunity for organizations

to gel and receive payment in a method somewhat like the prepaid group practice or the group practice demo. You can share savings on parts A and B. There's a structural incentive for physicians and hospitals and other providers to collaborate. So that's one policy line.

The other line that I heard you mention was that even if you do that within the traditional Medicare program, independent of the SGR mechanism, you think it's very important to identify other opportunities to begin pulling providers together to bridge the A/B gap and other payment silos that exist, things like bundling, DRGs, gainsharing. There are a number of different ideas that we've discussed.

so it's important to think of it on two separate tracks, an SGR track perhaps but also a traditional Medicare payment policy track, as well. Did I get the question?

DR. WOLTER: I guess my mental PowerPoint on alternatives to the SGR still more or less starts with our previous recommendation that it should be eliminated and that we should move away from something that hasn't worked very well, but that we need to outline aggressive tactics for appropriate resource utilization that would come in instead of it. And I think that's still an option we should

consider.

I'm not opposed to the mini-SGR conversation and all that stuff, but I'm really thinking about what's on that vision list that you presented us last time and staff presented us. There are many things in part A, in Part D that we could really look at in terms of volume and appropriate resource utilization. And then there's how the dots connect because physicians, in their interactions with these other parts of the program, can be real drivers of improvement if we can create the right incentives.

DR. HOLTZ-EAKIN: I liked everything I heard until the last part, which is I think it's sensible to think about the SGR from a broader perspective, just having it on Part B. We all know the problems with that. I think it makes perfect sense to try to have the system reward payments around high-quality outcomes with the efficient organizations providing them.

I just don't want to see us throw all our hopes on the second part without any evidence that it will work before we give up the first. And so I want to make sure that we keep track of the total dollars that are actually going to go into this system before we say that we've got

the rest figured out.

MR. BERTKO: Just a couple of comments. Again, a nice report as far as it went. I wanted to suggest, following up with Bob's statement here, we want to think about where we want to get to.

Number one, I think we might want to characterize the Physician Practice Group experiments differently, Middlesex being one that came into being -- if I recall right, Geisinger and a couple of others are well established. And while they might tell us about effectiveness, they don't give us much about how to get from single-specialty to that.

So along those lines, I'd encourage you to then look beyond those 10 groups. I'm thinking here there are IPAs in Northern California and the West Coast that you might look at and probably elsewhere where if you reached out to them, collect tax ID numbers or something, and run parallel types of things on those to see how they worked and maybe learn a little bit more about those, as well.

The last comment is I'm recalling from maybe either the original Medicare Risk or Medicare+Choice there was a PHO organization in there which, to my recollection,

was pretty much a failure. Some showed up and then they fell apart.

We might be able to learn from failures in the past on what happened here. I think I did some consulting for them about 15 years ago, but I'm losing my memory. I would ask you to maybe just check with some folks about that.

MR. DURENBERGER: On that point, would it not also behoove us to look at successful experiments which include the TEFRA risk contracting process we went through starting at '85, '86, '97, '99. It was a success in some parts of the country, including ours, and it was not a success in others because there wasn't the presence of the kind of groups that we're looking at here.

I don't know how well that's been researched. I don't know a place to go. The only person I know is a health service researcher at Marshfield by the name of Greg Nycz who has this thing locked. And he can just show you how, in the communities in our part of the countries and Hawaii and other places, they brought costs from above the national average to substantially below the national average in two or three years.

I don't know what -- we have peer-reviewed organizations in place to guard against quality problems. I don't know it will give you everything. But it is a success story that has been watered down by the fact that we failed to leave some of the savings in those communities.

DR. KANE: Just on examples that you might like to look into, Long Island Health Network, I think there was a fellow here from the last meeting who gave a comment at the end. But I've been working on a case study of them and they look like they've done some interesting things, mostly around inpatient care. But the physicians are totally community solo, there's no particular group except that the hospitals have gotten together and formed a quality program that affects all 11 hospitals participating. And they look like they've done some interesting things around improving cost and quality on the inpatient side. So it might be worth looking at that model.

What I wanted to talk about in terms of the policy discussion on SGR is, I will disclose right away that I have a conflict of interest because I teach physicians management skills. And I'm relating back to the comment that they don't particularly learn management skills in medical school

or in their residency. In fact, they learn anti- management skills, in my experience.

And they're smart people, so I'm not denigrating the intelligence of physicians. But the training is very negative towards leadership and being part of a team.

And in a program that I run for physicians to teach them management skills, the very first summer we teach them self-assessment, team behavior, how to lead a team, how to be on a team. They come away, just after two months, saying it's transformational. I know we're just scratching the surface.

But I'm wondering if we shouldn't try to start linking that up, some of the educational ways to reward physicians either by saying you're going to have a better payment either through less exposure to the SGR, exemption from SGR, or rewarding even the hospitals that include in their training and residency a required certification. Again, I know I've got a conflict here. But it's pretty clear to me physicians desperately need to be taught some basic management skills and some awareness of organizational behavior and there should be some way we can reward that.

I think that will get at the psychology that we

see of physicians refusing to accept any kind of control and defending their autonomy at all costs. So I just want to encourage that, that that be a part of the list of things that we find a way to reward in the payment system.

DR. MILSTEIN: Maybe we can also revive our memory of Nancy's comment when we discuss the IME topic.

Understanding where convergence may lie, I defer to Glenn, but a few comments. Fist of all, I think my sense is that there is a lot of support -- for whatever might be created either as a supplement or as a replacement for SGR, that it ought to be the sum total of resources expended rather than Part B only. You mentioned let's throw in A. I think we should throw in D, as well, clearly.

A second comment is that as I reflected on the testimony we heard from our selected group of experts on what is the evidence that physicians in groups perform a lot better than physicians who are not in groups, I was actually sobered up by their comments, saying that there are some standout anecdotes that writ large the evidence is not for this being a robust basis of a big bet on what we want to reinforce through an SGR escape route.

And certainly, per Bob's comment, the evidence is

even more challenged with respect to IPAs and sort of ad hoc -- wonderful anecdotes aside, Marshfield Clinic I agree with. But if you talk to anybody who is, for example, in California managing mixed groups of IPAs and multi-specialty medical groups, they'll tell you that they've been at it for 15 years and converting type two into a type one enterprise is very challenging, is almost impossible actually. They can close the gap somewhat, but are they never able to close the gap fully.

So given the fact that the evidence in favor of physician groups, especially more informally adhered formed groups, that being a tremendous basis of value advantage, that that hypothesis is really not supported. I then fallback and start to say what is it that beneficiaries need physicians to lead? My view is that they need physicians to lead in not small incremental change, in controlling health spending trend and quality. But they need very substantially motivated American physicians to get on a whole different plane with respect to their level of ambition and improving affordability and quality of care.

And so my conclusion from these observations is that I hope that our solution will be biased in favor of

letting the numbers do the talking. That is that the escape route from SGR, if we create one, should be focused on to the degree to which a physician who elects to opt out -- if that's the process we lay out -- is creating a substantial gradient in terms of quality, patient experience/satisfaction and affordability or total resource use.

And though I certainly would bet that Permanente Medical Group and other similar groups will be distinguished in a performance-focused SGR escape, I would like to hold open the possibility of what Larry Casalino and Lawton Burns referred to as small -- I know this is a pejorative term -- groups of maverick physicians who under the motivation of escaping from SGR begin to -- partly through the agility of their smaller size -- come up with innovations analogous to Southwest Airlines.

MR. HACKBARTH: Can I ask you about that, Arnie? Your basic point makes great sense to me, that in devising an escape, as you put it, you wouldn't want to be prescriptive and say that only these models -- especially models that have had at best a mixed history like IPA, can get through. So I understand fully where you're coming from

on that.

Where I have difficulty, where it's less clear to me, is how well we can assess the performance of these leading edge solo practices, or two or three physician practice models, in managing total costs -- which was one of your earlier points -- given issues of small numbers, instability, and the calculations and the like.

What are your thoughts on that?

DR. MILSTEIN: I think that is a good point but not an absolute barrier. If you think about currently available quality measures that would be attributable to a physician or patient experience measures or total resource use measures, as you begin to diminish the size of the physician denominator some measures drop off.

But that said, we're at a point in --

MR. HACKBARTH: But I would think that the cost measures, the ones I'm focused on in particular, the total cost measures.

DR. MILSTEIN: Let me comment on that. That said, if you look at what's evolved over the last five years in America's commercial insurance sector with respect to physician performance evaluation on resource use, the

conclusion of virtually all, if not the majority, of our national commercial insurers and is that measuring resource use at what I'll call the small physician group level, meaning the two to five physicians that are the bulk of the contracts that John and other national carriers manage -- that viable resource use measures are calculable and usable and translatable into meaningful reductions in spending and quality improvements on the quality measurement side.

So I think you are correct that it is more challenged but I do believe that I think the convergence of the thinking about the national insurers -- and many regional insurers that have gone down this road -- is that it is indeed feasible.

MR. HACKBARTH: It remains an area of interest and a question for me. We've been looking at the episode grouper tools as an example of how you can assess total costs for particular types of cases. And that's been very interesting to me. But I must say that based on what I've seen to this point I still have some reservations about those methods and the attribution and how well they would fly in the Medicare public policy context as a tool for measuring total resource use by individual physicians.

That's not an answer. I'm not quite there yet that I have oh, we know how to do this.

MS. BEHROOZI: I also appreciate the conclusion that you drew, Cristina and Jennifer, that it's not the size or the structure of the entity. And having spent quite a lot of time reading Dr. Casalino's paper last time, I can understand why you would come to that conclusion but what they do, the behavior.

I have a question about a comment that you made in the paper. Maybe it has some relationship actually to what Glenn and Arnie were just discussing. I'm not sure. You note that there's a study that shows that patients managed by family practice physicians have also been found to use fewer resources. I don't know if there's more information that you can give us from that study. Maybe it goes to the issue of how to measure in a smaller context. I don't really know what that means in terms of size and structure of the practice, whether you're talking about individual family practitioners or what that might show us?

MS. BOCCUTI: I think, connecting the dots a little bit -- and maybe I should do this more in the paper -- is that multi-specialty practices are more likely to have

primary care providers. So when they are part of the practice, is it that they're multi-specialty? Or is it that they have family practice involvement? Or what it is? But that's a connection that was not studied directly by the report.

But when you think about okay, this study showed that family practice, when they are involved, they have a better resource use or at least a more efficient one. And then you think, connecting the dots, that multi-specialty practices have these where single-specialty often do not. You sort of make this connection.

But that would be us making the connection, not so much the literature. But I'll see what I can do.

Does that help?

MS. BEHROOZI: I think it's just your question about what are the desired activities. If it is in the context of multi-specialty group practice, then maybe it's worth making that an express criterion.

MS. BOCCUTI: It could just be having a main physician. Like that's part of what the -- if we would classify that as an activity. That kind of gets into the pseudo-medical home, whether there would be an agreement

between the beneficiary and the practice, and if they had a specific doctor and how that would work.

We could discuss that being an activity, this kind of verbal soft kind of contract.

MS. HANSEN: This relates to the connecting of the dots further. I really appreciate this and especially the policy implications on this last page.

I wonder if there's been any research done on say a well-managed, the outcome aspect, the well-managed comorbidity patient who is 85 years old, somebody who has congestive heart failure, diabetes and some of these other multiples, and the people who don't go to the hospital.

Is there a way -- and I don't know if the data is available to track backward on the other side, rather than coming from the physician side, when you have people who don't use resources very much but do have these diagnoses? And coming back at it from just another way to look at what were -- what these pieces of care management and quality improvement activities are processes, but going back to the outcome of when somebody's well-managed what does their medical utilization profile look like?

And so it's just coming from a different end of it

rather than looking at it from the billing side of the physicians that way.

So I don't know whether that's available but it just fills out the side of looking at people who are well-managed and may actually use very few resources, what their physician profile ends up looking like. So it's a backwards look. And it relates, Glenn, to the whole aspect of episode groupers, which is another way to try to get at it. And I know this is kind of a softer area right now, but it just does fill out a picture coming from a patient side.

DR. BORMAN: Just a quick comment and question. I'm struck here that we have a fair amount of inferences about the sociology of the providers involved, predominantly physicians. I think an important piece that maybe we're not considering is the sociology of the patients. I recognize that the data about those are probably even softer, but there is a reason why certain kinds of patients pick certain physician structures to interact with. A small physician office is a lot less intimidating to some patients than is walking into a very large clinic building with multiple floors and multiple doctors.

And so I think that anything that we could sort of

-- I think some statement that there may be sociology on the patient side may have some merit in the discussion a little bit. I don't know that there are the data to answer but I think it is an important factor that we shouldn't leave out of the equation.

MR. HACKBARTH: Thank you. Well done.

Next up is physician outliers and episode groupers.

MR. BRENNAN: Good morning.

As you all know, the Deficit Reduction Act mandated MedPAC to produce a report on alternatives to the SGR physician payment system. One of the five mandated areas of analysis was a payment system that would key off the identification of physician outliers.

Today, we'll be presenting some findings related to our work examining the physician outlier issue.

First, Cristina has some slides that attempt to give you an idea of the overall magnitude of physician outliers in Medicare. Following that, I'll present some of the technical issues involved in identifying physician outliers as part of our ongoing work using episode groupers and Medicare claims.

With that, I'll turn it over to Cristina.

MS. BOCCUTI: By definition, outliers are considered extremely unusual observations that fall well beyond the general pattern of a distribution. So considering that, we have to ask ourselves two initial questions regarding the SGR alternative: how much spending and how many physicians would be affected by outlier payment policies? And would such policies capture enough dollars to warrant the effort needed to implement them?

So to explore these questions we examined Part B payments to individual providers in 2005 to identify outliers within specialties based on per beneficiary spending. This exercise is conducted simply to get an overall sense of total spending on outliers. It's not a mechanism for adjusting payments.

On this slide, it shows how the outliers were determined. So on the X axis we have spending per beneficiary and on the Y axis we have percent of physicians. So for each specialty we calculated mean per beneficiary spending, which is shown there with the green line.

Doing so controls for the size of physicians' Medicare caseload and spending differences among different

specialties. We also adjusted payments to control for payment differences due to input prices, which is a geographic adjustment to those input prices. If we define outlier physicians as having per beneficiary spending that is at least two standard deviations above the mean for their respective specialities, then outliers make up all the physicians to the right of that yellow line.

So how many physicians fit this definition? And how much money did Medicare pay them in 2005? For this slide we've put all physicians on the chart so the X axis is payment relative to their specialty mean and the Y axis is still percent of physicians. So for the outliers, we totaled Part B payments, which came to 4.6 billion, which is about 7.5 percent of Medicare's total physician payments in 2005.

And on the bottom right you can see that 1.9 percent of all physicians billing Medicare had per beneficiary spending greater than two standard deviations above the need for their specialty. So obviously, if you lowered the threshold for defining an outlier, the totals would increase.

This slide is an exercise that examines very

general scenarios which lower outlier payments. If payments for outliers were more reduced to the specialty mean, then the maximum savings would be $3.6 billion, which is shown in the green lines.

Savings would be about $1 billion less if spending for outliers were reduced to one standard deviation above the mean, as shown in the orange.

If Medicare were to implement an outlier payment policy, the methodology for identifying outliers would have to be accurate enough to account for physicians who regularly see particularly high acuity patients and patients with extremely rare diseases. This exercise, of course, does not account, for example, for subspecialists.

One method for identifying outliers could be to examine resource use within care episodes. So Niall's discussion explores the use of episode grouper programs to identify outlier physicians.

MR. BRENNAN: As you all know, we've been engaged in an evaluation of two commercially available episode groupers over the past year or so. Because these groupers can be used on large amounts of claims and can group claims into clinically distinct episodes of care, which can then be

compared across physicians, they seem like they could be an important part of a physician payment policy that keys off the identification of outlier providers.

Indeed, these tools are used by many health plans in the private sector to identify high and low performing physicians, mainly for the purpose of tiering. For example, patients who see physicians who have been identified as high resource use have to pay higher co-pays.

In the remaining part of the presentation, we'll focus on some of the technical issues that have to be faced in calculating individual level physician scores before concluding with some distribution of scores for several specialties in each of the six MSAs where we have been processing 100 percent of Medicare claims through the groupers.

Once an episode has been created, in order to foster system of accountability that episode has to be assigned to a responsible physician. Ultimately, physicians will be assigned multiple different types of episodes and their overall score will reflect their individual scores of these episodes.

For this analysis, we used a threshold of a

minimum of 35 percent of E&M dollars, evaluation and management dollars, in order for an episode to be assigned to a physician. That is, a physician needed to provide at least 35 percent of the E&M-related dollars in that episode in order to be assigned that episode.

However, I want to stress that this particular official was chosen for illustrative purposes only. Some of you might remember from our June report or from presentations earlier this year that there may be other approaches to attribution ranging from thresholds different to the 35 percent chosen in this analysis to permitting attribution of a single episode to multiple providers. Indeed, Glenn has already raised the attribution issue already this morning.

In general, we were pleased with the number of episodes that could be attributed to a physician. Across all episodes, 80 percent could be attributed to a physician. For certain conditions, such as sinusitis, attribution rates are much higher, in the mid-90s. We were also encouraged that the attribution rates from the 100 percent analysis we're talking about today using the ETG grouper were similar to those from the 5 percent analysis using the MEG grouper

that we presented to you back in March or April and included in the June report chapters, I guess an internal/external foundation type thing.

Once individual episodes are attributed to providers, we then aggregate all episodes provided by a unique provider in order to construct a caseload of all the care provided with by that physician. It is from this sample of physician level episode totals that the final pool of physicians to be measured will be defined, and against whom overall scores will be calculated.

There is general agreement among researchers that if you calculate resource use scores for a physician provider below some minimum threshold level of episodes, then there is a greater potential for error in the overall score that you calculate. Generally speaking, this minimum threshold seems to range between 20 and 50 episodes, depending on who is choosing to apply the threshold.

Of course, the higher you set the minimum threshold, the fewer physicians you will be able to measure in a given area. We found that with a minimum threshold of 20 episodes, we were able to capture 60 percent to 70 percent of most specialties in most markets, most physicians

in those markets.

Of course, this does raise the question of what should be done with physicians who do not meet whatever the minimum threshold chosen is. While it is true that they account for a small share of overall spending, because they do not meet the minimum threshold, they very well may be high resource use in the care that they provide. So one thing commissioners may want to consider is the ramifications of not measuring all of the providers in a given area.

Another issue involved in calculating an overall score for physicians is whether that score should be based on all the episodes that a physician provides or just the episodes that account for a clear majority of their practice. This is sometimes referred to as the market basket approach.

One can evaluate specialties and what they do most frequently and eliminate any potential confounding results that might be brought about by incorporating scores from low volume episodes. For example, a cardiologist might be low resource use in treating coronary artery disease because it's a condition that reflects his chosen area of specialty,

but he might be high resource use on a low back pain episode because he's unfamiliar with the most efficient treatment protocols for that particular condition, yet a patient has presented themselves with this to him.

In order to assess how much dispersion there is in practice patterns by specialty, we analyzed the most frequently occurring episodes for a range of specialties. Not surprisingly, the type of episodes seen by specialties such as general practice and internal medicine are quite diffuse, whereas other specialties are significantly more concentrated. Only three types of episodes account for more than 80 percent of all episodes seen by dermatologists, whereas the corresponding number of episodes that account for 80 percent of all episodes for internal medicine physicians is more than 70. Urology and cardiology are other examples of specialties that have the majority of their total episodes and dollars concentrated among a small number of discrete types of episodes.

Once we have attributed episodes to providers we can then calculate expected values and compare each physician's costs for a given episode to the expected value. For example, a physician with an episode of type 1 diabetes

has the costs for that episode compared to the average for all type 1 diabetes episodes in that MSA. If a physician's costs for a given episode were $120 and the expected value for that episode was $100, the physician's ratio or score, if you will, for that episode will be 1.2 and there will be multiple scores for multiple episodes.

However, this raises the question of what the comparison group should be. Should physicians be compared to national, regional or even subregional expected values? Further, should expected values be calculated within or across specialties for each episode type? Specialty-specific expected values could be thought of as a proxy for risk adjustment, the idea hat some specialties might see more severe manifestations of certain diseases than others. While the ultimate goal should be for all physicians to treat patients efficiently, in the short-term holding physicians accountable to a national expected value might be unrealistic and might hinder physicians' acceptance of episode grouping approaches. In using some form of subnational expected value, physicians could be introduced to the concept of being measured against the performance of their peers without being compared to set of peers who may

practice medicine in a significantly different way.

Another issue that needs to be thought of is whether or not observed-to-expected ratios should be weighted in any way. This is something that has cropped up in previous presentations where we've attempted to present composite scores. For example, should ratios for episodes that a physician performs most frequently receive a heavier weight than episodes that are performed infrequently, in light of the findings in the previous slide? While weighting ratios does have a certain intuitive appeal, the process of assigning weights is inherently subjective and would, in all likelihood, lead to disputes as to whether or not the weights were being applied appropriately.

I have a couple of tables to walk you through now and these tables reflect the distribution of overall cardiologist and urologist scores by MSA. Just to walk you through the table, obviously the MSAs are going down on the left, and then across on the right are percentile cut points representing overall physician ratios. So if a physician had 20 episodes and an observed-to expected ratio of 1.0 on all of those 20 episodes, their overall score would be 1.0.

Again, some of the other things I've talked about

might lead to weighting and the different things like that, could result in a slightly different score. But for right now, we're taking a fairly basic approach.

For this analysis we calculated a within-MSA episode-specific expected value. Each physician's score on each episode was aggregated into an overall unweighted score for that physician. We then examined overall average scores by specialty in each MSA.

If you look at the table, you can see that 25 percent of cardiologists that could be measured in the Boston MSA have an overall efficiency score of 0.75 or better, meaning that across all of their episodes they are 25 percent more efficient than the average physician in Boston. At the other end of the spectrum, 10 percent of the cardiologists that could be measured in the Boston MSA had an overall efficiency score of 1.44 or worse, meaning that across all of their episodes they were 44 percent less efficient than average in Boston.

These patterns are relatively consistent across MSAs, although the average physician score at each percentile does differ somewhat, most notably at the 90th percentile in Phoenix, where doctors above this threshold

are at least 62 percent less efficient than average.

This table presents a similar set of scores for urologists, and we can see some slightly different patterns across MSAs here. Urologists in Miami and Orange County, in particular, are having a wider distribution of resource use scores than cardiologists in the same area from the previous slide.

In conclusion, we continue to move ahead in refining our analysis. We feel that episode groupers are a useful tool that we're going to continue to explore both in relation to the physician outlier component of the SGR report and physician performance measurement generally.

We'll be back in December with more detailed physician level analyses that will incorporate risk adjustment and a closer look at how an individual physician's overall scores might be calculated, complete with information on the physician's scores on their individual episodes and the ability to drill down or target high resource use episodes to try and identify the practice patterns that are leading to high resource use.

In addition to some of the technical issues that we've presented here today, we'd also appreciate your

feedback on how a physician outlier policy might be incorporated into a physician payment system. These policy directions range from confidential physician feedback to educating physicians or establishing corrective plans of action in order to change their practice styles. More interventionist approaches might include public reporting of physician scores, differential payment rates, or payment updates and recouping any excess profits that might have occurred as a result of an excessive practice style.

Tomorrow Kevin will also be presenting some ideas on how you might combine an outlier approach with other approaches.

We'd be happy to answer any questions.

MR. MULLER: Niall and Cristina, I don't think anybody of us is surprised specified that there's variation in physician practice in America. We've heard a lot about that. I don't quite understand where this takes us without any measures of outcome, because we've also discussed that in previous years, as well, in terms of the difficulty of getting those measures of outcome, especially physician-by-physician.

But could you help me understand how far we can go

on this without those kind of measures of outcome?

MR. BRENNAN: I guess we're pursuing two different tracks, in terms of outcomes. You might remember in the 5 percent analysis we did apply some algorithms that we've developed of claims-based quality indicators. So that's one area that we're looking at. We know that they're not perfect, but they're certainly a place to start.

We also are going to work with the folks who produce the ETG grouper. They have produced a quality component add-on to their software called EBM, I believe that's Evidenced-Based Medicine, that also checks for -- it's not outcomes, per se, but it will look at that the rate at which physicians are adhering to evidence-based practice guidelines.

But you're right, and I think we've always said that any evaluation of efficiency has to include both resource use and quality.

MR. MULLER: I think Nick, among others, has been very forceful in pointing out that effective physician practice can avoid costs elsewhere in the system. So you might be able to pay out a couple of standard deviations up -- and I think Arnie's made the point as well -- you might

be able to pay a couple of standard deviations up for people who avoid costs of institutionalization or readmissions or can manage chronic care in a more cost beneficial way.

MR. BRENNAN: One of the things about the episodes is that strictly speaking you should be able to identify physicians who practice in a style that results in fewer hospitalizations than other physicians because we're not just looking -- we're looking at the full continuum of care, Part A, hospital inpatient, post-acute care, and Part B physician services.

DR. MILLER: Just so everybody follows that, so that if the physician did, in fact, avoid a hospitalization, they'd be more likely to be in the middle of the distribution instead of at the tail because both sets of data are captured, or both sides of it.

DR. REISCHAUER: But we get into the Miami/Minneapolis problem from last time, which is if 23 percent of the population has chronic heart disease in Miami and only 11 in Minneapolis, is that the underlying distribution or not?

DR. MILLER: But I think what Niall was driving at in some of his closing comments was that perhaps a starting

place for this is to go inside the market area. inside the condition, and inside the specialty so that you sort of say okay -- and then also, he's also got other work in progress on sort of looking at how you can do overlays of risk adjustment here. So we haven't ruled that out but we're not able to speak to it yet.

But if somebody said tomorrow you have to do this, one place to start might be inside the area, inside the condition, inside the specialty with the notion that that at least captures some of what might be related to risk. And I think Niall was driving it that at the end of his talk there.

MR. HACKBARTH: John, I think, has said that, in fact, that's how at least Humana applies it.

MS. BURKE: I want to ask a question following up on Mark's point, and I apologize if this came up while I was out of the room.

Help me understand, and I don't know how frequently this occurs, but depending on the specialty, help me understand the attribution issues as they relate to hospitalists, the extent to which there's a handoff that occurs for an acute episode and then a handoff occurs again.

And as you track attribution for the management of that particular patient over that period of time, how does the attribution rule work in that kind of a scenario, as compared to folks that are seeing people out of the hospital.

And I don't know how prevalent that is. It's certainly limited to certain kinds of specialties. But I wonder if that's an issue or one that lends a complexity to this?

MR. BRENNAN: I think it might be potentially an issue. The way it's done is that we look at E&M dollars on physician fee schedule claims. So to the extent that a hospitalist is submitting physician fee schedule claims, and if they exceed the 35 percent threshold, then they would be assigned to the episode. But to the extent that they're not, they wouldn't. And a physician in the community instead would be attributed that episode.

MS. BURKE: But if the goal over time is the episode, this sort of full management of the patient throughout the period of time that they're being treated, arguably there are certain aspects that each of them can control.

MR. BRENNAN: Absolutely. I didn't want to get too much into it for the purposes of this presentation. This is why you could have probably several multiple hour-long presentations just on attribution and how you do it. We picked 35 percent and we said let's just go with this and generate some scores and see what they look like. But in the report we said 35 percent might not be the right number. You might need different thresholds for different conditions. And for some things you might need multiple attribution.

The only cautionary note there is that the more approaches you take, the more complex it becomes and the more --

MR. BERTKO: Niall, on that point, if I can add for Sheila's benefit, only about 25 percent of Medicare beneficiaries have one or more admissions during the year. So while that's an issue to consider, we're also dealing with the 80 percent of beneficiaries treated by physicians who have no admissions.

MS. BURKE: [Inaudible.]

MR. BERTKO: Yes, of course.

MS. BURKE: You're absolutely right. The ratio is

clearly on the outpatient side but, in fact, the highest cost drivers are on the inpatient.

DR. KANE: If the physician in the community doesn't ever talk to the hospitalist and the hospitalist never talks to the physician in the community, they might well end up in the higher cost end. Just because you turn over inpatient authority to a hospitalist doesn't mean your responsibility ends in a good care system. In a poor care system, the responsibly ends but that's when you start losing information and losing the -- so I don't think the hospitalist piece, anymore than turning them over to a surgeon for the inpatient care, should necessarily absolve the primary care person --

MS. BURKE: And I'm not arguing that it does. My only question is how you -- One of the issues that Niall very correctly points out and the paper correctly points out is the whole point of this is how do you develop credible information that you can then use to alter people's behavior?

And the credibility will come with are you reflecting what it is that I can do? You're absolutely right, there ought to be a relationship that exists. The

whole concept of turning somebody over in and then saying not my problem, come see me when you're done, is crazy. But it is a question of can you accurately reflect decision points and then reflect are you, in fact. talking? Are you, in fact, managing this patient appropriately? That's really the question.

MR. BERTKO: Naturally, I have a thousand things to say, so I'll limit it to 10.

First of all, I wanted to congratulate Niall and Cristina for doing a lot of good work. I'd like them to go back to slide five. I think they've answered one of the questions at least to my satisfaction.

Is it worth doing this? That 4.6 billion is a lot of money. Cristina, I need to ask, is that Part B only or Part A and B?

MS. BOCCUTI: It's Part B only.

MR. BERTKO: So then I would suggest doubling it, as a rule of thumb, because the Part A stuff is generally 50 to 60 percent of total Medicare costs and at least on the private sector side, for under-65 people, we've found that relationship continues to hold.

Next, I guess I'd like to say that there's good

news here. Look on the left side of the graph. 70 percent to 80 percent of doctors practice in a very tight band around the mean. That's great news. The folks that we should be concerned about are the ones in the outlier region over there.

And then to add to that, I would suggest -- only this editorial opinion -- somewhere between the first and second deviations might be the right cutoff point. It varies by specialty. We seem to think it's 20 percent to 30 percent of physicians are the ones that you should try to be looking at. So the numbers there are quite large.

The third point I'd make is that I'm really happy that you validated with public sector data with a more or less transparent practice what the private sector has been doing. Your data here more or less matches what we're seeing. And I think it's important that we do that in a transparent way so that it be understandable to physicians whether or not they are agreeable to it.

So Glenn, your skepticism is certainly well deserved. And when you go to the next step, which perhaps was what Sheila and Bob were asking about in the last one, you can conceive of a scorecard based on this kind of data

that can be relatively simple. We've used this particular approach, we've had our Ph.D. stand out in front of groups of doctors and say here it is, by the way, we can give you a scorecard showing the reason for your score is you used 200 percent of the average lab use compared to your peers in Big City, Texas, in cardiology or dermatology.

That's the answer. And then the biggest question of all is what Niall has put at the end here, is where do we do that? So confidential to the docs.

I would suggest, and I think Arnie would agree with me, that the moment this is done, there will be an enormous demand from the employer side to say well, tell us what the answers are. And we need to be ready to face that, as well as from say the group physician practice managers, the leadership group that Nancy's trying to train. And Nancy, I hope you get every single potential leader.

I think I limited it to five.

DR. REISCHAUER: Thank you for leaving me five.

My basic question was going to be the one that Ralph asked. I think this stuff is fascinating and where it leads who knows, but we're getting a great education, I think, on this trip.

I was thinking can you look at the standard deviation of the range within any physician? Do people who are on average, who practiced inefficiently, for a third of their cases, they're very efficient. We've got a lot stronger case if they're just generally inefficient for virtually all of their cases.

The other thing is do we know anything about looking over time? This does have a time element. But as you expand the length of time, does the variance here go down significantly or not?

And then I think what Sheila was getting at, it would be interesting to look at the correlates of efficiency and inefficiency, that the hospitals that are the most inefficient or most efficient generally send their patients to. Age, is this something that gets better over time? Are they part of a multi-specialty group practice or not?

What it will do is sort of lead us to some ideas about how to operationalize some of this, what other levers should we be pushing on? Should it be having Nancy teach them all? Should it be encouraging them to get into multi-practice group specialties? What?

DR. CROSSON: Just a couple of comments on the

sizing of this. I'm not sure I agree completely with John here. I think if you look here on slide five, it's 4.6 billion and you can multiply that if you add other parts of Medicare payment. But that's only assuming you make it disappear.

MR. BERTKO: No, return it to the mean.

DR. CROSSON: If you look at the next page, if you look at page six, I guess if I were drawing this I would have assumed that you would be aiming to take it back to the second standard deviation.

MR. BERTKO: No.

DR. CROSSON: I guess that's the issue. But even if you decide that we should take it back to a place between the first and second standard deviation, I think the number is going to be less than 4.6.

The last point I would make is however valuable this is, and I'm sure it has value, I believe the value would pale beside moving the whole curve to the left. I think a lot of the other thoughts that we we're engaged in are fundamentally that.

MR. BERTKO: I obviously need to reply. You're right on this, the 3.6 billion starts at double it to get

the Part A stuff in, so you have 7 billion of potential. One way to do it, the way that most health plans do it, is you don't have those doctors available. So they go to the rest.

There is no reason to be satisfied with having the same appropriate amount of care, no stinting, but moving the cost of that care to the mean.

DR. REISCHAUER: Just to reemphasize that, when you look at Phoenix, the most inefficient area in your data, but then see that the 10th percentile is down at 50 percent of their mean, you realize whoa, there's a lot of room here if we can be comfortable that the care they're providing is high quality care.

MR. BERTKO: Right.

DR. CASTELLANOS: As a practicing physician, I really like this proposal. I think it holds a lot of promise, especially using the episodic groupers or whatever method to provide the physician with confidential data that allows him to compare himself to other people.

I'll be honest, I bet you some of those outliers, that 1.9 percent, don't even know they're outliers. They're out there thinking they're doing the best job in the world

and don't really recognize that perhaps they're not using resources appropriately. So I think this really has a lot, a lot of potential.

We need to make sure that the data that's provided to them is accurate. My only suggestion is you need to get the physician community involved right from the get-go to get this data together.

I think this is important, rather than applying targets. What Nick said earlier, and I would hope MedPAC would reaffirm their 2001 recommendation to replace the SGR using the expenditure targets with perhaps an updated process based on physician costs. We're not asking you to do anything different than what you do to other providers.

I'm concerned with the here and now rather than we're talking about potential things and when this is all going to get implemented. I'm very concerned over the here and now.

On the forefront, we have a 5.1 percent cut, together with all the other cuts. And there's been a lot of communication in the physician community that there may be an access to care to the Medicare recipient. I think it's real, that threat. And I think the cost of doing nothing

now or doing nothing at this time is very great.

DR. MILSTEIN: I wanted to speak in support of Ralph's point and a point made by several others that we shouldn't even remotely consider this being the single basis for any kind of a formula for SGR escape. It needs to be balanced, include quality, and from my perspective include some of the high potency ingredients outlined in the prior presentation, like credible means of care coordination, credible IT system to support longitudinal management. I'm not sure there's much disagreement on that point but that's my sense of what might work.

Secondly, we are going to, out of respect for physicians in smaller practices, we do need to begin to think about if this is an escape route from SGR for making sure that on a specialty specific basis the minimum number of episodes per -- I'll call it escaped physician unit, whether it's a single doctor or 10 doctors -- be what current research suggest is the number of episodes you need for statistical stability. I think the evolving research suggests that it's specialty specific. It isn't just 20. It might be 20 for some, it might be 40 20 some. There's other specialties.

So we have to understand what the current research indicates is a statistically stable minimum number of episodes per unit and make sure that on a specialty specific basis we've assured that for doctors so that we're not holding them accountable for noise, that we're holding them accountable for signal.

And last, as I look at this number and again go back to this issue of what's the job that beneficiaries need physicians to lead in this country, I want to reinforce some of the earlier points. It's not about getting all doctors who are in the tail and for which there's no good reason for them to be in the tail to stop being in the tail. It's basically to begin to set a mark for excellence such as top quartile performance, and then begin to think about rewarding physicians, whether it's through escape from SGR or P4P or both for physicians who can bring their quality and their resource use scores up to a point where their scores are not statistically different than, for example, the top quartile.

And that's my vision for how you could get to this very tight distribution. And from the beneficiaries point of view, a distribution that continuously shifts to the

left, if we're going to offset the cost additive effect of the biotech pipeline which is coming at us at apparently a higher rate in terms of its cost additive impact.

DR. KANE: One was a technical question and then a comment. The technical question is when you end up dropping out 30 to 40 percent of physicians to get them into the 20 episode threshold, how many outliers do you drop out? What's the correlation between that and are you going to lose all of your outliers because they don't do that many episodes? And have you checked that yet? I don't know.

And then I have a comment.

MR. BRENNAN: I'll give you a partial answer. All of the episodes have been already trimmed for outliers by the time we get there, on an episode-specific basis. So we look at all the diabetes episodes and we take off diabetes episode outliers, hypertension episode outliers.

Now some people think that instead of eliminating them from the analysis you should just -- I think it's called winds rising -- and take them down to the 95th percentile or whatever. Again, this is not set in stone.

It's possible that some of the physicians who don't meet the threshold are outlier physicians. But then

you get into the measurement and precision issues that I talked about. And even after excluding those you still have a pretty -- for most specialities it seems to go from 0.5 to 1.5 or 0.6 to 1.5.

So you're still getting a reasonable distribution, I think.

DR. KANE: Although you may well be missing those outliers that we were focusing on in the other study. I'm just wondering if you can tag those people and say in which episodes are we capturing them or not? By virtue of the rules we've created to create episode-based evaluation, are we automatically eliminating the 4.6 billion people? I don't know.

MR. BRENNAN: Also, we should make it clear that these were two separate analyses and Cristina's was focusing just on Part B, whereas the episode analysis was focusing on all dollars.

DR. KANE: I would just want to be assured that we're still capturing the outliers.

The other comment goes back a little bit to something that Karen mentioned, that the beneficiaries should also be part of this equation, and not just on the

basis of information. But once -- I noticed on the last slide the options for addressing SGR. Might we want to consider tiering and copay differentials to steer beneficiaries in the fee-for-service system towards the physicians who are going to be more cost effective and quality -- that's not even on the list right now, the beneficiary piece of it. But I think it should be at least talked about, even if we decide to back off because we don't know enough.

But if were going to go after -- I mean, having parents in Florida who are, I just think physicians are in feeding frenzies for fee-for-service Medicare patients with good secondary. And it would be helpful for them to know, for instance, who to avoid. And so maybe a tiering structure and a copay structure that helps inform the beneficiaries and drive them more towards the physicians who are better profiled would be something to think about, sooner rather than later.

DR. BORMAN: Just a very quick comment. I think this is fascinating work and I think it's really well done. I understand all of the concerns. I'm a physician. I'm a surgeon. I'm trained to take things apart, and hopefully

put them back together, too. And yes, you can anticipate that you provide this information, and one of the things that many physicians are going to do is say well, tell me how you did it and let me pick apart your model and that kind of stuff.

But I also would tell you, I would not underestimate the power of right now taking this analysis at the level of precision that we have, albeit imperfect, and starting to provide that information confidentially. You don't have to tie it to anything. It is not, in and of itself, clearly the answer to SGR.

But is this something practical that could be put in place fairly quickly, fairly immediately and say we understand all the disclaimers, we've got lots of disclaimers about the nature of the information here, but here you go. Here's comparative information.

I think that would be huge step forward to endorse some short-term implementation of this kind of strategy.

MR. HACKBARTH: Let me to just leap in and pick up on that. I generally agree with that.

In this conversation we've heard multiple different uses mentioned. One is education of physicians.

Second is education of patients. A third is identification of outliers with some consequences attached to that exclusion, tiering or whatever. Potentially as an overall performance assessment, presumably attached with some opportunity for gainsharing.

As you move down that list I think the level of precision required increases. If we're talking about confidential disclosure to physicians, I think you're talking about a very different game than if we're paying out trust fund dollars based on presumed savings where I think there would be -- or financial punishment if you're in the high end of the distribution. I think when you're down at that end of the continuum, the standard of proof is much, much higher.

So just to be clear, despite my earlier comments to Arnie, I think that this is a promising area particularly with regard to education of physicians and confidential disclosure. It's when you get to the other end of the continuum that I'm not sure whether it works or not. That's not an answer that it doesn't, it's just that I've got some unresolved questions and anxiety about it.

I also think that when you move from the private

payer setting to the Medicare setting there's a different dynamic. In part, that's just perhaps attributable to more dollars being involved based on the decision for many physicians because Medicare is a bigger share of their practice. But you also get into that this is a political process. It's more vulnerable to legal challenges of various sorts. The decision making mechanisms are just much more difficult and cumbersome than they are for private payers.

So I think this is potentially promising and we ought to keep pushing ahead. I feel perfectly comfortable with the recommendation we've already made that CMS ought to develop these tools for confidential education of physicians. It's just how far and how quickly we can move down that continuum. That's where my questions are.

DR. SCANLON: This comment relates very strongly to what you said. As we've been hearing about different potential applications, I think we do go along a scale in terms of what we really need to demand above the measures. The dimension that I would add to this is the issue of timely, that if we're talking about payment in particular, people are not going to be very happy if their payment is

based upon experience several years back. I think we need to, as we think of other applications, think about when will we have the capacity to be able to give this kind of feedback and use it for other purposes besides the confidential feedback that can be a bit remote? When will we have the capacity to do it on a timely enough basis? I don't know what the timely enough basis is, whether a year's lag is fine or a year-and-a-half or something like that.

But right now we really do have this problem of assembling data and being able to say what's actually happened within Medicare.

DR. HOLTZ-EAKIN: I wanted to just say thank you for all the good work and to echo that I agreed with your five, John, and your five, Bob. Especially the idea of looking within the physicians to see if they're uniformly good guys or not.

The other question I have, and I confess my feelings as a commissioner, I can't keep track of all the demos and pilots that exist in the universe. I think it would be fascinating if there was some live data and actual claims out of one of the good care demos, pay for performance or group practice or anything, and you ran this

on that. Do you get the same distributions? Do you get the same behaviors that we're finding in the broad pool in these things which are targeted to provide better care?

I don't know the answer but I think it would be interesting if you could do it.

DR. WOLTER: I'm certainly fine with this and I have no doubt there are areas where attribution to individual physicians and comparative data coming back can make a big difference.

The part of this, though, that interests me the most is how do we connect it to the larger issue of tackling high volume high cost areas in the program? And in those areas more often than not the care of patients is a team sport. And that's, I think, a challenge in terms of how do we take this information and connect it back to some of the other themes that we've been talking about today? But there's so much opportunity there if we can find a way to it.

MR. HACKBARTH: What I imagine would happen or the goal would be that if you feed this back to individual physicians, focusing initially on the high volume very costly things that if a physician sees that they're

consistently at the high end, costly end of the distribution, the question you want them to ask is am I using the right specialist consults? Is the hospital doing something wrong? And you try to get them to engage in a conversation.

So this is an analytic tool for trying to impose some order on what is often a chaotic set of relationships. And by using the analytic tool I assume the goal is to get people to think more systematically about their relationships with other providers.

Now that's a stretch. That's not a cinch to make happen. But I assume that's the goal here.

DR. WOLTER: I was even thinking that if we do try to create some incentives around virtual groups or units coming together to take better care in terms of coordination costs, quality measures, this information could be invaluable when you have those units that have come together. Because then you can connect the hospitalists with the outpatient physicians. Some organizations can even break their data down in terms of how many x-rays are being ordered for a certain episode and they can really start to work with the data. So I think there's a lot of value

there.

The other thing I forgot to mention, and of course this is the thing that's so hard and I don't how we get our arms around it, but the issue of appropriateness and utilization in volume is so hard to analyze in all this. Even if we can start to deal with the episode and the quality measures and the cost of an episode, which of those episodes could have maybe been prevented? Which are inappropriate because of care that was delivered that maybe wasn't necessary? And we kind of saw that a little bit in the Minneapolis/Miami example last month. That appropriateness issue is very hard to analyze.

MR. HACKBARTH: What I'm wrestling with, I take Arnie's point back in the earlier discussion very seriously about we don't to lock people into particular organizational models. We want to identify great care and reward it, whatever organizational form.

Instinctively though, I can more readily see this information being used by an organized delivery system of some sort for self-improvement than individual physicians in an atomized, unorganized delivery context taking it and say I'm going to get my specialists to behave differently or I'm

going to get the hospital to behave differently. If there's an organizational context for it, it just seems like it's a much cleaner shot to me.

DR. WOLTER: I think that's especially true again for these complex illnesses and the more complicated episodes. Of course, since that tends to be where the cost is, it would be a great place to put some emphasis as we try to find ways to use this information.

DR. MILSTEIN: On this point, I agree with the point that you're making and I think that additionally we need to consider the reality that across other industries smaller units of aggregation tend to be more agile and more innovative. So we're balancing two very valid points. And I very much accept the validity of what Nick and you were saying.

MR. HACKBARTH: All right, we're finished with this.

We'll have a brief public comment period before lunch.

MS. MARRONE: I'm Barbara Marrone from the Emergency Physicians.

I've been following this discussion over the last

few months, along with the demos from CMS and some of the other efforts. And one of the things that's difficult is if you're in a specialty that's not really going to fit into this model of attribution, it would be helpful if at least the heterogeneity of physician practice was recognized somewhere along the reports and the analysis because I'm not sure how emergency physicians and some of the other specialists that don't fit into the models, which is rightfully focused on high-cost high-frequency high-volume conditions, how they're going to escape from the SGR. Are they just going to sort of sail along on the proverbial coattails of other docs who learn how to handle this better?

I'm just not sure and it would be helpful if we'd get a little guidance for other types of specialists.

Thank you.

MR. HACKBARTH: Okay, we'll adjourn for lunch and reconvene at 1:15.

[Whereupon, at 12:01 p.m., the meeting was recessed, to reconvene at 1:15 p.m. this same day.]

AFTERNOON SESSION [1:17 p.m.]

MR. HACKBARTH: Next up is the mandated report on payment changes for Part B drugs.

DR. SOKOLOVSKY: Good afternoon. Beginning in 2005 Medicare implemented a completely new way of paying for physician administered drugs based on the average sales price. This new system not only reversed the trend in spending for these drugs, which had been growing at a rate of more than 20 percent annually, but actually resulted in a decrease in Medicare spending. Congress directed MedPAC to evaluate the effects of this new system on beneficiaries and physicians. Today we are presenting results from our second congressionally mandated report on the impact of these changes.

For this presentation, I will first present our analysis of changes in volume and expenditures for Part B drugs in 2006. Next we'll look at how physicians from different specialties reacted to the payment changes as well as more general changes in physician practices. We'll then return to an issue which some commissioners had expressed interest in, shifts in where beneficiaries are receiving care.

Commissioners also expressed interest in two drug payment issues, how discounts are allocated in ASP calculations when products are bundled together and the use of least costly alternative to determine payment rates for some prostate cancer drugs. And we will discuss these issues, as well

Last year we studied the effects of the payment changes on chemotherapy services for Medicare beneficiaries. As you may recall, we found that access to chemotherapy remained good but that some beneficiaries without supplemental insurance were more likely to be sent to the hospital outpatient department to receive chemotherapy.

This year we have been asked to study the effects of the changes on other specialties that provide physician administered drugs. We have focused on the experiences of urologists, rheumatologists, and infectious disease specialists.

We have also continued to meet with oncologists and beneficiary advocates to continue to track access to care for beneficiaries needing chemotherapy, and our analyses have combined claims analysis with interviews with physicians, practice managers, hospital administrators,

specialty group associations, wholesalers, manufactures, and other stakeholders.

As you can see from this slide, Part B drug spending is concentrated in a few specialties. Oncologists who provide chemotherapy to cancer patients account for more than 50 percent of all Part B drug spending. On the other hand, infectious disease specialists account for less than 1 percent. Much of what's included under the rubric of other are drugs that go through pharmacies and DME suppliers. In general, most specialties except for oncology use a small array of drugs. For example, rheumatologists are the main suppliers of infliximab for treatment of rheumatoid arthritis, and urologists provide more than 80 percent of drugs used to treat prostate cancer.

Total spending for each of these specialties on all services, which includes visits, drug administration, other procedures and tests, increased for all of the specialties but drug spending fell for each one of them.

The decline for drug spending ranged from only 1 percent for rheumatologists to 52 percent for urologists. A large part of the reduction in spending was attributable to lower prices under the ASP payment method. That is, ASP

resulted in substantial price savings for Medicare on nearly all drugs and these payment rate changes drove decreased spending. Part B drug spending fell from $10.9 billion in 2004 to $10.1 billion in 2005, which was the lowest amount since 2002.

In the last slide I showed you what happened to expenditures. Now I want to shift to the amount of drugs provided to beneficiaries. Here we talk about volume which is measured by spending with prices held constant.

for most specialties, the volume of drugs provided to beneficiaries from 2003 to 2005 increased. The exception was drugs provided by urologists. Here volume fell 15 percent. Although infectious disease specialists provided more drugs in 2005 than in 2003, the volume declined from 2004 to 2005. However, because the total amount of drugs they provide is so small, small volume changes appear as large percentage fluctuations.

In last year's study, we found that much of the volume increase for oncologists reflected the substitution of newer more expensive drugs for older therapies.

Urologists provided 16 percent less drugs in 2005 than in the 2004. The decline was in the number of

beneficiaries getting drug treatment for prostate cancer. This decrease did not result in more drug administrations in the hospital outpatient department. And declines were greatest in practices that had been providing the most drugs previously.

There are a number of possible explanations for the decline, including changes in physician practice patterns and lower payment rates for the drugs making them less profitable.

Hormone suppressing drugs are used for the treatment of advanced prostate cancer. However, early screening in the past decade or so has led to more early detection and treatment of low-risk cancer patients and these people may never progress to the advanced stage. However, rather than use a watchful waiting approach, many patients with localized prostate cancer have chosen to undergo hormone therapy. In fact, the percent of patients with any kind of prostate cancer undergoing hormonal therapy increased from 12 percent in 1991 to 41 percent in 1999.

In recent years however, more research has shown that the drugs increase risk for heart disease and other conditions. These findings may have discouraged some use

where benefits have yet to be proven for low-risk patients. Also, some physicians have recommended that patients take a break from the therapy both to maintain the drug's effectiveness and to improve patient's quality of life.

Finally, physicians may have been discouraged by the lower profit on the drug from prescribing the drug for patients in cases where the benefits have not yet been proven.

In 2006, for which we still have no claims data, some physicians have told us that they've begun asking patients to get drugs -- not just prostate cancer drugs but also bladder cancer drugs -- at pharmacies using their Part D benefit and then have the physician administer it in the office.

Rheumatologists provide a small number of Part B drugs in their offices, mainly to treat rheumatoid arthritis. They continued to increase the volume of drugs they provided for this purpose and spending on their most important drug, infliximab, was constant. Most rheumatologists continue to provide the infusions in their offices. There are some self-administered drugs, now covered under Part D, that can substitute for infliximab,

which is an infusion covered under Part B.

Rheumatologists generally told us that these drugs are interchangeable for the conditions that they treat, although individual patients may do better on one product than another. Before Part D nearly all Medicare patients without drug coverage received infliximab because of Part B coverage. Now physicians may work with the patient to determine whether it makes more sense for them to start with a Part D or a Part B drug based on the patient's drug spending in relation to the coverage gap and the out-of-pocket limit.

Finally, infectious disease specialists provide far fewer drugs in their offices than do the other specialists we've discussed today. Additionally, they are never the main purchaser for anyone drug and the antibiotics that they use most frequently are used more often in hospitals. Thus, they never seem to have the market power to get the best price for any drug that they use.

Typically, infectious disease doctors practice in facilities -- for example hospitals, nursing homes and long-term care hospitals -- and only the largest practices have opened outpatient infusion centers. However, the model of

the outpatient infusion center provides some advantages to patients with infections and compromised immune systems who would otherwise be hospitalized and exposed to more infections.

The 2005 decline in the volume of drugs provided to patients in their offices suggests that once the provision of drugs became financially unattractive more practices shifted at least some services back to facilities where they had typically been provided.

In our interviews with urologists, rheumatologists, and infectious disease specialists we found that physicians had made many changes to their practices in order to become more efficient. Efficiencies included constantly monitoring drug prices, reducing drug inventories, paying quickly to get prompt pay discounts from wholesalers, scheduling patients to ensure that there was little downtime when practices were open, and reducing staff or staff benefits or sometimes changing personnel mix.

These changes are similar to those that we talked about last year for oncologists. However, because of the greater relative importance of drugs to the practice of oncology, oncologists have most affected by the payment

changes and much of what they told us this year is similar to last year, but efficient management practices have become even more important to them.

We found that larger practices were more likely to achieve economies of scale both for drug purchasing and overhead for their infusion centers. So for example, more infusion chairs keeps the costs per infusion lower. Large practices also were more likely to be able to employ specialists in drug purchasing, and individuals to help patients secure funding for their treatments if they couldn't pay their copayments.

One consultant told us about helping some small practices form a virtual network to accomplish some of these efficiencies of the larger practices, particularly for drug purchasing. Although we were not able to speak to solo practitioners, physicians in different parts of the country told us that they had heard of small practices that were no longer able to provide drugs in their office.

We also continued to hear about patients without supplemental insurance being shifted to the hospital outpatient department and this is an issue that the Commission expressed concern about last year. Sarah is

going to discuss it in greater detail.

MS. FRIEDMAN: In our interviews, we heard that more physicians had either started sending their patients without supplemental insurance to the HOPD to receive their infusions or were shifting the site of care for more of their patients.

We examined the associated costs of this shift to Medicare and beneficiaries by comparing the payments in doctors offices to the payments in the HOPD for high-volume drug regimens in each of these specialties. Our estimates are only a snapshot of the prices in 2006 and will change in 2007.

We found that neither setting is consistently more expensive. The difference in costs for the two settings ranged from $1 to $40. The small difference we calculated does not take into account two ways extra cost to Medicare may be incurred when patients are moved to the HOPD. The first is through the 70 percent of aggregate patient bad debt that Medicare pays. Second, duplicate lab tests and physician visits result when patients are moved.

DR. SOKOLOVSKY: To sum up our key findings, we found that the payment changes resulted in savings for both

Medicare and beneficiaries. Beneficiaries continued to have access to drugs and the volume of drugs provided in general has continued to rise. However, fewer beneficiaries received drug treatment for prostate cancer in 2005 compared to 2004.

The payment changes have had an effect on where some beneficiaries receive care. As Sarah said, beneficiaries without supplemental insurance are more likely to be treated in the hospital than other beneficiaries. As we said last month, we found that few common measures are available to determine if quality of care has been affected by the payment changes.

As you know, last month we discussed some issues related to drug payments and I'd like to review one issue here and also discuss another drug payment issue.

Last month we talked about a particular issue connected to ASP. Some manufacturers make certain discounts for one of their products contingent on the purchase of one or more other products. Many oncologists spoke about a particular example of this kind of bundling that created a problem for them.

Let me remind you: product A and product B are

similar products that compete for private share. The manufacturer of product A also makes product C, which is a single source drug. All oncologists must provide at least some of this drug to their patients.

It's very unusual to get a large discount on a drug that has no competition. In this case, the manufacturer provides a significant additional discount on product C to purchasers who buy product A instead of product B. These discounts result in a lower ASP for product C and a lower payment rate.

Let me illustrate. And I just want to say again these numbers are entirely for illustrative purposes and don't represent any actual transactions. Let's say the list price for product A and product B is $100 and the list price for product C is $300. If the physician gets the bundled discount, which again for this illustrative purposes is 10 percent for A and 30 percent for C, they have no trouble purchasing either product at the Medicare payment rate. As you can see here, that would be the left side of the slide. However, if they prefer product B, they will lose money every time the buy product C.

In the short term, this bundling arrangement has

resulted in lower Medicare payment rates for all three products. In the longer term, it could drive product B out of the market, leading to higher prices for A and C. Further, some physicians believe that the practice is hurting their ability to choose a product based on clinical decisions.

Finally, other manufacturers of single source products could also use this method to increase their sales. If this happened, the integrity of the ASP payment system could be affected.

So here we have a draft recommendation which reads: the Secretary should clarify ASP reporting requirements for bundled products to ensure that ASP calculations reflect the true transaction prices for drugs.

In this draft recommendation we do not argue for or against bundling or propose any specific allocation method. In the text of the report we would look at different allocation methods. The goal here is to ensure the integrity of the ASP system. Discounts should be allocated in a way that does not create inappropriate financial incentives for clinicians as they treat patients and ensures that ASP reflects the true average transaction

price for drugs.

The spending implications here are indeterminate. Reallocation of bundled discounts could increase the payment rates for some drugs and decrease it for others. In the future, however, it would help to preserve access to care for providers and beneficiaries by ensuring again the integrity of the ASP payment system.

Last month one of the commissioners asked us to look into inconsistencies in the application of least costly alternatives, or LCAs, to hormone suppressing therapy for advanced prostate cancer.

LCA policies say that Medicare won't pay the additional cost for a more expensive product if a clinically comparable product exists. Virtually all local carriers apply this policy to hormone suppressing drugs to treat advanced prostate cancer.

When the policy was first implemented it covered two drugs, but now there are six products in this drug class ranging in modes of administration from monthly injections to annual implants. The clinicians that we spoke to agreed that the drugs were clinically equivalent, although physicians may favor one over another for a number of

reasons including quality-of-life issues.

Interviewees said that the policy is applied inconsistently across carriers and changes frequently. For example, in some areas all products are covered under one LCA policy whether dosage and unit are comparable.

Since ASP changes quarterly, LCA may vary from quarter to quarter and payments again then have to be adjusted for dosage. Some carriers may determine retrospectively which drug is least costly and ask for return of overpayments, sometimes going back for several years.

Some products are grandfathered in and others are not. So if you start on one product, Medicare will continue to pay for at the ASP plus 6 payment rate in the following quarters. For other products they will not.

The inconsistencies in the way that the policies are implemented are troubling and deserve further study.

In addition, urologists have remarked that although there are other drug classes which may have clinical alternatives these drugs are among the only drugs to which an LCA policy is applied. This could be an issue to look into in the future, to see whether there are other

drugs or drug classes to which an LCA policy could be applied.

This concludes our presentation. Commissioners will want to consider the draft recommendation and we would be happy to hear any additional comments you may have. I just want to remind you this report is due January 1st, so next month is the last time you'll be able to see a draft.

DR. CASTELLANOS: Joan, I think you did a good job. I think there are some issues that I'd kind of like to bring up a little different than you did.

The volume thing, I think, is important. In your slide that you showed, there was a 50 to 60 percent decrease in volume going from year 2003 to 2005. As we talked and I showed you data, actually that decrease started back in 2000.

From a clinical viewpoint I think we can explain it. Quite honestly, I congratulate you and MedPAC for bringing this to the clinicians' attention. Prior to this, the urologists in this community, or for this matter in the country or the AUA, had no idea that this was a clinical fact.

I think what's happened is treatment changes have

changed. We're not giving this drug to anybody except people with end-stage disease. We're picking up that disease a lot earlier so we're not having as many patients in the end-stage disease.

The other point that you mentioned about the holiday is a very, very true. We're often holding treatment because of the side effect profile, the complications as you mentioned, but also we found that the patient doesn't develop the resistance or hormonal refractiveness to the drug, so the efficacy lasts longer. So I think we can probably explain it on that reason.

That's not to say some doctors may have stopped giving it for financial reasons, but I don't think that was the main reason.

I think the two issues of bundling and LCA I'd like to comment on. Quite honestly, I think they're pretty the same from a physician viewpoint. What this does, it ties the treatment to the cost of the drug and not to the benefit of the patient. As you very aptly pointed out, under bundling some drugs are not available. They're underwater, so to speak. In other words, for the physician to give the drug he feels or she feels is most appropriate

will cost that physician because he's paying the bill for that drug a certain amount of money. So he's restricted in what he can do.

And the same with LCA. It changes from quarter to quarter. And as I said last time, these may be chemically or pharmacologically equal but they're not equal to the patient. The patient who's having a change in his or her treatment, it's emotionally upsetting, it's financially perhaps even upsetting. But more important, it disrupts the physician relationship with the patient. In other words, what's happening again is this ties treatment to cost.

Under LCA, again my recommendation is that it's not compatible with MMA. It doesn't let market forces dictate the price. The carriers have such a wide variety of how they implement that.

My suggestion on LCA is that we follow MMA's recommendations and get rid of MMA. CMS will not do it because it's not a national carrier decision. It's a local carrier decision and the local carriers, in my opinion, are not doing a very good job.

Again, what I'd like to say is that both LCA and bundling are in the same issue. If we're going to deal with

bundling, we need to deal with LCA because both of these issues ties treatment to the cost, not to the benefit of the patient.

Thank you.

MS. BEHROOZI: Thanks. This is really thorough. You've gleaned a lot of information and I really appreciate that you spent a lot of time talking with the providers.

I'm going to take note of something that you included under the heading that the providers with whom you spoke, I guess, reported that they need to carefully manage their business practices. I guess that's as a result of the lower level of profit that they're able to derive from the Part B drugs.

And the last note is reduced staff or staff benefits. You're saying say that some of the practices reported that they had lowered their personnel costs by reducing the size of their staffs, offering fewer benefits, freezing salaries or delaying raises. I really wouldn't want the Commission to be on record to say that that's efficient provision of medical services, is to make it so that the staffs who work for these providers end up not having medical benefits or raises.

MS. HANSEN: This was really interesting to look at the earlier conversation we had in the previous meeting about some of the shifting that's going on for people who don't have the supplemental insurance.

But a little bit related to Ron's comments I wonder if, in the course of all of these different pieces about some of the changes relative to the pharmaceuticals, whether we would be in the position to kind of coordinate the comments? I'm thinking about what Medicare's pharmaceutical policies or drug policies are, especially now that we have Part D added on.

You mentioned the impact to the beneficiary. But I just wonder if we could do an overarching piece on Medicare kind of pharmaceutical policy with the coverage.

DR. SOKOLOVSKY: I just want to say that's exactly what we hope to do in the spring, to look at the issues between Part B and Part D drugs.

DR. SCANLON: First I have a question and then a couple of comments.

In part it relates to what Jennie just raised with respect to the shifting. I think it's important because one of the things we'd like is the payment policy not to have a

negative impact upon patients and beneficiaries. And it's also because -- this is from our last meeting, I noticed but in the trade press it got picked up in terms of MedPAC's reporting that the shifting is occurring.

What I wanted to ask you about was in the meeting materials we talk about the claims analysis and saying that there is no discernible trend. I guess there's a question of which evidence should we really put more store in? I didn't know what you meant by a discernible trend versus that there is really sort of a problem here.

Because it could be that yes, there are instances that this is happening. But just as the way when we're doing updates we look at what's going on over all and we try to get as much comprehensive data as we can. I wanted to see how we should weigh the claims results versus the interview results.

DR. SOKOLOVSKY: In terms of the shift to the outpatient department, certainly we've heard it everywhere but we have not been able to pick it up. Our claims analysis only goes as far as 2005 but that is when ASP takes effect. We don't see a spike. There is continued growth in the use of outpatient infusion centers but it doesn't

increase at a more rapid rate and it continues to increase for most specialties in physician offices. And Duke University recently came out with a study which found the same thing.

DR. SCANLON: I guess I'm wondering if we should be more tentative about that conclusion.

MR. HACKBARTH: Can you think of any potential way to rationalize, connect those two pieces of information, the anecdotal reports with the claims data?

DR. SOKOLOVSKY: I think that when you think about the number of beneficiaries that don't have supplemental insurance, it's under 10 percent anyway and that's assuming that they all have chemotherapy. So we wouldn't expect a huge increase to show up when we eventually -- you all know about data lags and so on. But when MCBS finally comes out and we know who are the people without supplemental insurance, we might be able to look at this more clearly. But now all we can look at is gross aggregate, do we see a real spike? And we just don't see it at this point.

DR. SCANLON: In terms of other points, both last month and this month the issue of access has come up and partly physicians' access to drugs at something less than

ASP plus 6. I wanted to raise the issue of the competitive acquisition program because it was meant to be the safety valve for physicians that were not able to get a drug at ASP plus 6 or below ASP plus 6.

I understand, in some ways, introducing it with some restrictions. It's required that physicians get all of their drugs through the program, that a whole practice participate. Those rules may be too strong though some rules, in terms of restricting this program, may be important so that you don't create a situation where physicians are not incented to try and get the best deal on drugs. We don't want to do that.

But at the same time, we maybe should have a functioning safety valve so that when the isolated instances occur that there is a mechanism by which physicians can get drugs at the price that Medicare is willing to pay.

Also related to this issue of access, I think, is the issue of the ASP and the bundling. I'm supportive of the recommendation. I think that we really should reflect transaction prices in the marketplace. I don't know what true transaction prices might mean and I don't know how to exactly do this because I think that there is a variety of

arrangements that you can have in contracts that won't look the same but end up having the same effect.

One of the realities is that even when we do this, even though the prices of individual drugs may change significantly because of a reallocation -- not the price from the manufacturer but the price that Medicare is paying -- the advantage to buying a bundle still may be there because Medicare is, in some respects, paying you 6 percent more than the drug manufacturer's revenue. And so if you can get it for less, then you're going to be interested in doing that.

So I think that it's an issue that needs to be resolved because not reflecting an appropriate allocation is something that is problematic.

Let me just end by mentioning about the LCA. I think it's something we do need to explore some more in a number of contexts. One is this issue of local carriers and what discretion they should have. In one of the last reports that I worked on a GAO we actually recommended that we eliminate local carrier medical policy because physiology is not local. And so the science of medicine shouldn't be dictated by local medical boards or medical groups making

decisions. And when they actually are agreeing, spending resources to make the same decision one after another, and then some of them not arriving at that same point. It doesn't make sense.

The other thing that I think that's important for us in thinking about this for the future is this very much relates to what we've been talking about in the context of controlling Medicare costs and the cost-effective alternative. It's got to be a part of that. To the extent that we've got it here, we should be asking ourselves what's wrong with the way it's being applied? How can it be more effectively applied as appropriate for the future?

MR. HACKBARTH: Bill, can I just ask about your comments on the bundling issue? What I thought I heard you say was that you agree with the thrust of the draft recommendation but you're cautioning us that the solution may not be easy to find, that it's a complex issue. Is that your basic message?

DR. SCANLON: Yes. I think that what CMS will find -- and actually they're in the press now of trying to work this through for Medicaid as well with respect to average manufacturing price. What I think they will find is

there's a variety of arrangements under which drugs are bought. And the question is what are the set of rules that you want to have to apply to that variety that you can identify today, and then hopefully in some respects deal with the ones that develop in the future? Because these contractual arrangements can be structured in all kinds of different ways. We're talking about individual relationships between manufacturers and their customers. And they don't have necessarily a set of rules that will correspond to what Medicare dictates. They can do different things. They're going to influence the results that we get.

The numbers that Joan said are just illustrative. It does matter in terms of a how big of a shift there's going to be and how big of a difference there is in terms of the incentive you have to use drug A or drug B. It in terms of the numbers.

So how they're going to work out in actual practice is going to affect things.

MR. HACKBARTH: So it's complex, but do you think it's important to try to do it to preserve the integrity of the ASP system?

DR. SCANLON: I think it's important to do.

Preserve integrity of the ASP system sounds like such a lofty goal. I hate to go that far.

MR. HACKBARTH: That's why I used those words.

DR. SCANLON: I think it's important to do from the perspective of doing the best job we can and getting a ASP that's not too distorting, because ASP is flawed. This idea that we're not interfering with the marketplace when we use it in order to pay for drugs. I mean, let's be realistic to ourselves.

MS. DePARLE: I'm smiling because I think that when you were at GAO and I was at HCFA, now CMS, you guys recommended ASP as a solution to our terrible problems then of not only did we not have a lofty goal, but we didn't really have much of an idea. And we were paying what we called average wholesale price.

I can still remember your testimony, which is that it's not average, it's not wholesale and it's not a price. But other than that, it's a great way of doing it.

DR. SCANLON: And I still stand behind it as a step in the right direction. It is not something that takes us to nirvana.

MS. DePARLE: I agree with that and I guess I

wanted to speak in favor of the recommendation. I would even support going further, although as I sit here looking at this what is true transaction price? I think this is among the more difficult issues that we and those at CMS who are trying to get this right face. It will constantly be morphing and it will be very fluid in this marketplace, I think, for drugs. But I think it's really important that we acknowledge this issue now as the first that we've identified and that we keep monitoring it. Because it will be something else next month and it does distort not only what Medicare pays but what troubles me the most, and I know troubles many here, is it distorts what happens to beneficiaries, to patients, and the treatment that they might get.

And so we have to be very careful about that and make sure that we try to set forth the proper incentives, as I think everyone here agrees.

So I would support this.

DR. HOLTZ-EAKIN: I also wanted to speak in favor of the recommendation. There have been a large variety of issues raised regarding this, at least to me, many of which I think are ones we shouldn't worry about. And we should

put aside issues associated with the legality of the contracts. That's been raised with me. I think that's not our portfolio and not an issue.

I think bundling is a pervasive element of the commercial market in medicine and elsewhere, and bundling per se should not be perceived as the problem. Instead, I think what is at the heart of the issue is correctly matching discounts for agreement to use particular products. The proposal targets that, targets it effectively. And I think that's important within the context of the sub-nirvana ASP system -- do I have the current lingo -- because for this market one of the important elements of getting good outcomes is getting new products to enter and to compete effectively at the point of entry. The remainder of the incentives we can debate. But certainly at the point of entry, I think we want to make sure we get people in. And this, I think, is a step in the right direction in that regard.

We shouldn't pretend that it's a big cost saver. The recommendation said indeterminate. My instincts are actually worse than that. But I think it's the right thing to do regardless because of the long run properties. I

think we should make the recommendation for that reason.

The caveats I'd put are the ones I'm worried about on outstanding administrative issues in feasibility and doing this in a timely fashion and the awful fear of a precedent that we may come back to regret later. I don't know if there are other examples that people can point out where this is a bad precedent. I haven't found any. But these are the two issues, administrative feasibility and unintended precedence.

MS. BURKE: I want to draw on comments both by Ron and by Bill in the following sense, and this is specifically with respect to the bundling issue. I think Bill's point that, at best, we are trying to negotiate what is an ordinarily complex environment where there are, in fact, a variety of circumstances and a variety of arrangements, similar to what Doug has suggested, that exist in the market today. And our intention is not to wholesale either reject them out of hand or accept them all out of hand.

But I think while our goal, and I certainly support the tone of what it is we're trying to suggest in terms of the ASP system, while our goal ought to be for reasonable purchasing and taking the opportunity to take

advantage of lower cost in a rational way, I am very concerned at the extent to which it interferes with the practice of medicine. There is no question that there are decisions made on a variety of bases, in terms of the choice of pharmaceuticals that are chosen by a physician at any point in time for particular circumstances.

But when an issue arises because of the nature of the way we have structured the payment that leads to a specific outcome that is not, in fact, one that's balanced by the clinical issues -- which at least in this case seem to have arisen, perhaps not often, in many cases it's simply a choice of A versus B, they're both clinically similar, they both have the same result. In fact, we ought not interfere with the market in that case.

But in a case where it essentially allows a market practice that alters the decision solely on the basis of that, I am troubled.

And as Bill suggested, there are lots of different arrangements that exist. But ones that really interfere with this decision that is based on a clinical issue concern me. It's not clear to me, looking at the recommendation, what you anticipate to be the outcome of this as it relates

to that issue. Theoretically, I think going in this direction makes absolute sense.

But to Bill's point, I'm not sure practically what this means. Does it mean, in fact, that there ought to be a system that's developed that essentially, in assigning the cost in this case that our materials very nicely, John, you did a terrific job of laying out what are a whole set of complex issues. But this choice of Drugs A, B or C, when A and B are loaded on one side and C is on the other, and essentially the market practice is to essentially under price one of those in order to avoid essentially a market challenge by drug C, and essentially move the between two products, I'm not certain I fully understand how you would address it in this context.

Again, to Glenn's point, I don't ever want to get to the point where we are, in fact, interfering in market forces that ought to exist in honest market moves. But to the extent to which it begins to radically alter a decision that is a clinical decision based on what drug makes the most amount of sense because it is inherently different, and they have taken the opportunity in the structure of the bundling to essentially overprice that piece, I'm troubled.

And I'm not sure I fully appreciate or understand how this begins to get up at that, nor what is the message that we're sending in terms of our concerns about this practice.

DR. SOKOLOVSKY: I guess what I would say was that I didn't hear enough consensus here on a particular allocation method. And so this is put in there as to say this is something that we are concerned about. And then in the text discuss, for example, how Medicaid, how the discounts are allocated there, discuss a number of different ways in which it could be allocated and not come down on any particular one.

MS. BURKE: And the presumption in that case then is the allocation method ultimately, if in fact this is a practice that essentially loads the discount so that it disadvantages a particular product, under pricing it by the value of the discount on the other side, that the allocation, if corrected, will in fact result in a more equitable balance in the market between those two drugs. That's the presumption, I presume?

MR. HACKBARTH: That would be the goal.

MS. BURKE: I think if that's our goal, I think that's terrific. Again I think theoretically I'm quite

comfortable. But I guess I would argue that only to the extent there's consensus, that a statement that suggests that markets ought to work. But at the point at which it interferes with a clinical decision-making process is where, in fact, there ought to be an intervention, even if it's a market intervention. But that one piece I'm not certain. I think you've laid out a very terrific sort of look at but I don't know whether we've said that sufficiently, clearly.

DR. HOLTZ-EAKIN: I had a reaction. In particular, because I think there's some words in there, and even in some of the presentation, that I don't think we A, should engage in using and are really not our portfolio.

So in particular, I think this issue has nothing to do with a dominant product or a sole source product, which is I think the term you used, somehow the notion that there's just one thing out there. That may not be even be the facts in this case.

The issue is the correct attribution of discounts for purchases.

MS. BURKE: That's a way to get at the issue.

DR. HOLTZ-EAKIN: That's the heart of the issue. If there's a competition policies issue, a tying issue where

you are inappropriately using one product to get more power than another, sue them. Not job.

MS. BURKE: Well, it is our job if our payment policy --

DR. HOLTZ-EAKIN: If our payment policy produces it. But we're fixing --

MS. BURKE: -- disadvantages a clinical decision-making process.

DR. HOLTZ-EAKIN: My point is we should focus on fixing the payment policy. Will it be the case that payment policies affect clinical decisions? Every day. We want people to be cognizant of what things cost when they make care decisions.

MS. BURKE: Of course we do.

DR. HOLTZ-EAKIN: So I don't know where that line begins.

MS. BURKE: I don't disagree with your premise that, in fact, part of this is how you pay, that part of this in fact involves a decision-making process that happens every day. You choose one device versus another device. One is more or less expensive than the other.

But in this particular instance, at least as I

perhaps poorly understand, there is a particular practice in bundling as it relates to pharmaceuticals that, in fact, it is a direct intervention into a clinical decision-making process because it puts someone clearly at a disadvantage around a price issue when, in fact, if given all things being equal if they had a clinical decision to make the decision would be made to purchase X versus Y.

But the way we've structured the payment system is so dominant in terms of the ability to price A and B that essentially you don't really legitimately have a choice of C. That's what concerns me, unless I misunderstand the issue.

DR. REISCHAUER: I guess I'm going to side -- the economists are going to stick together on this one.

MS. BURKE: Of course. God knows.

[Laughter.]

DR. REISCHAUER: What Bill said was very true, we're a long way from perfection and we can never reach perfection and this is a step in the right direction. But just to provide an example for Doug's point, in a case where we aren't really looking at prices, the DRG is set for an artificial knee, an artificial hip, and one company has all

of these products and one of the products isn't exactly as good as the alternative is, but it says I'll give you a discount on the volume of sales to the hospital and the hospital will say we're buying the cheapest package altogether. It's affecting clinical decisions all the time.

It's sort of a boundary and we don't go there and can't go there. But where we can help things along we should.

MS. BURKE: In that case, essentially, it's an array of all of their products that they're discounting. And so you're forced to take a product that, in fact, is not the product you want.

DR. REISCHAUER: Is clinically inferior to the competitors --

MS. BURKE: Because it's part of a much broader range of products.

DR. REISCHAUER: Right.

MS. BURKE: Not a product-to-product comparison. It's a much bigger grouping. Yes, I think that's troublesome.

MR. HACKBARTH: So payment systems like the DRG system, where we bundle services together and pay a lump sum

price, inherent in those systems is potentially an effect on clinical decision-making. Indeed, some would say that's their intended purpose.

In the case of this particular payment system, ASP, this is a narrow payment system not a bundled one. We're paying unit prices. And generally when you use those payment systems, the effect on clinical decision-making in general would be less because there's no bundling going on, unless you've got prices that are really out of whack. And so they're so far out of whack that clinicians can't buy the drug and that interferes with their decision-making.

The way I look at this particular issue is this is a narrow unit price payment system and what we're trying to do through this draft recommendation, as Doug says, is get the prices we pay as accurate as possible. In that way, we have the maximum likelihood of neutrality in clinical decision-making. But as Bill says, we should have no illusions about our ever getting to perfection.

So I like the way Doug characterizes this with the narrowest possible rationale. Let's try to make the system work as accurately as best it can. And by doing so, we'll achieve your goal of greater neutrality and clinical

decision-making.

MS. BURKE: The difficulty, in part, I'm the last one to argue against the principles behind DRGs or PPS. I understand. But it is a much bigger averaging. Yes, we do pay for a bundle of things. But it is an on average. This, as Glenn just pointed out, is a very narrow, very limited range of things where that kind of averaging doesn't play. That's the difference here, is the narrower we get, the smaller the unit, the less ability there is to -- no question. What you choose in terms of your pacemaker or your joint replacement, it's the point I was making. It's in a large grouping of things that, on average, it works.

This becomes a very narrow band and there is less opportunity for that to occur. And that concerns me. But I don't disagree at all with what you've said.

DR. REISCHAUER: We all agreed, although we want to continue arguing.

[Laughter.]

MR. DURENBERGER: Well, I'm not going to continue arguing. I want to make an additional point. I want to thank Sheila for the comments that she made because I think the therapeutic value is the issue. And we spend our time

on the pricing because we have been denied legitimate pricing information for so long by a variety of these drug companies that it is a policy effort to try to get at it and we're trying to supplement that policy.

But I must say what bothers me, having not been here last time and just read the report, is that we're not talking widgets. Just trying to amplify on her argument, we are not talking widgets. This is not Adam Smith.

This is a government-granted monopoly to one inventor, through a patent system, which has some accountability that goes with it. And while the legislature may not have carefully crafted what that accountability should be, I would argue as a patient or as a beneficiary the potential that either costs are going to deprive me of access or they're going to, in one way or another, affect my surgeon or physician's judgment, that gets at the accountability that a monopoly-granted privilege has to us as a society.

That's what I think I find most offensive about the particular monopolistic -- I don't have a problem with the bundling. I'd love to see somebody, not us, investigate bundling more in a wide variety of technology areas to see

how much money we're in effect losing or care quality is being diminished.

But on this one, I really just want to add the dimension to Sheila's argument. I think there is accountability and responsibility that goes with the grant of that patent monopoly. And I'm not sure that it's being exercised appropriately in this case.

MR. HACKBARTH: Let me ask about draft recommendation one. Is there anybody who has fundamental reservations? I'm not asking for a vote at this point. We'll vote in December. But if people have fundamental reservations about draft recommendation one, I'd like to hear them now so we can potentially address them.

DR. MILLER: Bill, you made your point that the word true -- and you guys might want to put this up -- you made the point, Bill, that you wanted the word true out of there. Certainly, if that comes out, it doesn't change --

DR. SCANLON: I wouldn't know how to define it if you asked me to.

MR. HACKBARTH: So we'll drop true from the draft.

DR. KANE: Do you want to say something about the way the price is set, if when in doubt should favor enhanced

competition?

Isn't that what we were just getting at was that -- well, there is no true transaction price in a bundle. It's an arbitrary decision. Unless you accept that there is a market out there for the competitive product, and then there is theoretically a market-based price. There's no cost build up you can do to get to that.

So what's a transaction price for a bundled product? That doesn't get you anything. You have to say with some kind of goal in mind, or it's up to that manufacturer to make up the price.

DR. MILLER: The way I've been hearing this conversation and trying to balance the notion of whether we're -- the concern about clinical and competition, but we're administering a price here. And so can we get the price right and then hope that downstream or upstream, whichever way this works, that it has an impact on these other things that we're concerned about.

That the way this would work, the way I'm hearing it is we make a statement like this -- and you also asked the question, what are we accomplishing here?

So the way I would try and articulate this, CMS is

grappling with this issue. We've made a statement here with this recommendation that says we think there's an issue here, there's a problem, and that we think a fix needs to be investigated.

In the text, I would see us, for example, laying out as clearly as we can the notion that the incremental difference in that discount, the way Joan went through her example, is one of -- and the presumption here is, and I think there's some support for this, that those kinds of arrangements are reflected in contracts. And that that incremental difference needs to be allocated back to the drug in question. And that the enforcement mechanism for this, which we mentioned last time but not again this time, is that we're not envisioning CMS going through item-by-item and looking at these agreements. There would just be a random look-behind on the part of an inspector general or someone like that to be sure that the manufacturer is reporting the ASP following those rules.

We would also lay out that that is not the only way that one could think about allocating it. We would give other examples for how someone could allocate that difference.

DR. KANE: So you're going to say the transaction price definition is, for example, for this particular arrangement, here is how it should be? Or are you going to say we have principle behind which price transaction prices should be evaluated?

DR. MILLER: I think our principle is that if the discount gets triggered by the drug, then that discount should be allocated to that drug.

DR. KANE: That's what you mean by true?

DR. MILLER: We took true out.

DR. KANE: I'm just saying I think you need a principle or otherwise there is no true. It's whatever the manufacturer wants it to be.

MR. HACKBARTH: The principle is the draft recommendation, and then Mark is providing a specific illustration of what that might mean in the example case. So you allocate the incremental discount to the second drug.

DR. KANE: But in these more complex situations what does the inspector general do, or whoever is auditing? Prices come from two places. They either come from a competitive marketplace or they come from a monopoly manufacturer setting something. So which one is the true

one?

And if you're going to set that one example, is that supposed to be the one that there's a principle behind it that should apply across the board as best as one can apply? Is that what you're trying to get at? And that principle seems to be that you are fostering the competitive pricing model whenever possible, that when there's competition for a drug then it's the noncompetitive drug that you put the discount on?

Is that what the principle is or not? I'm just trying to get a sense of what do you mean by...

DR. MILLER: Certainly to the first half of your comment, we're saying that this applies to all situations. So it's not picking a situation and saying you allocate in this instance and you don't. Where you have these contractual arrangements that say a discount is dependent on two drugs being together, you take the difference, for example, and allocate.

The thing I am purposely navigating around here is that there is, only in a matter of degree, slightly different opinions expressed about whether this is price only that we're playing with and the concerns over clinical

and promotion of competition.

So I think that we're trying to say here is we should get the price right, and I've given you an example of how -- you, CMS -- of how to think about this. And there may be other examples. Our hope is, our expectation is, as best as we can understand it, is that it will, in fact, foster better clinical conditions and competition.

What I'm afraid of is if you put the word in that says you should do this to promote competition, it raises questions about well then what is the definition of competition?

DR. KANE: There's two sources of what are prices. There's either a competitive market or in a monopoly that's whatever the manufacturer makes it, or a negotiation between the manufacturer.

MR. HACKBARTH: We have a mixture of each.

DR. REISCHAUER: That's what we have now.

[Simultaneous discussion.]

MR. HACKBARTH: We've got some monopoly drugs and some competitive.

DR. KANE: But you're worried about bundling.

DR. REISCHAUER: It's conceivable that you could

have two monopoly drugs and the manufacturer could say if you buy the second one where you bought the first one, I'll give you an incremental discount. And then the question is where do you put that incremental discount? It's with the behavioral change that brought about the discount.

MR. HACKBARTH: Buying the second drug.

DR. REISCHAUER: It's the buying of the second drug, so it should go on the second drug.

DR. KANE: So you want an outsider to figure out which drug the manufacturer was trying to sell when they applied the bundled discount?

MR. HACKBARTH: Well, you know. It's in the contract. It says you only get this if you do this. So you assign it to that.

DR. KANE: So the principle here is going to be whichever drug you're trying to sell...

MR. HACKBARTH: That's where the discount is assigned. If you only get the discount if you do this, you assign it to that, the incremental discount.

DR. KANE: You only get the discount on this drug if you buy that drug. So the that drug is the one that gets the discount.

So what principle is that?

MR. HACKBARTH: That you try to get accurate prices that reflect -- yes. I know you're resisting that, but that is the principle.

then that has secondary effects on making the decisions neutral for clinical decision-making, and that's a good thing. But the guiding star for the policy is trying to get the transaction prices as accurate as we can within the inherent limits of these systems.

DR. SCANLON: I guess I have concern that I don't know what accurate means. If I pick up the newspaper and it says buy one get one free, is there really one that's free? Or am I paying 50 percent of the list price? And if I say I'm paying 50 percent of the list price, that's one allocation rule. There's another allocation rule which says I got one free and I paid full price for this other one.

Well, that's where we are on this.

The issue about our example, we talk about competition but we've got three different ASPs in that example. We don't combine drug A and B and do one ASP, because they're not the same drug. They're competitive but they're not competitive enough to have the same ASP, which

is another issue that's involved here.

I think there needs to be some allocation and my extreme of buy one get one free is kind of the absurd case but I think we could get close to that if we're not careful.

I think Sheila's concern is extremely valid, and this is in terms of not being able to do something that's perfect. Because we're talking about allocation of price rules here. We're not even thinking about the clinical side of this, and that would complicate this much more it.

That's why I'd like to make another plug for the competitive acquisition or some other safety valve that says when -- sort of the best price rules that can possibly imagine, we've still got a problem, we've got a way of dealing with that problem.

MR. HACKBARTH: Could I just pick up on a piece of that?

The reason that I'm fixated on trying to couch this in terms of accurate pricing, despite all of the difficulties, is that I think having level playing field for clinical decision-making or fair competition, they're way more difficult to define and operationalize as your guidepost for policy. This one is hard. Those are way

harder.

So let's stay focused on what we can most manageably do. I think the secondary effects on clinical decision-making are desirable.

With regard to the CAP program, the Competitive Acquisition Program, I'd like to hear some more reactions on that.

DR. MILLER: Let me just say one thing to deal with Bill. Bill, first of all, I don't think we have any problem within the chapter talking about the CAP program.

MR. HACKBARTH: Describe it so people know what it is.

DR. MILLER: I'll get Joan to do that in just one second. I just want to say one thing.

Also, cast your mind back. We made recommendations the last time we dealt with this issue in which we tried to improve the CAP program. And assuming everybody's in the same place, I don't think there's any problem with inserting language if it will help you that says and by the way, we really need to be working on this.

You and I had some conversations where you suggested ideas. We can throw those out, put that on the

agenda and work towards it just as a process thing. So decidedly, that can be dealt with.

MR. HACKBARTH: Joan, would you give us the 30-second reminder on CAP.

DR. SOKOLOVSKY: The MMA included an alternate way for physicians to get drugs, and that would be that vendors would compete for contracts with CMS to purchase all the drugs that a physician would need under Part B and supply it the physician, and the vendor would bill both Medicare and the patient for the drugs. And the physician would not be involved in any monetary transaction, at all.

However, I think we talked a little bit about this last year. Many of the actual way in which it was set up were not attractive to either physicians or vendors. So right now there is one vendor, very few physicians, and the vendor does not supply all drugs under Part B. So it started, but it's not full blown as of yet.

MR. HACKBARTH: But what I hear Bill saying is that it has not taken off because of the specific rules and restrictions that were added onto it, but the core idea still has merit as a safety valve, to use Bill's term. I find that appealing myself.

DR. MILSTEIN: More of a question.

As I heard articulated how these so-called true transaction price might be arrived at, it sounded to me like we were saying that in the event that the price of any drug is made contingent on the purchase of another drug, the incremental discount associated with that drug should be attributed back to the contingent drug. So maybe contingent drug, I think would be a helpful part of the vocabulary in articulating this particular solution.

DR. CASTELLANOS: Maybe I'm missing something but I don't see any recommendation or any discussion on LCA and I think that's an important issue, also.

MR. HACKBARTH: I wanted to come back to that. I think I'm in a similar place to Bill on that. The notion that this policy varies significantly across the country troubles me. A long time ago now, five or six years ago now, MedPAC did a report on how the programs run in response to a Congressional mandate. One of the general thrusts of that was there's way too much variation in some of these policies where, as Bill says, the physiology doesn't vary, it's just sort of random variations. It's not even constrained discretion, it's just random variation.

So I'm definitely sympathetic on more uniformity in things like this.

The thing that troubles me about closing the door to LCA altogether is that I can imagine that the concept is potentially a useful one to deal with new technology and basically setting up payment systems where we say these are clinically equivalent. We're not going to say to people you can't have the new thing. But if you want it, there's some additional cost to be paid. You've got to pay something out of your own pocket to get that. We think that they're essentially the same.

I'd hate to see, given the long-term issues that Medicare faces with the growth technology and the associated costs, our saying no, that's a door that should never be opened.

So more uniformity and care in the administration without closing the door for the long-term, is where I would be on LCA.

DR. CASTELLANOS: I don't know what if that's going to answer the problems that I'm dealing with from a clinical viewpoint. Again, I'm going to be forced to use a drug based on cost. And I don't think it's fair to the

patient and it's not fair to me.

I understand your concerns about closing the door on that whole LCA picture, but I think we need to look at it from what's practical to the physician also and to the patient. We're not doing that. We're looking at it just from, again I'm wearing a different hat but I should be where my Medicare hat. But I think we also have to think of the beneficiary.

MR. HACKBARTH: What I hear you saying -- correct me if I'm wrong, Ron -- is that at the patient level you don't see the drugs as being equivalent, that they're looking at one notion of equivalency that's incomplete and it doesn't take into account the full range of clinical considerations including the impact on the patient. So you really don't see these as equivalent at all?

DR. CASTELLANOS: That's correct.

DR. REISCHAUER: It strikes me there's two very different issues here. One is it's being applied inconsistently across geographic carriers, the carriers areas. And another is that because of the way we do this with quarters, referencing quarters, you can find yourself on the short end of the stick, which seems to be unfair.

And then there's the issue that you two guys have been talking about.

I think we can clean up the other two and make things better.

DR. MILLER: I think actually there's a third issue. You're seeing variation across carriers and you're seeing within the LCA categories things with very different dosage and administration properties being put together in the same category. I think that is at least two of the things that you're reacting to.

I think what Glenn said and better execution of it, that if we can speak to the process in getting less variability across the country that's simply the product of the carrier and much cleaner categories of saying these two are comparable to substitute for one another. I think that begins to address the clinical issues without closing the door on the concept entirely.

DR. CASTELLANOS: That's correct. but there's one other issue where the price is changing on a quarterly basis. And the problem is based on that I'm forced to make different clinical decisions, whether I give X or Y drug. As I said last time, one's an abdominal wall injection and

one is an injection in the hip. And I don't think it's fair to the patient.

MR. HACKBARTH: Other comments on the LCA issue?

MS. BURKE: So do we have a LCA recommendation?

MR. HACKBARTH: Not at this point.

MS. BURKE: Do we anticipate developing one relating to carriers or the issues that have risen?

MR. HACKBARTH: That's the question on the table.

MS. BURKE: Is the question shall we develop a recommendation?

MR. HACKBARTH: Would you favor that?

MS. BURKE: I certain think, as you identified the three different issues, whether we can come to an agreement on what we would say about similarity of application, whether getting rid of the variation --

DR. REISCHAUER: We do the true application.

MS. BURKE: Yes, it would be the big T.

If we can figure out how to articulate that, one of the concerns is that, of course, is true across Medicare, is that the carriers have wide discretion on a whole variety of things.

Query whether in this case -- I mean, I don't

disagree this is where we want to go. The question is do we want to pull this one out, compared to every other decision the carriers make that vary, whether you're having a good day or not.

DR. MILLER: That's exactly right. And the reason that we are here at this juncture is Joan looked at this and there is a level of complexity here on the very specific issue that's being raised and the question of why this? Why not think about this more broadly.

And so what we did is we put this on the table to see what your reaction is, which is what we do a lot. The question is whether if we pursue this do we want to think about this issue more broadly and address some of the issues of not closing the door and thinking about the categories and the rest of it?

And if that's the direction people want to go, I am reluctant to say that by three weeks from now we will be back in the room with a hard case recommendation that people go I understand it and I'm ready to go.

I do believe that, given what I've heard here, everybody would at least agree that this is something that should be discussed in the chapter and said that this is an

issue that we're going to pursue. I think that much there seems to be agreement on. And then we could discuss that.

MR. HACKBARTH: Reactions to that proposed approach, which is to lay out in the text the concerns and the different facets of it but not do a boldface recommendation at this point?

MS. DePARLE: I would agree with that approach and I find myself in the somewhat surprising position of defending the carrier medical policies and this particular policy, the least costly alternative, because I was frustrated when I was running Medicare often by some of the variation out there.

But I became convinced over time, in part after discussions with clinicians, Ron and others, who said to me there is really a -- there are some negative examples you can identify, some anecdotes that you might not like.

On the positive side, there are examples where that flexibility allows Medicare to defuse new technology more quickly than it might otherwise do so and test it out, let local clinicians who are either believers in it, have used it, understand it, test it out.

So there's a lot of complexity to all of this.

And I would really hate to make a quick decision here that would constrain that flexibility.

My view was what, Ron, you said, that Medicare should be the same for everybody. It shouldn't matter whether you're in Mississippi or whether you're in upstate New York. The problem is it's very difficult to do that with the kind of staffing that Medicare currently has. You have to use the kindness of strangers, I guess, to get this program administered.

So I became convinced that you really needed something like that and I would hate to, in one fell swoop, say that that's the wrong way to go.

MR. HACKBARTH: The experimentation argument, I think, is a very legitimate one, that this is an opportunity to see how these things work in practice.

The only reservation I have about that is if we're going to do an experiment, let's do it in an orderly way and say okay, we're going to allow it in this particular area where we've got some experienced clinicians. And we're going to hold off in other places and do an experiment and see how it works and then apply it.

But to me it's not experimentation to just say

everybody do what they want. That's just chaos.

MS. DePARLE: I don't know that it's everybody do what they want. It certainly is loose.

One of the reasons why that occurs, though, I think, is because at least heretofore the Agency has been constrained by the need to go through a rather formal process, at least informal rulemaking, before doing something like that.

Now recently I've noticed they seem to be more flexible about making those sorts of changes and doing demonstrations without going through that process. But in the past to do something like this policy, the least costly alternative, to do it nationwide -- which is what I think Ron would argue, if you're going to do it, do it nationwide -- that would have taken a rulemaking that could take two years. And so we have to weigh the timely administration of the program in here, too. And I understand that there are people here who disagree with that particular policy.

But I do think if you want them to have some ability to react to things, this is part of why it ends up being done by local carriers as opposed to the Agency itself doing it the way you said.

DR. SCANLON: I do think there's an intermediate step, which is that local carriers can pay for things without having a coverage policy. By the time you reach a coverage policy, there's been enough experience that a carrier is making a decision and feels they can actually promulgate a policy.

I guess I would argue that we should be doing that at the national level. We still can give some carrier's discretion to allow some experimentation and that there be sort of a formal learning process.

The other thing I'd underscore what Nancy-Ann said, which is we've got to start running Medicare on the cheap. You can't have a Medicare program that's done right by borrowing on the goodwill of your friends.

MR. HACKBARTH: We are going to have to move ahead. We are running behind.

I think what this discussion says to me is that we're not ready for a boldface recommendation on this. I think we can/should have the discussion in the text both on the more consistent administration and truly trying to find equal equivalency from all standpoints. But boldface would be a bridge too far at this point on LCA.

Thank you very much.

Now we're on to rural hospital payment systems and the mandated report.

DR. ZABINSKI: The Congress has mandated MedPAC to study the effects of certain policies in the MMA that adjust payments for rural hospitals. Today we'll take our final opportunity to discuss the results of our analysis of this rural report.

We'll start by discussing a recommendation that affects payments in the outpatient PPS and then after that we'll open up for discussion on the whole report.

In the previous two Commission meetings we discussed two current policies that supplement outpatient PPS payments for rural hospitals. The first of these is a redistribution that takes about 0.4 percent of the outpatient PPS payments from all hospitals to increase outpatient PPS payments going to rural sole community hospitals by 7.1 percent. This policy transfers about $90 million to the SCHs, with most of the money coming from urban hospitals.

Secondly, there's a hold-harmless policy that adds about $50 million to the outpatient PPS payments to small

rural hospitals that are not SCHs. This policy is set to sunset at the end of 2008.

In the previous two meetings, we estimated that the hold-harmless payments would add $70 million to the rural hospitals, but now we estimate the lower amount of $50 million because our earlier sample included some hospitals that are now critical access hospitals. Some of these CAHs had received hold-harmless payments but they cannot receive them any longer because they're exempt from the outpatient PPS and they currently receive cost-based payments.

Also in previous meetings, we stated that our primary issue with the existing policies, the hold-harmless payments and the redistribution to the SCHs, the problem is that neither policy efficiently targets hospitals that are in need or are important to beneficiaries' access to outpatient services.

So in response, we proposed a policy that would give low-volume hospitals a percentage increase over their standard outpatient PPS payments instead of either the hold-harmless policy or the redistribution to the SCHs. We proposed this low volume adjustment to replace the current policies because the data show that hospitals exhibit

economies of scale in their outpatient departments and consequently smaller hospitals are at a competitive disadvantage relative to larger hospitals.

Also, the data show that rural hospitals tend to have lower outpatient service volumes than urban hospitals, so the rural hospitals have lower scale economies.

The advantage of the low-volume adjustment is that it would be more efficient than either the hold-harmless policy or the redistribution going to the SCHs. In particular, if designed properly a low-volume adjustment can more efficiently target hospitals that are important to beneficiaries' access to outpatient services. Also, it can directly target a factor that affects hospital financial performance and is typically beyond the control of isolated hospitals, that being whether the hospital is low volume or high volume.

In an example of how a low-volume adjustment can be advantageous to either of the existing policies, consider a situation where two hospitals are in close proximity and they get into a medical arms race. These hospitals could receive higher hold-harmless payments because of their rising costs due to the arms race. But under a low-volume

adjustment, their increased spending from the arms race would not lead to higher payments. The only way they could receive higher payments is if they are isolated low-volume hospitals.

The features of this proposed volume adjustment would be the following: first, hospitals would have to be a minimum distance from any other hospital in order to receive low-volume assistance. Also, the adjustment rates would decline as hospital volume increases. That way the lowest volume hospitals would receive the highest adjustment rates. Finally, the policy would not begin until 2009, after the hold-harmless payments sunset at the end of 2008.

In this slide we talk about the primary effects of the low-volume adjustment. These include first, that it would restore most or all of the dollars to the system that would be lost when the hold-harmless payments sunset. In particular, we have developed two alternative draft recommendations for the Commission's consideration today. One of these alternatives would add about $35 million to the outpatient PPS payments going to rural hospitals and the other would add about $55 million, where the $55 million is about equal to the amount of money that hospitals currently

receive from hold-harmless payments. Our intent is to have the Commission consider these two alternatives and select one if they so choose.

A second effect of the proposed low-volume adjustment is that it would redistribute dollars towards low-volume hospitals which tend to have lower outpatient margins than larger hospitals. This would end the redistribution that favors sole community hospitals and instead low-volume hospitals, including low-volume SCHs, would receive low-volume adjustments.

On this slide we show the effects on specific categories of hospitals of moving from current laws that would be in 2009 that would include the SCH redistribution but would not have a low-volume adjustment to the proposed policy that would include a low-volume adjustment but there would be no SCH redistribution.

On the first line we have low-volume small rural hospitals that are not SCHs. On this slide, this is the group that would benefit the most from going to a low-volume adjustment because they would receive the low-volume adjustment and they would no longer have to fund the SCH redistribution. This group encompasses about 200 to 220

hospitals.

In the second row you have larger small rural hospitals. In other words, these are non-SCH small rural hospitals that would not receive a low-volume adjustment. These hospitals would benefit a little from moving from current law to a low-volume adjustment because they would no longer have to fund the SCH redistribution. This group would also encompass about 200 to 220 hospitals.

In the third row you have relatively small SCHs that would receive a low-volume adjustment. These hospitals would lose their current redistribution but they would get the low-volume adjustment. They would be about equally well-off under current law or under the proposed policy. This group encompasses about 250 to 280 hospitals.

Then, on the final row is a group of hospitals would be the only clear losers from moving to a low-volume adjustment. These are the relatively large sole community hospitals would not receive a low-volume adjustment. However, because of their size, their expected outpatient margins under the proposed policy would be roughly equal to that of the margins of the low-volume hospitals. This is the smallest group of the four and it encompasses about 130

to 160 hospitals.

I'd like to give the commissioners their final opportunity to view a draft recommendation that you will vote on today. Today we actually have two alternative versions, as I discussed earlier, of this recommendation.

The first version is the draft recommendation that you saw at the last meet Commission meeting. However, some commissioners were concerned that this first version returned less money to the outpatient PPS system than the sunsetting hold-harmless policy. So we have the second alternative that is identical to the first, except it returns to the system about the same amount of money as does the hold-harmless payments. In particular, the specific differences are that the second policy would set the cutoff for getting low-volume adjustments at about 125,000 outpatient services, while the first alternative set it at about 100,000 outpatient services.

Secondly, additional payment for rural hospitals be about $55 million under the second alternative versus $35 million under the first alternative.

The recommendation itself reads as follows: After the scheduled sunset of the hold-harmless policy, the

Congress should replace the SCH redistribution policy with a graduated low-volume adjustment to the outpatient PPS. This adjustment should apply only to hospitals with fewer than 125,000 outpatient services and that are more than no more than 15 road miles from another hospital.

The implications of this policy is that it would increase budgetary spending by between $50 million and $200 million. And also, because the hold-harmless policy sunsets at the end of 2008, this recommendation would help maintain the financial circumstances of rural hospitals and help assure beneficiaries' access to outpatient services.

That concludes our discussion and I turn it over to the Commission for consideration of the draft recommendation and discussion of any issues on the rural report.

MR. DURENBERGER: By going from the $50 million to the $200 million, do they affect the hospital beneficiary at all? You're not buying votes from the large rurals --

DR. ZABINSKI: No, the $50 million to $200 million, that's sort of a required bucket. The estimated amount of this particular recommendation is $55 million and we have a bucket of $50 million to $200 million that it fits

into. That's the idea there.

DR. REISCHAUER: Just the categories that we established for the cost of these things, the range. That's all.

DR. MILLER: You're asking a different --

[Simultaneous discussion.]

MR. DURENBERGER: That's what I assumed when I read the 125,000, we were getting into the larger hospitals.

DR. ZABINSKI: Yes, you get slightly larger hospitals under the second alternative.

DR. STENSLAND: But it does two things. One, it gives a little bit more money to the smaller hospitals and it gives more money to hospitals, when we go up to $55 million.

MR. DURENBERGER: [Inaudible.]

DR. WOLTER: I guess I'll start by saying I think that the policy shifting to a low-volume adjustment from hold-harmless probably does make a lot of sense from a policy standpoint. And I did appreciate the chance, Glenn, to talk to about this, which really got me thinking about it.

I guess I do have a number of concerns about where

we stand with this. The first concern I have is that generally speaking across-the-board outpatient PPS margins are quite negative. That would be true in larger hospitals, as well. I've really been worried about our direction in the last few years of lumping that with the inpatient margins as we make our decisions, because I think over time there can be distortions in behavior if we have a separate payment system that continues to run margins in the negative 10 to 12 percent range on a consistent basis.

I honestly don't think that's very good policy, in and of itself. And I find what we're doing here, in some ways, is we're targeting that margin and we're trying to stay consistent with it. That would be the summary I would have.

You didn't show these charts today, but last month you showed under proposed policy that 2009 outpatient low-volume eligible margins would be, for outpatient minus 18 percent and for overall minus 4.5 percent. You showed a chart that showed the proposed policy -- and this, I think, would be at the 100,000 services -- for the not low-volume eligible, they would have outpatient margins of minus 16 percent and overall margins of minus 6.4 percent.

My concern is that we've moved a long ways away from the days when we were targeting payment policy to covering the costs of an efficient provider. I think that what we have here is extremely negative margins. And even the overall negative margins are more negative than the average overall hospital Medicare margins.

I'm really worried about the changes if you look at the bigger picture. And I think we are overdue to have a look at outpatient prospective payment policy in general, just to make sure that it's set right because I think we're in trouble.

I'm also a little troubled by the argument that this is taking money away from urban hospitals, current policy, because after all my assumption is -- although we didn't have the data in this chapter -- this is not likely our DSH and IME group of hospitals. This is not a group with wage index that was favorable relatively speaking. And so this is a group that is kind of caught without some of the other variables in Medicare payment policy that help them, and I'm very concerned about the average overall Medicare margins that we're dealing with here.

Those are my worries. Some other issues have been

raised about what is a service? Can we really do all-payer service counts that easily? When we made this recommendation about inpatient low-volume adjustment, it got translated in a way that really didn't have any impact, and we talked about that, Glenn.

Those are the worries I have about this recommendation.

DR. STENSLAND: Maybe I can shed just a little light on who the winners and the losers are. I don't want people to be confused and think this is a take from the rich and give to the poor, this SCH redistribution. The overall Medicare margin for the SCHs in 2004 was, I think, negative 3.9, which is a little lower than the negative 3, which was the average for all hospitals.

But of course, to fund that 7.1 percent add-on to the SCHs, you're taking money from everybody. So it's kind of take a little bit from everybody, stack it up, and then give it to this one group that's really, on average, about average. So we're taking some money from some people would have negative 7, 8, or 9 percent margins and some people who have positive 7, 8 or 9 percent margins and giving it to this SCH group.

MS. BURKE: If I could just follow with a question specific to that, as I think I understand the numbers that you've suggested, I see essentially 400 hospitals lose to gain for 200. That's how these numbers play out for me, unless I'm misunderstanding. Let me walk you through my math and tell me if I'm right.

Just to the point that's being made, and maybe I just misunderstood. I understood in the categories that you have on page six, in the first category essentially folks that currently get nothing under current law, there are about 200 hospitals who would gain from a low-volume adjustment.

In the second category the small rurals that get nothing and nothing, they get nothing. And there's about 200 hospitals there; correct?

The folks in the third category get something now and will get something comparable? And there are about 200-plus hospitals there.

And the last category that get something and are losing something, there's about 200. So I guess it's the 200 to 400 -- reverse, because the second category gets nothing now and would lose nothing. Lose nothing/gain

nothing, that's 200 hospitals.

So essentially, you've got 400 hospitals, 200 of whom are essentially going to -- well, 250 will gain plus 200, so 400 gain. So a loss of 200. Is that right?

You've got the last category lose. They get nothing.

DR. ZABINSKI: The last category lose and there's like --

MS. BURKE: That's around 160.

DR. ZABINSKI: There's about 130 to 160, depending on how you set the parameters.

MS. BURKE: The first and the third categories gain; correct?

DR. ZABINSKI: The first category gains. The middle two categories are about break even, and the bottom loses. The bottom one is the smallest of the four.

MS. BURKE: You have a slight gain then. That assumes the hold-harmless. So you have essentially a net. It's just who essentially gains?

DR. ZABINSKI: Right.

MS. BURKE: Thank you.

DR. WOLTER: Another question I had, just quickly,

was I guess CMS was asked -- this was in the paper -- to calculate what they thought the cost differences were for the sole community hospitals and that's how they came up with a 7.1 percent. I guess the first part of the question, was that all based on outpatient cost?

DR. ZABINSKI: Yes.

DR. WOLTER: Secondly, what would be the difference in their logic from hours, to choose 7.1 percent? I think, in a way, we're looking at redistributing 0.9 percent.

DR. STENSLAND: Just to go along the timeline, Congress said CMS, tell us, do rural hospitals have higher costs? CMS says no, not on average. But what if we look at a subset of these hospitals? If we look just at SCHs, on average, yes, they do have higher costs.

Then we kind of took it a step further and said let's look within the SCHs. Who in the SCHs have higher costs per unit of service? It looks like only really the low-volume SCHs are the ones that have the higher cost unit of service, not the higher volume SCHs.

So I kind of think of the SCH add-on has being kind of a poor proxy for low-volume.

Also, they did things a little bit differently in their econometrics, but that's probably the easiest way to look at it.

The other thing that we do that's a little different from what they did is we say that as you start to get really low volume, we think volume becomes more important. So say for the hospital with 15,000 visits or 20,000 visits, that one extra patient in our model is given a lot more weight that it would be for a hospital that has 300,000 or 400,000 visits. That one extra patient wouldn't be so important for them. But the way the CMS did the modeling, they said that one extra patient is equally as important, no matter what your volume is. It's basically they had a linear function where we had this spline function, with a steeper slope.

DR. WOLTER: I think where we are in agreement is that the low-volume adjuster might be a much better proxy, in terms of how to deal with the issues. I'm just concerned that the proposed policy leaves us with outpatient margins of 6 to 8 percent worse in this group of institutions than it does for the overall hospital average around the country, 16 to 18 percent negative, and that the overall Medicare

margin of negative 4.5 to negative 6.3 percent is another 2 percent to 4 percent worse than what we see in the larger institutions.

That seems disadvantaged to me when I look at those numbers.

DR. STENSLAND: The numbers are a little bit better than that. I think those are the members from the $35 million adjustment. So the numbers are a little bit better if we go to the $55 million adjustment. So essentially, the outpatient margins are little bit worse than average, but not much when we move to the $55 million.

DR. WOLTER: It's hard to imagine that that small change is going to take the negative 18 percent low-volume eligible margin to negative 10 or 12 percent. But it would be nice to see the numbers.

DR. ZABINSKI: It takes it to minus 14.

DR. REISCHAUER: Aren't we just redistributing? I mean, if we take the second option here, we're redistributing the money that's there now. No?

DR. WOLTER: No, because the sole community hospital's 7.1 percent is just gone. So what we're redistributing is only the dollars in the hold-harmless --

DR. REISCHAUER: That's the law; right?

DR. WOLTER: The law has it expiring. I thought we were trying to ascertain appropriate policy going forward.

MR. HACKBARTH: We're doing a mandated report here and I just want to get clear what the mandate is. The mandate is just to report on the impact of the various provisions in MMA on rural hospitals, is that right? As opposed to make policy recommendations on the outpatient department payment system, for example? So it's report on the impacts.

Then we said we may go beyond the mandate in this particular case and suggest a more rational way to target assistance within the rural outpatient department system.

You've raised some concerns, Nick, that go way beyond this particular recommendation to the overall financial situation of rural hospitals, both inpatient and outpatient.

It feels like to get into recommendations on those at this point, this might not be the right vehicle. The right vehicle for that, I suppose, is the discussion on updates of we'll have next month.

Maybe what we ought to be doing here, if you have reservations about the specific draft recommendations here, is just drop them and just go strictly with a report on the impacts, as required by the mandate.

Those, to me, seem to be the two basic paths and then we can look at the broader financing issues of all types of hospitals next month in the update recommendation.

What are your thoughts?

DR. WOLTER: I think one of the points I'm raising is when you look at proposed policy margins, which I have not seen the recalculations except for what you just said, would we have any appetite to try to get this group of institutions at least in the same ballpark as other hospitals and outpatient PPS? We're still a point or two away in terms of our recommendations.

MR. HACKBARTH: In the aggregate you're talking about all rural hospitals?

DR. WOLTER: Yes. We had an appetite for redistributing a small amount of money from one negative group to another, I suppose you might say.

It stands out to me when I look at this margin data that we have a group here that seems to be in a

different place than larger institutions.

DR. STENSLAND: I just had a little bit on the data part of it. I want to be clear that the margins we're showing here are margins from 2004 data which we have, which is our most recent data. And then we make some adjustments for these policy changes. When we move to the 2005 data, which I think is what we'll be discussing next month, that baseline may change and rurals may look a little better next month than they do now, the reason being that some of these MMA policies that we're estimating the effects on hadn't fully come through in the 2004 data. So some of these extra money that we're talking about here, this 2.3 percent increase in rural payments overall, might be moving through the system -- it was only partially through the system in 2004 and we'll see more of it in 2005. so the differential between urban and rural might shrink between 2004 and 2005 data. So just bearing that in mind.

MR. DURENBERGER: Trying to be responsive to your question, Nick, and trying to think about what that part of the Congress, which has posed this particular question, would like by way of a response. I think when they say impact, they are also asking for our recommendation for what

to do about whatever we say the impact may be. So that attracted me to the policy solution that the staff has come up with, or everybody has come up with, however we got it. But I like that.

I'd leave it to Nick's recommendation as to, if there's a flaw in this formula that we need to change that might be appropriate. But I do believe we shouldn't just send up the impact information without adding what we think is an appropriate alternative on the issue of what is access in rural America.

DR. BORMAN: I'd like just to support some of the concern that Nick has outlined. I think that a lot of these hospitals have a reduced ability by comparison to all hospitals of a higher commercial fraction through which to move moneys around. And I think that they are skating at the very thinnest of the ice here.

And there is a bigger issue here of do we move them to the still thin ice but somewhat thicker that other folks are sailing on? And also with an idea of trying to just kind of hang on, white knuckled, from year-to-year, to be able to make some plans over a several year period of stability.

What I hear from these folks, at least in my region, is that this is a very difficult thing to look forward toward any kind of meaningful future, to take forward some of the initiatives that have come out here in terms of quality, in terms of IT, including all of those kinds of things just move -- they're at such a negative end of the margin here that they can't begin to think about those things.

And so I think there would be some good -- I don't know if there's a way to soften this or to say we think it's hugely important to have a look at the bigger picture at some point. I'm not enormously uncomfortable with this but I do think it begs the big issue.

DR. CROSSON: I just wonder, based on what Dan said a couple of minutes ago, whether we may not actually be doing an interim report here. If the impact of the MMA provisions is likely to change the baseline data from 2004 to 2005, it might be a little premature to make recommendations at this particular point, but rather actually make comments about what the impact is and that it's not clear yet and outline in the text that there may be recommendations needed. And then when the data comes in

clearer, I think the basis for the recommendation might be more solid.

Is that an implication of what you were saying?

DR. STENSLAND: Yes.

MS. BEHROOZI: Ultimately, I think I'm going to ask a question of Nick. I enjoyed reading this paper because it offered a resolution or a proposal that was easy for me to understand, which is maybe too low a threshold for what should be a MedPAC recommendation, but it certainly was a more elegant solution which I think we're always in search of to matching the payment policy to what it's supposed to be addressing.

So if it's a matter of what the result is, Nick, what I wanted to ask is is your concern specifically related to those 130 to 160 losers, as Sheila helped us break it out, in particular? Or is it overall?

Because of its overall, then it's a matter of the size of the pot I think, as both Dan and Jeff said. If you put more money into it, then you could address those margins. If you're starting from a different baseline, the margins will look different.

But is it about the shift or is it about there

just not being enough in the pot?

DR. WOLTER: I think it's about -- I wish we had the chart from last month that protected what the proposed policy would do for the low-volume eligible and for the not low-volume eligible. And it gives both the outpatient margins and then the overall Medicare margins there. It seems to me we're targeting very negative margins, recognizing -- I think that was a good point, Jay -- if we're going to see some changes that still flow through, that in and of themselves that might change this -- is that what you were suggesting -- it might be that we'd be looking at different numbers at this point in time next year.

But it may be that we don't have enough in the pipeline to put these institutions at least on some kind of level playing field with what else is going on.

The bigger question I'm raising is are we really happy with the outpatient prospective payment system and are negative 10 to 12 percent margins across the board for everybody, is that a good place to be? And that's a much bigger discussion for down the road.

DR. STENSLAND: If I could just make a quick clarification, and that's that we're talking about what's

going to happen between 2004 and 2005. Essentially, all the extra money that's going to be coming in that hasn't already shown up in our 2004 figures is inpatient money because almost all of those increases in payments that we talked about in the first page or so of the report are inpatient.

So we really won't be seeing much change unless there was some underlying change in general in profitability of outpatient. We won't see any change in the outpatient margins due to Medicare policy from 2004 to 2005. We should see some change in the inpatient and overall margins due to those changes.

DR. WOLTER: I think the overall is part of what we've been trying to look at for others.

MR. HACKBARTH: Here's where I think we are. The proposal on the table is a redistributive proposal to better target the money. What I hear you saying, Nick, is in the abstract it sounds like a sensible approach. But you're worried about redistributing money from institutions that have negative margins to other institutions. You're worried about the level of payments that underlie the whole system.

We often talk separately about distributive policies, redistributive policies, and base rate policies

that affect the level of rates. It may be that this is a case where we should not be doing that separately. I guess I would be inclined to drop the draft recommendation. I think the proper place to address your concerns about the base rates paid to rural hospitals, both for outpatient and inpatient services, is in the update discussion.

I have no illusions that it's going to be any easier there but at least it's properly placed, that's the right forum for it.

I think it just makes sense to go with a report that focuses on assessing the impact of the MMA system.

DR. HOLTZ-EAKIN: Does that mean that we would have in the text anything that looks like recommendation 1A?

MR. HACKBARTH: We can discuss it in the text. In fact, we've discussed it in the text, I think, in a rural report last year. Actually --

DR. ZABINSKI: We had it in the March chapter last year.

DR. HOLTZ-EAKIN: I don't think you can remind people what good policy is too often. And I would hate to lose that.

MR. HACKBARTH: That's fine with me, if there's no

objection to putting it in the text.

MS. BURKE: I was going to say that it seems to me, to Doug's point, I think that while we probably aren't ready to go with the recommendation, I think noting this, because in fact we are going to, at some point, address the issue that there's a sunset, that going forward we might want to think about better targeting. But we need to look at this overall question.

Arguably one of the big issues that potentially could complicate this further is if we get into DSH and you start making radical changes in terms of DSH as it relates to rural -- I mean, the overall impact on rural hospitals, a variety of policy changes, as well as the outpatient margin issue.

But I do think, to Doug's point, saying that as we go forward this will be one thing we'll want to think about as that sunset occurs. But also the broader question of reimbursement strategies for rural hospitals is going to have to come up in a broader context.

DR. KANE: I find this very confusing, and this goes back to is there anything here to recommend at this point.

One thing is there's a sunset provision that's a $50 million value. The other thing is a sole community hospital add-on that actually doesn't start, according to your thing, until 2006, according to your paper.

I'm confused as to why we're taking away something that hasn't started yet to replace something that hasn't sunsetted yet. It says beginning in 2006, CMS is adjusting upward by 7.1 percent payments to SCHs for outpatient PPS. And what's sunsetting is this old hold-harmless provision.

Can we just address the sunsetting and say we think there should be an outpatient volume adjuster to replace that, and leave SCH to when we get a better understanding of what's going on in the hole?

You've combined -- the hold-harmless is different than the SCH adjustment?

DR. ZABINSKI: Yes.

DR. KANE: Hold-harmless disappears pretty soon, in a couple of years?

DR. ZABINSKI: Yes.

DR. KANE: One thing you found is that the ones who really need that are the low-volume hospitals. Then somehow SCH got combined into that, that $90 million dollar

value that hasn't started yet. And now you're trying to throw that into this how to fix the hold-harmless piece.

DR. WOLTER: If I understand this right, it's because they're linked in the sense that the sole community hospital payments are related to their outpatient costs. It's just that CMS came up with a different number in terms of the add-on they give.

And then what I think I heard is that within that group some are much more costly because of low-volume than others. So the goal here was -- I thought that was a good word -- an elegant solution that would try to be a better way to target where the issues really are, which I am fine with, I think, in concept.

I'm just so uncomfortable with were these margins are. And I would hope we could include the margin data if the chapter, also. That would be a request, if that would be possible.

DR. KANE: I think I'm with Mitra. I think that this is sort of past comprehensive then, because I don't understand this recommendation, and why the SCHs add-on is included in the resolution of the hold-harmless disappearing? Because they looked like they were too

separate --

MR. HACKBARTH: I'm going to resolve it by getting rid of the recommendation. That's the most efficient way to do it.

We'll have a discussion of this in the text, and then when we talk about updates and base level payments we can talk about the broader issue of the financial status of rural hospitals, inpatient and outpatient.

DR. MILLER: I just want to do one thing in terms of managing expectations. Nick and I had had some conversation on this, so just to give you all the benefit of it.

Nick is raising issues about the broader equity and how well the OPD system is functioning broadly. There has been a desire among the staff to get to this issue, build a model and do an analysis not unlike we did on the inpatient side where we tried to look at the equity of the payment system of the inpatient side.

We've been given some fairly large mandates in the last couple of years, specialty hospital report, SGR report, as you guys are all aware of. And we haven't been able to get to that. But to manage both the distribution and the

level we probably really need some of that work done. And so we are trying to get to it. I think we can look at this issue more broadly in how the OPD is functioning.

MR. HACKBARTH: Okay. Thank you.

Next is IME and disproportionate share.

MR. ASHBY: Okay, we will start today's presentation by briefly reviewing some key findings from our September and October presentations. And then we'll present some data on the impact of options for reducing the IME adjustment and distributing the savings among all hospitals by raising the base rates.

Lastly, we'll discuss policy options and present a draft recommendation related to uncompensated care and DSH payments. You may also want to continue a discussion of IME policy options based on the information that we present today and that we presented at earlier meetings.

First, some descriptive findings. Spending on IME is $5.5 billion and DSH $7.7 billion, together accounting for 14 percent of all inpatient payments. About three-quarters of all hospitals get DSH payments, 30 percent get IME, and about a quarter get both adjustments.

Hospitals getting both IME and DSH, as a group,

have the highest Medicare margins, although we should note here that this will inevitably be so, given that the denominator of this calculation is the cost of treating Medicare patients and the numerator includes the extra payments related to Medicare patients.

Hospitals getting neither adjustment then have the lowest margins and the gap between these two, those getting both, those getting neither, has been steadily growing over the last decade.

In terms of analytical findings, our analysis documented the size of the IME and DSH subsidy, that is the portion of payments that is not explained by the impact of teaching or low income patient care, on the cost of treating Medicare patients. We found that the IME adjustment includes $3 billion in subsidy which is 60 percent of the payment. This finding is based on a regression model, which documented that Medicare costs per case rise 2.2 percent for every 10 percent increment of teaching intensity.

Then we found that the DSH adjustment includes $6 billion in subsidy, which is 84 percent of the payment. The regression finding in this case was that for urban hospitals with at least 100 beds Medicare costs rise 1.4 percent for

every 10 percent increment of the low income share.

We found no relationship, though, between costs and low income share for all other hospitals.

Finally, our analysis found little evidence of any relationship between hospitals' uncompensated care measured as a share of their total expenses, and the IME and DSH payments they receive. That finding, you'll recall, was based on data from the mandated reporting systems of five states.

MR. LISK: So let's move on and discuss our analysis of the potential impact on providers of changes in IME payment levels under different scenarios.

In our analysis, we simulate the potential impact of different changes to IME payments on Medicare margins and the distribution of Medicare payments. For this analysis we have simulated a base case margin using 2004 data that adjusts payments to reflect certain policy changes that have taken place since 2004. These include reflecting MMA DSH policies that raise the DSH cap for rural hospitals and urban hospitals under 100 beds, an IME adjustment of 5.5 percent which is the adjustment that will be in place starting in the 2008 period and beyond. This is lower than

the adjustment that was in place in 2004 but is higher than the current your adjustment for 2007, which we are in now, which is set at 5.35 percent.

We also adjusted the fixed loss threshold for outlier payment cases so that the full 5.1 percent outlier pool was paid out to hospitals. As a reminder, in 2004 the fixed-loss threshold was set too high, so only 3.5 percent of the pool was paid out to hospitals. This change has the effect of increasing our base margin from what you might have seen for 2004 in the past.

We were not able to include in our analysis the effect of the shift over to cost-based weights from the charge-based weights that were in place in 2004. Taking account of these policy changes, our simulated base market is a little higher than what we actually observed in 2004.

This next chart shows the overall Medicare margins by teaching status under three different scenarios. First, is the baseline margin which I just discussed. Next is the margin if the IME adjustment were reduced by one percentage point with the savings returned to the base. The second scenario we show is what happens to the margin if the IME adjustment is reduced to the empirical level of 2.2 percent,

again with the savings returned to the base.

As you can see, as we move from the baseline margin reducing the IME to the empirical level, the margins start to converge and the differences in the hospitals' performance narrows.

If we look to the left at the baseline margin, we see the major teaching hospitals' overall margins are about 12 percentage points higher than for non-teaching hospitals. If the IME adjustment reduced by one point to 4.5 percent, the difference in the overall Medicare margins between major teaching and non-teaching hospitals would narrow to 10 percentage points. And if the IME adjustment were brought to its empirical level of 2.2 percent, overall Medicare margins for major teaching hospitals would still remain 5.5 percentage points above non-teaching hospitals.

Although we don't show it on the slide, the gap in the aggregate financial performance between major teaching and non-teaching hospitals would narrow further to 3.4 percentage points if both IME and DSH payments were brought to the empirical level. So that just gives you an idea of what happens when we take everything to the empirical level in terms of the differences in performance at those

hospitals.

This next slide shows the same information, only for inpatient margins. Remember that it is the inpatient payment system that the DSH and IME adjustments apply to. So this slide shows the effect on the inpatient margin.

Here again, we show a similar narrowing of the gaps between major teaching and other teaching hospitals as we move from the baseline policy to a one percentage point reduction in the IME adjustment and reducing the IME adjustment to the empirical level, although the differences are larger than we saw for the overall margin.

For the inpatient margin we see a 17 percentage point difference in the base case compared to major teaching and non-teaching hospitals. And this difference is cut in half when the IME adjustment is reduced to the empirical level.

On this chart yo can also see that the margin for other teaching hospitals actually goes up slightly. And this happens because base payments for this group in aggregate would go up more than they would go down from their reduction in IME payments.

This next slide shows the distribution of

inpatient payment changes if the IME adjustment were reduced by one point to 4.5 percent. The blue bars show the distribution for teaching hospitals and the green bars shows the distribution of payment change for non-teaching hospital. And in this chart we combined major teaching and other teaching hospitals into the teaching hospital group.

If the IME adjustment were reduced to 4.5 percent from 5.5 percent, 7 percent of teaching hospitals would have Medicare inpatient payments fall between 2 percent and 4 percent. Another 38 percent would see payments go down less than 2 percent.

52 percent of teaching hospitals, those are the smaller teaching hospitals, however would see payments increase. These are hospitals with small teaching programs, less than eight residents per 100 beds.

87 percent of non-teaching hospitals would actually see payments increase. In this group, the group that sees no change -- that you see there in the middle -- are basically sole community hospitals who are paid on the basis of hospital-specific rates. So from putting the money back into the base, they would not get an increase in payments and see no change.

In this next slide, we show the distribution payment changes for reducing the IME adjustment to the empirical level. And here we see a wider spread in the distribution of payment changes. Hospitals with higher resident-to-bed ratios will see the largest reduction in Medicare payments but would still receive the highest IME add-ons. 19 percent of teaching hospitals would see Medicare inpatient payments fall by 4 percent or more. That's the accumulation of the three leftmost bars.

Over 85 percent of non-teaching hospitals would see payments increase between 2 percent and 4 percent. Teaching hospitals with less than eight residents per 100 beds would actually see a slight increase in payments. Again, this happens because the increase in base payments offset their decrease from the IME.

Now Jack will talk about collecting uncompensated care data and some other issues dealing with uncompensated care.

MR. ASHBY: To support development of a mechanism for offsetting hospitals' uncompensated care, Congress, in the BBRA, back in 2000, directed CMS to begin collecting the necessary data from all PPS hospitals. CMS, in fact, did

add an uncompensated care schedule to the Medicare cost report in 2003. But there has been widespread recognition that the form has not resulted in accurate or consistent data.

In this next slide, we show some of the problems with the current S-10. We probably don't want to get into much detail here, but I'll summarize by saying that we think it's critical to have separate reporting of bad debts and charity care, and also to have separate reporting of Medicare and other payers bad debt, since there is a mechanism already in place for Medicare to reimburse hospitals for the unpaid copayments of beneficiaries. Perhaps most importantly, hospitals need guidance on what they can and cannot include in bad debts and charity.

Based on input from several accounting and financial management experts, we have already provided CMS with detailed suggestions on the form and accompanying instructions. Your briefing books provide some additional detail on the improvements that we think are necessary. And if you have any questions on that material, I'd be glad to respond to that after the meeting.

A related issue is that there currently is no

federal requirement that hospitals maintain a formal written charity care policy. Although as an aside here, we now have a California law going into effect on January 1 of 2007 that will require it for California hospitals.

Most hospitals have developed a policy which typically defines eligibility for charity care on the basis of the patients and their family's income, assets and financial obligations for Medicare. But CMS's data collection instrument asks hospitals about this and some hospitals, particularly rural facilities, have reported voluntarily that they do not have a written policy.

CMS might consider requiring hospitals to maintain a charity care policy, perhaps as a condition of participation, because without it CMS would be unable to conduct a complete audit of the data that hospitals report on their S-10.

This leads to our draft recommendation, and that is that: The Secretary should improve the form and accompanying instructions for collecting data on uncompensated care in the Medicare cost report and require hospitals to report using the revised form as soon as possible.

The recommendation pretty much speaks for itself but I would add that we stand ready to work closely with CMS on this and we'd like to get started quickly because it will take about two years to obtain useful data, even assuming that the instrument can be finalized in the next few months.

This recommendation would have no implication on Medicare spending and it would bring about a small increase in hospitals' reporting burden.

Perhaps the optimal way for the federal government to finance a social good is through a broad-based revenue source. Medicare is probably not the best vehicle for an uncompensated care payment as a social good for at least three reasons. First, that the impact of uncompensated care on the cost of treating Medicare beneficiaries is probably small, like the impact of Medicaid or SSI patients, as our analysis has shown.

Second, that uncompensated care comes from all patient groups.

And third, that a payment to offset uncompensated care costs would protect access to care, again for all patient groups.

The concept of a separate federal program to pay

for a portion of hospitals' uncompensated care has been proposed in the past. Financing could come from general revenues, either as a direct appropriation -- as was done, incidentally, to implement an IME payment for children's hospitals -- or through a mandatory entitlement structure to mitigate the uncertainty of the appropriations process. General revenues are less regressive than the payroll tax financing the Part A trust fund, and of course the trust fund is scheduled to be exhausted in 2018.

An alternative approach, though, would be to fund the uncompensated care payment through a broad-based tax on the revenue of health care organizations such as hospitals or insurance companies, as several states have done to finance their own charity care pool.

If the Commission would like to retain the uncompensated care payment within Medicare, we would turn to the current DSH payments, $7.7 billion in 2004 you recall, to provide the funding. The Commission would have to decide whether to recommend using all of the DSH funds for the uncompensated care payment or using some of the money for that purpose and retaining some within the PPS to improve payment equity among all hospitals.

This policy direction would represent a way for Medicare to make its contribution to offsetting hospitals' uncompensated care costs and perhaps other payers would follow suit.

Once the amount of funds is established in relation to DSH funding, the next question would be how to distribute the payment. It could be paid in the same form as the DSH adjustment, a percentage add-on to the Medicare payment rate. But that wouldn't work well because hospitals with small shares of Medicare patients would have a lesser proportion of their total uncompensated care costs paid, and we already have evidence that some of hospitals providing the most uncompensated care do indeed have below average shares of Medicare patients.

A better option would be to break the link to per case payment by distributing payment based on each hospitals' total uncompensated care costs. Once the funding level is fixed, policy would articulate the allocation among hospitals. Basically, each hospital would be entitled to a share of the budget corresponding to its uncompensated care costs as a share of national uncompensated care cost.

Even with Medicare's uncompensated care payment

limited to paying out a fixed amount of money, the payment would probably still lead to significant political pressure to increase funding over time. One way to address that pressure, as well as to target the payments to the hospitals doing the most for patients of limited means, would be to limit the payment to hospitals' charity care in contrast to its total uncompensated care or charity care plus bad debts. And then the payment could be further narrowed by limiting it to the charity care provided to patients whose family income is below a certain threshold, such as -- just as a example -- twice the federal poverty level.

Although it imposes an additional recordkeeping and reporting burden on hospitals, some states have taken this approach for their charity care pools, and hospitals have been willing to provide the necessary data.

Finally, targeting at the hospital level might be improved by limiting payment to charity care exceeding a certain threshold share such as a 5 percent of a hospitals' total patient care costs.

In this last slide, we present several principles for developing a payment to offset hospitals uncompensated care. First, such a payment is predicated on CMS revising

the S-10 and collecting the first round of data, probably doing some initial auditing and analyzing the data.

Second, the payment could be organized as either a separate payment funded by some type of broad revenue source, or within Medicare funded from the Part A trust fund. You will want to discuss whether to be more specific on this issue.

Third, the payments should have a fixed budget. Of course, policymakers would need to devise some way to increase that budget appropriately over time.

Fourth, the allocation of the payments should not be linked to hospitals' volume of Medicare cases.

And fifth, the payments should target hospitals playing the largest role in meeting the needs of patients unable to pay their bills, using one or more of the mechanisms that we saw on the last slide.

So that's our presentation and we open it up for discussion.

MR. HACKBARTH: What I'd propose we do is discuss these one at a time. Let's start with IME.

MR. MULLER: The Medicare program has a long history of supporting IME, explicitly since at least '83,

and I would argue implicitly really going back to 1966, because from 1966 to 1983 we had a cost-base system and the costs of teaching hospitals were incorporated inside that. As the chapter indicates, the DSH payments came in '86.

Part of what IME is for is something that people have different opinions on. It's at least there for the higher costs that a teaching hospital incurs from training the future generation of physicians and other caregivers, largely by having residents and medical students.

As we know from the chapter and our previous work on this, the more residents that a teaching hospital has the higher the margin. So in a sense the more it needs the social mission for which IME payments are set, those having more residents, providing more physicians of the future, the higher margin it has.

Secondly, as we point out, in the DSH program, the payments from the DSH program include both for Medicare beneficiaries that are low-income, and also for Medicaid beneficiaries. That's how we determine the DSH payments. As Jack noted there briefly in his introduction, therefore just as an arithmetic calculation, DSH margins are going to be high in the Medicare program because the payments are

being made on behalf of patients -- that is Medicaid patients -- who are not Medicaid beneficiaries. So you're going to have high margins.

So the more a teaching hospital meets it's social function of training future physicians, that is having more residents, the higher the margin it has. The more it takes care of people who are poor by taking care of Medicaid beneficiaries, the higher the market it has. And then we act surprised.

This reminds me of the scene from the movie Casablanca, where the police inspector comes into Rick's Café, which is also a casino, and all of a sudden notices after a turn of events that there's gambling going on and proceeds to try to close the casino when a courier comes up, "Your winnings, sir", as if this is some kind of shock.

The point here is that the social policy here is to have more residents being trained and also take care of people in the Medicaid program, which increases the Medicare margin. And then we shouldn't be surprised at all that there's a high Medicare margins in teaching hospitals when they have a big teaching program and when they have a big program in DSH.

I would argue we've known this for a while. That is a social mission. And that mission is to cover those costs.

Furthermore, it came up earlier in the discussion of rural hospitals, the high inpatient margin is used in part and at other times to cross-subsidize a very high negative outpatient margin, which obviously -- and teaching hospitals in general have very large outpatient programs, given the scale of their programs.

Also, we don't have the IME payments in some of the rehab component, in the skilled nursing home components, and in the psych components. So we have negative margins in teaching hospitals in those programs that also are covered by these large inpatient margins in Part A. So that's one of the reasons we like to look at total Medicare margins and not just focus on the inpatient margins.

We also know that we have difficulties in the DRG system. This commission dealt with that in the specialty hospital report a year and a half ago. And some parts of our recommendations at that time to modify the DRG system have been implemented in part. But our recommendations on severity adjustment have not yet been implemented. I think

it's the feeling of many people that once there's a better severity adjustment system, that might better reflect some of the costs of teaching hospitals as well.

Having seen what happened with our recommendations on how to better capture hospital cost-to-charge ratios and see how it was first proposed by CMS to be implemented, which is different than we had interpreted, I would first like to see how CMS implements any severity adjustments we ever come up with. But certainly, if we had better severity adjustment inside the system, we could probably have a better reflection as well of the true acuity of costs inside teaching hospitals.

Jack and Craig, I'm a little concerned about how we did our simulation here, as well. Because, for example, you note that you look at these high margins and obviously the high margins then become a target for people looking at where monies can be looked at in the Medicare program.

But for example, to put the outlier payments in at a simulated level rather than at the level that they're at just overstates the margins. I don't quite understand why we don't put them at the level at which we're paying the payments rather than at the level at which they should be

paid. In other areas we look at the payments that are being made, not what the payments could be.

Furthermore, I'm also concerned on the DSH side, in a sample of five states in terms of uncompensated care and how we did that calculation. I must say the findings here that the DSH payments are almost randomly correlated with levels of uncompensated really surprised me. That has not been my experience in looking at hospitals. I don't have the whole database memorized the way this report purports to do. But I think we need to look at more than just those five states because those findings were so surprising to me. I think we all would have concern if DSH payments are randomly correlated with levels of uncompensated care.

Obviously, since the calculation is not on uncompensated care per se, but on Medicare and Medicaid SSI, and as we pointed out that is probably not the best proxy in the world for uncompensated care. But to have it randomly associated, as our chapter indicates, is very surprising to me. So I would like a little bit more analysis of how representative those five states are and what a national sample would look like, because that finding just totally

perplexed me that it was that far off.

In summary, I feel we've had this discussion for a couple of years that obviously it's easy to see and the empirical evidence indicates that teaching hospitals have higher Medicare margins than other hospitals. But I would say it's a direct result of the programmatic design that says the more teaching you do, the higher the inpatient margin you have. The more uncompensated care, or as we define it the more Medicare patients you treat, the higher the inpatient margin. Those are policy decisions that go back at least 23 to 20 years. I think they're well built into the system.

And then given the fact that these hospitals also provide other services on which they lose an awful lot -- I'm trying to remember from last year, but I think the SNF margins for teaching hospitals are well beyond the negativity that Nick referred to for outpatient programs. I seem to remember they're north of minus 50 percent.

So when you think of the fact that we have to cross-subsidize all these other programs within those inpatient margins, it doesn't bother me as much, obviously, that these inpatient margins can support the enormous social

goal that teaching hospitals provide.

MR. ASHBY: Can we respond to those two points? We'll do in order, Craig will take on the outlier one.

MR. LISK: One thing, just to clarify on IRF and psych PPS's, there are IME adjustments on those payments systems, just to clarify that.

On the outlier payment system, and the reason why we modified things to put it at 5.1 percent, because that is what, in theory, is supposed to be paid out by CMS. CMS doesn't always hit the target. So sometimes it's 3.5. It was 3.5 in 2004, but in theory CMS should hit the target. Sometimes they over hit the target. And so that's what we are doing, and our policies are just comparable, assuming 5.1 percent outlier pool throughout the options that were consistent across that.

One other point though to say, in terms of how we were conservative in our estimate of the IME adjustment of 2.2 percent, 2.1 percent if we look at the actual policy that was in place in 2004. If we actually corrected that for outliers, the actual empirical level, the IME adjustment would be 1.9 percent. Instead, it would actually be a little bit lower. So I just wanted to give you that little

piece of information.

The other thing, in terms of when you look at the outcomes of our margins and when we actually take out the DSH subsidies, it's to give you an idea of also our empirical simulations that we are being, I guess, conservative in our estimates and how we're approaching this. Because otherwise they may have narrowed right to zero if we accounted for absolutely everything. We're still seeing the margins higher in the teaching hospitals versus other hospitals.

DR. MILLER: Can I just make one point on that? The pattern of narrowing the differences between the three categories of hospitals would still be present whether you modeled it at the 5.1 level or the actual level.

MR. LISK: And that's absolutely correct. That pattern would really be the same if we did that, yes.

MR. ASHBY: On the pattern of relationship between uncompensated care and IME and DSH payments, we were concerned too that five states might not be totally representative of the nation, even though the states have the best data systems for an analysis like this. So we actually replicated the entire analysis on uncompensated

care data from the AHA annual survey.

It was really rather interesting how similar the results were. We recreated the same graph that we have in the report and it looks almost exactly the same. So evidently what we found is fairly representative of the nation and GAO did a good job of picking states for the analysis.

DR. MILLER: I would just be a little careful about representative of the nation. We've have had some issues with the national AHA data. So we ran it both ways just to sort of see what two datasets with different sets of flaws would produce in a sense. We think the five state data is probably the best that's available at the moment. The reason that there's only five states is because that's whose basically collecting it at this point.

The other thing I would say on that comment, the characterization was that it's randomly associated. Do we feel like it was randomly associated or just not particularly one-to-one?

MR. ASHBY: Randomly associated might be a little strong. You can see at the top of the distribution that there are indeed some hospitals with large DSH payments that

do have large uncompensated care. But you'll also see many examples on both ends where they have large uncompensated care, low DSH, and vice versa.

So there is some relationship but it's a rather limited one.

MR. MULLER: I want to come back on the DSH statement, because Glenn asked that we talk about the IME first.

Let me just make one more point on the teaching hospital that just comes from this morning's discussion about both the organization of physician groups and potential options on the SGR. And that is in so far as we have some slight policy preference for more organized groups and more accountable units, the teaching hospitals with their employed medical staffs and larger multi-specialty groups become a natural setting in which one has multi-specialty and accountable units.

I don't want to pretend that they're anywhere near as organized as a true group practice, as Jay represents. I don't want to stretch it that far. But they do have a multi-specialty nature. But more importantly they are truly accountable units because you do have 500, 1,000, 1,500

physicians under one organized governance process and they can be, in that sense, an accountable unit.

If one of our real objectives in terms of the long-term overall reform of the Medicare system is to have more accountable units, especially that link both the -- to use Medicare jargon, Part A and Part B, or to use more natural terms as linking physician and hospital policies -- I think they become a good natural setting for that kind of effort.

MR. HACKBARTH: The topic for the next 15 minutes or so it's going to be IME.

DR. CROSSON: On the IME discussion, I just want to get a couple of quantitative things straight.

With respect to the two options that we had there, a one point reduction or reduction all the way to the empirically justified amount, I think that's about one-third of the way. Is that right? The difference is about three points, between 2.2 and 5.1; is that right?

MR. LISK: It's 5.5 to 2.2, so 1.1.

DR. CROSSON: So it's somewhere between a quarter and a third.

The second one is this issue of the likely impact

of severity adjustment, the severity adjustment part of the recommendations that we made previously. Any idea quantitatively what impact that would likely -- I realize it depends -- but what impact that would likely have on increasing margins for large teaching hospitals?

DR. MILLER: This is what we were talking about in the hallway last night; right?

MR. LISK: Yes.

DR. MILLER: Craig caught me in the hallway at the end of the night and we were talking about this. This is fairly complex. You arrive at it by if all of this and not this, and if all this and not this, and you have to do it a couple of different ways.

My takeaway from the conversation, and I'm not sure about the answer to the margin question, it's about in the neighborhood of a point; right?

MR. LISK: Severity adjustment itself, APR-DRGs, brings down the empirical level of the IME adjustment by a little less than a point, about a point. But the other things on top of that, the cost-based weights and those things, raise it back up to pretty close that it's a wash between the current system and the APRs in terms of what the

empirical level is for IME. But severity adjustment, by itself, lowers it by about a point.

DR. MILLER: You understand that the different adjustments in the DRGs cut in different directions on the teaching hospitals, the severity adjustments help it, some of the other don't.

DR. CROSSON: So the net is up, down, or nothing?

MR. LISK: The net, the empirical level goes up a tiny bit when you do everything, all the refinements, together. It's pretty close to what the current system is, in terms of defining the empirical level for the IME.

MR. HACKBARTH: I think what Jay is asking is how much money does the severity adjustment shift towards teaching hospitals? How does that compare to the won percent reduction in IME?

MR. LISK: And that's pretty close.

DR. BORMAN: Just a couple of things to clarify. In the paper we say that 20 percent of teaching hospitals roughly receive only IME, so roughly one in five. And that particularly institutions that receive both in large amounts are tightly concentrated, one might even say 90th percentile and up is a pretty huge chunk of the pot, people who are at

the 90th percentile and up.

If I heard you right on slide at number nine, that was the distribution of reducing to the empirical level inpatient payment changes, it was roughly 20 percent -- I think you actually said 19 -- that go from minus four or potentially more negative. Right?

MR. LISK: In terms of change of payments.

DR. BORMAN: Out of that group of folks, this minus 19 percent, how much of that is represented by those really high-end recipients?

MR. LISK: The above 8 percent is roughly the hospitals that have a resident-to-bed ratio of greater than 0.5, so 50 residents per 100 beds or more.

DR. BORMAN: Because I think one of the things that I'm interested in this is a bit what might be lost in looking at the aggregate that you learn by looking at the distribution here. Because I'm a little concerned, particularly when we've collectively now have thought about these issues together and discussed them together, that we keep banging on -- there is a small subset group that's getting a fair amount of money here, there's no doubt about it. And my sense is that that's where some folks here have

their biggest concerns.

So I just want to be clear on things that redistribute, one would hope redistribute more away from those that we perceive that currently may be the most unfairly advantaged.

Is that what you perceive as happening here? You're familiar with the data. You see from whom to whom we're talking about going here, because we're looking at bringing people to a margin that's under 2 percent based on some best guess scenarios about which there have been some cogent concerns.

So is this a distribution that mostly takes from richer to less rich or more poor to less poor, or whatever? Is this a redistribution that benefits people who are at the lower end of the spectrum within the community?

MR. LISK: Yes, in general that's the case. Of course, there's a distribution among teaching hospitals and their own performance but yes, generally we're taking money from people were doing by far the best under the program and giving it back to the people who aren't getting the adjustments and would be increasing their margins in terms of the non-teaching hospitals, for instance.

DR. BORMAN: I couldn't agree more with the importance of the recommendation to get data and get better data and get it fast. To move these things around with the implications for the future in a non-data-driven matter really is a default of everyone's responsibility that's a party to all of this, not just the folks in the room. I certainly have banged on my folks at home, which is about where all I can do that. But I think it's hugely important to do this in a data-driven way.

I would just reiterate Ralph's comment that most academic medical centers, certainly most university ones, are very much closed staff models and offer the perfect opportunity for some of the demonstrations and taking ownership of some of those issues and perhaps some of us have not done as good job of that as we can. But I think going forward we certainly represent a big chunk of that community in the direction that we believe there may be good opportunity to go.

MS. HANSEN: I'd like to come at this perhaps as the going forward comment that, Karen, you just ended with of having Medicare be a value purchaser for IME. I think Ralph, with the comment of the fact that the payments have

been going on in this format for training residence for the past 20 or 30 years.

The value purchasing equation I'd love to see inserted on a go forward basis is a comment relative to the expectation of knowledge of Medicare recipients; i.e., geriatric types of content or evidence-based protocols, teamwork processes that could really ultimately affect the quality of care.

I know oftentimes this has been indicated that this may be a little bit more on the graduate medical education side, the GME side. But it seems like these components are linked frankly to treating a beneficiary. So the outcome I definitely would love to see is that opportunity to have a product for the money that's given to the institutions that receive them.

DR. HOLTZ-EAKIN: I just want to make sure I'm thinking about this right. The way this seems to me is that the empirically derived level actually solves the targeting problem, and you've now got the money matching the social mission of compensating for the cost of having these folks around.

And then the question is what do you do with the

rest of the money? One thing I hear people saying is well, you could fix the worst of the targeting stuff by trimming the upper end of the distribution or something like that. But that doesn't solve the question of what are we getting for this money that doesn't match the mission?

So what I heard you say that I thought was appealing was there ought to be some accountability groups or something. So take that money, make it available to hospitals, but make sure they deliver something for it. Have a fund that's an enhanced pay-for- performance or something. But you don't just hand it out just because they happen to have people walking the halls with labels on their heads that say student. I think you have to get something for this.

I think you should put a lower priority on arguments that say that we don't know if CMS will implement the recommendation right. I worked for Congress and the White House for six years. That shouldn't enter the equation. You're not going to be able to guarantee that.

I'm also less sympathetic to the idea that doing this right somehow doesn't solve all the problems. I think we have to get this right. This is about these monies, this

is a lot of money, and we ought to get something for it. That seems to me the right way to frame up the problem.

DR. KANE: I'm just going to, first of all, repeat what I said in the last meeting because Ralph wasn't there then. I think if you look at page six that shows the overall margins, overall Medicare margins, major, other, and non.

I come from a state where we have a lot of major teaching hospitals. And what this has really meant is that the major teaching hospitals are able to be in a much better competitive position.

Nick was concerned about low margins in the rural hospitals. And if I were Nick, I would be speaking up and saying why do we have this baseline case? What is the social -- again what Doug said, what's the social benefit of that?

Congress, I know back in 1984, I was around actually for that, I thought part of the reason they doubled the empirical value was to make sure teaching hospitals supported the implementation of DRGs. I think we can all impute certain social goals here but we don't really know what they are. And what's happened is what happened,

whether or not Congress intended it.

But I think if you look at where we are now, we really do see a competitive disadvantage for community hospitals, for non-teaching hospitals. The way that plays out is actually going to affect who wins at pay-for-performance and who wins at getting physicians into groups that are actually manageable. Teaching hospitals have the resources to buy up physician practices, to insert the IT, to train the physicians to become more cost effective and quality oriented. Community hospitals really have to get it out of a different source. I think we really have to level the playing field.

Most of our physicians are not affiliated with teaching hospitals. They are in the community. And we want these community hospitals to start doing more of the role of leadership in helping doctors get the IT systems and the infrastructure in place. We've given the teaching hospitals a running head start on that, but I think it's really time to think about what we've done to the community hospital playing field.

One argument I've heard is well, the community hospitals are better able to negotiate better rates with the

commercial sector. Well, I have not seen that in Massachusetts. It's actually not the case in Massachusetts in a truly competitive market.

But I think the other side of that is all it means is they've been able to cost shift better than the private sector. Is that a good social mission? Is that what we really want to have Medicare policy encouraging?

So I would just encourage us to think very hard about how to make this an equitable payment system and not just pay for some kind of unfocused goal of better societal goals that we haven't articulated?

And I support Jennie's idea that we should be asking for more of the teaching hospitals in terms of who they train and how they train the residence. That may well fall into something more related to how we pay for the residents, the direct medical education piece, who they train and whether there are caps or limits, and whether we maybe lift the limits on the caps if they'll train gerontologists and primary care docs. That may be the easiest way to get that kind of social policy made clear, instead of some kind of vague add-on that we don't demand accountability for.

So I guess just to reiterate, I think this chart on page six suggests that we've created a fairly inequitable system here for the non-teaching hospitals and that we really have an obligation to try to level the playing field and make community hospitals a little more whole so that they're enabled to do the kind of things that we hope everybody can do in pay-for-performance and quality improvement.

DR. MILSTEIN: I support Ralph's suggestion of linking the redistribution of these calculated overpayments into the base payments, linking that to implementation of our recommendations on severity adjustment. No? You didn't say that? It wasn't sure.

Then I'll say that on my own.

Secondly, I also want to strongly reinforce a number of comments made that irrespective of how this first issue is resolved of doing much more to link these payments, both direct and indirect, but today's topic is indirect, to a more honed vision of want the social mission is of training. As Jennie outlined, focus on aspects of training to be much more valuable to beneficiaries.

My short list from the last two years of

discussion would have, in addition to geriatrics, medical informatics/IT and the use of systems engineering to improved efficiency and quality of services. I think if one were to do an audit today of the number of full-time faculty FTEs, faculty that are primarily expert in these three areas, it would not be a happy result.

The speed at which this happens, obviously I would look to leadership from AAMC and teaching hospitals to guide us. But I think we've been through 40 years of no conditions on both direct and indirect medical education payment in terms of educational content and it's left us with an equilibrium that -- if I can paraphrase Jay -- is a situation where well run delivery systems keep telling us it takes them a year or two to untrain and retrain the products coming out of our medical schools. I think enough is enough.

MR. HACKBARTH: Let me pick up on the Arnie's proposal to link a change in IME to implementation of a credible severity system. But before I go there let me just go back one step.

When we started this conversation I think we identified two broad categories of problems. One is

illustrated by this graph. Do we have a payment equity problem among the different types of hospitals? And then the second was an accountability issue. We're putting out billions of dollars. What exactly are we buying for that?

We've talked a bit and thought a bit about whether you can do anything on the accountability front after the act. Can you go to hospitals once they've received the money and say what did you use it for? And file reports on that.

I have mixed feelings about that. On one level it seems like a commonsensical thing to do. On the other hand I'm concerned about the credibility of the information that you would get. Because really the question you're asking people is what would you drop if you didn't have this money? And that's a hypothetical question to which people can generate hypothetical answers and they're not real, hard answers to the question.

So as I've thought about that track of after-the-fact reporting, it doesn't seem useful or productive to me. You've got to deal with this issue on the front end before the dollars go out the door, not on the back end.

Now thinking about the payment equity piece of

this, MedPAC has recommended implementation of a severity adjustment system. We talked a little bit about the magnitude of the dollars that would be shifted by that system towards teaching hospitals. It seems to me that it may be an opportunity to say, rather than do that and shift more money in this direction, let's use this as an opportunity to do one of three things with the money. I think there are three potential paths you might take.

One would be to say we'll take a piece of the IME adjustment about the empirically justified amount when severity is done and put it back in the base to be redistributed to all hospitals, and address -- at least in a small way -- the graph that's up on the screen.

A second path would be to say okay, let's take a piece of that money and start tying it to performance and get something specific for it and, for example, put it in a pay-for-performance pool which would at least allow teaching hospitals an opportunity to earn some of it back based on superior performance, defined with these measures.

A third path would be the one that Arnie and Jennie have suggested, which is to use these dollars to begin promoting and encouraging supporting a change in how

we educate our medical students and residents and link it to things like training more geriatricians and so on.

So I think those are the paths that at least seem obvious to me.

Just one last point on this. I think that a severity adjustment is a very good thing to do. I would have liked to have seen it done in the initial package as part of our overall DRG refinement recommendations. For a variety of reasons that didn't happen.

Now I fear it's in jeopardy. It's become isolated, if you will. And because it redistributes money towards teaching hospitals and away from community hospitals and rural hospitals, I think it's vulnerable. It's good policy that's vulnerable because the politics don't look very good, in view of this graph.

So I think that if we were too link a change in IME to severity, in addition to good policy it may also be good politics and increase the likelihood that we can actually get a severity adjustment that targets the money to the institutions that truly serve the sickest patients, which I think is an important thing to do.

As for how to direct the dollars, whether to put

it in the base, pay-for-performance, or medical education, I think there are pros and cons of each of those paths. For myself, at least at this point in time, I don't have a really strong feeling that one is right and the other is wrong. We could try to reach consensus on that or we could simply lay out the alternative paths and some pros and cons to each.

So those are my thoughts and they are informed by conversations with all of you. I would welcome reactions.

DR. REISCHAUER: Let me come to Ralph's defense and then side with the opposite forces.

[Laughter.]

DR. REISCHAUER: The question was why pay more than the empirical amount? And the empirical amount is associated with the extra cost for services to Medicare beneficiaries but presumably they're extra costs to serving the general public, as well. And one could argue that this is a broader social function of training people that are going to serve the society as a whole, not just Medicare patients, so give them more for that purpose.

The opposite argument or the counter argument would be well, shouldn't private payers, Humana, Aetna, and

those people, belly up to the bar and pay their share? And then Ralph, who runs the hospital, says yes, but they won't. They'll just go somewhere else. They'll send their patients somewhere else.

I think they should. And so I'm would actually not succumb to that set of arguments.

Nancy said look at these disparities and margins here. And we have to remember that these disparities and margins also include the DSH payments as well. And before we talked about how unlevel the playing field is, you would want to see these without the DSH additions to them because the DSH is for something else.

So this really gets into a horrendously complicated set of considerations.

Glenn suggested where it could go if we took it away into the base payments, medical education or pay-for-performance. I would just say that pay-for-performance I think it would be very hard to set up a separate pool for teaching hospital pay-for-performance as opposed to pay-for-performance in general. And if it were for everybody in general, which is fine, I think it would hardly be considered adequate by those who were involved with teaching

hospitals.

MR. HACKBARTH: Just to be clear, what I envisioned was not a separate teaching hospital pool but it would enhance the overall hospital pool and make it bigger so it has more power. And then if teaching hospitals do well on the measures they could earn back some of the money.

MS. HANSEN: I'd like to tie all of the three thoughts you had, the severity adjustment, the pay-for-performance, as well as the geriatric contact.

I like the idea of the severity adjustment or the risk adjuster on the patient. My concern about the complexity of taking that by isolation is the fact that oftentimes older people inadvertently get into the situation of receiving iatrogenic care. In other words, they go in the hospital, something else gets worse, something else gets worse. I think the New York Times article that was included in our packet showed that.

So if we get paid for that complexity to the fourth degree, then I don't know that we're incenting incorrectly unless it's tied to an appropriate sense of quality and pay-for-performance for this, which then is

implicit with knowing how to treat complex geriatric patients.

If we do these things, I'd like to show how they are actually interrelated. And I don't want to inadvertently pay more for accidental care that creates more severity.

DR. HOLTZ-EAKIN: I just want to say that I also think they're all related and not related separate. My vision is that the difference between those lines at the top and toward the bottom is that those are harder cases and they're genuinely better outcomes and the students learned that that's what works, then teaching hospitals can get the money and the lines can stay apart. I have no problem with that. We just need to know that's what's going on.

MR. MULLER: Let me also just speak to the point that Bob made, and Nancy, since a lot of this is driven by the higher margins, a lot of that margin is driven by DSH. So to just use the IME lever as a way of dealing with the margin when half of it is DSH, we're just pounding a nail because we have a hammer.

I think we should look at the interrelationship of dish and IME, as Bob pointed out.

In our discussions in the past -- and I think there's a lot of appropriate questions about the distribution of DSH, as the chapter indicates. As usual, in all our discussions over the years, we focus on IME even when we say we're going to talk about IME and DSH.

MR. HACKBARTH: Yes. We are going to shift gears.

MR. MULLER: I do think we should not just look at the IME. If we want to look at those margins in a different way, we have to realize it's a combination, as Bob said, of IME and DSH, not just IME.

MR. HACKBARTH: Any reaction, Ralph, to what I said?

MR. MULLER: I think the severity adjustment is something I was in favor of year-and-a-half ago. I'm still in favor of it now. And insofar as it therefore changes the funding for teaching hospitals in a positive way, I think your suggestion on the IME is a fair one.

I think the question of how to -- on the pay-for-performance and the target, I think there's a lot of attraction to thinking about whether it's geriatrics or informatics and so forth.

They're obviously, as Arnie indicated, if there

are, by his standard and other people's standards, too few people doing this, there must be powerful signals in the overall health care economy that keep people from going to these fields, as opposed to being cardiologists or...

So I think whether one could have a sufficient signal just within Medicare payment policy to overcome all of those other signals, and those are signals that are not just having to do with income, have to do with lifestyle, have to do with so many other factors.

I am, on the one hand, persuaded by the fact that it would be good to send some signals in that direction. My sense is we wouldn't be able to send powerful enough signals to overcome all those other ones. So we might feel good about but I don't think the signals we could send are powerful enough. There's real reasons why people don't go into that. I, too, would wish more people went into it. But I don't think we have enough to target in that direction.

MR. HACKBARTH: A quick comment on this and then we need to move on to DSH.

DR. BORMAN: Just regards to a piece that was in the report, relative to the prevalence of certain services

such as burn care, trauma care, transplantation, concentrated in major teaching hospitals.

I think that there may be others, and again I think number one, one can say all of the things I've just listed are not exclusive to Medicare beneficiaries. But that we would all agree that probably they are a piece of our health care system that we want. I think there's probably some others that are concentrated in teaching hospitals, in terms of neonatal care, in terms of potentially some kinds of oncology care, bone marrow transplant programs come to mind, some of those kinds of things.

I would point out that I think preserving those makes you want to be a little bit careful about just how low you bring this margin, what you may be putting at risk. So I would just remember those background services a little bit.

MS. BURKE: Glenn, if I can just ask going forward, I think we need, because I think the visual aids lead one in a direction, I think we need to have charts that show IME separate from DSH and what those margins look like. Because I think this confuses the question.

To Karen's point, I think there are a variety of issues, I would argue, in fact, that teaching hospitals do do that are different. And we ought to at least understand how much of a margin are we moving around? What's the result of that? I think it is a much more complicated question but this certainly masks and suggests that we're going to have these wholesale shifts when I'm not sure that's entirely the case, if I understand that these numbers do include both in the margins. If they don't, that's one thing. But if they do --

MR. ASHBY: Just to clarify, the DSH payments are in all three of the numbers you see up there. You are seeing the impact only of the teaching changes.

MS. BURKE: I understand.

MR. LISK: Although like I said, if we go to the fourth thing that's not there and I mentioned is if you put DSH to the empirical level, which is kind of treating it differently, you still see the major teaching hospitals having about a 3.5 percent overall margin that's higher than the non-teaching hospitals. If you look on the inpatient side, that difference is about 6 percentage points.

MS. BURKE: Again, as we look at DSH and we look

at its impact and what that distribution would look like as we look at IME separately and its distribution, I think those are important questions to keep in mind. And how the money is used, to Karen's point, is an important question.

MR. HACKBARTH: Let's turn to DSH.

What I hear is a clear consensus that we ought to again recommend collection of data on uncompensated care. That's a repeat of a past MedPAC recommendation.

I also hear consensus that those data then ought to be used to rewrite the formula, to direct the dollars to the institutions that provide the uncompensated care.

Implicit, and I think needs to be explicit, is that what we're talking about is a system that allocates a finite pool of dollars. I'm not sure exactly off the top of my head out to define that, as opposed to our saying that the federal government should take on an open-ended commitment to fund some percentage of uncompensated care

With regard to DSH, here again I hear some different options that we need to grapple with a bit. And these are options that have to do with the placement of this revised payment adjustment. One option, of course, is to leave it in Medicare, in which case it could be structured,

I guess, so that it's not payroll tax financed. Personally, I don't have real strong feelings on that for reasons that some other people I think have mentioned. The payroll tax is not perfect by any stretch, but this payroll tax is uncapped, unlike the Social Security payroll tax. And so it has that element of progressivity in it.

I think more the issue about keeping it within Medicare is an issue of stability and confidence in the financing that it's going to be there, as opposed to an appropriations process where it will be up against competition with many other important worthy programs. At least some of you have said to me that you draw some comfort from it being within Medicare.

If it is within Medicare perhaps the most important issue, from my perspective, is it really ought to be unhooked from Medicare admissions so that the amount of dollars flowing to an institution is not a function of its Medicare volume, since many of the institutions that most need the money for caring for uncompensated care patients have low Medicare volumes, not high Medicare volume.

We thought a little bit about some other options for placement, one being Medicaid where there is a

disproportionate share system. But I don't know a lot about the Medicaid disproportionate share system, but what I've heard doesn't inspire me to think that that's the best place to get the dollars well allocated.

So to sum up, what I'm hearing is collect the data, rewrite the formula, keep it in in Medicare, unhook it from admissions, and whether it's financed with payroll taxes or some other way probably isn't something where we've got expertise. That's not a health policy judgment. That's a federal fiscal judgment that we probably ought to just leave to other people, namely the Congress.

Reactions to that summary?

DR. KANE: Just because I've been involved a lot with state reform and DSH issues, a lot of uncompensated -- uncompensated care currently is very hospital-centric. And yet, what you really would rather is that it was primary care-centric, or at least included the physicians and had a broader reach.

I think to be responsible, we really should think a little bit about whether it should be hospital-centric if you're going to pour $7 billion into trying to support the uninsured or the underinsured. Where would be the best

place to put those dollars?

And in part of the reporting in that supplemental schedule 10, that hospital thing, we might want to add something about community health centers that are supported by you, or for physician -- a lot of teaching hospitals and non-teaching hospitals have to pay the doctor to show up to take care of the -- and I'm just trying to think, should we just be hospital-centric about how this money gets allocated? Or should we try to expand the way we think about how $7 billion ought to go to support the uninsured?

MR. HACKBARTH: Two quick reactions to that. One is that given the press of other topics, all of the update recommendations, the SGR report, et cetera, we don't have the time or resources to invest a whole lot more in this. Certainly, we could mention that in the text.

The second reaction is your comment reminds me of a piece I saw in the New York Times I think about two weeks ago. It focused on hospitals actually deciding well, the way to deal with this from their own standpoint is to do outreach to patients. And they focused on care for diabetics on an outpatient basis. As opposed to waiting for them to land in the hospital and become a very expensive

uncompensated care case, why don't we invest some dollars further down the pipeline and try to get them better care on an ongoing basis? Which would be very consistent with what you said.

DR. HOLTZ-EAKIN: Given your summary, I may be in the distinct minority but I think it's important to recognize that this is not a Medicare problem. This is not about serving the Medicare population at all. So I don't think it belongs in Medicare.

I was the one who suggested Medicaid, not because I wanted to trumpet the virtues of the Medicaid DSH payment. I don't. It's an awful setup. But there are these two disconnected systems, ostensibly under the same problem.

If you're going to keep this in Medicare for reasons that are outside the standard objectives of Medicare policy, they ought to at least be coordinated. It doesn't make any sense to me to have two bad systems floating around out there not hitting a problem that's very real.

So I'm not suggesting you put the money in Medicaid, at all. I don't want that misunderstood.

Then there are two things that I think are overstated. First of all, I think the financing issue is

irrelevant. Medicaid is general revenue. Medicare is general and payroll taxes. The dollars flow back and forth. So I wouldn't worry about that a bit.

And I don't think going forward, and this is pure speculation, an enormous difference between the stability of appropriated and mandatory programs. Everything is going to be under fire and the Congress has shown a steady willingness to fiddle with mandatory programs on an annual basis. So that labeling is also, I think, largely illusory.

I think if you've got a poorly targeted program that's costing money, you're a target. And it's better to have a program that makes some sense somewhere, it's more likely to be stable in a political environment if it makes some sense. And that's what I think we should aim for.

DR. CROSSON: I would support the approach you outlined.

I have one technical question, and it has to do with the future accuracy of the data on uncompensated care and sort of thinking about the problem we're going to look at two or three years from now.

I couldn't tell from the information about the S-10 form or the suggestions for improving it that you're

going to put in. Is the quantitation a function of hospital charges or hospital costs?

MR. ASHBY: The hospitals would report charges and they would be converted to costs with an RCC.

MR. BERTKO: I'm going to agree with you, Glenn, on saying that whether it's payroll tax or general revenue is outside of our domain. Other people are paid and elected to do this.

But I'll disagree with Doug and say that I would certainly want us to have some modest discussion because the Part A trust fund will run out soonest of all of all of these things and put some pressure on the payroll tax. I think a general revenue source here is preferable over the long run.

DR. SCANLON: Just to raise -- I think you have set out some good objectives. But there's a question of how far you go and whether you're trying to make an incremental change to what we have now which might produce better targeting versus trying to make a much better program and meeting a lot of objectives and having Medicare as the administrative of it. I think if we take everything that you say we may be in that latter camp.

I could think about how I could improve targeting, still use payments per Medicare admission, and take into account the Medicare admissions relative to their uncompensated care load, and get the money in the right places. I don't know exactly how I'd do a finite pool in terms of controlling that over time without some kind of a new structure within Medicare.

And then as we start to move in that direction, if we're to take Nancy's idea and say it's not just hospitals, we're again moving and broadening the objectives, making it harder to say we're doing this in the context of Medicare.

Just a comment on Medicaid. I think the problem we would face on the Medicaid side is Medicaid is not homogeneous. We've got 56 formulas out there. And it would be this issue of how do we impose something that requires rationality on the part of all 56 of the Medicaid programs to coordinate with Medicare.

So that's why I think it's not someplace we can go, or the Congress, even. The Congress has been reluctant about too many mandates on states.

DR. HOLTZ-EAKIN: Just to make my point clear, my point is not that we're going to impose anything on

Medicaid. I have no illusion about that. Tennessee doesn't get any Medicaid DSH payments. Zero. They missed the boat in 1997. So in designing anything you do in coordination with Medicaid, you have to recognize that. That's all.

MR. DURENBERGER: I'll do this quickly. I didn't want Dough to be the only one on the Commission aligned with the theory of why are we in this business, and I only reacted in response to what John said, if we are -- as we should be -- really truly concerned about the bankruptcy of Medicare then we should get out of both of these businesses, IME and DSH.

I don't think we're prepared to say that, but I think it is a reality that these are institutional support payments in which it would be nice if everybody thought it was a good idea, but they don't.

And so as a consequence of that, I just philosophically wanted to be associated with the idea that if we had a vote on pulling Medicare out of both of these programs and building up our capacity to reimburse for performance in the system, I'd like to be associated with that.

MR. HACKBARTH: Okay. We need to move on.

DR. MILLER: A quick process thing. What I'm hearing here is this conversation will be reflected in a draft chapter. The only recommendation we've spoken to is the data collection one. And from a process perspective, hopefully we can come back in December and maybe just deal with that in sort of a very narrow way, take a vote on the data collection. And then meanwhile, you're reacting to what's written in the chapter, trying to capture these concepts that we've all been talking about.

So you get a sense of the process and how it will play out. Everybody see that?

MR. HACKBARTH: Okay. Thank you Jack and Craig.

We are now to update on Medicare private plans.

Welcome, Carlos. This is your first time at the table. Who's going first?

MR. ZARABOZO: I'll be going first.

The three of us will be talking about topics related to private plans in Medicare. We'll give you an update of enrollment figures for 2006, plan payments as they compare to fee-for-service expenditure levels, and beneficiary access in 2007 to MA plans. We'll also be reviewing past recommendations that the Commission has made

related to Medicare Advantage and Part D.

As far as enrollment, this slide shows that there's been a significant growth in enrollment in 2006. As of July, overall enrollment in private plans stood at 7.4 million. This includes MA plan that participate in the bidding process and other plans such as cost plans that do not bid.

Between December 2005 and July 2006, the overall enrollment grew by 1.2 million or 20 percent. As a result, total penetration was at 17 percent as of July. That is 17 percent of the Medicare population is enrolled in private plans through which the beneficiaries receive their Medicare A and B benefits. This is very close to the historical high of 18 percent in 1999.

Enrollment growth has been particularly strong in rural areas where the rate of growth was 77 percent. We should note, however, that 40 percent of the rural MA enrollees are in private fee-for-service plans and in rural areas over half of the enrollment growth, 52 percent, is attributable to the increased enrollment in private fee-for-service plans.

This next slide gives you an indication of what is

happening in private fee-for-service. The total enrollment growth is 20 percent but in private fee-for-service between December 2005 and July 2006 the enrollment growth was 270 percent, compared to 11 percent in local managed-care plans.

Regional PPOs, which had only 82,000 as of July, they are not available in the previous year. And non-bidding plans such as cost plans had a decline in enrollment. As pointed out in the note there, nearly half of the total enrollment increase is in private fee-for-service plans in this time period.

To set the stage for the discussion of the MA benchmarks and payments, this slide is a reminder of the Commission's position with regard to payment neutrality and payment of Medicare Advantage plans. The Commission strongly supports private plans in Medicare and believes that beneficiaries should be offered the choice of delivery systems between Medicare fee-for-service and private plans. However, the Medicare program should be financially neutral, that is the program should not pay more for one choice versus another. If beneficiaries are given this choice, over time they will gravitate to either the fee-for-service system or private plans, depending on what they view as the

most efficient and highest quality option for them.

In that context, we'll review now our updated analysis of plan payments in relation to fee-for-service levels.

Our analysis of MA benchmarks and payments is an update of an earlier analysis that was published as an issue brief in June of this year. The updated analysis is based on July 2006 enrollment data whereas the earlier analysis was based on the distribution of enrollment as of December 2005. The updated analysis has similar findings overall, which are that enrollment weighted benchmarks are at 116 percent of fee-for-service expenditure levels across all plans, which is very similar to the prior level of 115 percent, and that payments based on the plan bids are at 112 percent of fee-for-service costs for the counties where the MA enrollees reside.

The change in the overall numbers, that is the 1 percentage point change, is primarily due to the effect of the increase in private fee-for-service enrollment. The next slide presents more detailed information by plan type.

Here we repeat the overall numbers of 116 and 112 along with the overall enrollment, but we're looking at

individual plan types except that we have not included 500,000 enrollees in special needs plans.

The HMOs have the lion's share of enrollment among these four types of plans and therefore constitute the major component of the overall numbers. For the HMOs, plan payment levels are closer to fee-for-service expenditures compared to the other two major plans in terms of enrollment.

For the next category, local PPOs, they're bid-based payments are close to the benchmark levels. The local PPOs are drawing enrollment from counties where benchmarks are high in relation to fee-for-service expenditures for those counties at 120 percent. Enrollment in local PPOs is not very high, at about 4 percent of the overall enrollment.

Similarly, for regional PPOs, enrollment is very low and payment is very close to the benchmark. Benchmarks are 112 percent of fee-for-service in part because of the way the benchmarks are computed for regional plans, which is based on the weighting of local county level benchmarks weighted by the population in those counties.

The last category shown here are the private fee-for-service plans. The payments for these plans at 119

percent of fee-for-service are the highest of any plan category. Compared to other plan types, the benchmark levels for these types of plans are also the highest in relation to fee-for-service. Almost 90 percent of the private fee-for-service enrollees are in floor counties, that is in counties in which there was legislation establishing a minimum private plan payment level.

The next slide discusses benchmarks and bids as they relate to rebates.

As you are aware, the MA program is a bidding program. The law specifies county level and region level benchmarks against which plans bid. If a plan bids above the benchmark, the plan is paid the benchmark level and beneficiaries would pay a premium representing the difference between the benchmark and the bid. The benchmark represents the maximum Medicare program payment to the health plan.

for a plan that bids below the benchmark, 25 percent of the difference is retained in the trust funds and the remainder, 75 percent, are rebate dollars that plans use to provide lower premiums, including lower Part D premiums, lower cost-sharing, or extra benefits to their enrollees.

So total payments to the plan, in that case, consist of the bid base payment plus the rebate amount.

The rebate amounts vary among plan types with the highest rate of rebates, expressed as a percentage of fee-for-service expenditures, being among HMO plans and the lowest level being among regional PPOs.

Scott will now discuss plan availability.

DR. HARRISON: Private plan alternatives to the fee-for-service Medicare program are now available to all Medicare beneficiaries, a very slight change from last year or this year actually when 99.6 percent of beneficiaries had access to a private plan, and a significant increase from 84 percent in 2005.

There was not much growth in beneficiary access to local coordinated care plans in the past year. For purposes of categorization, we consider HMOs and PPOs to be coordinated care plans. In 2007, 81 percent of Medicare beneficiaries will have a local HMO or PPO plan operating in their counties of residence, up from 80 percent in 2006 and up from 67 percent in 2005.

I want to note also that the 81 percent figure is a national average that doesn't show the large differences

between urban and rural areas. Less than half of rural beneficiaries have access to a local coordinated care plan, while more than 90 percent of urban beneficiaries have access to such a plan. This large difference does not occur for the other plan types.

Access to regional PPOs was unchanged with no plans entering the five regions that didn't have plans in 2006, although those regions that have plans in 2006 will tend to have more plans in 2007.

Private fee-for-service plan availability, however, has increased substantially in 2007 to virtually 100 percent of beneficiaries. In 2006 private fee-for-service plan service areas had included 80 percent of Medicare beneficiaries and that was up from 45 percent in 2005.

Overall, most plan types are widely available and beneficiaries will have many more plan options to choose from in 2007 than in the past. An average of 20 plan options are offered in each county in 2007, compared with 12 plan options offered in 2006 and five per county offered in 2005.

Now I will briefly touch on two plan variations

that are not detailed on this table but are experiencing rapid growth for 2007, the MSA plans and special needs plans.

High deductible plans linked to Medicare Savings Accounts, or MSAs, will be available for the first time in 2007. MSA plans combine packages with high annual deductibles and catastrophic level beneficiary out-of-pocket caps with savings accounts that can be used to pay for covered health care services below the deductible and for qualified services that are not covered under the package.

MSA plans will be available in 38 states and the District of Columbia through one insurer. The deductible will range between $2,500 and $4,500 depending on the county. The deductible level is equal to the catastrophic cap, as required by law. Beneficiaries pay the full Medicare allowable costs for care until they reach the deductible and then the plan pays for all Medicare covered care about the catastrophic cap.

The sole source of funds for the MSA accounts is the Medicare deposit to the account consisting of the difference between the plan bid and the benchmark. The entire amount is deposited in the beneficiaries' account.

There is no retention of the 25 percent in the trust funds, as Carlos indicated would be the case for other types of MA plans with bids below the benchmark.

The plans cover Medicare A and B benefits only, as MSA plans are not permitted to offer plans that include drug coverage. Of course, the beneficiaries can choose to buy their own Part D coverage.

In addition, beneficiaries in New York and Pennsylvania can join a demonstration plant that is a variation of the MSA model. In the demonstration there are separate deductibles and catastrophic caps. The demonstration plan can pay for some care such as preventive care below the deductible and also, for the demonstration plan, there is cost sharing for expenditures that occur in the range between the deductible level and the catastrophic cap.

Including both the MSA plan and the demonstration, 77 percent of beneficiaries will have access to an MSA plan in 2007.

Special needs plans, or SNPs, are allowed under the 2003 MMA. They are MA plans in all ways, except they are able to restrict their enrollment to one of three groups

of beneficiaries, the Medicare/Medicaid dual eligibles, the institutionalized, and beneficiaries with certain chronic or disabling conditions. It is also expected that the plans will offer special benefits tailored to these groups of beneficiaries.

The number of SNPs have grown exponentially to 276 plans this year and will grow to well over 400 plans next year. Over 80 percent of the SNPs this year are for dual eligibles. There are only 13 chronic condition plans and there are 37 institutional SNPs, but most of those are offered by one insurer who had previous offered similar plans under a demonstration.

The growth in SNPs will increase the percentage of Medicare beneficiaries that have an opportunity to enroll. In 2006, 59 percent of Medicare beneficiaries live in counties where some type of SNP is offered. In 2007, 76 percent of Medicare beneficiaries will live in a county where a SNP is operating.

The distribution of plans will change for 2007. Most of the growth is in chronic and institutional plans although again in the institutional market one insurer will offer almost 60 percent of the plans.

Now looking quickly at enrollment, in July there were about 440,000 beneficiaries enrolled in the dual eligible SNPs, about 70,000 enrollees in the chronic condition plans, and about 20,000 in institutional SNPs. Combined there were more than half a million beneficiaries in special needs plans.

I am now putting up our recommendations from our June 2005 report, which is the last time we made formal recommendations on the Medicare Advantage program. This will serve as a reminder of our positions on Medicare Advantage because they will be included in the private plans chapter.

We recommended that the Congress should set the benchmarks at 100 percent of fee-for-service costs and those fee-for-service costs should be calculated without including the indirect medical education payments that the Medicare program makes directly to hospitals on behalf of all Medicare payments, both fee-for-service and private plan patients.

If the benchmarks are set at 100 percent of fee-for-service, we further recommended that any savings from plans bidding below those benchmark should be redirected to

a fund that would redistribute the payments back to the plans based on their performance on quality measures.

We also recommended that the Congress make a technical adjustment to the calculation of regional benchmarks so that local plans and regional plans would be on an equal footing, and similarly, if you go down to the bottom bullet, we recommended that Congress eliminate the stabilization fund that would allow higher payments for only the regional PPO plans. And we recommended that the Secretary collect enough quality data from the traditional fee-for-service Medicare program to enable comparisons between fee-for-service Medicare and the private plans.

Now Rachel will discuss our past recommendations as they relate to Part D.

DR. SCHMIDT: Last month I told you about two demonstrations that CMS initiated for Part D. Just to review, current law says that for 2007 CMS should weight Part D plan bids by their levels of enrollment in 2006, when figuring out the national average bid, plan payments and enrollee premiums for 2007. CMS is also supposed to use enrollment weighting to figure out the thresholds that determine which plans are premium free to beneficiaries who

receive Part D's low-income subsidies.

CMS made the decision to transition to enrollment weighting for both of these purposes in two separate demonstrations. Under the first demonstration, this means that enrollees will pay lower premiums than they would otherwise because there's a higher federal subsidy. Under the second demonstration, this means that more plans qualified to be premium-free to beneficiaries who receive Part D's low-income subsidies. So fewer low-income enrollees will need to switch plans for 2007 or beginning paying part of the premium to stay in their current plan.

Now according to CMS's Office of the Actuary, these two demonstrations will cost $1 billion in 2007. They will also have costs in future years but we don't know how much yet because CMS has not determined over how many years enrollment weighting will be phased in.

The Office of the Actuary estimates that the second demonstration will reduce the number of low-income enrollees who would otherwise need to change plans or pay some of their premium to 500,000 people from what would have been 3.3 million people under current law.

CMS took this action using its general

demonstration authority, which brings me to this recommendation on the slide. The Commission supported this recommendation last January in a report to Congress about how changes in payment policy are affecting oncology services, and you may want to consider whether you'd like to repeat this recommendation for our upcoming March report within the context of these Part D demonstrations.

The recommendation reads: The Secretary should use his demonstration authority to test innovations in the delivering of quality of health care. Demonstrations should not be used as a mechanism to increase payments.

An ongoing concern of the Commission is that Congressional support agencies and other organizations obtain access to Part D claims data in a timely manner. The Commission needs drug claims to help us carry out our mandate of advising the Congress on Medicare policy. Until recently, CMS has not been very clear about whether it had authority to use Part D data for purposes other than payment. In other words, it wasn't even clear that other parts of CMS that are not involved in payment, such as those that conduct evaluations of Part D and other types of research, could have access to the claims.

Last month the Agency issued a proposed rule that clarifies their authority to make claims data available to other parts of CMS and to private researchers and other Executive Branch and Congressional support agencies so long as they sign daily use agreements. That proposal would rely on CMS's authority to add additional terms to its contracts with plans to make this happen. If this proposed rule goes forward, it would address concerns that the Commission has raised, but there's no guarantee that it will necessarily go forward.

Unlike some of CMS's other proposed rules, there's no obvious deadline that drives this process of moving this proposed rule forward, other than the fact that CMS wants to use claims data for evaluation of Part D and other nonpayment reasons.

You maybe also interested to know that Senators Grassley and Baucus introduced a bill in September that would explicitly give authority to CMS to share Part D data with other government agencies, Congressional support agencies and private researchers.

The Commission supported a recommendation in our June 2005 report about Part D data. The recommendation then

reads: The Secretary should have a process in place for timely delivery of Part D data to Congressional support agencies to enable them to report to the Congress on the drug benefits impact on cost, quality, and access. You may want to consider whether you would like to repeat this recommendation in our March 2007 report.

Another option that you may or may not want to consider would be to provide more certain guidance through a change in law by, for example, adding a few words to this recommendation, beginning by reading Congress should direct the Secretary to put a process in place to again have a timely delivery of Part D data, and so on.

That's the end of our presentation. Were happy to take comments and questions.

MR. BERTKO: A couple of comments. First, a compliment on the three of you, getting through this set of slides as quickly as you did.

On the MA slides, one, I think directionally all of your answers are certainly in the right direction. And I will only quarrel on the magnitude very slightly. As I mentioned to Scott and Carlos earlier, the infamous VA/DOD ghost is still not present yet here. It's worth something

and there's urban legend that it might appear in the rate book next year. But what it is is it's a small amount, perhaps a percent or so, that is understated it the rate book and so the comparison of the 112 is probably a little bit less than that.

A second point on this is just to remind everybody here for 2007 the BNRA, Budget Neutral Risk Adjuster phase-out begins, dropping from 100 percent amount in '06, for example, to 55 percent. I don't know what other companies will do, but our modeling would show that's a significant drop, perhaps as much as 2 or 3 percent, out of that. Scott and I have had these discussions a couple of times already. So I'd just throw that out there as a somewhat unknown, because there are several other moving parts, including who signs up where.

Lastly, just a comment that companies like ours and people trailing us quickly behind are doing what we think Congress intended us to do, which is to march into rural areas and offer health plans. More important than just offering the health plans, our enrollment now is of a scale and experience that we're beginning to see things. And private fee-for-service is not a formal coordinated care

plan, but we're doing a lot of stuff there. And we're seeing some efficiencies again -- and I won't give you a number -- but measurable. We think that with more experience, we will be able to gain some more.

So I would suggest again that while I support our recommendation overall, giving us time to achieve those in order to continue offering these things in rural areas is a good idea.

DR. REISCHAUER: I'll start with a quip to you. You said you're gaining efficiencies in rural areas, which probably helps Humana. But how does it help Medicare?

MR. BERTKO: Well, over the long run --

DR. REISCHAUER: Okay, that's enough.

[Laughter.]

DR. REISCHAUER: I want to ask Scott just to educate me and others a little bit about the MSA plans. You said the deductibles were going to be between $1,500 and $4,500. What's the size of the deposit that's being made into the medical savings account, sort of a rough idea? Question one.

Question two. Will there be a Medigap policy that is available not for the amount below the deductible? But

once you're in the catastrophic realm the text here said that the catastrophic plan pays everything that Medicare is supposed to pay. But I didn't know if that left cost-sharing or didn't leave cost-sharing, that it sucked up the whole thing.

Then what price does the beneficiary pay below the deductible? Do they pay the 100 percent of what Medicare would pay? And so it will vary widely across the country for the same service because Medicare's payments to providers vary across the country?

And then what happens at the end of year one when I have $2,000 in my account and I've been just healthy as a horse, and I sense something happening and I sign up for John's plan the next year? What freedom do I have to use the $2,000 that's still in my medical savings account?

DR. HARRISON: First, we got some numbers from CMS on the deposit amounts. I don't know that they're public yet. The website is still a little funny on the MSAs. And so I'll just say that it's between $1,000 and $2,000 per year, in that range.

They pay 100 percent above -- no cost-sharing above the deductible and no help below the deductible. You

pay the full Medicare rates. I believe they are guaranteed to be able to get Medicare rates?

MR. ZARABOZO: Right, guaranteed the Medicare rates. it is at the option of a plan to allow balance billing if they want to do that, that is above the allowable charge. If they want to.

DR. REISCHAUER: There's no Medigap coverage for when I travel abroad or something like that?

MR. ZARABOZO: The Medigap situation is the same as any other MA plan, which is Medigap does not pick up any costs related to MA.

For one thing, even if you had a Medigap plan, no coverage is possible because these are "non-Medicare" covered.

DR. REISCHAUER: There's those coverages like foreign travel coverage.

MR. ZARABOZO: Foreign travel, you could --

DR. REISCHAUER: Which an MA plan can cover.

MR. ZARABOZO: These plans can also offer optional supplemental benefits. They cannot have mandatory supplemental, but they can have optional.

DR. HARRISON: But they did not choose to offer

any this year.

MR. HACKBARTH: Can I ask you about what you said? The plan may permit balance billing. How is that accounted for relative to the deductible? Is the amount over the Medicare fee counted towards meeting the deductible?

MR. ZARABOZO: I think so. I think if the plan says we recognize 115 percent of the amount, the allowed balance billing, I think that would be counted towards it. I'm not entirely sure about that. But I assume that most of them would say we will just recognize the Medicare allowed amount.

DR. REISCHAUER: I want to know what happened to my money at the end.

DR. HARRISON: You get to keep it in the account and you can use it for any IRS qualified medical service.

DR. CROSSON: This is speaking to the draft chapter and the restating of the recommendation with respect to setting the MA benchmark at 100 percent of fee-for-service.

I think, as we discussed at an earlier time, I think in the original chapter there was a discussion about trying to mitigate the impact of this by phasing this

recommendation over a period of time. I'd like to suggest that we at least reiterate that or perhaps expand that part of the text for a couple of reasons, and these were discussed last year.

One is the fact that this change will undoubtedly have an impact on beneficiaries. There will be an acceleration of benefit reduction, most likely, as a consequence of this. And as we've seen before, there's a higher proportion of low-income beneficiaries in MA plans. And therefore I think these individuals will need time and the plans will need time to adjust to that.

The second point may be peculiar only to our organization. Not totally, but we are the largest organized delivery system serving Medicare beneficiaries, and almost all through MA. And that has to do with the impact on capital planning, particularly for an organization like ours. We have about a seven-year time frame from the time we conceive of the need for a hospital until we open the door. Some of that has to do with the peculiarities of California, but nonetheless that's the reality.

Both of those things, I think, speak to the need, particularly for organized systems, which is what I can

speak best to, for some sort of reasonable consistency and a timeline that matches the need to plan for capital improvements, and also more recently for complex and expensive information technology systems, the use of which is another goal of MedPAC.

So I would just like to see, as we bring forward this chapter, that we at least restate this issue and perhaps expand on it to some degree.

MR. HACKBARTH: We, as you know, did discuss it the last time in the report where we initially made these recommendations. And we'll pull for that language and you can take a look at it and we'll deal with that.

MR. DURENBERGER: Thank you. I was going to ask the question Bob asked but I have another one that relates to the dual eligibles. I really like the special needs plan approach and the way the plans are adapting to it.

There's 440,000 people in dual eligibles today. What's the alternative that's in place in most other places for the dual eligibles? And to what degree is it being -- are these plans replacing something else?

DR. HARRISON: I think most dual eligibles, whether or not they're in managed care on the Medicaid side,

are in the fee-for-service Medicare program and the state Medicare program would pick up the copayments, sometimes. Sometimes they set their rates below Medicare rates and so there really aren't a lot of copayments that they pay. But that's generally what happens.

A lot of the 440,000 that are enrolled were actually what was called passively enrolled. This was a one-time thing for 2006 where if you were in a Medicaid managed care plan as a dual, that plan had the option to become a SNP and to have you rolled in. You could opt out if you didn't want to stay in that plan, but a lot of the involvement came that way.

MR. DURENBERGER: I'm just curious as to where the 440,000 are coming from, also, because I assumed it would relate in some way to whether or not you lived in a state that had a program in which the states were contributing.

DR. HARRISON: As I recall, it was sort of in the states with big managed care in general. We have not been able to get the passive enrollment data to see sort of where the big groups came from. So we haven't been able to do that. And in general it just looked like big states had big enrollment in the duals.

There were also some rollover from duals who were already in managed care plans.

DR. CASTELLANOS: Rachel, I almost hate to bring the subject up but the oncology demonstration project, where are we going with that? I'll leave it like that.

DR. SCHMIDT: Joan was the author of this report. She's the most knowledgeable person about it. But the Commission has made this recommendation about the demonstration. And I think the status of things -- Joan, do you have more to add?

DR. CASTELLANOS: I have some very big concerns over that demonstration project and the worthiness of it and the validity of it.

MR. HACKBARTH: Those were the concerns that we expressed that lead us, in part, to this recommendation.

To make a long story short, it looked like demonstration authority was being used to increase payments to oncologists without a serious design that would yield data to help improve the program. So we considered that an inappropriate use of the demonstration authority, and hence, the recommendation.

Is that a fair summary, Joan?

DR. SOKOLOVSKY: I think that sums it up. Also, that was in 2005. There was a much smaller demonstration in 2006, for which we haven't seen any data yet. Going forward, we don't know that there's going to be anything.

MR. HACKBARTH: So these new demonstrations are actually much, much larger in terms of their fiscal impact and raise the same concerns about is this the right way to make policy. And hence, the new recommendations to that effect.

Let me just quickly check. We've got how many draft recommendations in total, in this package? I'm not counting the restatement of the MA. So it's just the two that relate to Part D?

DR. SCHMIDT: Yes.

MR. HACKBARTH: People feel okay with those? I just wanted to make sure.

All right, we are done with this topic for today and down to our very last one, which is the first draft of the context chapter.

MS. BURKE: Glenn, I apologize. Do we have a new recommendation?

MR. HACKBARTH: There are two of them. They are

on pages 15 and 16 in the packet.

MS. BURKE: That's old language for new? This was in the June report.

MR. HACKBARTH: We're using, as I said, the old language to make a new point with regard to these Part D demonstrations.

MS. BURKE: We're restating our old recommendation?

MR. HACKBARTH: Using the same language but saying this time it's not the oncology demonstration that we're objecting to. This time it's these Part D demonstrations that we're objecting to. And then the other one has to do with access to claims information.

MS. BURKE: So the language we're going to use is the language on 15 and the language on 16, which mimics the language which was --

MR. HACKBARTH: Exactly.

DR. SCHMIDT: Just to clarify with respect to the Part D claims one, I kind of gave you two options. One was to use the language as given. Or if you believe there needs to be a stronger force of law, you could modify it slightly to say that the Congress could require the Secretary to have

in place is process.

MR. HACKBARTH: Okay. Context.

DR. SCHMIDT: Each year in our March report, we include a chapter that puts the Commission's recommendations on payment updates within their broader context. To help us think about that chapter, last September we brought to a panel of experts who gave their perspectives about Medicare's financial sustainability and what to do about it.

Several of those panelists spoke about how Medicare's situation is really part of a bigger crisis, a general problem that the entire country is facing due to rapid growth in health care spending. Today, I'm going to quickly remind you about Medicare's financial situation. We've talked about it on several occasions. But in the spirit of what our panel experts told us, we'll also talk about some of the broad forces that have gotten Medicare and other payers into our current situation.

Just to review what the Medicare trustees found for 2006, the trustees project that the trust fund for Part A will be exhausted by 2018. Medicare has no authority to make payments once the trust fund is exhausted, so Part A will require major new sources of funding.

The SMI program's trust fund is financed primarily with general revenues and beneficiary premiums. And just to remind you, general revenues are federal tax dollars that are not dedicated to a particular use and they're made up of individual and corporate income taxes.

The SMI trust fund technically cannot be exhausted like Part A's trust fund. However, the trustees say that SMI would need very large increases in revenue to cover projected spending. This means that fewer resources will be available for other federal priorities. And also, on average, beneficiary premiums and cost-sharing will grow more rapidly than incomes.

Under current law, the trustees are to warn the Congress whenever 45 percent or more of Medicare outlays are financed with general revenues. This is known as the 45 percent trigger. The trustees said that general revenue funding would reach 45 percent in 2012. If they have the same finding in next year's trustees' report, the Congress must consider legislative changes to Medicare by the spring of 2008.

This slide is just to remind you that Medicare is not in this situation alone. All payers are confronting

health care spending that is growing considerably faster than our national income, and that's shown on this slide by the general upward trajectory of all of those lines.

The draft in your mailing materials talks about some of the consequences of rapid growth in health spending. Some consequences are good. Our health care system generates a lot of medical innovations and some of those can improve health outcomes. But other consequences are more worrisome, such as the decision of some workers to forgo taking up health insurance because the price of payments is so high, or the decisions of some employers to quit offering health coverage.

These are worrisome in the sense that the United States has a relatively large uninsured population and increases in the numbers of uninsured can raise demand for public coverage and, in order to finance providers uncompensated care, can raise health care costs for those who are insured.

In most sectors of the economy, we rely on market forces to set prices and determine how to allocate resources, whether more of our societal resources should go to produce iPods or televisions, for example. But

economists have long argued that health care is different from other sectors in some important ways.

First, in other sectors, consumers are deciding whether or not they want to buy an iPod and then they do so if at its price the iPod has greater value to them than other things they could purchase. In the case of health care, patients often don't know what services they need. Sometimes they don't know what condition they have. And rarely do they do what the price of those services. They rely on providers, usually physicians, to diagnose them and help them decide what treatment they need. Providers have to tailor these services for each individual patient. And while the professionalism of providers usually leads them to try to furnish appropriate care, providers often do not know exactly what their patients would prefer among treatment options.

There's also a huge amount of uncertainty surrounding decisions about treatment. There are simply limits on our society's medical know-how and certainly limits on how much anyone provider can know. For these reasons, there may not be much consensus on what type of care is appropriate for certain patients. Similarly,

providers do not always know the relative value of newer technologies compared with alternative therapies and may use newer technologies more broadly than their relative value merits.

Most patients pay for their care through insurance. There is some substantial literature that suggests that at the margins such coverage leads patients and their providers to use more care or more expensive care than they would otherwise.

Finally, some parts of the health care sector are less competitive than others. For example, some providers may have a local monopoly for their area or maybe there is no comparable alternative treatments for a new medical technology. This can lead to relatively high prices and sometimes little incentive to improve efficiency over time.

So most of these are general characteristics of providing health care that all types of payers face. These characteristics, along with the incentives that are built into particular payment arrangements, can affect how well prices act as signals of value in this sector of the economy. When prices are not very good signals, that can lead to a misallocation of resources over time. For

example, if RVUs for certain physician services become overvalued, over time that may affect the decisions of medical students about whether and how they want to specialize.

I don't want to spend much time on this slide but it's here to remind us that as market oriented as our economy is, federal and state governments are heavily involved in health care. Governments get involved as a regulator, as a major payer through incentives it creates through tax policy, gets involved in promoting public health, and to conduct and finance medical research.

People can and do certainly argue over whether some of these roles for government are justified or whether the governments can carry out these roles well. But again, this is just to remind you that the role of the government in health care is substantial today.

Federal and state governments get involved in health partly because of the characteristics of health care I just outlined in the previous slide. But they also get involved in order to address other redistributive goals, as we've talked about today.

Let's turn now to some of the forces driving

growth in spending for all payers in our health care system. One of the most important forces is income. Many international comparisons of health care spending point out that there is a strong correlation between a country's GDP and its health care spending.

One recent paper argues that we should expect to continue to spend more on health care. As our standard of living continues to grow, the U.S. could reasonably expect to spend 30 percent of its GDP on health care by the middle of the century, according to these estimates, compared with about 16 percent today. The argument goes like this: as individuals become better off and their consumption increases over time, the incremental value to people of buying another iPod or another television falls but, by comparison, the value to them of extending their life doesn't fall as quickly.

However, even if you support this point of view, there's still the question of how much more we will spend in the future, as well as how to finance it. Given evidence of inefficiencies in health care spending, it's hard to argue that all health care spending is appropriate.

Other factors driving growth are insurance and

technology, and the two are interrelated. I already touched on the point that when an individual patient and provider are deciding about treatment options, insurance can lead them to use more care or higher price services, and often those include newer technologies.

However, a recent paper suggests that insurance may have bigger effects when you look more broadly than at the individual level. Amy Finkelstein looked at what happened to hospital spending around the country before and after the start of Medicare. She found a bigger than expected effect on hospital spending, and she believes that the increase in demand for hospital care at the start of Medicare lead more hospitals to enter the market and encouraged them to expand and purchase new equipment and that sort of thing.

Insurance coverage and our rising standard of living have helped to finance innovations in medical technology. David Cutler and his colleagues recently published a study arguing that, on average, increases in health spending, which he largely attributes to advances in medical technology between the years of 1960 and 2000 provided reasonably good value in terms of gains in life

expectancy. The same study notes, however, that the average cost per life year gain has been declining over time and growth in costs for the elderly in particular have been outpacing gains in life expectancy.

At the same time, the literature by Fisher and Wennberg continued to point out that there is considerable geographic variation in Medicare spending and that higher spending is uncorrelated and sometimes negatively correlated with indicators of quality. From this, the authors believe that a sizable amount of spending is inefficient.

Another force driving health spending is our country's underlying health status and related changes in provider's patterns of care. A recent study by Thorpe and Howard estimates that most of the growth in health care spending for Medicare beneficiaries between the years 1987 and 2002 can be attributed to patients with five or more conditions. The proportion of beneficiaries with that many conditions grew from about 31 percent in 1987 to about 50 percent in 2002. At the same time people who have five or more conditions now have a higher self-reported health status. In 2002 about 60 percent of them said that they were excellent or good health compared with about 33 percent

in 1987.

The authors conclude from this that providers are treating healthier patients, maybe lowering their thresholds for treatment, and that treatment is improving health outcomes, or both are occurring.

The authors also believe that obesity plays a part in this because many obese individuals have multiple comorbidities and the prevalence of obesity has been growing substantially.

The back end of the draft chapter discusses approaches policymakers could use to address Medicare's financial sustainability, and I've shown them on this slide. I should note that one area we were looking at for the June 2007 report looks at potential changes to Medicare's premium and cost-sharing, its benefit design, as well as the role that supplemental coverage pays in that. That's just a pitch for future work we have going.

The draft chapter for March that was in your mailing materials also talks about how the effectiveness of policy changes could vary across health care sectors and depends on other broad trends in health care delivery. For example, if policymakers wanted to constrain payment rates

in Medicare's fee-for-service payment rates over a long period of time and other payers were not doing the same thing, that could backfire and lead to access problems for Medicare beneficiaries.

With that I'll close and be happy to take your comments.

MR. DURENBERGER: Thank you, Mr. Chairman, and thanks very much, Rachel.

I've already sent my suggestions but I'd like to reinforcement it wit just a brief conversation I had with Humphrey Taylor on the telephone the other day. He's the Harris Interactive person. He says lately in all my speeches I say how many of the people in the audience believe that there's a lot of inappropriate and unnecessary health care in this country? And all the arms go up. He says now let's have a show of hands for all of you who have sought inappropriate or unnecessary care. Of course, no hands go up.

[Laughter.]

MR. DURENBERGER: But I think the point of what I was trying to contribute to the context is to start out right up front and say the program's financial outlook and

wide variations in quality and cost to individual beneficiaries are driving change in the health care system. Just put it right up there and then speak to both as we go through the context chapter.

We certainly have a record in the quality, the performance area. And it just helps the reader of this context to know why we believe that the financing, if we could ever align the financing system with the results we want in this country, that would save the Medicare program.

And so the same suggestion goes when we get to the end to the various options, to talk about safety, and to talk about quality, and talk about performance, and those sort of things as specific ways in which we might reduce the costs of an entitlement program.

MS. BEHROOZI: Thanks very much, Rachel. I hope you husband is doing the daycare pick up tonight?

DR. SCHMIDT: Mother-in-law this time.

MS. BEHROOZI: I just want to go to the point about restructuring benefits and controlling costs.

There's a danger in assuming that when people use less services or products because there is a cost associated with it that that is, in fact, controlling costs by

eliminating wasteful use or inappropriate use of costs or services. In fact, use of services may go down but it may be appropriate care that people are not accessing because too great a share of the cost is being put on them. In other words, the cost doesn't go away. It still costs a lot of money. But by putting too much of that cost onto the individual people don't access to care. It comes up in so many different contexts.

You made a reference earlier to working people not being able to afford the premiums to pay for insurance that is so-called offered by their employers. Similarly, if Medicare moves to a system where people on fixed incomes -- they may be, as you say in the paper, doing slightly better than -- the elderly may be doing slightly better than they did before in the aggregate. But individuals who are facing a burdensome share of costs may be, as you do note in the paper, avoiding appropriate care and then in the end costing Medicare more because they haven't received appropriate care at the appropriate time.

So I think we really need to be sensitive to that and not presume every time that we see a reduction in use because of a cost share to the person that that's a good

thing, and that that's lowering overall costs.

MR. HACKBARTH: The RAND health insurance experiment years ago looked at that specific question and found that higher cost-sharing lead to reductions in both appropriate and inappropriate care.

Then the next question is did the loss of that appropriate care affect health status? And with the exception of low income people, they found no effect on health status. Now the RAND health insurance experiment did not include Medicare beneficiaries, but there is research on the issues you're raising.

MS. BEHROOZI: Right, but the paper also cites more recent research. And I think there's even more recent research going on as cost-sharing has really gotten out of hand. It's qualitatively different now, I think, across society, not just in Medicare, than it used to be.

MS. HANSEN: Three short ones. One I spoke to Rachel about.

Just kind of putting Medicare, as you noted in your presentation, relative to the whole health care system issue so that Medicare by itself, even though we are looking down the pike of 2018, a big issue. So I just didn't want

to have, frankly, the politicalness of the programs of entitlement almost kind of singled out. It's an issue of the health care system.

The second one is to corroborate, I think, Mitra's point about especially people who tend to be a little bit more vulnerable, who this cost-sharing is high.

And I wonder, and I know this is more informal, John and I were talking about whether or not there is a different way to look at cost-sharing. In other words, certain things that preventively we want people to do, there should be no cost-sharing, and to do that preventively versus things that are a little bit more questioned in terms of there evidence base, there would be some tiered cost-sharing.

The third and last point is the whole area, your point about many of the diseases now, people have five chronic conditions, and whether or not the whole directionality of care coordination that we're going into maybe could be -- it's in the chapter but it could be lifted as a highlighted area because the nature of the Medicare program is so different now than it was 40 years ago.

So raising that in terms of the directionality

side.

MR. BERTKO: One quick add-on to this recent discussion that Jenny referenced and Mitra said. On benefits, I think we should at least think about looking at some minimum cost-sharing level. Several people today referenced that it's not only the physicians who do this but, as I think Dave joked, it's how many people have had inappropriate care.

Supplemental insurance, whether it's a Medigap-type or whether it's an employer-sponsored type, can generate induced demand and everything else. So perhaps with the context that evidence-based preventive care services ought to be considered, as well.

Congress took some action, adding two Medigap benefits with the MMA, this could be something.

The last one I would suggest also that we might want to approach as a major topic is a public health approach to obesity, much in the same way that 40 years ago we had one to smoking. This is only for the current group, but for say most of the people at this table who are approaching Medicare age.

I'd just maybe put some words in about that if you

feel it's appropriate.

MS. THOMAS: I think the IOM just recently released a report on the state of the art in where we are with changing the trend on obesity. And we could certainly characterize what they found in the report as a way to get a little bit more specific.

MR. HACKBARTH: Okay, thank you, Rachel.

We will now have a very brief public comment period.

That's just the right length.

[Laughter.]

MR. HACKBARTH: Thank you and we can reconvene tomorrow at 9:30 a.m.

[Whereupon, at 5:30 p.m., the meeting was recessed to reconvene at 9:30 a.m., on Thursday, November 9, 2006.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, November 9, 2006
9:41 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
MITRA BEHROOZI
KAREN R. BORMAN, M.D.
SHEILA P. BURKE
RONALD D. CASTELLANOS, M.D.
FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
DOUGLAS HOLTZ-EAKIN, Ph.D.
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
WILLIAM J. SCANLON, Ph.D.
NICHOLAS J. WOLTER, M.D.

P R O C E E D I N G S

MR. HACKBARTH: Good morning everybody.

We begin this morning with two sessions related to the SGR-mandated report and a distinguished panel to begin.

Cristina, will you do the introductions?

MS. BOCCUTI: Gladly. Good morning. Today we are lucky to have Dr. Fisher and Dan Gottlieb with us today from the Center for Evaluative Clinical Sciences at Dartmouth.

Dr. Fisher is a Professor of Medicine and Dan Gottlieb is a statistician at the Center and their research focuses on exploring both the causes and the implications for health and health policy of regional variations in Medicare spending and practice. They really don't need that much introduction because I think most of the commissioners are aware of their excellent body of work. Thank you.

DR. FISHER: Thank you very much, Glenn, Cristina. It's really a pleasure to be here.

The slides that I'll be presenting on the screen may have one or two changes from the slides that you have in front of you, just a heads up. I'll try to steer you in the right direction. We won't be talking about all of the detail that's in the slides in order for us to have plenty

of time for conversation.

Here's a map that many of you have seen and are familiar with. There are huge regional differences in spending across the country. I had a great pleasure of presenting this to the Senate Finance Committee staff a year-and-a-half ago and they complained bitterly about what were the high cost or sort of bad states in their perspective or bad regions being labeled red. So when I went to the White House, I have a similar map that shows exactly the same data. But whichever your preference is, there are now two colors that you can use to label the states.

When you look at the differences in spending across regions, it is hard not to respect Uwe for what he asked, which is how can the best medical care in the world cost twice as much as the best medical care in the world? What I'll try to summarize in the next two minutes is what Dan and I and a lot of others have learned over the last 10 years.

When we look across regions of different spending levels, and we've also repeated most of these studies at the academic medical center or hospital level as well, comparing

populations served by different hospitals, we see the following: higher spending regions have more hospital beds per capita, more medical specialists, and more internists.

In terms of the content and quality of care, we see on average that technical quality in the higher spending regions of the United States is slightly worse, on average. They don't get any more major elective surgery -- what Jack Wennberg would call preference-sensitive care. But they do get lots more hospital stays, many were frequent physician visits, they're much more likely to be referred to subspecialists. And if you're lying down and spending time in the hospital and seeing more specialists, you also get more tests and minor procedures because that's what we do when you're there.

We've looked at the outcomes of care and we find that the higher spending regions actually, adjusting for everything we can do -- and that's the Annals studies that Dan and I were working on and published in 2003 -- see higher mortality in the populations who are cared for in the higher spending regions. There's no improvement in their function. We've now interviewed physicians across the country. And when physicians describe the quality of care,

they say the quality of care is worse in the higher spending regions than in the lower spending regions.

We have some preliminary data about patient reported quality, mostly from California, in terms of satisfaction with hospital care. The higher cost system's patients seem to have less satisfaction with care. When we look across the country, they perceive worse access to care in the higher spending regions compared to the lower spending regions.

The more worrisome finding was the one with the Jon Skinner, Doug Staiger and I published in Health Affairs in the spring or just about a year ago, when we know there have been tremendous gains in survival following myocardial infarction over the last 20 years. But interestingly, the gains have been smallest in the highest spending regions and those regions with the highest growth rates. The gains in survival have been greatest in the more conservative regions. The higher spending regions also seem to have the greatest growth in per capita resource use following a heart attack.

As a clinician and now as a sociologist studying what's going on, the key difference in both growth and in

spending, growth over time and differences in spending across regions, are related to this category of care that Jack Wennberg and I have been referring to now for years as supply-sensitive services. We've now used clinician vignettes to look at physicians practicing in different regions. They are equally likely in a high and low spending to do the right thing when we know what the right thing is. When the guidelines say do this particular treatment, they're equally likely to do it in high spending and low spending regions. The difference in spending is largely due to discretionary decisions in the gray areas of medicine where there is uncertainty about the right thing to do. Should I see this patient in a month? should I refer them to a specialist?

As I've tried to sort out what the problem is likely to be, and I think yes, the likely diagnosis for -- unwarranted variations in care, poor quality, and growth in spending is the problem of local capacity and culture and the fact that now no one is accountable for local capacity and political culture. Clinical evidence is an important but very limited determinant of physician practice. Physicians practice within a local organizational context in

a policy environment that profoundly influences their decision-making. The payment system that we currently have ensure that we're all able to stay busy. And any new capacity, recruiting new physicians, a new orthopedic surgeon, a new interventional cardiologist, is able to stay busy as well. And that creates the culture within which these physicians are practicing. They all need to stay busy, they see their patients more frequency.

The consequence is that what appear to the individual or to the system in the current payment system to be reasonable clinical or policy decisions, recruiting new physicians, lead in aggregate to the higher utilization, greater costs, and inadvertently to the lower quality care and the worse outcomes that we see.

So accountability capacity is going to be essential to control the growth in spending.

So a theory, would be to strengthen local organizational accountability for the decisions that drive higher costs and worse quality, decisions about capacity, what services to invest in in the local hospital, the local community, whether to recruit physicians, whether to allow certain physicians to practice within that community or

within that organization, the issues of accountability for longitudinal costs and quality, and accountability for care coordination and communication.

I've read your minutes, you're all familiar with what we know about how many different physicians are involved in a given patient's care and how many care transactions are experienced. I'll come back to that in a few minutes because I think some of the approaches that we'll be laying out offer us a path forward to dealing with these kinds of organizational accountability issues.

There are a number of potential approaches that have been nominated. Individual physicians, the notion of an advanced medical home, which you've all discussed. Established multi-specialty group practices. The problems are that individual physicians only control their own practice and it is very hard, given the five physicians involved or the hospitals that are involved, to think about how a primary care physician is going to influence the practice of a cardiologist across town. Establish multi-specialty group practices are few and far between in current U.S. health care.

So building on work that Mark and Peter Welch did

in the 1990s thinking about inpatient hospital stays and how to foster accountability among physicians for the services provided during hospital stays, we've tried to build a model that extends that to all beneficiaries and all physicians within the American health care system.

The empirical work I'll present really addresses four areas: the feasibility of making the assignments to these medical groups? Characteristics, do they seem to have some kind of face validity? How could we measure performance of these levels and what might the kinds of measures we would be implementing look like? And then how might the extended hospital medical staff work as a framework for assessing volume growth? And then we'll have some discussion of some of the advantages and disadvantages.

Feasibility. Let me briefly describe the general approach we've taken to assigning patients. If a physician works in an inpatient setting, we assign them to the hospital where they provided care to the greatest number of Medicare beneficiaries say saw. If they get no inpatient work, we assigned him to the hospital where the plurality, or actually the majority in most cases, of their patients they billed for were admitted. So if you touch a patient,

you identify all the Medicare beneficiaries they touch, and you see which hospitals they go to.

It turns out, not surprisingly, that you can assign virtually all physicians billing Medicare to a hospital. So 95 percent of the ones that we cannot assign are either excluded because they are caring for patients in a non-U.S. hospital or were in a specialty in some of the few categories that we could not assign because we wanted to know the specialty of the physicians.

When we look at the populations they serve, to how to identify the population served by an extended hospital medical staff, for all Medicare beneficiaries we assign each patient to their predominant care physician, usually a primary care physician or medical subspecialist. If they did not see a primary care physician or a medical subspecialists, we then allow very small percentage of the patients to be assigned to a general surgeon or some other specialist. That's the only other specialty to which we assign patients, the predominant one.

An important methodologic advance we think we've made recently is we first assign patients to their primary hospital based on their physicians assignment. But we also

identified a secondary hospital for each hospital in the country. Which hospital is the next most frequently used hospital by the patients who are cared for at that particular hospital?

There are many hospitals that have well-established referral networks with another hospital. Smaller hospitals will refer to a specialty hospital. In our region, it's all of the outlying rural hospitals refer their patients to Dartmouth-Hitchcock Medical Center. You can imagine that there are well-established referral networks. And so we also identified the secondary hospital used by each beneficiary, each hospital's patients. It's usually a referral hospital.

We can again assign virtually all Medicare beneficiaries. If you saw a physician during a two-year period, we can assign you to that physician. If you only saw one physician, only had one visit, you still get assigned. And we've been using the 20 percent sample and we find that about 93 percent can be assigned to a U.S. acute care hospital based on the visits that they've had during that period.

The next question we address and will walk you

through a little bit is do these extended hospital medical staffs have some kind of face validity? For the purposes of this presentation, I'll show you the averages of some characteristics of the medical specialty groups. But we've also grouped them according to whether they're urban or large town hospitals and whether they're large, medium or small hospitals, and then we looked at rural areas. The key point here is that basically 90 percent of physicians and 90 percent of beneficiaries are in large hospitals and most of them are in urban areas or large towns. We will come back to that in a second.

So here, for instance, is a display that shows how many physicians per hundred beds are there in each hospital? Bigger hospitals will obviously have more physicians? So the average hospital in the United States has about 30 primary care physicians per hundred beds and then 21 medical specialists, 21 surgeons and a bunch of other physicians associated with it, pathologists, radiologists, et cetera.

I've bolded on the slide a distinction to help you understand that these actually do seem to make clinical sense as multi-specialty group practices, if you will. There are relatively similar number of primary care

physicians across the size of the hospitals, 30 and 30 in this particular case. But in the urban large hospitals, there many more medical specialists, any more surgeons, and many more other kinds of physicians. So they look like multi-specialty group practices when step back. And similar patterns hold in the rural areas.

How many physicians to inpatient work? And if you're trying to create a medical staff that has some coherence, how tightly affiliated are physicians? And what proportion of their work is provided at the hospital to which we've assigned them? It turns out 62 percent of physicians perform inpatient work. 62 percent of those, by chance, happen to work at only one hospital. So 100 percent of their work is at their primary hospital.

But we were about the physicians who rotate from hospital from hospital, so we looked at those, as well. 38 percent of physicians work in multiple hospitals but 75 percent of their work is at the hospital to which we assigned them. Most physicians have a predominant hospital where they provide their practice.

So therefore, from inpatient physicians, 90 percent of their inpatient work is assigned to their primary

hospital. That looks pretty good. These are coherent groups are really are practicing within a local environment.

Among the physicians who perform no inpatient work, dermatologists, radiologists, community radiologists -- those are some of the specialties that would be in a -- or pathologists who were running labs -- 38 percent of them performed no inpatient work but 56 percent of the admissions for their patients are at their assigned primary hospital. So again, they're pretty tightly affiliated.

The next less frequent hospital is much, much lower than 56 percent. So the remainder of their admissions tend to be spread across a number of other institutions, not to their primary institution.

This is a complicated slide but it really is there primarily to emphasize one major point: that is the key question if you're trying to foster accountability for the care of Medicare beneficiaries and improve the coordination and use of services, you'd like to see that if we've created these virtual groups that most of the care to those groups is actually provided by the physicians who work within the groups that we created. This is all the magic of computers somewhere. And wed like to know that the beneficiaries who

are assigned to these groups actually get most of their care from the organization, either the physician or the hospital, to which we've assigned them.

The slide distinguishes primary and secondary hospitals. But if you look over on the left-hand side, that average for all U.S. hospitals, what you see is that about 70 percent of the evaluation and management services provided to beneficiaries assigned to a hospital is provided by the physicians within their primary hospital, the group that we've created, and about another 10 percent is provided at their referral hospital. So over 80 percent, on average, of the evaluation and management services, the really cognitive services that would be required for care coordination, are provided at the hospital to which we've assigned them. They look like coherent groups, slightly lower for proportion of medical admissions but still pretty good. And surgery is a little lower. Because surgery is often referred to other specialties, there are many categories of surgery which even your next referral hospital won't perform so more of them will be referred outside the system.

As you look across 90 percent of the Medicare

beneficiaries are in systems that have a very high degree of coherence, if you will, those large urban, large medium, and large rural hospitals, where there's a high degree of coherence within the medical staff and the patients they are caring for.

Can we measure performance at this level? I know you've all been thinking about this when you think about physician efficiency, and I think this slide has a couple of key points. What we see is that however you are attributing patients to physicians, if you're trying get a predominant care group for chronic disease patients, like patients with diabetes, there are about half of physicians who have no patients assigned. So if we look at physicians with one or more patients assigned, we have about 250,000 physicians to whom we've assigned no patients. But among those to whom we have assigned -- maybe that's 300,000. So we have 250,000 who got a patient. But their panel sizes are relatively small.

It gets a little worse if you throw into the denominator all the docs that never touched anybody. That's that little column so we don't really need to pay much attention to that. But it still underlines the point that

there are going to be lots of physicians for chronic disease who are not included in any kind of accountability or performance measurement if we focus on the individual physician.

But if we step back and say let's assess physicians as members of their extended hospital medical staff. Suddenly everybody has lots of patients that we can evaluate them on. 98 percent of physicians are now in medical groups where they're estimated to have more than 500 Medicare beneficiaries who can be followed.

You have similarly high numbers if you restrict it to patients with chronic disease. This is for all patients but we can provide you the data on those with chronic disease.

So what kinds of performance measurements can you now do if you have created these larger medical groups? You can do traditional measures of quality of care. The first four measures there are traditional chronic disease measures. so any of the AQA or other measures that are being considered for performance measurement at any level can be performed at the group level.

I've just grouped the hospitals according to the

average spending in their region in our original Annals stratification, updated to 2003, because we think there's no evidence that those in the higher spending regions have achieved better performance based on all of our data. We know that the high spending regions don't have better outcomes, have slightly worse technical quality on other measures that we've looked at. This is just updated to look at 2003 Medicare data.

But what you see is you can look at preventive services. They're less likely to get mammography screening in the high spending regions but more likely to get colorectal cancer screening, perhaps because many more beneficiaries are getting a colonoscopy for all sorts of other reasons and regardless of the indication it's counted in the AQA measures as a screening colonoscopy. And I can promise you that they are doing more procedures of other kinds in the high spending regions. They are about equally likely to get an eye exam and slightly less likely to get a hemoglobin A1c if they're diabetics, which I found quite surprising.

But I think the really important set of measures are the ones in the next two categories because now we can

start to look at how frequently are the patients within this group hospitalized? 30 percent more frequently in the high spending systems compared to the lower spending regions.

We're not substituting hospital care for SNF stays. They're getting more SNF stays.

We can start to look a care transitions. How many Medicare reimbursed different care transitions did the patients experience in one group of systems compared to the other? You see it's almost 30 percent higher in the groups who practice in the higher spending regions than in the lower spending regions. And you can also look at physician services and acute hospital services. These are age, sex, race adjusted using standardized payments per beneficiary services in the low spending region. In the groups located in the low spending regions compared to the groups located in the high spending regions it's 60 percent higher and about 26 percent are for acute hospital care services, again using standardized payments.

What about the EHMS or extended hospital medical staff? I think I forgot to reverse those. I'm not sure this is the right name for those things. Anyway, EHMS we'll call it for the moment.

There are two approaches. You can look at all services billed by the medical staff, including those for patients who were not assigned to them. And the advantages are that attribution and responsibility are absolutely clear for the services billed. You touched them, you billed for it, I know you did it, we're going to hold you accountable for it.

The real problem is that it includes some patients who they touched once and some patients who they are fully responsible for. And so over time, if referral patterns change quickly or groups merge, the changes in the populations served can really fluctuate and I think are going to make it very hard to interpret what a per beneficiary cost means if you're using as a denominator anyone they touched.

Also, the problem is every beneficiary gets captured in every group, so that you end up double counting in a way that doesn't let you disaggregate back to per capita spending.

Secondly, you can't easily expand it beyond Part B to include all services because of this overlap in which you can't define the denominators appropriately.

The disadvantages of this extended hospital medical staff, all services provided to their patients regardless of where or by whom, the disadvantage is that out of system care isn't directly controlled by the group that you've created. In some cases about 20 to 30 percent of it is at other places. Although that's a relatively small proportion. And if I were a Medicare beneficiary or if I were a physician, I would think it's a great idea to have me or our group be responsible for what's happening to our patients if they're somewhere else, especially if I know exactly where it is. It's that secondary hospital to which we refer all of our patients.

So the advantages are the population is well defined, providing a stable denominator for rates, measurement can easily expand to little services as I just showed you, and now the incentives come to manage care both of your own patients within your system and of the patients if they're outside your system.

So what I'm going to show you now and what I actually showed you on the prior slides is this analysis that focuses on assigned patients.

What this slide does, we have use standardized

payments for physician services. We grouped all of U.S. hospital referral regions according to the magnitude of the growth in per beneficiary spending on physician services over a four-year period. So we took those that had the highest absolute increase in per beneficiaries at the regional level, because I wanted to make sure we had stable denominators, and said which reasons had the highest per beneficiary growth and which had the lowest?

So what you see is that -- and each of those red to pale colored lines and dots represents a quintile, a fifth of the Medicare population. These are stratified in the number of the beneficiaries within the regions to create these equal sized groups.

so what we see is that there are differences in absolute growth and in relative growth rates. There are regions where in this four year period, using just standardized payments, so this is basically volume and intensity growth, it's the numbers of services provided, and perhaps some shifting from level two to level three codes which would be included here, we see an $800 per beneficiary increase on average in the highest growth regions, 32 percent overall, and an absolute increase of about $360 per

beneficiary in the lower spending regions.

The fun starts to be when you get to look at the regions that fall within these. I can never resist a regional analysis. So if we look at some of the higher growth areas, those include Miami, Los Angeles and East Long Island, areas that have long been red in our maps -- I guess now blue. And then if you look at the regions with the lowest growth in spending, they are regions including Des Moines, Portland and Albuquerque.

Interestingly, there is one region in the highest growth regions that began in the lowest spending quintile in terms of absolute rates. We haven't figured out why that is. Maybe staff and you all will want to know. But it almost certainly is that something happened within that region to recruit more physicians and generate more physician services.

It's a relatively small region so you wouldn't have to recruit many new physicians to have a substantial increase in per beneficiary costs, if it were one group recruiting four new cardiologists or six new orthopedic surgeons, because I believe fundamentally that that's the driver of growth in spending that you have the opportunity,

through the policies you're thinking about, to control. If we try to control volume at the individual physician level it means cutting fees, whereas if you look to the future and encourage people to make wise decisions about the capacity they're putting in place, that's their professional approach to maintaining their incomes in the future.

What are the advantages? I think performance measurement is more tractable. It can include all physicians who contribute to care within the frame of measurement immediately. We can do it tomorrow -- well, six months -- with adequate sample sizes. It allows much broader measures: quality, outcomes, coordination, costs. It may, in fact, face lower resistance from physicians than individual reporting. I think many physicians will be much more comfortable to have their aggregate performance of their group publicly reported and rewarded than to be on the Internet as the high cost outlier, especially using systems much I'm uncertain about whether the outlier status is well deserved if you include regional analysis.

The last issue, and this really comes from my experience on the IOM Committee thinking about performance measurement, and if we are to make performance measurement

robust and effective it's going to have to include auditing. It's going to have to include accountability for the accuracy of the measures that we're using. If we decide that we're going to look at 5,000 hospitals and their medical staffs and we sample patients within them to audit, to measure performance on, to survey patients, to look at how they're doing, we now have 5,000 units that we have to worry about instead of 500,000. I think it will be much more administratively feasible to get what I believe are really good measures of patient outcome, patient-centered care, the degree of coordination, risk-adjusted outcomes. You could review enough charts in any these systems to identify the baseline risk characteristics and look at outcomes of care. I think it's a much more tractable approach than trying to think of it at the individual physician level.

It does establish a locus of accountability for capacity, and I don't see any other local candidate that's going to do that.

If you do it at the regional level, I don't know how you are going to prevent a new MRI center from opening, whereas if the physicians themselves decide that they don't

want to open one I think you have a shot at it.

And an SGR-like formula at the medical group level would create incentives for the physicians to say, hey, the way to preserve our incomes is not to recruit six more cardiologists next year. We've already got 20. If you're in Leary, Ohio they probably have 30.

I think the third reason is that hospitals have the organizational capacity in the current environment. Large medical groups do, too, but there are just not very many of them to intervene to improve quality. They can finance the electronic health records for associated physicians, and there are examples around the country of where that is now happening. It seems to change the conversation even among physicians who are in solo practices if the hospital has bought the electronic health record for them. This is the experience anecdotally from some of hospitals in Boston, where they have purchased electronic health systems for the private practice physicians who are associated with that hospital. I think hospitals also have the capacity to intervene to improve quality, much more so than individual physician offices, who will be hard-pressed to build the capacity to do this.

The barriers, there are plenty and we shouldn't dismiss them. Current market has been and clearly is going in the opposite direction of physicians, the association between physicians, medical staffs and hospitals is tortured at best in many regions. But that is, I think, largely a consequence of the payment system that we've established that rewards physicians for moving out of the hospital.

We have lack of organizational structures and physician groups in medical staffs that may be hard. There are legal obstacles that will have to be overcome. And there's variation across hospitals and markets in the relative coherence of these staffs. It won't surprise you to hear that the least coherent places in the country are places like Miami and Los Angeles where still the average concentration of care for beneficiaries is well over 50 percent, but it's not the 70 percent that's average for the country. So we have to think about how to address that variations in market coherence.

So how might we move forward? I think there's some options that you could consider about ways to enhance the coherence of the hospital medical staff. Provide incentives for physicians to choose the hospital with which

they wish to be affiliated for performance measurement or for accountability for the SGR. Perhaps provide incentives for beneficiaries to identify their responsible physician, although that wouldn't be essential in this system because most patients turn out to be highly loyal to the hospitals and doctors where they receive their care. You could also provide positive financial incentives for a shared electronic medical record at that level that would link the hospitals and the physicians who are associated with it and start to achieve the integration that we know we need to achieve.

I think even starting to report performance measures at the hospital medical staff level is important. It can be done now. In fact, we've been doing it in the Dartmouth Atlas since last January. The hospital-specific measures of the care of patients with severe chronic illness that Jack Wennberg and others developed are available on the Web to tell you the relative costs of care for seriously ill, chronically ill Medicare beneficiaries across hospitals. There are dramatic differences. Those differences are due, we believe, to the hospital with which these patients are associated and the medical staff who is

practicing within those systems, and the relative capacity of those systems relative to the size of the populations they serve. But we could do much better. We need to report quality measures at that level so that we know that the lower cost places are actually providing care.

And then we need to think about payment reform. Are there shared savings demonstrations that could be pursued? You're all thinking seriously about whether we should establish growth pools at the extended hospital medical staff level.

Let me end with a slide that I really owe to Chris Castle and Garrett Harden and Howard Hyatt. The physicians in this country are sharing a medical commons that Medicare beneficiaries and taxpayers are funding us to provide. The challenge is that we are all rewarded for putting more sheep on the commons in the current system. The challenge you face, we face, is to try to think of a level of organizational structure that will allow physicians to have the conversation about how many sheep they should have on the medical commons.

I don't see how that can happen at the national level. I don't see how it can happen easily at the regional

level. I think it can happen at a medical staff or physician group level. And so I would encourage us at least to consider it as one element and a tool that we bring to bear to address the growth in spending.

Thank you very much. I think there's enough time for conversation and I look forward to it.

MR. HACKBARTH: Thank you Elliott, as always a great job.

To kick off the discussion, I'd like to throw out a few additional ideas that I think are complementary to this and get your reaction to them.

As you well know, we have the assignment from Congress of producing this report on alternatives to the current SGR, and we are a long ways from having the answer to that question. Personally, I have a few touchstones that I've been developing and I'd like your reaction to how they fit with what you just presented.

Three ideas intrigue me at this point. One is introducing geography into any system of targets. And so the basic idea being that if we're going to have targets and constraints established by policymakers, that we ought to design a system that applies more pressure in the areas that

have the highest costs and relatively less pressure in other places. Leaves lots of very difficult questions to be answered about how exactly to set those targets and apply that pressure, but directionally that makes sense to me.

A second point is that if we're going to have such a system of constraint that it makes sense to apply it at higher levels of aggregation of services within the Medicare framework, Part A and B services, as opposed to just on Part B, as is done currently with the SGR. There the basic notion is, and I think this is quite consistent with what you just said, what we need to do is get providers engaged with one another and thinking about how to reduce total system costs as opposed to just their silo.

The third notion that interests me is within such a framework of total cost and geography creating opportunities for what I'll call accountable organizations to get their own performance assessment. So if you have a geographic system the target would still be the target for the geographic region. But as opposed to their payment consequences being based on the whole region's performance, it could be for a smaller subset like an extended hospital medical staff and they would have their own cost and quality

assessment and be rewarded or penalized accordingly.

At first blush, it seems like what you've presented fits well within that framework, but let me ask your reactions to it. Let me just ask you reactions to those ideas.

DR. FISHER: As a geographer for the last 25 years trying to study the implications of geography, I'm strongly supportive of the notion of trying to redress the imbalances in spending I see in resource use that are unrelated to quality that we see across geographic regions. I support each of those three ideas, and I think they're very important ones.

The question that I have about incorporating geography into targets, and I will need to think more about this and I'm happy to correct my testimony by sending you some notes or talking to you if I have further reflections.

I don't know where the conversation about capacity growth happens at the regional level right now. If we are to try to -- in my still evolving understanding of the health care system here, if you did it at the hospital referral region level, many of these places have 50, 100, 200 hospitals and medical staffs within the region. And if

setting a growth target at a regional level that penalized them all for untoward growth, but I think would penalize within that region those who are doing better, if everybody else still decided to be selfish and thought that the way they would make money would be to grow their own system.

But maybe having a regional cap and internal targets at the same time and penalties for untoward growth at the internal level as well would foster the conversation of let's merge, where is the FTC, we need their advice about how you could pull that off, but let's create larger organizations that are cover more patients, that are more integrated. Maybe you would create that conversation.

But that seems to me to be the challenge. We know already that the regional levels reflect the average of the groups within it. So that a group level reward that was appropriate, that was well designed, should, if it were based on some absolute growth rather than percentage growth, would make the higher spending places grow more slowly by relatively rewarding the groups that kept their prices. You could achieve the same goal, I think, at the accountable staff level.

I love your notion of accountable organizations.

It's exactly the right thing we want to create. And I agree completely with applying it to all services. It should include the whole gamut of care so we get rid of the silos, because you look at the numbers of care transitions and you just see that these places are churning patients from hospital to acute care to nursing home back to the hospital. So I agree that those two principles -- and what I wonder is whether the third goal could be achieved through the first one.

MR. MULLER: Elliott, thank you, as usual, for good data and a stimulating conversation.

This idea is very attractive to me, not so much in my current role in a hospital but my once upon early life as a political scientist. And I think if I can draw an analogy from that, when you think about all these kind of efforts 30 or 40 years ago to create metropolitan governments and how they all came awash and never -- these are theories being offered in terms of how to get some kind of collective good. But they also came up against the reality of existing organizations called cities and suburbs and so forth that fought against it.

I think one of the real advantages of the extended

medical staff is we have over 200 years of histories of volunteer hospitals in America. They are legal entities that are licensed by all states and sometimes cities. They are regulated by CMS and the Joint Commission and many other entities. They have governing boards. They have all the faults of governing boards, some are good, some are not so good.

The important point is they really have constitutional authority and they can, in Glenn's words, be accountable units. I think what's very attractive about the data you pointed out today, which I was not familiar with before, is that you can, as you say, assign 98 percent of physicians to one of them.

None of this is to gainsay all of the kind of political problems of do doctors want to be part of medical staffs? And how do you control the governance of a hospital? And all those kinds of things.

But I think the fact -- I worry about trying to create new geographic units that don't exist in American medical care right now, such as regional units and having SGR at kind of super regional levels. The fact that we have hospitals and they're there for 200 years and we know their

service areas, I think it is an incredibly attractive to -- I say my one time mind as a political scientist. And it allows you to then think about this in terms of how do we organize and manage medical care.

Now obviously as a payment advisory commission, we tend to focus very much on financial incentives and behavior. My feeling has been for many years the real problems in the system. And it's not to gainsay, as you said too, the financial incentives right now get in the way of doing want to do. And we have to keep thinking about how one overcomes some of them.

I think the really heavy thinking on this has to go into how you get accountable units, how you get responsibility in governance of medicine in this country. If I can use my analogy to political units, you have states and you have cities, and you have a national government. Almost everything in between doesn't work that well. On some levels -- you know, counties do work.

So I think taking organized structures that have been there for a long time is the right way to go and we should be spending more time, perhaps not in our role as a payment commission, but we should be spending more time

thinking about how one implements something like this because getting accountability in the system, I think in many ways, is the biggest failing we have right now, not again to gainsay some of the real difficulties we have with payment incentives.

So I find your suggestion very attractive and to supplement your data that you offered today, I think at least shows us there is an end in sight where one has units that exist to which one can assign physicians and start thinking about how one has an organized process of governing these entities that deal with the issues that are so powerfully demonstrated once more by your work today.

MS. BURKE: Elliott, I too think you've made a number of suggestions that make an enormous amount of sense. I think the opportunity to begin to look at essentially the full episode truly of services and the incorporation of both A and B into that view because you essentially match the physician side with the hospital side is very much the direction we all want to go. So I agree, I think this is terrific in that respect.

I had two questions, both of them I suspect relatively narrow.

One is just a question in terms of the likely diagnosis. I was interested that in the list of the things that you think had an impact in terms of spending you did not mention legal. Yet in the barriers at the latter part of the presentation you did mention legal issues.

I wondered if, as part of the diagnosis, the suggestion that one hears not infrequently is that there are a series of things that occur, largely around testing, on interventions that are a result of a fear of reprisal if one doesn't do everything one is supposed to do. That's really tossed out. Not something you noted, and I wondered why that was the case.

My second question again is a fairly narrow one. And that is I wondered how one dealt with the relationships that exist in places like the Cleveland Clinic, the Mayo, Hopkins, places that are essentially utilized by folks that come from a much broader catchment area because of the nature of the services they provide where, in fact, you do have this sort of break in relationship. People come, they're treated, they go. And trying to link those relationships in the pre-admission, admission, post-admission management of the patient, how you might imagine

that we would track folks of that nature, as well.

Again, a small universe arguably, but nonetheless if you look at utilization, certainly high-cost patients are a relatively narrow percentage of the Medicare population but they are the folks that use obviously the most services, some of whom would fall into that category.

DR. FISHER: Good questions. The malpractice I didn't mention for want of time. But it is a factor that does not explain much of geographical variation in practice. Every doc in the country is terrified of malpractice.

Now there are differences in the relative malpractice pressure that physicians experience, and from the best data that I've been able to find, it's about 10 percent of the twofold variation in spending across regions is due to differences in malpractice pressure.

There have been some ideas that I've heard of and haven't studied well around group liability which might actually be enhanced if you created organizational units and allowed the liability to be more corporate rather than individual. I think Bob Berenson wrote some stuff about that about 10 years ago, if I recall.

the malpractice is important. We ought to do

something about tort reform.

The Cleveland Clinic, Mayo, Dartmouth-Hitchcock, we get half, 40 or 60 percent of our patients from outside the hospital -- I mean patients who reside outside and are referred for specialty services. I think that almost all of those places actually do care for relatively large defined populations already. So Mayo does care for, we've identified nice populations, well circumscribed, who get all of their care from within Mayo. So they should be rewarded for doing a good job with them.

I think that the issue of referrals, transitions, I conceptually don't mind the idea of putting the responsibility back on the primary care delivery systems or extended hospital medical staff for choosing which places to send their patients to.

If the Cleveland Clinic, for example, can do aortic resections and repairs better and more cheaply than anybody else in the country, I'd want my hospital to send me there. So I think it actually starts to put in place -- it starts the conversation between the local hospital and the local referral center around what's good care for these patients? What do they really need? I don't want my

patients trapped at the tertiary medical center getting too much care. I have a strong incentive to pay attention to getting patients back to me when it's at the ideal time to do it.

There's obviously more complexity to how one -- the problem of accountability without control, in a sense. That is, the hospital makes the referral to the specialty hospital and they get you in trouble because they are doing much too much. So there may need to be some what you can imagine ways of sharing financial rewards across the primary and secondary unit, for example, I think. Although I'll have to think more about that. It's a very good question.

MS. BURKE: One quick follow-up to that if I might. Glenn. The reference you made to Dartmouth and the fact that 60 percent --

DR. FISHER: Some percentage. It could be 20 to 80.

MS. BURKE: -- or some percentage comes from outside, somewhere between 20 and 100.

To what extent do you believe that the decision to go outside of the traditional catchment area is a decision made by the hospital, the referring hospital, by the

physician, or by the patient's choice? Because the penalty/reward system, in part, also reflects -- I mean, I had a recent experience where my husband chose to be treated at Stanford. We chose it for a lot of reasons, having nothing to do with what anybody else told us to do, having to do with our own research. So it wasn't a local physician here, it wasn't a hospital here, it was just a right decision we made based on information.

So to what extent do you assume in that structure that, in fact, the relationship is such that the reward/penalty system, in fact, is appropriately placed on -- just because I live near NOVA or whatever hospital I live near, Sibley or whatever it is, has absolutely nothing to do with the decision that I make?

DR. FISHER: A couple of comments. On one side, I would like my local system to have strong incentives to want me to check with them about where I'm going and then give me the information support that helps me choose wisely. So that if you have an incentive system such as we're imagining, the hospital and its staff would have a very strong interest in making sure you know how to stay in touch with them, that you're supported in the decisions that you

make, that you're making wise choices. Because if they're responsible for your choices, they should be helping -- they'll be contracting with some good managed care plan who can help them get great information to patients, perhaps.

But I think it puts incentives in the right place.

There are tweaks that you could do, adjust copayments the way point of service plans are doing it, the various tweaks to help give the hospitals some shot at having the patient's pay attention.

But I think it starts to put the accountability right where I want it because so many of these decisions are based on advertising on the Net. There's a lot of bad information out there as well as good information and I'd like people not choosing on the basis of U.S. News and World Report's Best Hospitals but based on good clinical information.

DR. SCANLON: I share Sheila's and Ralph's admiration for this because there's a lot of interesting aspects of this and recognizing that particularly complicated care is not delivered by a single physician and that the idea of finding some kind of workable accountable group is truly challenging. At least with the hospital

staffs we can presume there's some communication that goes on among them. It's probably variable but we can assume that there is some.

You've already anticipated the idea of pushback and I'd like to follow up a little bit on that, and it's actually in the context of what you and Sheila were just talking about.

Because if you go to your chart on concentration of care, you see different patterns in terms of who is using the primary hospital versus the secondary hospital. It raised for me the issue of risk adjustment, and thinking of risk adjustment potentially in a different context than we normally do, which is normally in risk adjustment we're thinking about adjusting for health status. Here there's a question of do we also need to adjust for scope of services?

And what you just raised in the conversation with Sheila, in some respects, you could think of it as services that I have direct control over and services that I may be able to influence. There's a question of how acceptable it will be to be accountable for things that I only might be able to influence, and that may depend upon who are the neighbors. Because certainly distance matters, in terms of

a lot of this.

My question is have you thought about this aspect of things, how to risk adjust?

I think it could go also in the direction of when you presented the two alternatives of dealing with all of the services that a hospital provided verses dealing with the patients that are assigned to the hospital, which of those two models, whether if we had some kind of adjuster we could bridge that gap and reduce some of the disadvantages of the two different models in some process.

DR. FISHER: Bill, I think that's a great question and I've spent a fair bit of time trying to think about how you could do it and I haven't yet come up with an easy way or a way that I can get my hands around. The place that I stumble is around the appropriate denominator or population for each of those judgments, because the referral hospitals, if they touch them once they've inflated their denominator dramatically and they look efficient.

But I think the notion of trying to think about scope of -- the second barrier that I stumbled against was the incentives. Because the incentives, as soon as you can do better by getting somebody out of your system and

shifting those services that you could provide yourself to somebody else who now becomes responsible for that cost, even though they might not have wanted it. That is you say why don't you just go down the street to that place, they do much more open heart surgery than we do. As soon as you have the financial incentive on the primary staff to shift more services away, I think the thing unbundles and people are competing to make more money by moving patients around to other systems. That was the second barrier that I came up against.

I'm a relatively simple epidemiologist. I like to know the denominator for the rates that I'm calculating and not be unsure about whether a piece of someone has shown up somewhere else. And I really worry about the incentives for pushing people to different systems. Maybe it's possible. It's certainly worthy of further thought.

On the risk adjustment, I do want to comment on the risk adjustment. And it's that we'll all have to think really carefully about risk adjustment because everything I've seen in the last two years, as I've now struggled to try to do this, and we've tried to do these geographic comparisons, is that almost all of the risk adjusters that

are available to us are based on how many diagnoses you've accumulated in the claims data. And the best way to make people look sick is to send them to see more specialists. And so we see much higher "risk" in populations that have the same mortality rate in high-cost regions where they're fragmenting the care across multiple specialists. So far I haven't figured out a way in the Medicare data -- and it's even going to be problematic when you ask patients about what conditions you have, because they're going to have learned that from their doctors. So the person who has arthritis in Miami is someone who has aches and pains in Minneapolis.

DR. CROSSON: Elliott, I'd also like to compliment you for what I've now come to understand is a character characteristically, clear, logical and thoughtful presentation.

I don't know how much I like the acronym EHMS.

DR. FISHER: Me neither.

DR. CROSSON: I probably would choose another one, MGIF, which I would say is medical groups in formation.

DR. FISHER: It sounds a lot like some tumor markers we've --

[Laughter.]

DR. CROSSON: That would probably give away more of my thought that I'd like. So we'll go with EHMS.

DR. FISHER: No, I like Glenn's accountable organizations, ACOs, accountable care organizations.

DR. CROSSON: But obviously this does point the way to try to get this general movement we've been interested in, which is to get physicians to work with each other, to get physicians in groups to work with hospitals, and then to create more accountable organizations because we have some, as you say, but they're not present in every single part of the country.

But the question I have specifically is within the universe of extended hospital medical staffs that you've been looking at, as I think you indicated, there's probably a range of extended medical staffs entities, some of which are probably completely disaggregated and chaotic, and others of which are not because, in fact, there has been some work over the last 10 or 15 years.

The PHO movement, the integrated delivery system construct that I think fell apart in most places, didn't everywhere, and there are some places in the country where

as a consequence of that medical staffs have been working cooperatively with hospitals.

There are, in the academic community, faculty practices that are more organized and more medical group like than in other places. I think of places like Vanderbilt for one, the University of California at Davis, and others.

So the question is have you or can you look into your database and look at if you could characterize them somehow, look at issues of already of coherence, as you call it, in the relationship between the patients and the doctors and hospitals, issues of quality and efficiency?

And the reason to think about it would be that were this change to come about the first question would be in all of these places that now have incentives to come together and create accountable organizations, how did they do that? How did they avoid the failures that we saw 10 years ago or so?

And so if we were to look at the success stories over the last 10 or 15 years and try to look at issues like what actually have the doctors and hospitals done in terms of things like payment systems and governance, how to share

governance and control? How to use information technology already? If we were to look at the ones that have succeeded or are succeeding or are building this irrespective of the current incentive situation, what lessons might there be for how to assist the newer version of these on a path to success?

DR. FISHER: Jay, thank you. There is remarkable variation in the data and we can certainly provide staff, we have measures at the regional level of the degree of coherence both at hospital and for physician services and medical services and surgical services. And there is a modestly strong correlation between fragmentation and spending. That is, the more fragmented places are in the higher spending regions. So that the Miamis of the world tend to have slightly lower degrees of coherence.

There are a quarter or 30 percent of Medicare beneficiaries are in what already appear to be highly integrated systems where 80 to 90 percent of the care is provided to what looks like a hospital and its closely affiliated medical staff.

I think it would be well worth pursuing the political science and sociology of the successfully

integrated organizations in a variety of settings, that is those that were academic, those that were private practice but non-academic, successful groups.

I understand that in the Physician Group Practice demonstration there is at least one hospital that has physicians who were already in a PHO, in Connecticut I believe.

If we are to move this idea forward it will require careful thought and enough research to help guide those who need to learn how to do it. And so the idea is nominated and the responsibility falls to me and others who think it might be worth pursuing further to try to get the support there to allow it to happen.

But certainly I think that the anecdotal or qualitative research that I've done through talking to people now as I get to go more fragmented and less fragmented higher cost and lower cost markets would lead me to think that it will be challenging in the most fragmented places because many docs are actually excluded from the medical staffs of hospitals. They might have wanted to have admitting privileges but are not granted them. There's variation in that.

And there are many hospitals that want every physician in the community on their medical staff because they want to get all of their admissions and they're competing for their admissions. So there will be some challenges moving forward.

But it's pretty remarkable, and we can provide the data to staff, on the range of variation in degree of affiliation and degree of coherence across these 5,000 extended hospital medical staffs. And even the lowest numbers are relatively high. That is, it's close to 50 percent of the care being provided by the docs. And the next lower one really drops down to 10 percent, so that the second hospital is really pretty low.

So at least on average it looks pretty good. And in bigger hospitals it looks very good. That's where most beneficiaries are getting their care. The fragmentation really seems to be in the -- the greater degree of fragmentation is in the smaller places. Is that helpful?

DR. CROSSON: Yes.

DR. FISHER: It will be work, though.

MS. HANSEN: Dr. Fisher, this is really extremely interesting and really informative. I come from probably a

history of a bit of an anomaly, the PACE program. So that we integrate Part A, Part B, Part D and Medicaid. So ironically these small organizations are the accountable entity, per se.

My question has to do with something I raised with Glenn before in a conversation we had about what you mentioned to be the churn that tends to occur with the fragmentation.

I also hear your comment about being careful about risk adjusters because one of the concerns I brought up yesterday is when sometimes an older, more complex person goes into the hospital what happens is there's iatrogenesis that occurs. And there's a lot more conditions and they get sicker. But then should we be rewarding for induced frailties or complexity?

So how do we address that issue of getting a -- what's going to help mitigate that churn to be able to do the right care? It's almost like the five rights in medication administration: the right patient, the right treatment, the right time, and so forth. So that we don't create, frankly, more diagnostic conditions for billable purposes but are not good for the beneficiary?

DR. FISHER: It's the most -- I think it's actually the most important question we're facing a we think about performance measurement and pay for performance. And I don't think it's particularly easy.

I'm increasingly nervous about performance measurement, the current performance measures we have, because they focus on a narrow scope of practice that is easily defined as correct and is not very broad. It doesn't identify any of the issues that you -- giving the right medication for a pneumonia is kind of trivial. Getting the patient out alive and without complications is actually really important.

As I think about one of the advantages here and what I hope we can start to pilot, perhaps, is the notion that we really ought to identify either the populations that we serve and measure their quality of life -- and this goes back to Bob Brook, 25 years ago or 15 years ago, let's measure everybody's functional status and health status at time one. Let's measure it again at time two and let's see if they're better. Bob was pushing that 20 years ago.

I think we really ought to revisit that. One of the advantages of having 5,000 accountable units is that you

can sample 1,000 patients there. Or if we care about Medicare patients a lot, we'd actually have them all fill out an online health status survey that wouldn't ask them about do you have rheumatoid arthritis? It would ask how well are you functioning? And we'd know enough respect factors that we could look at your predicted risk of death. And then the system would be measured on how those patients were doing on average a year later or two years later.

We've been in some conversations recently at Dartmouth as we try to figure out how to encourage our clinical groups to be inspired or incented to do better. And the notion of setting the goal not around providing 30-minute time to reperfusion but around a goal that says will have all of our heart disease patients at national norms for functional status a year after they first see us, or we'll get as close as we can do it and we'll be the best place in the country for that.

The clinicians all start to say now that's something I could work for. I think it does some of what you're asking for, which is align the work with a goal that we really care about. That is, improving function, preventing time in the hospital. You'd ask not just

function. You'd ask did your doctor listen to you? Did you have informed patient choice? I come from Dartmouth. We care about patients not being told by their docs what to do, but about making informed choices about the risks and benefits.

I think we really need to think more carefully about what are the performance measures that we really want that will give us in five years the delivery system that we need. A large enough accountable organization, and then performance measures that are really important that capture the important dimensions of care. It's the only path forward I see that's not going to make things a whole lot worse and reward physicians for doing things that I think are really stupid, to use the technical term, and harmful.

DR. REISCHAUER: Elliott, as always, a great presentation. Every time I hear you I'm convinced you're right and then get terribly nervous because you made it sound so doable. Here we are out in search of an accountable organization in what is basically a free range environment and you had a great ending slide, but it really wasn't the right one. It was a whole bunch of well behaved sheep eating on a prepared lawn. And really it should have

been the Serengeti. It should have been one with some lions and some hyenas and elephants, and them not only eating the grass but also each other.

[Laughter.]

DR. REISCHAUER: We're looking for some kind of accountable organization wherein we can measure growth in spending, measure quality, set updates possibly, reward performance and so on. I think your work has convinced many of us skeptics that if you really went to a unit like the extended hospital staff, you encompass a lot of the care that's provided and there doesn't seem to be a whole lot of questionable accountability. Should it be here or there? It really is much more concentrated than any of us believed before we saw your work.

That doesn't create an organization. What it basically does is say if you drew your line around this group it could work. But then there has to be an organization. And I want to hear whether my skepticism about the existing organization off of which one might build is warranted or just too pessimistic.

You have, as you say, a group of docs who are associated with this hospital who do have a relationship

with one another and with the institution. But then you have a whole bunch of other ones. And right now their relationship often with hospital administration is not, shall we say, a peaceful collaborative wonderful organization. It has some conflict in it. And if one puts in all of these other consequences the relationship might be even more problematic.

You're going to get a lot of other people who say well, if this is going to affect updates or performance measures, I want a voice at the table. I want to be part of this organization, as well. And I wasn't quite sure where the nursing home, the ASC, the lab, the home health agency that are sort of out there and are part of this, fit into -- I can see us defining something and then having to create decision rules for this organization. And maybe these exist somewhere and can serve as a model for us, but I'm a little still skeptical on that front.

And then I asked myself well, Medicare isn't everything. We're acting -- in a way if this were just Medicare, maybe we could work this out. But over half of what's going on has nothing to do with Medicare, and how would we account for that? Or would accountable groups or

whatever just say I don't want to be part of Medicare if it's going to involve all of this? And we develop, in a sense, two systems out there.

DR. FISHER: I've got a bridge I'd like to sell you.

There's no question that there is variation across markets and across organizations. So there are plenty like Rochester, New York or Northern California where they really look remarkably coherent and I think all the docs are pretty tightly associated. When I presented these ideas to hospital associations, one in particular, there was pretty strong support for the notion that we've been driven apart by current policy and this would get us all on the same table because we know we've got a bunch of nursing homes popping up and we need to coordinate care with them.

I think the specialty hospitals, the surgeons, the ASCs, the nursing homes, independent labs, those are going to be challenging.

But I guess the question is really whether we want to think about the long-term goal and try to make steps that we take in the meantime more likely than not to need us to that long-term goal. I think that's really important.

Because I worry that if we say all right. the feasible things to do in the short term, the easiest thing to do, is we'll do the silo-based updates, we'll drive these people further apart, I think we're going to further commercialize an upend the clinical delivery system.

So if, starting with performance measurement, and maybe tiny pieces of the update that encourages people to start having a conversation -- and if we took as given the current system, the real gains for efficiency and quality are changing the trajectory of where we're going so that not having another ambulatory surgery center open in your community and not having six more for-profit not necessarily very good new institutions spring up because they can make money doing it, if they understand that the long-term incentives are aligned, that they will be penalized for that kind of behavior, I think you start to create the opportunity to move the system in a different direction.

But you know, Ralph is a political scientist and I am a naive epidemiologist.

DR. BORMAN: A couple of technical questions and a couple of more philosophic ones, maybe.

On your slide 17 that's got the coherence

histogram, this would not then capture the independent testing facility or the independent imaging center in this, what you've got currently. So patients who had lots of work up done either through an independent clinical lab or independent imaging center only their actual hospital-based part would capture them in this. Is that true?

The reason for my concern on this point is that pretty cleanly the highest growth or the most rapid growth spending areas are testing and imaging. And to get a handle on that, while this is a very powerful organizational argument, to not be able to capture that piece of that seems to be a problem.

DR. FISHER: If you go to the -- I think it's the next slide. But the key question is, the first question is to define the group of physicians who we think are responsible for the care of these patients. That was our first challenge. That slide shows us what proportion of evaluation and management services and hospital-based services are provided by the physicians and hospitals to which we've designed these patients.

For performance measurement purposes, you can capture all of the services provided to those patients. So

I can tell you for each of those places what was spending on imaging. We can look at growth in imaging across these systems, across these extended hospital medical staffs, from 1999 to 2003. We've offered to provide staff, when I met with Cristina before this, with growth at the hospital staff and regional level stratified by type of services, which would include testing and labs.

And what I believe we'll see when we look at that is that you will see there are places that have remarkably grown their imaging and testing. And there are other places that haven't. There's one place in the country that seems to have had a decline in physician services in terms of standardize prices. One out of all the markets in the country. And it's not a very big decline and it's a small market. So we will see heterogeneity.

And it is captured, when you look at total services. When you look at total services provided to the beneficiaries that you're responsible for, we do capture testing and we do capture imaging. And so much of the decision-making there is by the physicians who are responsible for the care of those patients, the ordering of MRI scans, the ordering of CT scans.

Some of it will be the radiologist ordering more, I need to take more cuts because I want to see the pelvis in addition and I can bill for extending the service there. But the total cost of that care will be attributed back to the medical staffs that we've defined. And those docs are the ones I'd like to hold accountable. I'd say don't send them to a radiologist who's going to provide unnecessary services to the beneficiaries for which you are responsible.

Does that answer your question? Because they are grouped in terms of you have a population and now we can look at all the services that are provided, too.

DR. BORMAN: I guess the practical encounter that I have on a relatively regular basis goes as follows, and this is in part what I'm trying to get at. I ultimately get this stack of reports that come with the patient because I'm in an academic medical center, also. And you know how the folks arrive.

And as I start looking through to see what was done prior to that patient encountering me, I find that they got sent for test X, ordered in very good faith maybe on a very good clinical rationale by doctor number one. The test comes back with X result, could characterize further by next

test. That test gets done, comes back, could learn more from Z test, Y test or whatever. So by the time I see the individual, probably five tests have been done and maybe two of those needed to be done.

On the other hand, I'm real sympathetic to the doctor who got that report that now is certainly freely available to all manner of folks that has implied that the next appropriate care is to do more.

And I worry a little bit about yes, we say that that doctor did order the test but they did face some relatively potent pressures to do that, and certainly practice guidelines and so forth somewhat address some of that. A piece of it that I think may not get addressed and that I would have to respectfully disagree and with some trepidation disagree with your enormous knowledge base about the professional liability piece and the geography of that.

Because I think the geography, I think there is important geography but I think the geography distribution is not as obvious because it is hugely specialty driven. And that if you did it on a specialty specific, by geography there would be huge variation and there is an underlying piece of this. And that's not the only answer to wasteful

care but I would make that conclusion, at least from my viewpoint, that I would worry about that, is a little more geography.

But what I'm trying to get at is how do you get back to properly attributing that test? And yes, in the ideal world, this would come back to where I would say to the radiologist you know, I really wish you would quit writing that kind of report or whatever. But I think my power to influence the imaging and lab pieces is maybe overrated.

DR. FISHER: The radiologists and the pathologists are all assigned to hospitals under this model. So if the radiologists buy that new MRI scanner, stick it in and start -- or buy the new ultrasound machine and stick it in and start recommending oh, the MRI didn't give us the answer, I want the CT, or I saw something at the top of the kidney so I want to go all the way down, they're going to be in the same pool of penalty for having recommended that additional service.

DR. BORMAN: And if's at an imaging center that the own, how is it captured?

DR. FISHER: It's captured in the professional

services and you can certainly include the outpatient -- we haven't yet built in standardized prices for outpatient services because we're struggling to figure out how to do that exactly correctly. But it's all completely built in here. Testing would be built in here.

It would not immediately change the conversation among the physicians but it would promote an environment where those physicians would have an interest too in the conversation about how do we test wisely?

And on the malpractice, we actually have looked specialty by specialty. To some extent there is variation in the malpractice pressure. People do seem to respond to it for certain things. It just doesn't explain much of the difference in regional variations in per capita spending in the empirical work we've done.

There's lots of -- when you interview physicians in our physician surveys, half of the physicians pretty much everywhere are saying they do things because of their fear of malpractice. It's somewhat higher in the high spending regions than the low spending regions, but it's not a big driver of the differences across regions in the overall costs. And that's largely because the overall costs are in

these what we call supply sensitive services. Do you see your patient in three weeks or do you see them in six weeks? That's perhaps the most expensive decision physician make, do I see them in a month or two months?

DR. BORMAN: And I think it also might relate to specific conditions that may be higher risk litigation areas.

DR. FISHER: Neonatal care, high risk OB.

DR. BORMAN: There's a lot of ways to slice and dice this.

DR. FISHER: Absolutely. We need to change the payment.

DR. BORMAN: It wouldn't be measured in the --

DR. FISHER: We need to fix it.

DR. BORMAN: In the interest of time, just a quick philosophic thing. You've given this very nicely in a way that the physician responds to likely diagnosis. My challenge to you is what's the differential diagnosis?

DR. FISHER: Good question. Do you want me to talk about the differential diagnosis?

DR. BORMAN: I asked the question.

DR. FISHER: The differential diagnosis include,

it's all patient preferences. And we've got pretty data that suggests it's not. There are some differences in patient preferences across regions but it's very hard to figure out how they could explain the magnitude of what we see, given the small differences in patient preferences in our interviews.

The second one is malpractice, and I've already told you that doesn't really expect a lot of the difference.

So malpractice, patient preferences, physician training. But that sort of falls into the clinical judgment and clinical culture, and we've actually looked at that. Physician training does seem to have some impact on how physicians are making decisions.

That's why I come back with my likely diagnosis, and it's a hypothesis. But I think it's the only hypothesis I've been able to come up that really explains at the level of the clinical practice why one group of physicians would see a patient with hypertension every month, well-controlled hypertension, and another group of physicians would see those same patients after six months or every 12 months. And that comes down to how many docs there are in that local delivery system and the need to stay busy.

It's invisible, it looks like it's a reasonable decision to see them in a month. It feels good. There's good clinical reasons when you talk to the clinicians, and we ran focus groups. They said well, you know, my patients are going to forget to fill their meds. So I need to see them once a month. And some of the other docs are saying every six months.

MR. HACKBARTH: We're going to need to do some time management here. We're running over. This is an important discussion so I want to get to the four people I have who have been waiting: Arnie, Nick, Nancy and Ron.

We're sort of taking time from our next session, which fortunately is also on SGR. So I think we're sort of company the two, to some degree.

DR. FISHER: And I'll try to be concise.

MR. HACKBARTH: Arnie, you're next up.

DR. MILSTEIN: Elliott, non-salaried physician medical groups have generally struggled to moderate individual physician grazing habits. And I think it's fair to say that hospital-affiliated IPAs, even in California's capitated HMO market, which is a very substantial fraction of payment in California, have equally struggled.

I've had a chance to personally sit with the medical directors of both these hospital-affiliated and non-hospital-affiliated IPAs and hear them talk about how difficult it is for them to take symbolically a physician symbolized by the sheep in the foreground and get them to look like the sheep upward and to the right. It's very tough for them.

And while I certainly agree with the point that several aspects of performance measurement, especially for chronic illness, are hugely easier at larger units of aggregation, there are certainly some aspects of performance measurement that are reasonably attributable to individual physicians.

And so if we want to anticipate the struggle that the medical directors of tomorrow's -- I hope I have this right -- EHMS.

DR. FISHER: Accountable care organizations. We're going to take Glenn's name.

DR. MILSTEIN: If we move forward, some day there's going to be a medical director of such an organization and a beleaguered board chair who are going to be facing the same kind of struggles that today their

counterparts in IPAs in capitated California face.

And my intuition is that we could help them a lot if for at least those aspects of measurement and accountability that are reasonably attributable to the individual physician level we also had some Medicare incentives operating that pushed individual physicians to reach for excellence in resource use and in quality.

For example, I guess the cleanest example would be an orthopedic surgeon that does hip fracture repairs. That's clean.

DR. FISHER: Absolutely.

DR. MILSTEIN: So I guess I'm asking for your endorsement of a two-engine solution or three or whatever because I worry that --

DR. FISHER: This is going to come back to bite me, I can see. Let me quickly answer.

I think there is tremendous value to helping physicians understand how they're practicing and to the feedback that's done. If you look at what's happened in Rochester and others in terms of the feedback or at Partners in Boston, about they use feedback to help physicians make wiser choices, I think it's very powerful.

A couple of things. First, I think some of the difficulty around changing individual behavior will be incredibly difficult. But if I look 10 years down the line, what I want to influences is whether that group recruits four more physicians because that's going to change what spending is 10 years from now.

So this system, even if you can't change the behavior of that group of physicians, the big thing that's going to change their behavior is giving them fewer beds to work with, converting some of those beds to nursing home beds and having a really good local right in the hospital nursing home, and not recruiting another 10 cardiologists because that's how we make a lot of money in the short term, by doing more cardiac procedures.

So the decisions about future capacity growth are the ones that I think this really influences. Since there's so much discretionary decision-making around how to see a patient and when to refer, that's what I wanted to target with this policy.

I'm perfectly open to individual physician performance measurement, certainly on as many dimensions as we can reliably do it. We don't want to have the discussion

about ETGs or other groupers here. I read the lively debate that was carried on and I hope I can contribute in constructive ways.

I believe it should be done within these groups because that's the level at which capacity is having its influence. And so relative to the performance of an individual group within which you're working, I think that's where you would actually see ETGs actually start to be useful as a tool and much less likely to lead to the false conclusion of he's an efficient doc but that's because he's in Miami and they chop people up into lots of episodes.

DR. WOLTER: Like everybody, my mind is racing with how might you translate this into something practical, because I think it is absolutely the right direction. And I think the power of placing the accountability at some organizational unit level clearly is really important. Arnie and I have had this conversation about individual versus group many times, but I guess I would boil it down to this: I think the best way to hold individual physicians accountable is through the group process of other physicians using data to work with individuals. We don't have that now in American health care. We have an incredibly fragmented

cottage industry around which nobody is holding anybody accountable.

I think maybe the insurance companies can do it but that's been basically a miserable failure, I think, over these many years. So what we're talking about now can be incredibly powerful in terms of how physicians come together to hold one another accountable, but at the same time put system approaches in place that can really tackle, in the initial years, the high-cost highly complex diseases that really is where all the money is.

So this is the right direction. There are 10 million barriers, and it does seem hopelessly impossible to go from point A to point B. And I couldn't agree with you more, the way to think about this is that this is charting about a 10 or 15 year course, rather than something that is going to respond to the immediacy of the SGR-mandated report or the change in control in the Congress that just occurred, or whatever is on the hot button plate.

So how might one get there? That's what I've been kind of racing about since this presentation began.

I was thinking, yesterday we had a great presentation on multi-specialty groups. I was thinking

about all the enthusiasm in the '90s around integrated systems. And at that time Jeff Goldsmith, who has presented to this body in the past, wrote an article I just thought was fabulous. It was called Driving the Nitroglycerin Truck. It was about the absolute cultural differences between physicians and hospitals that basically meant that this approach to integrated health care was going to blow up.

He really called that one, I think, very, very well.

How could it be different this time, I think is really the question. And I think the reason possibly it could be different is if we chart a course that makes it clear we do have a long-term view. But along the way we're going to take this in some sort of steps. One way we might do that would be to identify some of those high-cost, high-volume areas, and make it very clear that we're now going to pay for them in a way that puts A and B together, which would cause certain physician groups in the way that you've analyzed it to have to come together with hospitals to take care of diabetes or congestive heart failure or asthma, et cetera.

And over time we could migrate more of what goes on in the care of these patients into that sort of organized approach to care. That would allow for a lot of the boutique-ey thanks to run their course that are going on, and not everything necessarily needs to come into these systems of care anyway.

I would say, Ralph, that there are many physicians who would definitely not want the hospital to be the unit of organizational accountability because there's just so much mistrust of hospital control behaviors. But I think new organizational entities can form, as they did with Middlesex that we saw the presentation on.

So I think there would be a way to chart a course that would allow migration into these models over time. And if it was clear that was the direction and we did start to put some payment incentives in place I think we could create a trend in the right direction as opposed to -- I couldn't agree with you more, so much of what's in the incentive system right now is taking us in the other direction. And that's the real danger over the next 10 or 15 years if we don't rechart the course.

Lastly, I would say we know a lot about sheep in

Montana.

[Laughter.]

MR. MULLER: I think the evidence of the '90s in trying to create physician groups around payment and around capitation and the miserable failure of the Phycorps [phonetic], MedPARs, and so forth shows you it takes 100 years to create Mayo, 50 years to create Kaiser, et cetera. I think we should learn from that. It takes forever to create these groups. And that's why I argued for taking existing constitutional structures, rather than thinking -- and what we saw yesterday -- and I'm all in favor of multi-specialty organized groups. But I think the notion you can slap them together was incredibly disproved in the '90s. And I think if it takes 100 years to create them, we should plan on taking 100 years to create them.

That's why I was arguing for taking existing constitutional structures.

DR. KANE: I'm a little bit with Nick on the payment side of now do you get groups who have historically warred over who gets which piece of the pie, and I think that's where a lot of the PHOs fall apart in the past.

The other piece is is it really realistic to take

a fee-for-service and a DRG-based system and basically a per-unit of service system and expect them to start to improve quality if that means their payments are going to get reduced by the reduction in the volume of emergency room visits or inpatient care?

Do we really have to just think of a completely different way of payment unit besides fee-for-service and even DRG to get to the kind of incentives? That's the first question? And I'll give you my second one because I found that once people get started, you don't get a second shot.

My second question is you said several times that constraining supply is really the main goal of what we should be after that. And I've got little bells ringing off here. I hear Mike Porter talking to me, or somebody who thinks that competition and consumer choice and all of that should be fostered. And somehow constraining supply doesn't go with this notion that we should be encouraging more choice and more opportunity and that this accountable -- whatever we're calling it -- would actually probably seek to constrain supply and constrain the number of new cardiologists that come in, and constrain the specialty hospitals, and constrain the availability. And so where do

you see this? Where does competition and consumer choice fit into your motto?

So how should the payment system changed to foster these kind of collaborations that we need? And then what do we do about competition? Or where does competition fit in?

DR. FISHER: Competition actually fits pretty well in that 90 percent of Medicare beneficiaries live in markets where there would be multiple accountable care organizations. Now it depends on where the FTC is and it depends on how you define them. But they're hospitals, there are lots of hospitals and their medical staffs.

The way to constrain supply effectively would be to have great performance measures that let us know which systems were really providing better care. The flaw in Mike Porter's assumptions is that people in the current system can actually evaluate the value of the services we're providing and that you can chop people up into disease entities that will have competing disease entities when most people have multiple chronic conditions. The last thing you want is to be sent across town for your cancer when you're being cared for for heart disease at someplace else, I believe.

But the payment system, how could you do this in a payment system? I think we're learning a lot from the Physician Group Practice demonstration and the notion of a shared savings model, which is fundamentally what a SGR-like formula if you put the A and B together would essentially be, that is you would be rewarded next year if you reduced total spending within your group for the beneficiaries you serve while providing high enough quality care.

Again, when I look at, from by epidemiologist perspective, about the difference in spending across systems, it's not about the services that are clearly defined to be beneficial or that patients would really want if given adequately informed choice. It's about unnecessary visits to the physician's office, which most patients would rather forego. I'd really rather do it by going than being told to come back. And it's about imaging procedures, trips to the lab, other services, time in the hospital that could otherwise be spent at home.

And so if we look at the categories of services that are overused in our current delivery system, I think that's the tool whereby supply would have -- supply would have it's impact on the discretionary services, not on the

necessary or even plausibly beneficial services, I believe. And that's just 20 years of epidemiology and Jack and I crying in the wilderness while everybody else believes more medical care is better. With good performance measures, we might actually see that more medical care is actually bad for you in many of these circumstances, especially the kinds of unnecessary services that patients are now receiving, time in nursing home when they don't need to be there, time in the hospital when they really shouldn't be there.

So I'm not going to give up my worries about the overuse and the harms which the first slide really outlined pretty clearly from more medical care, and the need to design a system that gets us better performance.

DR. KANE: On the payment side though, doing less means less inflow unless we get away from fee-for-service and per unit payment.

DR. FISHER: But you could still use a fee-for-service unit payment system with a shared savings model. I think we ought to get away from fee-for-service in the long run. We've argued that pay-for-performance is a way of learning how to change the payment system. I'm certainly happy to get rid of fee-for-service, don't worry.

MR. HACKBARTH: I think a practical concern is whether the shared savings are powerful enough relative to the underlying fee-for-service.

One way to think about that is that there's an alternative where people can go that is decapitated. The fee-for-service system is the base system for better or worse. We're not going to be able to change that. But you can create alternatives.

Ron, the last word.

DR. CASTELLANOS: First of all, I really appreciate this conversation. I learned a lot.

I looked at the slide and I didn't see the Serengeti. I saw a bunch of doctors out there ready to get sheared.

[Laughter.]

DR. CASTELLANOS: I have to tell you, I am a practicing neurologist in South Florida.

But the more I listened to you, I like the idea of the accountability and the organization, be it the hospital or a group practice.

Like Sheila, I had a little different concern than she has. I lived in South Florida. My population goes from

500,000 in the summer up to 1.5. We have very poor coordination of care along regions. We've thought about episodic coordination of care but we really never thought about it -- or at least I never thought about it -- regionally.

I think with accountability of organizations we will have some coordination of care. And I think that's really important. I think we could have tremendous cost savings on that part. We could have better quality of care. We could have efficiency. As we said, we can have more appropriate care at a less price.

I guess my concerns are this, that a lot of these patients come down and are not in the hospital setting but I see them for chronic diseases or cancer, et cetera. This is under Part B. How is that accounted without a hospital involved?

DR. FISHER: The way we've assigned -- I mean technically, in this data, we have probably assigned you to a hospital, even though you never admit a patient, you may not be doing inpatient care. And we've assigned a group of patients who the ambulatory physicians are providing care.

For many of these Medicare beneficiaries in the

data that we've looked at, they're never hospitalized during the year. But they're part of the group and their care -- if I understood your question, their resource use, care coordination, would be managed at the level of the physicians who are affiliated with this group.

DR. CASTELLANOS: I understand when that's in the same region. But what it's two entirely different regions, thousands of miles apart.

DR. FISHER: Snowbirds are going to be a challenge. We have the same problem in Vermont, where they all go south for a month and our geriatricians take a month off.

But I do think the notion that's in one of the slides there at the end, if patients assigned to -- chose the physician or the group with which they were going to be affiliated, and then that group had some responsibility to communicate, if it were my patients in Vermont, had some responsibility, I would have some responsibility to communicate with you. When I was practicing at the VA and my patients went south, it was always very hard to get the conversation going with the physicians in the other communities.

But that's, I think, what we need to do. And this would give someone the incentive to pay attention to that communication.

DR. CASTELLANOS: There's no question, it gets doctors talking to each other, it gets doctors and hospitals together. I really think there's a lot of attention here. Thank you for your report.

DR. FISHER: Thank you.

MR. HACKBARTH: Thank you again, Elliott, terrific job.

It is 11:25 and we are going to finish at 12:30, the scheduled time, for those worried about getting to the airport.

Our next session is on SGR again, and it has two components. One is about combining SGR alternatives and the second is setting targets for physician specialties.

So Kevin, what I would ask you to focus on is the setting targets for physician specialties. I think we've touched on the other topic a bit in the discussion we just had. But I want to make sure we get to the specialty-based target discussion.

What I'll do is allot about a half hour for that

and we'll pare down the hospital-based SNF discussion to 15 or 20 minutes and then have a very brief comment period and be done at 12:30. That's the plan.

DR. HAYES: Just to revisit where we are here, recall that the mandate for the SGR report identifies a number of different alternatives to the current policy that we should consider, geographic area, type of service, hospital medical staffs, group practices and physician outliers.

The law is not so prescriptive, though, as to preclude the Commission from considering other ideas, and this session is intended to be an opportunity to do so.

The two ideas that we would like to offer this morning are combining SGR alternatives, at least some of them that are listed in the mandate, and then the other idea would be to set targets for physician specialties. I've got three slides on the specialties idea. We'll go over those. And then the rest of the slides concern the idea of combining SGR alternatives.

Looking at the physician specialties, we see that they vary in terms of how fast the volume of their services is growing. Looking just the top 10 specialties in terms of

volume of services furnished to Medicare beneficiaries, we see that their volume growth varies relative to the growth in real GDP per capita which you know is the allowance for volume growth in the current SGR policy.

Some specialties are at or below real GDP growth, general surgery 0.6 percent, this is '04 to '05. Two other specialties are within a percentage point of real GDP growth. Internal medicine is at 2.9, ophthalmology at 2.4. Other specialties differ from real GDP growth a bit more. At the far right we see two specialties, emergency medicine and neurology, differing from it the most.

So the idea with setting targets for specialties would be to just try and rely, take advantage of peer influence to work through physician specialty organizations. This would be specialty societies, certifying boards and residency review committees, and see if they couldn't come up with some ways to use peer influence to bring about more efficiency in the delivery of health care.

We have some examples of this kind of thing already, not an all-inclusive list but there are some appropriateness criteria that have been developed for imaging services. We have the American Board of Internal

Medicine has changed the way it certifies physicians, moving away from once-in-a-lifetime certification toward a maintenance of certification program. And they're finding in preliminary research is that more knowledgeable physicians provide more appropriate care but also a more conservative type of care.

More in the way of quality improvement, we have efforts on the part of the American College of Surgeons, Society of Thoracic Surgeons, to engage in some data collection, provide some feedback to physicians, or to physicians and hospitals together.

Doing this kind of thing comes potentially with that advantage of taking advantage of what specialty organizations can do. There are some questions, though, about this kind of SGR policy would work. And that we've listed them here. I won't go into any detail here, but if you have questions about this I'd be happy to try and answer them.

The basic questions here center around things like whether this kind of setup would work against physician collaboration of the type that the Commission has been advocating, say in the area of care coordination, some

concern about how physician specialty is designated by physicians. This is this something that they do for themselves? Would does lead to perhaps some changes in behavior there? And then there are a set of questions about how to set targets for physician specialties.

MR. HACKBARTH: Is that the end of the specialty piece? Could we just pause there? I want to make sure that we have an opportunity to discuss that.

Any questions or comments about that?

MR. DURENBERGER: I don't so much have a question as first, a compliment to Kevin for the work, and for the inclusion of examples that already exists in the profession. You haven't here mentioned them all, but I think in the report you did. And I think that's really quite valuable.

As I'm listening to Elliott and I'm listening to the Chairman's question and so forth, to articulate the goal that's up through here, I'm reminded of old Walter McClure, who was Paul Ellwood's partner in Minneapolis 30 years ago. One of the things I will never forget that he said is that American medicine is remarkably inventive. If you just point it in the right direction and with the right incentives, it will continually improve the quality, the

value, the satisfaction of the system better than any other industry. We haven't had that experience with American medicine in a long time.

My personal judgment is we've never had the incentives lined up in the appropriate way, and we now seem to be in a situation where for a variety of reasons, some of them professional and some of them to get the incentives changed, a lot of these specialty associations are doing the hard work of data gathering so that they themselves can improve a clinical performance.

It strikes me that whatever we do as we articulate this chapter and build it into these alternatives, whatever we do to encourage them to continue to do that, to take that next step which is through maintenance certification or whatever it is, to do that periodically as a way in which a profession helps to police performance of its own members.

We eventually get to the point where hopefully we begin to combine clinical outcomes information with price or cost related information and within the specialties we see a lot of that performance enhancement that we're looking at. It's not an exclusive remedy for the problem, but it strikes me as being a critically important one, particularly at a

time when the associations themselves are asking.

The last question will probably be around financing and so forth, because at some level it would be helpful to fund this. And what occurs to me, as one who is neither a doctor nor anything else, is we're spending an awful lot of money on Medicare Advantage organizations trying to get them to do this same sort of thing with data. It might be worth spending a relatively small comparatively amount of money in helping the specialties themselves fund some specific goals that we might set out for them.

With regard to the disadvantages you set out, would a specialty SGR work against physician collaboration? Again, it's just an impression that the collaboration problem is not so much one specialty versus another specialty, as it simply is one doc and one specialty and another doc and another specialty in a community or something like that.

Is there an issue with physician specialty because it's self-designated? If I understand that, in reality the Supreme Court a long time ago, I think it was Brandeis, gave a legal definition to a profession. And there is an obligation to self-regulate built into the profession. And

so I'm less bothered, if they take it seriously, by the self-designated part of it.

And I think on the last one, how would the Congress or the Secretary set the targets? Once we began to establish a base or a benchmark for performance, it would seem to me that the specialty organizations themselves will provide, through the performance that comes through the system, will provide the benchmark or the base that you need to continue to enhance that performance.

DR. CROSSON: I had a somewhat similar comment, so I'll make it short.

I think my initial reaction was thinking about disadvantage number one, and that is that it doesn't appear to have the characteristic that we've talked about, which is encouraging physicians to work together. I'm not sure, though, that I actually believe that it would work against it. I think it's probably neutral to that goal.

But the one I thought bothered me the most is the last one, and it's not so much how Congress or the Secretary would set the targets as much as the fact that setting the targets really would require a judgment about the clinical issues relevant to that specialty in that particular year.

Because as science advances, even though some of this may result in unnecessary spending, nevertheless a lot of it results in appropriate spending. But science advances non-linearly. And in each specialty from time to time there are break-throughs which result in appropriate increases of volume.

So my thought here is that the problem would be that Congress or the Secretary would really have to make some difficult clinical judgments about what was an appropriate volume increase at any given time and what wasn't. And that's generally not what they like to do.

DR. REISCHAUER: But they could rest on the advice of MedPAC.

[Laughter.]

DR. REISCHAUER: I was wondering, Kevin, if you had broken down the volume growth on page three into that which was associated with doing more of the same things versus an increase in the intensity. I think the way these things are done is it's number of things weighted by the DRG associated with them.

If you think about it, these numbers are remarkable if it's sort of doing more of the same thing per

Medicare beneficiary, 4 or 5 or 6 percent increase in the number of artificial knees you put in the average person. At some point you can't do anymore. This would be getting to Jay's point, if a very high fraction of it was an increase in intensity, then there's a question of is it because new and more complex and expensive stuff is available? Or is it because the number of E&M visits per hip transplant has gone up 11 percent a year? You might get some insight.

I think I'm with Jay. The bottom line is that this is probably something we shouldn't pursue because it gets us or the Congress into areas well beyond our competence.

DR. WOLTER: My instincts aren't taking me to this either. I just think that it's not going to be easy to decide how to set the targets. I think another one of the disadvantages is when you do have regional variation of such significance, how do you deal with the fact that one area may be driving volume more than another? And what's the equity in that? It's very difficult to think of how this might be administered.

I'll say it again, I think we went on record as

saying we don't think the SGR has been effective in a previous statement. I wish we could really dig in and start focusing on the tactics that are more likely to get us to appropriate resource utilization. I think these global formulas have not worked very well for us.

MR. MULLER: I feel somewhat the same as the last few comments. I think while I admire what the specialty organizations do in terms of development of practice guidelines, certifications of new physicians entering into the field, and basically the kind of science of what they do, I'd like to go back to the previous discussion with Elliot. These are not accountable organizations. Nick and others have just said it. so I think using them for this purpose is fraught with too many difficulties without an awful lot of gain.

DR. CASTELLANOS: I'm going to take a little different approach. I think the SGR issue is no question, I don't think it should be used there as a target.

But as we talked about yesterday, when you educate physicians and show them that maybe they are an outlier, you need to look at that. And you need to let the physician community know that.

I happen to be a urologist and one of the things I mentioned to Kevin yesterday, I said Kevin, what's the story here? He was unable to give me the breakdown. And what we had discussed afterwards is that I would love to look at that, and so would my specialty, like to look at that to see if we can identify appropriate volume growth versus inappropriate volume growth or, as Mark had used an expression once, looking at the root causes of this volume growth.

So in this little section, I think that's important. I don't think we should use it as an SGR target. But I think to identify volume growth, I think, is very important for the physician community to be acknowledging that and to look at it.

MS. DePARLE: I like what you've proposed here, Kevin, or what you've come up with. I think that it is true, as Ralph says, that there is a merit to trying to use currently existing organizations as accountable organizations. Hospitals certainly are those. And we had a long discussion before this about why they make more sense ultimately.

But I view this in a step in the right direction

away from something that we know isn't working and the combination of these alternatives seems to be moving in the right direction, I think.

DR. BORMAN: Just quickly, I think that the other thing that is advantaged by this information is the nature of the services, at least in some groups here, are fairly different. Volume here is a function, I think, of frequency and intensity of the services. And I think that's pretty hard to tease apart unless you break out some things that are already packaged, for example the 90-day major surgical package versus an individual one time encounter.

And so I think this does help inform the discussion, and I would agree exactly with Nancy-Ann that it's a means to an end that is kind of here and now and could be helpful.

MS. BEHROOZI: Just quickly, I would want to add my voice to supporting the notion, and I think this is somewhat -- unless I'm misinterpreting you, Karen -- implicit in what you're saying. The type of service is an important thing to look at. I wouldn't want to lose that as one of the factors that we were supposed to be considering.

I think in terms of looking at the SGR, I don't

know how complete the correlation is been looking at specialties and types of service. I know it's all fraught with making those value judgments that are very difficult to make, but I think it's hard to get away from that when you're talking about controlling inappropriate volume growth, to use a word that we've used before.

MR. HACKBARTH: I think that the work that specialty societies are doing is critically important work, and I'd love to see it not just continue but grow rapidly. I, for one, would hesitate though to organize the payment system around specialties, for some of the same reasons that others have mentioned.

Like Jay, I'm not sure that it would make collaboration worse. But I don't think it would help make it better. If there's one point that we keep coming back to over and over and over as a fundamental shortcoming of our care delivery system and is that there's not enough collaboration, integration, coordination of care.

So if you're going to make a new major payment change and go through the administrative challenges and the political challenges of doing so, to do something that isn't going to address one of the fundamental problems in the

system, seems like an enormous lost opportunity if nothing else.

I, for one, also agree with Jay about having policymakers struggle with decisions about the level and rate of growth by specialty or type of service. That's not what policymakers do well. That's not their role in society, as I see it at least. It's their role to say here are the constraints. Here's how much we can afford to spend. They have legitimacy in doing that. That's what they're elected to do.

But it's clinicians and other providers who are trained to make the decisions about how to best use the available resources to improve care for patients.

And so let's have policymakers do what they are responsible for doing, establish the broad limits. And then have clinicians do what they're trained to do, which is to allocate the available resources as best they can.

I don't see any of that has being inconsistent with your point, Ron, that you made several times about outliers and providing information back to clinicians about where they stand relative to their peers. I see that as a complementary strategy with some of the other ones. And I

agree with you, I think that's very important. That's a big opportunity.

And then last, Nick, a couple times over the last two days, has made his point about formulaic systems in general and how in the past we've opposed such systems. This is something that personally I'm really wrestling with. I've got the litany of why formulaic systems are bad down pat, I've done it so many times over the last five years. And so that is a message near and dear to my heart.

I think ultimately, not today but ultimately, we need to decide how to best to respond to Congress and the question it has asked. Some think that they want us to tell them what the best of formulaic option would be, even if it wouldn't be our first choice which of the formulaic options would we elect?

I'm not sure we can get a consensus around that. We may come back to Nick's fundamental point that we can't embrace any formulaic system. The best we could do in response to the mandate is say here are the pros and cons of different alternatives, without a formal embrace of any of them. And I think that's very much an open possibility.

The fact that we're looking at all these in

detail, I don't want you, Nick, or anybody in the audience to infer from that that the end product of these deliberations will be a MedPAC boldfaced endorsement of any formulaic system.

DR. WOLTER: The practical question I'm wrestling with is at what level does a formulaic approach change behavior? And if we were to do a cardiology SGR, would the annual meeting of 8,000 cardiologists take a vote on something that would change behavior? Or are we doing this more just because we might get a financial result if we cut reimbursement? I think that's maybe what we're doing, is we may not be able to control behavior but at least we can cut payment.

I don't know if, in the long run, that's going to be the best way to control the resource utilization. And so that's what I'm wrestling with. I'd like to get to the aggressive list that might really work better than the SGR has to control resource utilization, of course.

MS. BURKE: I absolutely agree.

Glenn, I don't disagree at all with what you've said and the challenge that we face. And I guess the thing that I continue to struggle with is we've spent this

morning, and we have in prior discussions, informing ourselves as to what the drivers seem to be. There is clear evidence that there are drivers that relate to geographic location, all the things Elliott went through this morning in terms of how one behaves in the area in which one lives and what the incentives are, the resources that encourage you to either utilize or not utilize services.

There are also specialty related activities, I mean things that are -- the chart here very specifically looks at volume as it relates to specific types of practices and specific kinds of services. Arguably, there's also a geographic impact on that and how people behave and resource allocation.

So I don't disagree with you that formulaic options are ones that we are fundamentally not comfortable with. This morning's conversation suggested a system that addresses the issue you raise, which is the communication issue. How do you suggest that people begin to organize themselves or talk with one another?

And so the problem, at least that I have, as you look at each of these, there is argument to be made for a geographic solution or some kind of intervention at a

geographic level. The suggestion has been made by Ron and others that the availability of information that encourages the physician to understand how she functions in the course of her colleagues and how she might use that information to better inform herself is something I think we would all agree to.

So I think there are pieces of this that reflect on the geographic issues, reflect on the specialty issues, that are part of a solution. And the information sharing, it would seem to me, is one that we are all moving towards.

So I wonder, as we all look towards next discussion, trying to understand pieces of this that may not be the whole solution or may not simply repeat a new formula that's equally as challenging to apply, but what are the pieces that we can piece together that while we can't give you an absolute solution to the current SGR, which we can't stand, we know there are certain kinds of things that we ought to do that reflect on the realities that there is a geographic issue, there is a resource issue, there is a specialty issue, that we ought not simply, I think -- and I'm not suggesting you're going this direction -- simply give up and simply say we can't or simply say here are the

pros and cons of each of these.

There ought to, I think, also be an attempt to try, if we can, find those things where there is consensus and there is the opportunity to move the ball ahead, even though it's not a total solution.

MR. HACKBARTH: I agree with that.

DR. KANE: I guess part of the problem with geographic -- I was having this discussion with Congressional staff people this morning -- is that if you try to put something out in the political domain that looks like you're going to move resources from one part of the country to the other, it's kind of dead in the water before you start.

So one variation on geographic area SGR-types of tailored limits would be that you pick a national best practice in the top 25 percent target and instead of saying let's move resources away from Miami to Minnesota, you say here's the best practice target and then try to reach that.

But I think specialty bothers me a lot because I don't think you know what you're getting. But that there might be some sort of a per capita age and sex adjusted for best practice target that's nationally based that everybody

tries to strive toward.

Then I guess, yes, it will end up being geographically implemented. But you're not going through Congress trying to say Minnesota should get a lower target than Miami. You're just saying there's a national -- I didn't mean to pick on Minnesota. But if you look at all the maps, it looks like the lowest rates of growth are in places like Minnesota.

MR. DURENBERGER: I don't want to drag the topic on but I just have to respond to that.

How do we think performance improves? Some cardiologist, some drastic surgeon, some urologist from some part of the country is setting a standard and then it spreads. This is naturally what happens.

Sheila has got the right idea here. At the end, I hope we mix this. But we should not put all urologists in the same category and all whatever it is in the same category. Because the only way to improve the performance within those professions is to allow people in their professions, who are already setting the standard -- whether it's Miami or Minnesota -- to help the others improve their performance.

DR. CROSSON: I just think we should not shy away from the original intent out of fear of the word formulaic. I think everybody recognize how complex the SGR is and it failed. But I think the fundamental idea here, if I understand it, is how can we take within the fee-for-service payment system for physicians and potentially for hospitals, and create incentives over time for the appropriate management of resources, one important element of which is inappropriate volume? And that there ought to be some reward, and it probably based on all that we've heard, could reasonably be directed at something called accountable organizations which can be formed over time. How can we then direct incentives?

The attractiveness of the update payment system, as opposed to payment within a year, the kind of withhold or reward system, the attractiveness to me of using the update system is that it allows relatively small changes to accumulate over time and turn into an important incentive.

In other words, if you end up, to fast forward this, if you end up with a 2 percent differential between one SGR pool and the payments delivered to a successful accountable organization, that may not in itself be enough

to change behavior. But if that 2 percent is replicated year after year after year everyone understands that you can't allow that to happen without changing behavior.

MR. HACKBARTH: I'm actually feeling like this is starting to come together. There are certain themes where I think there is very broad consensus. I think what we come up with will have multiple parts that will play on those multiple themes. And I think realistically what we come up with as a direction is something that would unfold over a period of years. This would be sort of a long-term direction. This isn't an overnight snap solution for a new SGR system.

But I'm feeling like we're making good progress. There are some really difficult decisions to come, but I felt good about the progress we've made to this point.

Kevin, I'm sorry for having to cut short your presentation, but we are going to have to move ahead and have a brief presentation on the last item on hospital-based SNFs.

DR. KAPLAN: The purpose of this presentation is to report what we heard about hospital-based SNFs on site visits.

Before the SNF PPS, the number of hospital-based SNFs increased rapidly. Following the PPS, a number of them closed. At the same time, however, a large number of hospital-based SNFs remained open.

To find out how hospitals make decisions about closings SNFs or keeping them open we, Kathryn, Craig and I, with Urban Institute folks, went into the field to talk to hospitals.

The chart on the screen shows the rapid increase in the number of hospital-based SNFs prior to the implementation of the PPS in 1998 when SNFs had a cost-based payment system.

In 1997, the Congress required CMS to design and implement a prospective payment system to control Medicare spending on SNFs.

As you can see, the number of hospital-based SNFs peaked in 1998 when the PPS began. The PPS pays a daily rate for routine, ancillary and capital costs.

Since the SNF PPS was implemented, the number of hospital-based SNFs declined. From 1998 to 2004 about one-third of hospital-based SNFs closed. Nevertheless, two-thirds of these SNFs remained open.

We worked with Urban Institute to identify and arrange interviews in five market areas. Corbin Liu and Emily Jones are in the audience.

We interviewed administrators, referring physicians, and discharge planners at 15 urban and rural hospitals in or near the cities listed on the screen. Eight have closed their SNFs and seven still have their SNFs open.

We also talked with administrators at three freestanding SNFs.

Hospitals made clear to us that their mission is providing acute care. To the extent that a SNF is seen as furthering that mission, it will probably remain open. To the extent that the SNF is seen as detracting from the mission, it will probably close. For example, if the hospital needed the space for another purpose, the hospital closed the SNF. I'll get into this more in a moment.

All hospitals weighed the same set of factors in making their decisions. For hospitals that closed their SNF, the losses from the SNF could not be offset by the SNF facilitating a shorter hospital length of stay. Physicians frequently failed to recognize that the SNF was different than the hospital. they would order tests and labs for SNF

patients as if they were in the hospital. These practice patterns made it difficult to control cost for SNF patients.

In addition, most of the hospitals that closed their SNFs had found a more profitable use of the space the SNF used. That might include adding to hospital beds, opening cardiac catheter labs, or adding imaging. At least one opened a long-term care hospital in the former SNF space.

Another issue was the difficulty of staffing hospital-based SNFs with RNs. These difficulties frequently added to costs. For example, RNS in hospital-based SNFs are paid the same rates as other hospital nurses. Turnover was sometimes a problem and the cost of agency nurses were even higher than staff RNs. RNs often preferred to work in the acute care area rather than in the SNF unit.

Hospitals that kept their SNF open usually do it because they can shorten the hospital length of stay by quicker transfers than they could make to freestanding SNFs.

Another issue is other post-acute care providers' unwillingness or inability to treat patients who need a high level of nursing care or need specific costly services. Hospitals that kept SNFs open also told us that the SNF

allowed them to improve continuity of care and frequently physicians were negative about closing the SNF.

We heard about three different models of hospital-based SNFs. The first model focuses on providing rehabilitation services to patients who are likely to be discharged home. We were told that the SNFs do this because rehab patients are financially attractive under the SNF PPS.

The second model focuses on medically complex patients. These SNFs had more nursing staff. In addition, physicians visited frequently and often did not distinguish between the hospital and the SNF in their practice patterns. The reasons for these SNFs' focus on medical complex patient is to shorten the hospital length of stay.

The third model has few Medicare patients and many nursing residents. This model is similar to a freestanding SNF and we found this model in New York City. Hospital-based SNFs may use this model because of either historical reasons or because Medicaid payments are relatively generous in these areas.

We've done some preliminary data analysis for the hospital-based SNFs we visited and the results show or the results suggest that these models do indeed exist.

We also heard that certain patients are more difficult to place at discharge from the hospital. We were told that these include patients who require high levels of nursing care and/or services not adequately reimbursed by the SNF PPS. We were consistently told that these services included ventilators, IV therapy, and equipment and staff to handle bariatric patients.

The next steps for this are more work on hospital-based SNFs and continuing work on refining the SNF PPS.

That concludes our presentation.

MS. BURKE: Sally, thank you for following up on this.

One question that I had, and I'm sure we've discussed it before but I just can't bring it to mind, and that is the geographic distribution in terms of the closure. As you look across the array of hospital-based facilities, did they tend to be located in certain areas -- I mean certain areas of the country, have they seen a disproportionate reduction in the availability of services as a result of the closures because they were more dependent on hospital-based as compared to freestanding? Is there any -- I mean because then you begin to get into real access

issues, as well, and distant issues if you're only available SNF is 100 miles away from your home.

But as you looked at the hospital-based, did they tend to be focused in certain parts of the country? Or is it pretty widely distributed? So that as you saw closures, you don't see any shift in availability?

DR. KAPLAN: I don't know that I can directly answer your question about the distribution.

MS. LINEHAN: If you go back to that side, the second slide that shows the growth and decline in supply of hospital-based SNFs, I looked at this sort of by state just to see if there were any differences. And in fact, there are distinct patterns. There are some states where the supply was basically flat and there are other states where the supply looks like you see here nationally. I could look more closely at the relationship between that and certificate of need laws but I think that probably has something to do with it. So this explosion in growth and the decline was not distributed evenly across the nation.

There was a study that I think MedPAC actually paid for that looked at what happened when hospital-based SNFs closed. It did find that the ones that closed tended

to be in urban areas that had other alternative post-acute sites of care and that they also tended to be SNFs that had opened recently. So they got in during this period of growth and then went out.

MS. BURKE: I think going forward, as we continue to look at this issue, as you continue to gather data, I think it will be help to understand that. It will be helpful to look at whether or not you've seen patterns that -- I mean, if they are largely urban, if there are essentially -- if this is also a competition issue.

But also, I think, the attention. There's no question, at least anecdotally, you hear that the acuity of the patients treated in hospital-based facilities is higher.

Query whether that, in fact, has proven to be actually correct and whether or not the absence of these facilities that do have a higher preponderance of RNs and tend to have patients that are ventilator dependent, that are in need of a higher level of services, whether there is over time an access issue. Because there may be a freestanding SNF available. They may not be a SNF that essentially wants to deal with a ventilator-dependent patient.

So are we seeing a change in the nature of availability? Even though the bed may be there, is it the same kind of bed? And what are we seeing in terms of behavior? So just as we go forward, it would be helpful to understand that as well.

then query whether they're staying in the hospital or where they go? And are we seeing changes in lengths of stay as a result of that? Or what's occurring?

MR. LISK: Just to answer that, in some of the places that we had visited, for instance, the ventilator patients may just have stayed in the hospital or the SNF may never have done ventilator patients. So that may not have changed things. But in many cases, the cases that end up staying in the hospital may end up becoming outlier cases. And from a reimbursement standpoint, financially it was more advantageous for them to change.

In other markets, you had markets where there are availability of those things outside. And so it was kind of a no-brainer decision then for those places to close those places. Again, a lot of the decision was there's better use of the space in many, many cases.

DR. SCANLON: I just wanted to add to this point,

and Craig brought it up to a degree. I think as we look forward in this and looking at data that we need to look at both the hospital-based SNFs, the freestanding SNFs, as well as the swing beds, all as alternatives for basically the same service to be able to assess access appropriately.

MS. HANSEN: One other question I had was the readmission rates at all, whether or not we look at whether people are getting discharged potentially a little more quickly, and as a result another episode starts over and they come back into the hospital. I don't know if that was looked at.

And then the question about New York is a bit of an outlier state there, is that affected by the rate of the reimbursement from the Medicaid side, just because it is so significantly higher than anyplace in the country?

MS. LINEHAN: I'll answer your last question first. We think so but we need to look more at this. New York does have a differential payment for hospital-based and freestanding SNFs, so they pay more.

As part of the work that Andy Kramer did, that he talked about in September, he looked at national rates of readmission. But one of the things that we're looking at

going forward with that work is to look at whether there are differences across freestanding and hospital-based SNFs. So we're going to have the results of that work in the spring.

MS. DePARLE: Maybe you said this, Sally, but in the discussion we were just having about ventilator patients, I wondered if you looked at availability of LTAC or long-term acute care hospital beds in a market, these five markets, and whether that would tell you anything about the likelihood of a hospital-based SNF bed to still be there or not?

MR. LISK: To give you an example, I think it was Tampa I don't think had any long-term care hospitals. I can't remember. But in many of those places, the patient just remained in the hospital or they found other places where reimbursement was better and in some places transferred those type of patients like Ohio and other states. Because the state had poor reimbursement they found other places where the reimbursements were better because most of these patients were going to not be Medicare patients after they reached their limits. And that's one of the things that they're looking at for some of these really long stay type of patients that may be requiring more acute

care.

I don't know if that answers your question.

MS. DePARLE: It starts to, but you must have thought of this. Do you know anything more?

DR. KAPLAN: When we chose the areas that we went to, we actually chose them based on the fact that there was some variation in whether they had long-term care hospitals and also IRFs.

New York does not have long-term care hospitals but all the other areas do. Tampa did. Actually, in Omaha, we heard about how one hospital chain had close three hospital base SNFs and opened up three long-term care hospitals within hospitals in the place where the SNFs were. They still had one hospital-based SNF left open.

But we really didn't find a pattern of where the hospital-based SNF closed, immediately a long-term care hospital moved in there. We did not find that pattern.

MS. DePARLE: Not to prolong this, that's interesting that it was that direct. But if there were, let's say in an area, some LTACs that were established, would that add to the decision-making of a hospital to decide maybe these beds aren't needed? It sounds like you

don't know but it's interesting thing to think about.

MR. LISK: It's a question whether those places were originally taking those type of ventilator patients to begin with, because many of the hospital-based units weren't. In New York, for instance, the place we visited had a 20-bed ventilator unit in their SNF.

MS. DePARLE: There was a ventilator demo that Medicare did -- I'm dating myself but Sally, you remember it.

DR. KAPLAN: I do remember because I was involved with the evaluation.

MS. DePARLE: I think some of those hospitals were in that area. Philadelphia there was one. It seems like there might have been one in New York.

DR. KAPLAN: Temple, Mayo, and I can't remember. Yes.

DR. REISCHAUER: Sally, I don't remember if we did this in your previous work but did we look at the occupancy rates of hospitals which closed their --

DR. KAPLAN: Frankly, I don't remember ever looking at occupancy.

DR. REISCHAUER: Versus those who kept them open.

That might get to the point of the beds could be used more profitably in other activity. And then we could also look at those that were still open and see what the threat was going forward.

DR. KAPLAN: Occupancy really was more often raised as an issue of why one opened a hospital-based SNF before the PPS. If you had access demand and you needed to free up beds or you weren't using all your beds so you'd open up a -- we did hear it in a couple of places where they really felt pressure to close a SNF and open additional MedSurg beds.

DR. REISCHAUER: But it's a little unseemly to talk about it as a reason you closed your SNF, as opposed to opened it.

DR. KAPLAN: We can certainly look at occupancy.

MR. MULLER: I thought the chapter captured the choice process quite well. Obviously, the PPS dramatically reduced the payment. I was trying to remember yesterday what it was, but was it minus 30 percent or minus 40 percent? What's the margin on hospital-based SNFs? Minus 86, big number.

It gets people's attention and they close units.

We should be surprised that this happens.

So patients get backed up in the hospital. As Craig says, every once in a while some of them fall into outlier status. Most of them don't. So it becomes a loss inside the hospital and bad care. At minus 86 percent, people notice and close units.

I'm not saying we should get rid of an 86 point gap and save the money for SGR, but none of this should surprise us when the payment policy changes that dramatically. Unfortunately, I think the patients get backed up in the hospital.

DR. MILLER: Ralph, some of the point was why did so many stay open and what are the strategies that they're using? I think that was really -- because we all have discussions about how much accounting is going on inside the minus 86. So the question was at minus 86 you would think anybody would close anything that moved that was minus 86.

And so the point of this was to get a better sense of inside why were people staying in the game? And I think that's what --

MR. MULLER: I get that quite well, because it's the only way to get the continuity of care and also to free

up the hospital beds. Because oftentimes there are not other nursing home placements available in the area that your medical staff feels comfortable with. So as a way of getting to the care for your population you do it, even though it's a big loss.

Obviously, you don't run 500-bed SNFs at minus 86. A lot of them are fairly modest.

MR. HACKBARTH: Thank you. Sorry for the shortened session.

Okay, we'll have a brief public comment period.

Kathryn, do you want to go to the microphone and make a public comment? I cut you off when you started to make one.

DR. MILLER: Just indicate what organization you're with.

[Laughter.]

MR. HACKBARTH: Okay. We finished ahead of schedule.

[Whereupon, at 12:20 p.m., the meeting was concluded.]