MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
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COMMISSIONERS PRESENT:

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P R O C E E D I N G S

MR. HACKBARTH: Let's get started.

MS. RAY: Good morning. As you recall, at the September meeting Joan and I presented a workplan on how we were planning to examine disease management, the use of disease management in the fee-for-service traditional Medicare program. During our discussion you raised some questions and issues that we will have to consider as we proceed with this analysis, including questions regarding typology, how do you measure, how do you evaluate effectiveness, how do you target different population group.

We thought as a next step that we would present a panel of experts and they would give you--talk about disease management from different perspectives. So I'm going to be very brief in my introduction. Their bios are in your mailing family materials. Our first two speakers are researchers. Glen Mays is going to open the discussion. Glen is a senior health researcher from the Center for Studying Health Systems Change. Following Glen will be Dave Knutson. Dave is a director of health systems study from the Park Nicollet Institute for Research and Education. Then Jeffrey Simms will follow. He has actually implemented

a disease management program. He's with North Carolina Medicaid and he's the assistant director from the division of medical assistance. Gentlemen.

MR. HACKBARTH: Welcome to you all. We appreciate your willingness to share your expertise on this very timely topic. Glen?

MR. MAYS: Thank you very much. Employers across the country are now into their fourth consecutive year of double-digit annual increases in health insurance premiums, with 2003 being the largest increase since 1990. In response, a number of employers and health plans are now embracing disease management and related care coordination strategies as a way to potentially rein in those costs, and really in response to facing few other alternatives for cost containment and quality improvement.

Today I'm going to share with you some findings from the most recent round of the community tracking study conducted by the Center for Studying Health System Change to offer insight into the experiences of health plans and employers across the country are having with disease management in health care and what lessons might be drawn for Medicare. And I do want to acknowledge my co-authors

Ashley Short and Jessica Mittler in this research.

I want to just by way of background just briefly give you an overview of the community tracking study. This is a study that is designed around 12 randomly selected communities across the country that are studied on a rolling basis every two years. So we've been tracking these markets longitudinally since 1996. These markets were selected randomly so that they are nationally representative of health care markets across the country, and in particular markets with a population of at least 100,000.

In each round of the study we conduct interviews with a wide range of health care stakeholders, 70 to 100 interviews in each of those markets, speaking with representatives from health plant, employers, providers at the physician and hospital levels as well as policymakers to get a broad and balanced view of trends in health care and health care delivery. That allows us to triangulate results and to develop a balanced perspective of how these markets are evolving over time. The findings I'll be talking about today relate specifically to the most recent round of research, that's the round four site visits that were conducted between September 2002 and May 2003.

The community tracking study sites, as you can see here on this map, a broad geographic representation here. Again, these are all markets with at least 100,000 population.

It's clear from this round of the research that employer and insurer interest in disease management has clearly grown substantially over the past two years in response to a number of factors. Clearly, as we have seen over the past three to four years, other cost containment tools that health plans have attempted to use, and those tools specifically associated with managed care, have largely faded from use in many markets in response to consumer and provider dissatisfaction with some of the more stringent approaches to health care management. In particular, strategies such as prior authorization and primary care gatekeeping have been de-emphasized by health plans in many markets in response to these dynamics.

At the same time, as we mentioned earlier, health plans and employers have continued to confront double-digit increases in health care costs and in health insurance premiums so there's still a need to find other approaches for managing costs that are perhaps more acceptable to

consumers and providers. Along with that there's been a growing awareness of gaps in health care quality and the fact that we have an enormous gap really in many areas in terms of the evidence that we know about health care strategies that can work to improve health and the types of health care that patients actually receive in real world health care settings.

So a growing concern among health plans and employers in finding strategies for closing that gape between evidence and practice. As a result there's a lot of optimism about the role that disease management and related care coordination strategies can play in closing that gap. In addition, we found a real desire among employers to find strategies that move beyond simply reducing benefits or increasing cost sharing on consumers as a way to rein in health care costs. That's really why, a major reason for the growing enthusiasm in disease management.

Health plans and employers are pursuing two related approaches in this area. One is the traditional disease management concept which encompasses programs that target defined populations of members that have specific health care conditions and applying standardized protocols,

treatment protocols and interventions to address those conditions. So it's really a population-based strategy for affecting health care delivery.

A second related strategy, often termed case management, intensive case management or high-cost case management is really a much more customized approach. It targets individual patients that are deemed to be at high risk of health care complications and high health care costs. Often these patients have multiple conditions they're facing, so it's not a disease-specific approach but it's really highly customized to the individual patient needs. Therefore, the interventions that are used to coordinate care are highly customized and often go beyond medical care services to include social supports.

Increasing we're finding that health plans and employers are viewing these two strategies as really being interrelated efforts for reducing cost and improving quality of health care. So we're seeing in many cases a blurring of the distinction between these two approached in private health insurance markets.

Who offers these kind of programs and how are they purchased? Clearly, most employers purchase disease

management programs from their health insurers still in the markets that we studied. Health plans in turn, some health plans develop their disease management programs internally while others contract with specialty disease management vendors to offer these programs.

More recently we found in a few markets some of the larger self-funded employers have begun to contract directly with the specialty disease management vendors for these programs rather than purchasing them through their health plans. One rationale for that that some employers cite is the ability to cover all of their employees with a single set of disease management programs, even though they may offer multiple health plan choices. So that all employees can be covered on a single set of programs, they can realize perhaps by some economies of scale in providing those disease management programs while still offering their employees a choice of different health plans and benefit designs.

Also in some markets medical groups and hospitals are actively involved in developing and offering disease management programs. We've seen that particularly to be the case in markets where you still see a lot of risk

contracting between health plans and providers. So when providers are actually bearing the financial risk for health care services you see substantial involvement of hospitals and medical groups in directly developing and offering these disease management programs. And necessarily in those markets, health plans find it--are less engaged directly in delivering these disease management interventions because it's really that responsibility has been delegated down to the provider level.

Over the past two years we have seen evidence in most of the 12 markets that we study of expansions in disease management offerings by both insurers and employers. Employers in most of these markets are pressing health plans to offer more programs that more targeted to the specific health care needs in their workforces. Historically we've seen a lot of activity among health plans in offering disease management interventions in some of the most prevalent disease areas such as diabetes and asthma and chronic health--congestive heart failure. Many employers have begun pressing health plans to offer an expanded array of interventions that are perceived to more directly address the health care needs in their employee populations.

Employers, for example, that have predominantly younger workforces are often dissatisfied with the limited range of programs that may be offered by the health plan because they don't perceive their workforce as having intense needs in the chronic disease areas. They'd like to see more programs targeted to health conditions affecting younger populations. So in response to that we have seen health plans over the past two years undertaking a variety of efforts to add new programs. So moving beyond those traditional areas in diabetes and asthma to look at things like low back pain, osteoarthritis conditions, orthopedic injuries, obesity. So a broader range of health conditions that would be of interest to employers.

A second important trend that we've seen health plans adopt is beginning to migrate their disease management programs from the HMO product, which has historically been where many of these disease programs have been developed and rolled out, into other types of health insurance products. Particularly, finding ways to adapt these programs to fit PPO products, given the fact that in many markets we have seen a rapid growth in enrollment in the PPO products and really a stagnation or even a declining enrollment in HMO

products. So there's been, in several markets, a lot of work by health plans to adapt these programs for the PPO products and for less restrictive managed care products.

Additionally, health plans have been investing intensely in activities to boost participation in these programs by members. So they're looking at ways to engage consumers, to provide outreach to consumers, educate them about the programs, and encourage their participation. This has really been in response to problems that health plans have historically had with low rates of participation in many of these programs. Along with that, plans in a number of the markets have been making considerable investments in information systems designed to support their disease management programs. So systems that would both provide information to consumers about their disease states and about self-care strategies and also systems that can provide information to providers to help empower providers to support member participation in these programs.

In Seattle, for example, several large health plans were developing systems that would be able to provide information to providers about the specific patients in their panel that would be eligible for specific disease

management and case management interventions so that a provider could begin to play a role in encouraging participation in the programs.

Another major finding from the last two years of experience in the private health insurance markets that we're studying is that health plans and employers have begun a new focus on intensive case management over the past two years. So as I mentioned previously, this involves targeting smaller subgroups of members that are really perceived to be high risk or high cost members. So it's not necessarily a disease-specific strategy but across the patient population to identify the subgroups that are at higher risk of health care complications and health care costs. A number of plans are now experimenting with predictive modeling applications as methodologies for identifying those high risk cases prospectively. So the interest is in identifying patients before they have incurred catastrophic health care costs and help to coordinate their care so that some of those costs can be avoided.

The focus of these intensive case management programs really varies across plans and across markets.

Some of them are focused pretty tightly on reducing hospitalizations among at-risk populations. Others look at lowering total health care costs, so their predictive models are really developed at trying to project total cost for their members and targeting those high cost cases.

Then other plans have developed these case management programs around addressing care management for non-compliant patients. Often those approaches really rely heavily on providers for identifying patients that are having trouble complying with recommended treatment regimens, and then enrolling those patients into the program.

Interestingly, in a number of cases we found that the reason in particular for large self-insured employers being interested in intensive case management programs were requirements from stop-loss insurers that employers who are--as a condition of obtaining stop-loss insurance employers need to have these case management programs in place for managing high cost cases. In some cases it's a requirement. In other cases employers can obtain lower premiums for their stop-loss coverage if they have these programs in place.

Health plans and employers are taking a variety of

different strategies for integrating the intensive case management programs along with other disease management programs. In some cases, in a number of markets health plans are actually introducing these case management programs alongside their traditional disease management programs. Here the plans really view the case management programs as filling in the gaps that are not addressed by disease-specific disease management programs.

Other plans have actually adopted intensive case management programs as a wholesale replacement for their disease management programs. In one case in Seattle, a large insurer that had been investing pretty heavily in disease management over the past four years has really made an about-face over the past two years and discontinued all but one of its disease management programs and replaced that with intensive case management. The rationale there was that, the health plan reported that the disease management programs were spending a lot of resources identifying the full population of patients with disease but only a very small percentage of those patients with a particular disease such as diabetes were actually not managing their disease effectively and really needed the intense support. So by

moving to an intensive case management approach the plan thought it would be a more efficient use of resources by targeting the case management resources only on the very high-risk and high-cost patients.

Additionally, a few plans actually are offering employers a choice of different types or levels of management that include both disease management and intensive case management approaches, often with the different programs targeted at different levels of risk for patients. So they would really profile patients based on their level of risk and then assign them--map them into disease management or intensive case management programs depending on their health care needs and level of risk and conditions identified.

I next wanted to turn to issues around perceptions of program effectiveness, which is clearly an area of enormous interest for payers and health plans in this arena. In general, the hard evidence of effectiveness in return on investment is fairly limited for disease management programs and case management programs. We have good evidence, solid evidence for an array of specific programs where there's been strong controlled clinical studies that look at these

issues. But where the gap exists I think is in how these programs are actually operating in practice, and the cost-effectiveness and return on investment in these programs once they are implemented in different health care settings.

Certainly, we've seen--there's a lot of variation in how these programs are rolled out by individual employers and health plans in different markets. As a consequence we found that perceptions of the effectiveness of these programs varied pretty widely, both across markets as well as within markets. In fact most of the health plans and employers that we spoke with in this round of interviews actually indicated they did not have enough experience and/or not enough enrollment in these programs to be able to yet assess the effects on cost or quality at this stage.

Just by way of example, to give you a sense of the variation in perspectives of program effectiveness, in Seattle one case that I mentioned already, and insurer discontinued virtually all of its disease management programs over the past two years because of the high cost of administering those programs, fairly low rates of participation, and also the perception that the members who were participating were not--a very small fraction were

actually benefitting by the program because a very small fraction were actually not complying with the disease management protocols and recommended guidelines already. So that insurer actually discontinued four of its five disease management programs and moved to an intensive case management approach. The one program it retained was a program that focused on high risk pregnancy and that was the one where it did have some fairly solid evidence of return on investment over a fairly short period of time.

In contrast, we found several insurers who did report significant findings in terms of the effectiveness of their programs. A large insurer in Boston, for example, reported that a program it had in place for congestive heart failure resulted in a 33 percent reduction in hospital admissions for the patients participating in that program and a 5 percent drop in total cost for patients participating in that program. Similarly, a large employer in New Jersey that had started an intensive case management program for high-cost conditions in its workforce reported a $2 return on its investment for every $1 spent on that case management program.

But the fact is that many other insurers and

employers in the markets that we studied indicated they did not have clear evidence, particularly on the issue of cost savings or return on investment. A number of health plans were able to report some significant findings with respect to improved adherence to recommended protocols and guidelines, improved screening, improved patient compliance with self-management strategies. But many of them indicated that they were not able yet to assess actual economic outcomes and cost savings from these programs.

A few of the challenges to program effectiveness that health plans and employers noted. Clearly, limited member awareness and participation is a major challenge. Along with that, challenge of engaging providers in disease management and enlisting their support in getting patients involved in the programs. Health plans, the commercial health plans face a large problem with membership turnover, the fact that their members frequently switch health plans and they often don't have many members long enough in their programs to realize the benefits from their programs, and particularly to realize a return on investment.

Then also difficulties that health plans face in measuring and demonstrating their program effects, being

able to look long enough into the horizon to measure program effects. And also issues around different perspectives between insurers and employers and what the important outcomes of interest are.

To address some of those challenges we have seen some experimentation with ways to enhance both member and provider engagement in disease management programs as a way to improve the effectiveness. Health plans in several communities, for example, have begun to offer members lower copayments in exchange for participation in disease management programs. We saw that in markets such as Miami and in Syracuse. Several other health plans, as a way to target providers and engage them in the programs have started to offer exemptions from prior authorization requirements for providers that are participating in disease management programs and that are compliant with the practice guidelines associated with those programs.

Then additionally, health plans in Boston and Orange County, for example, have started to experiment with using financial incentives targeted to providers, again, tied to physician compliance with disease management protocols. So these are some of the strategies that are

beginning to be tested as a way to improve program effectiveness.

Finally, just in conclusion I wanted to summarize our findings here. I think it's fairly clear in looking across markets and the experience of private health plans and employers that clearly plans and employers are investing more in disease management despite relatively limited evidence of effectiveness of these programs. Plans are increasing the number of programs they are offering. They're also increasing--they're offering these programs in a broader array of health insurance products, and particularly focusing in on ways to offer these programs in PPO products which have really become the predominant model of health insurance delivery in most markets.

At the same time, employers are pushing for programs that are more tailored to the health care needs of their workforces, and also pushing for more evidence about program effectiveness. I think the bottom line here is that while there is a lot of enthusiasm for these programs and a lot of experimentation, a lot of innovation in private health insurance markets, there's still strong demand for more evidence of the effectiveness of these programs.

I'll stop there.

MR. HACKBARTH: What I'd suggest we do, as opposed to having questions for each presenter, why don't we get all of the presentations out on the table and then have a broader conversation. David?

MR. KNUTSON: Thank you very much. Disease management is a growing industry, as we just heard. The phenomenon is a child of many parents, many trends in health care, and is now seen as a way to improve quality and efficiency of care, primarily for individuals with a dominant single chronic disease. Disease management and chronic illness management are nearly synonymous when one considers the problems that are addressed and the approaches that are encompassed.

So what are these characteristics of a disease management program? There are so many resources we could use to identify these, the Disease Management Association of America, Ed Wagner's group and others, a project that John Christianson at the University of Minnesota and I conducted in the mid-'90s with a national expert panel reached these conclusions, that a chronic illness care program--and I would submit a disease management program--includes the

following key characteristics. Clinical and referral guidelines, a team approach with care coordination. This requires a restructuring of care and all the relationships among members of the team, nurses and physicians particularly. This came through loud and clear, no program--it has to be an organizational level approach. It can't be based on a primary care office visit, for example. None of these can be based on office visits. Therefore, even if it's a provider-implemented program it can't be embedded in a visit. Patient self-management programs are needed, patient registries and reminders, an ongoing performance measurement and feedback.

When one looks at these they distill down to some key features. One is, of course, the guidelines, and the fact that guidelines have really become much more accepted. You're less likely to hear physicians say, this is cookbook medicine. The idea of evidence-based medicine is now commonplace.

Then we look at the clinical IT. This is happening; the Holy Grail. It's been a long time but it seems to be happening where the kind of IT capacity is becoming available so that one can do the things you need to

do to track, monitor, and respond to changes for people with chronic illnesses and for anyone in a disease management program. We also need to consider the patient and we have to find new ways to engage the patient, not only with education but skills for self-management.

Then finally, the restructuring. This is the most difficult part of the whole thing, and provider organizations have not been good at change management. But I submit that the restructuring will occur when a number of other ingredients are in place.

I'm going to skip ahead. We heard about the first stage of disease management, the independent, direct-to-patient disease management programs that are prominent today. They're less difficult to administer because you can avoid dealing with the network. They're a useful start but they probably are of limited potential. I submit that increased benefit may be obtained through a more difficult integration of disease management within the provider setting. This is certainly something that managed care organizations are attempting to do, and insurers, but often it's been a more direct route to go directly to the employee/beneficiary/patient through a vendor.

But I also would submit that the optimal design for a disease management program would more explicitly focus on the provider-patient relationship, and I'll talk about that later.

But before that, what do we know about the effectiveness of disease management? There are a few, not many, meta-analyses and critical reviews of the literature available. I again look back to the team I'm on led by John Christianson. We reviewed 399 articles evaluating managed care organization sponsored programs. The vast majority of those evaluations were poor quality. Either the patient characteristics were poorly specified, the intervention was poorly specified, or the outcome poorly specified. We ended up with only about 35 to 50, based on how rigorous we wanted to be, articles that seemed to be good enough so we could understand something about where they might generalize.

But through all that we found evidence that disease management programs do improve care. But we also found evidence that they had poorly diffused into routine care. In other words, everyone had a pilot and everyone focused on one disease, and everyone had a true believer site, artificial funding, work-around systems, and they were

doing something, but very little had happened to diffuse it into usual care.

Another more recent meta-analysis published in BMJ by Weingarten and group conducted a meta-analysis of 102 articles meeting criteria. His keyword search started out with 16,000-plus articles, so one of his conclusions was that the field is littered with poor quality studies. But what he did then is break down these different interventions into the types of strategies the program used. They were either strategies directed at changing provider behavior or at changing patient behavior and informing patients. So programs used either patient education, feedback, and reminders and/or they used provider education, feedback, and reminders. The one additional strategy that they found was patient financial incentives for participation.

The programs that use any of these strategies produce modest to moderate but significant statistical improvement. But as Weingarten says in his conclusion, little is really known about the relative effectiveness and cost, therefore cost effectiveness associated with these different strategies.

So let's go back to the providers. What is the

extent of diffusion of disease management practices in the U.S. physician organization let's say? I would like to first turn to a recent article in JAMA published by Larry Casalino at the University of Chicago and his former group at Berkeley, Steve Schartel and others based on a national survey of all the physician organizations in the country with 20 or more physicians. I won't go into the details of the methods. I wanted to point out that the primary focus of the study was to try to identify their use of what he calls organized care management processes. Now if you look at these, this list on the slide is the list of so-called CMPs, case management, self-management registries and reminders, guidelines and physician feedback; the usual suspects. They asked whether these processes were used for the following diseases; also the usual suspects, diabetes, asthma, CHF and depression.

The findings and the number of--he had a 70 percent response rate, 1,104 groups responded. The findings were that 15 percent of these groups use no CMPs, 18 percent use some for all four diseases, 49 percent use some CMPs for at least one disease--that's diabetes--and 9 percent use all CMPs for all four diseases.

Looking at diabetes, which was the disease for which there was the most effort, case management 43 percent, self-management programs, 57 percent. Now for those of you who are really paying attention you'll know that this does not jive with the previous slide. It is what was reported in JAMA, and I think the issue there is that they asked about self-management which is patient education generically. They didn't ask it about a specific disease, those four types, so it's very likely that most groups are going to say they have patient education programs. I'm surprised that it's only 57 percent, but that's the disconnect between the figures on the previous slide. Registries 40 percent, guidelines and reminders 38 percent, physician feedback 48 percent.

He also looked at factors related to CMP use. First is the availability of external quality incentives. He asked the medical groups whether they in fact were paid, or whether they were experiencing any of these incentives, some were financial, some were not financial like public reporting. 74 percent said they had at least one of seven types of external incentives, 17 percent four or more, and 33 percent no incentives. Again, these are the numbers

reported. I went back to find the nuance that would indicate what the denominator was but I couldn't find it at this moment, but these are the numbers reported.

With regard to clinical IT capacity, they asked a series of questions that tried to probe the stage of development of the use of clinical IT for the management of these four diseases. Fifty percent reported that they had none of these six clinical IT functions available and 76 percent reported two or fewer. In the study the analysis showed that both external quality incentives and clinical IT capacity independently were significantly associated with an increased use of CMPs. So this is providing some high level, but some evidence that some of these tools and pressures or incentives seem to play a part. There could be many other factors that do, but at least this is some indication that there's an association here.

If we look particularly at providers and how they are reacting to the need to integrate disease management programs in their practice they would identify a number of barriers. The first is financial constraints, of course. The second is provider time burden. Again as I mentioned, it cannot be visit-based so it really does need to be a

separate program. Many of them lack clinical IT capacity. In some cases they have the capacity but they haven't developed the disease management application yet.

On another study that we've just started where I'm involved in an organizational economic evaluation of the implementation of a diabetes program in 11 medical groups in the country it is very interesting that some have implemented EMRs but have not yet developed the registry capacity. In other words, it's been a little bit of an afterthought. For others it's been, of course, the first thing we want to do is do this. But what I've observed in many groups is that went in the EMR is in place it's an explosion of opportunity perceived by even the rank and rile physicians, and it's an amazing thing to behold. So I've come to the conclusion that clinical IT by itself will be a milestone and a breakthrough in allowing for what we call disease management to be successfully implemented in medical groups.

I do think also thought that the incentives need to support this. In another project that I've just become involved with funded by HRQ, we're looking at how incentives are translated to and within provider groups in Minnesota

and Colorado. We are trying to understand the new pay for performance phenomenon and try to understand it from the provider's prospective. Some of these demonstrations are also good starts, just like targeted disease management, a good start but possibly self-limited. Targeted pay for performance is a good start, probably self-limited because they have some Pavlovian idea of a response to incentives and don't typically--haven't tried to understand the incentives in the environment of a medical group. But we're going to try to address some of these and we're going to build on the work of Casalino, Schartel, Wagner, and others.

The wild card in all this though, I think, is the poor mechanism for patient involvement. I think that's something where we really don't yet know how do that well. I'll explain what I mean in a second. I've got very limited time so I'll move much faster.

Judy Hibbard, who some of you know as--I guess you could call her a guru on the consumer behavior, and others, have made a number of observations recently. Hers in a very good overview article that was just published. She identifies three types of roles for patients, consumer/beneficiaries. One, of course, is the informed

choice role we've all been pushing. She says, as I and others have found in our own research, that consumers still show little use of the kind of information we're providing in report cards and seem not to be switching as often as we think they should in a rational consumer-driven market. It's happening but not to the extent that anyone has hoped.

She also talks about the evaluated role where the consumer's perspective, primarily through satisfaction surveys, are included as a quality measure. But she talks more now about the co-producer role; the patient as a collaborator with the physician in this case, and the values of that. Underneath all that would be the concept you're familiar with self-management, shared decisionmaking, and collaborative care. I could go into details but maybe during the Q&A.

I think one of the observations though that they all make and that we've made is that the provider-patient relationship remains a dominant force. Not matter what we try to do produce a consumer choice market we can't deny this force. Even when you talk to someone like David Lansky at FAACT and they produce physician-specific quality information for patients, the patients instead of saying,

this bothers me, I'm going to switch doctors. They bring it to their physician and say, maybe I can work with my physician to improve his care or her care. That's a different world than was contemplated I think.

We all know that patients more successfully participate in disease management programs when physicians recommend or refer. That's a common experience. If their physician says, I think you should do this, they will go to it, they'll stick with it much better. As you heard, some of the independent stand-alone programs aren't getting good, what they call compliance. I think it's the concept of compliance that is fundamentally the problem.

One of the things we haven't done is try to understand this provider-patient relationship from a lot of perspectives. I think providers will be able to administer disease management when EMR is implemented. I think maybe some small providers need help but I think that by itself will do a lot. Programs must be operated at a physician organization level. They can't be physician based. We know that, but a lot of medical groups are aware of that. New incentives must be developed but they have to get beyond just targeted pay for performance. Therefore we need really

a broad conceptual model of the economics of the whole thing. In that model I think needs to be focus on the patient-doctor relationship.

I don't think we have enough explicit attention, as we try to push choice, in the role of agency. I think that we assume the primary care physician is a trusted agent for the patient, but we don't know, especially when consumers are paying more and there's more cost-sharing for choice in treatment, how the patient's perspective is being enlisted in the decisionmaking process. We know the primary care physicians aren't trained well to do this; some of the good ones do. But I think if we build the incentives, build the information around optimizing on that relationship then I think we have a better chance of producing cost-effective care in general, let alone disease management.

Thanks.

DR. REISCHAUER: Thank you. Jeff?

MR. SIMMS: Good morning and thanks for the opportunity to tell you about North Carolina's experience with our Medicaid program with disease management, but also with our primary care case management program.

We have a program that's called Community Care of

North Carolina. Over the last couple years its name has changed a couple of time but it's referred to as ACCESS II and III. But it's built upon a program that's a statewide primary care case management program called Carolina Access where we have more than 75 percent of the Medicaid population in the state linked with a primary care provider, so the basic fundamental or foundational step is there where we've been able to link the Medicaid patients with the primary care provider. While building upon that foundation we implemented or we began implementing in 1998 the Community Care of North Carolina program which joins together all of the community providers, all the stakeholders at the local level, which are the hospitals, the health departments, the departments of social services, along with the providers because we realize that it's a multifaceted approach this needed to really serve the Medicaid population across the state. It creates community networks that assume responsibility for managing recipient care.

The program focuses on improved quality, utilization and cost-effectiveness. Now ideally, when we started the program some five years ago we really wanted to

have the opportunity to focus in on quality improvement initiatives, but that was also about the time the states began seeing major problems in their budget deficits so we began having to quickly shift and figure out ways--because we all agree that quality improvement initiatives will result in cost-effective care, but it's not going to give you an immediate cost effectiveness that we were needing and that the legislature was requiring of us during that time. So improving quality, utilization, and cost effectiveness.

So what we began doing was building upon the Carolina Access program which had all the contracts with primary care providers across the state, and we began developing networks with 2,000 or more--currently we have 13 networks with 2,000 or more physicians participating and more than 417,000 enrollees enrolled in the Community Care of North Carolina program.

As you can see, this is a map of the state which gives you the different 13 sites. It's probably difficult to see on the black-and-white printout but we're covering the state. We've got urban versus rural areas. We're really trying to get the providers to network together and the communities to network together as opposed to setting up

new sites. We really want to begin just building and expanding upon what we currently have in place across the state now.

The Community Care networks are set up as nonprofit organizations, or some of them, the public providers end up serving as the administrative entity for the Community Care networks. In a number of the sites the federally qualified community health center is the administrative entity. It's comprised of the safety net providers, of course, those who have traditionally continued to serve the Medicaid population. They have to establish steering committees, medical management committees. They received $2.50 per member per month care management fee. It's important to understand, like I said earlier, this is still based upon the fee-for-service reimbursement. So they still receive their regular Medicaid reimbursement on a fee-for-service basis, but on top of that they receive an additional $2.50 per member per month. Then with that money they're able to hire care managers and medical management staff to do the care coordination and care management for the patient population.

The networks assume responsibility for the

Medicaid patients. They really come in and as the providers have their patients linked with them--we systematically link the patients with the provider and then that provider and the network becomes responsible for the services provided to the patient population that's linked with them. We identify the costly patients and the costly services, or we allow the networks to do that and we want them to figure out ways to do that intensive care management that my colleagues were talking about earlier. They develop and implement plans to manage utilization and costs, and they create the systems to improve the care.

Some of the key program areas in managing clinical care for Community Care of North Carolina is that you've got to implement the quality improvement strategies or the best practice processes. Disease management happens to be a very integral part of our program in North Carolina. We're managing the high risk patients. We're managing the high cost services, and we're building accountability through monitoring and reporting.

One of the things that must happen and that we have continued to have is having strong provider support. But in having the strong provider support and buy-in, you've

got to provide them usable material in a timely manner where they can know what's happening. A lot of times just peer pressure alone ends up resulting in the providers wanting to change their behavior. But you've got to be able to provide them the information as quickly as possible, and that has continued to be a challenge for the North Carolina Medicaid program. But most Medicaid programs across the country face that challenge of having the information system to be able to give that information in a timely manner. Most of them don't have the information systems built to provide that sort of information so they're having to go back and change it be building data warehouses and those sorts of things.

This is just a schematic of the managing of clinical care. This shows you how we handle it at the state level. We have a clinical directors group which is represented by a medical director from each of our sites coming together on a consistent basis to identify targeted disease management or care management processes. Then at the local level each of the sites have a local medical management committee that implements the initiatives that were led down to them by the state clinical directors group. But then they can also take on local initiatives. There are

some sites that are participating in grants that they've received to do things with child development, developmental services, with ADHD, those sorts of things. Then it goes down to the practice level where each practice usually has a physician champion or a clinical champion who makes sure the practice implements the protocols and the processes as well.

With implementing the best practices, it's evidence-based guidelines, it's improvement specialists. Like I said, there are practice champions. There are the establishment of the improvement processes. And there's benchmarking and goal-setting. Again, that brings in the accountability and the pieces that we've got to have in place where they can see targets that they need to be striving for. So really is getting the providers bought in and sold on the approach.

We have implemented disease management strategies specific to asthma and diabetes. The clinical directors have really worked to set the performance standards. For example, with asthma we're just using the national guidelines for that. Then the local provider buy-in is obtained.

The standardized physician toolkits. There is a

need to standardize your processes and the approaches. When we first started out the program in '98 we really wanted to take this as an opportunity for the local communities to not feel that the state was coming down and driving them as to how things should be done. So in our pilot sites we had different strategies being done. But what we realized over the years is that there's got to be a way where we pull in some consistency and some standardized measures and approaches to it. But we still at the state level are allowing the local sites to do it. We give the local--we provide assistance with the local infrastructure and the consistency. But we just provide technical assistance and tell them, ask them how you can get it done at your local level. I think that has gotten us a lot of support from the local communities. And then the practice level quality improvement system processes.

The accountability is there, again as I was stating. The chart audits, the practice profiles, the care management reports which identify the high risk, high cost patients, the PAL which is our pharmacy advantage list scorecard, and the progress toward the goals and the benchmarks. We have been able to really provide some data

that allows the providers to become better advocates for you and really identifying some of the patients that they need to understand may be frequent fliers, and they work very closely with those patients. Those are the sorts of information and material that we provide to them.

Again, some of the programs; asthma, diabetes. We've also had to do some things with targeted emergency department management, pharmacy, and therapies. The pharmacy is one that we had to being tapping into because of the immediate cost savings that we can see result from the initiatives that we put in place, because the others are not going to give us the immediate cost savings or give us the greatest bang for our buck. So we have the opportunity with the infrastructure that we have in place to look at things related to pharmacy and there's some information later in the presentation regarding that.

Our asthma initiative, we have pretty much, like I said, implemented the asthma guidelines for the national benchmarks and guidelines. You can see that some of the process measures which include the number of asthmatics with documented staging in the charts, the number of staged asthmatics with inhaled corticosteroids, the number of

staged who have an asthma action plan. All those sorts of things based upon the chart audits and the process measures that we're doing, we're seeing improvements in those areas and we're hoping to continue to see that.

But as we add on more practices--and now we're moving beyond the practices that were excited about coming onto the program and we're now beginning to expand and having to bring in providers who were not necessarily the champions but what we're saying to them is, this is the way we want to see Medicaid provided across the state of North Carolina so we really need you to come on board. So as we're seeing that, we're having to change a lot of behavior with some of our providers.

As you can see, this is some outdated data here but we're trying to get the more recent data. But you can see just by the case management and care management that we're doing with asthma, the episode cost in comparison to those patients under the age of 18 who are not linked with ACCESS II or III provider is a lot less.

Our diabetes initiative, again, these are the chart audits where you can look at the different sorts of process measures in relation to diabetes. We're seeing

improvements in that area as well.

ED utilization, the same thing. For patients who are not linked with a primary care provider who is in ACCESS II and III we're seeing their ED rates are higher than those providers who are with an ACCESS II or III network. Most of the Medicaid programs across the country have really felt that our hands have been tied in a number of areas in relation to emergency room cost containment because of the changes with IMTAL and prudent layperson, but we're trying to work as best we can with some of the care management and case management with these patient populations. We identify the frequent fliers, we do the follow-up calls with them. We have letters that go out to them. We try to do as much education as possible with them to contain that cost.

Then as I was stating earlier, we felt that we needed to pull in some things in relation to pharmacy, because we knew that we could see an immediate cost savings with that. So that's why we began doing things like our prescription advantage list, the nursing home polypharmacy project, and the ambulatory polypharmacy project as well. If you'll notice with this, in most primary care case management programs across the country the nursing home

population is not included in that sort of a system, and the same thing in North Carolina. But we have the infrastructure in place that allowed us to build upon it and look at populations who would not traditionally be included in the PCCM models.

The PAL pharmacy--we've developed a pharmacy committee through the clinical directors, the statewide clinical directors committee. The pharmacy committee defines the drug classes and unit doses. Medicaid calculates the relative drug cost and the ranking. We then inform the Community Care of North Carolina physicians and then we measure the changes in prescribing patterns.

This is just an example of what is actually sent out to the providers. It's important to understand, this is a voluntary program. It's not something that the state has mandated. The providers are taking this on as their initiative. We were required by--we went into our budget session two years ago and immediately began telling them about the things we were doing in Community Care of North Carolina and they immediately cut our budget by $29 million and we had to come up with some ways to--strategies to make sure that we would see that materialize, and the physicians

felt the need to begin dealing with pharmacy. So they began voluntarily expanding the PAL list and they have continued to do that statewide as well.

The preliminary findings show that we are seeing somewhere, about 22 percent lower expenditures compared to the pre-rollout; post-rollout as compared to the pre-rollout. So that actual savings for that period of time was about $640,000. But we're seeing it continue to grow.

We are now in the process beginning November 1 we're taking it statewide. Again we're asking the providers to voluntarily participate in it. We're working with the local medical societies, we're working with specialty societies as well and telling them, this is the only way that we can really begin working together and really creating a way to save dollars for the Medicaid program. The providers are excited and working with us to get it done. The hospital association is helping us as well, because this is expanding beyond just the primary care providers. But again, one of the benefits to Community Care of North Carolina is it has established the infrastructure for us to build upon it to take on other initiatives.

The nursing home polypharmacy initiative, we've

got it in place where we've got pharmacists and physician teams working together. They review the drug profiles, the medical records of Medicaid patients in nursing homes. They determine if there's a drug therapy problem, recommend a change and perform follow-up to determine if the change was made.

The screening criteria is that the nursing home residents wither greater than 18 drugs used in a 90-day period--and the numbers show that we had about 9,208 residents who met this criteria. Our database, the Medicaid database is used to flag the charts according to the following criteria: inappropriate drugs for the elderly, the Beers drugs, the drugs used beyond usual time limit, the warnings and precautions. We still tag it or attach it to the PAL list. And also the potential therapeutic duplication.

Preliminary findings, we've had the 9,208 patients reviewed. As you can see, the recommendations made on 8,559, unnecessary therapies 19 percent, more cost effective drug 56 percent, wrong dose 7 percent, potential adverse reaction 9 percent, needs additional therapy 3 percent, other 6 percent. As you can see, the ones that we

implemented, about 74 percent.

Based upon these findings, the teams are cutting cost. This is an opportunity again. Community Care of North Carolina has given us the opportunity to do some of these more intensive care management things, and specifically with the nursing home polypharmacy. As you can see, the evaluation is being conducted by the UNC School of Pharmacy.

Other initiatives that are under development is the continued statewide expansion, the dually eligible-- expanding it to dually eligible population, and figuring out some ways to really work with that population; most of the time some of our most costly patients in the Medicaid program. But again, it's an issue of where some of the federal regs prevent you from being able to mandatorily link them with providers and to deal with them in our environment, but we're figuring out ways to do it.

We're also realizing, like my colleagues were stating earlier, we've gotten the providers who have been the volunteers and the ones who want to do this and now we've got to figure out how do we sustain this down the road, so incentive programs that got to be put in place.

Our secretary for the department of health and human services is very committed to looking at health disparities, so Community Care of North Carolina gives us the opportunity and the infrastructure to look at things like disparities.

Improved collaboration with public providers, which is where--we're in the process of revamping our mental health system and that's another provider and stakeholder that we're having to tap into. Looking at in-home care and targeted disease management, continuing to do that as much as possible and building upon it. The infrastructure is there for us to be able to build upon that.

The lessons that we've learned? The top-down approach where we come from the state level and say, it's got to be done this way, doesn't work in North Carolina, and the providers will fight the system. So we decided, let's come together and figure out how we can make it work. I would say that we've been successful with that in North Carolina. We've also had a very supportive legislature in regards to provider reimbursement as well. They have been very supportive of the Medicaid program with our reimbursement rates for our primary care providers, so that has helped us as well.

The community ownership and working with the local communities, that just reinforces the concept that we can't do this alone. We must partner together. The incentives must be aligned. In North Carolina, the major incentive and the push for getting Community Care of North Carolina up and running and the disease management strategies was that the providers in North Carolina have not been strong supporters for the MCO model for the Medicaid population. We have a very limited MCO option in North Carolina. It's only in Charlotte and Mecklenburg County, and we only have about 10,000 Medicaid patients who are linked with an HMO in that community. So the providers have really felt vested and had a vested interest in seeing this sort of model run.

We must develop systems that change behavior, and we must be able to measure the change. Change takes time and reinforcement, and that's what we continue to have to battle with our legislature to let them know. We're trying to do as much as we can to get it implemented and to see the immediate cost savings, but it takes time.

Thank you.

MR. HACKBARTH: Thank you. Ralph?

MR. MULLER: Thank you to the three of you for

that very helpful overview. I have two questions that are interrelated. One is that from the point of view of the Medicare program, especially with the elderly part of that, what do we know about how effective disease management is given that, obviously, many years have already passed by before they become Medicare eligible? A number of you pointed out that the evidence on disease management isn't that conclusive yet, but what do we know about the Medicare part of that in terms of effective investment is for Medicare given that perhaps a lot of it should have been done, as you pointed out, in the Medicaid population a lot earlier?

Secondly, you point out that there is a lot of at least preliminary evidence that case management, especially around high cost, high risk cases may be a more cost effective way to go. Can you speak a little bit to the interrelationship of disease management and case management, especially if you think that disease management may be a way of, if it is a good marker for which cases you may want to case manage. I understand that it may not be cost effective to do disease management across a whole population of diabetics, asthmatics, et cetera, but is that a good marker

for the cases that may be case managed or are we better off--are there other markers of which cases one may want to case manage if that's where the most cost effective interventions can be? I know those questions may interrelate, but any of you want to take those two on?

MR. MAYS: I'll start with the first question. I think in terms of how effective we think these programs can be for the Medicare population, I think there are clearly some unique opportunities in Medicare for implementing these programs and it may bode well for their effectiveness in the long run. One certainly is the relatively high prevalence of chronic disease which many of these programs target. The other being a relatively stable membership in the Medicare program. So Medicare is not going to confront these problems of membership turnover that's really confounded a lot of the efforts in private health insurance.

Thirdly, you have the ability to take advantage of population data systems as a way to begin to prospectively identify what patients might benefit from disease management and case management. I think there are also potentially some unique challenges that Medicare faces as well, one being the fact that the population often has multiple

chronic diseases and may be at later stages of disease that may be less amenable to intervention and cost savings.

Additionally, the importance of a pharmacy benefit for many of the disease management programs, managing pharmaceutical therapy is an important component of many disease management programs that are out there in the private sector. The fact that not having that benefit in place in Medicare and not being able to take advantage of pharmacy claims data in the process of managing disease is a challenge that Medicare is going to face. So I think those are elements that are going to play into implementing these programs in Medicare.

Certainly in the markets that we examined, the health plans in several markets that had the most experience with disease management and were making the most investments in disease management were plans that had a history of participation in Medicare HMOs in the Medicare program. So I think there are certainly in markets that have had more experience with Medicare managed care, there are health plans that have particular experience in using disease management for Medicare populations and some of them are able to report significant results with their programs,

particularly on the side of quality improvement.

MR. KNUTSON: As a researcher it's probably not appropriate for me to say we need more research, but for congestive heart failure it's close to a no-brainer in terms of disease management intervention as you can get, and then moving out from there it becomes murkier. I think the question for us is, the first observation about Medicare is that a whole lot more of what should go on is probably embedded in good primary care because of the complexity, especially as we move to caring for people with complex medical conditions or the frail elderly.

I don't think we know yet, or at least I don't, how one would on the margin figure out where to put energy. For example, do you really go after, beyond CHF, the most severe end of the spectrum for this condition and then move on to--I don't think we know that. We don't know the relative cost effectiveness of any of this, or cost benefit I should say in this case. So I think that kind of research is needed.

I think it's promising the new demonstration projects that CMS has been initiating. I think this story from North Carolina is promising in the sense that you can

start working in the fee-for-service world and maybe build from that some capacity to introduce what we call good managed care. But I don't think we know enough to know where to start, and where to go next, and where to go after that; at least, as I say, I don't.

MR. SIMMS: I would say just with your second question dealing with how do you tie in the intensive case management with the disease management, what we've done with the North Carolina experience is it ends up being more of a care coordination thing.

Specifically with the children that we serve in our program, like for example the children who end up being asthmatic children, we figure out ways to really do care coordination for them by tapping into other case managers that are currently coordinating service for those children, like the child service coordination. That's why it's so important to have all of the stakeholders bought into it at the local level because what we end up identifying and finding is that, you're right, there are a lot of other case management programs going on with some of the patient population but what we're able to do through Community Care of North Carolina is really try to develop a system of care

for that particular population. So I think there is a need for the coordination with the intensive case management in addition to what's being done on just the disease management side as well.

MR. MULLER: Jeffrey, especially you point out that when budget crises come all of a sudden there's not as much investment in these kind of programs. I think one could certainly see, given the complexity of the American health care system why one would for qualitative reasons want to invest a lot in care coordination and care management. But given the kind of budget crunch where we talk about budgets for Medicare, Medicaid and so on, my guess is the bigger thrust will come on cost savings rather than quality improvement because that's what people I think are more likely to put their dollar behind is where you can get the big cost savings.

I could see where in disease--if you could have a low cost disease management program from identifies--I'm talking about this now from the point of view of cost savings rather than from quality improvements, a low cost disease management program that then helps you target where the costly interventions perhaps can be avoided. Because I

know there's evidence, for example, in using prenatal care as a way of avoiding infant mortality and premature birth and so forth where you can obviously save some big dollars. More in the Medicaid program, obviously, than the Medicare program, by getting people to prenatal care and then trying to avoid obviously the very costly consequences in dollars as well as obviously in the quality of life of prematurity. So in that sense, if one can use low cost interventions like just monitoring a person during pregnancy as a way of avoiding that one--what I'm searching for is, are there lower cost disease management programs that then led to big cost savings, because I think that's--insofar as we are looking at disease not for quality of care but also as cost dampening strategies, my guess is that's where the real appetite is going to be for those kind of cost savings.

MR. KNUTSON: If I could make one more comment. One of the areas that might be promising and I assume you probably thought through this a bit, is monitoring the introduction of palliative care benefits by some insurers. Even though it's a little early it seems to be promising from a lot of perspectives. It would be one of those areas where we start with the assumption that the individual--

nobody wants the care that's being provided, and which just haven't figured out how to get the right decisionmaking environment. I mentioned this agency problem before. Palliative care is a great example where you're continuing treatment but you're adding this thing and it looks like it's producing some savings or least breaking even.

But again it's early. There's been some Robert Wood Johnson-funded studies that are worth looking at, and maybe more that I'm unaware of, but I certainly would think that would be a good start and a way to try to figure out how to get a new perspective on decisionmaking or on treatments that really nobody wants, including the patient.

MR. FEEZOR: Thank you. I'd like to thank all three of your for an excellent presentation. I feel a little bit like it's old home week. In my previous existence out at CalPERS I was always a part of the health system changes survey; looked forward to that exchange and see some of the information coming back. And actually before leaving for California I worked with Jeff to set up one of those community care programs and it's good to see a report and see you again, Jeff.

A couple of observations. David, first I'm struck

by your comment that we have not spent enough time looking at how important that patient-provider decisionmaking role is. I'll take your bid for additional research. Probably need to look more in terms of variation of how disease management, various disease management programs engage the providers or bypass them, and perhaps trying to get some better analysis around the kind of consumer, whether it's as Judy would say, one of the more engaged consumers or not, to really begin to tool up our effectiveness. I think that would be ripe for research.

Glen, one question for you and then--let met start with a comment on Jeff's comments that will follow up a little bit on yours, Ralph. I think one of the important things that made the community care programs begin to really take off was the feedback of information. Jeff mentioned that in his presentation. This went to providers or to those committees, and it is analogous with what I think Glen was talking about, that most employers now are pushing very hard from, whether it's certain disease management vendors or their claims-payers, for the kinds of information to begin to target that.

I think to underscore another component that came

out though in Jeff's comment is that that $2.50 or the monies that go back, don't necessarily go back to be spent for clinical decisions. His comment about having the health department, social services sitting at the table, that many instances those monies will get allocated for something else, which I think is something that is an interesting juxtaposition if you start thinking about how do you apply this to an older population.

Having said that, I think a key difference in the community care programs in most of the communities, areas that I'm familiar with that Jeff's presentation referenced, you have a smaller subcomponent of the physician and provider leadership there, and a group that probably works together even though they're not in any sort of large group practices for the most part, but probably work together in more of a community spirit that you may not have that same dynamic to broader providers who in fact are dealing with the Medicare population.

Then the obvious or the final thing is that obviously the Medicaid population tends to be less hospital and more outpatient, so it's in the individual physician's own interest I think to participate more actively in some of

that and I think that has been the success of the program.

Glen, one question for you. In looking at those employers or employment-based coverages that are beginning to do what you call high risk identification on the front end, any discussions or problems noted with respect to privacy issues or ADA implications?

MR. MAYS: I think those are definitely concerns for employers that are trying to move in this direction. We didn't hear of any employers actually encountering barriers or not being able to proceed because of those issues, but they're certainly issues that they have to work out in moving those programs forward. Particularly we heard of some employers who are looking at ways to bring together their health care claims data together with their information on their experience in their workers compensation to better target these interventions and also to better monitor effects on the back end. In doing that those same issues also come up and integrate in those databases.

But again we didn't hear--certainly those are issues that employers are confronting in moving this forward, and to be sure there's not a lot of employers out

there doing this at this stage. It tended to be very few, large employers in the markets that we studied. They're addressing those issues but they don't appear to be game-stoppers in terms of...

DR. NEWHOUSE: I'd like to echo the thanks to you for taking the time and effort to come and sharing your information with us. I'd also like to go along the lines that Ralph and Allen started, how do we take this over and apply it in the Medicare context? My first question is actually just something for my own information. I struggle, like everybody else is with, how is this organized within the context of traditional Medicare?

So my question is, if traditional Medicare is having demonstrations of disease management, which I thought I heard somebody say, who is running these demonstrations? Not CMS, but how is it getting implemented on the ground? What is the entity that is actually out there is managing disease and how does it integrate with traditional Medicare? Can anybody enlighten me on that?

MR. HACKBARTH: Can any of the panelists answer that? If not, I think one the staff probably--

MR. KNUTSON: I can make a start. I think maybe a

staff person would know more. There are five or so demos that one could, if you look inside of them see some, for example, quality incentive or it's a disease management demo, per se. There's the capitated disease management demo where possibly 30 sites are soon to be announced, between 20 and 30, and those will be typically provider-sponsored organizations. They can be M+C plans but the preference is not. If it is an M+C plan selected, they have to enrollee two from fee-for-service for every one that they rollover from their M+C product.

There are others. There's a demo that is a straight disease management demo where a case management fee, I believe, is paid to a disease management organization and then they need to show savings.

There's a physician group practice demonstration project which--

DR. NEWHOUSE: That second one, how are the beneficiaries identified?

MR. KNUTSON: I know there are two or three sites and from what I understand, and I'm going to be right out on the edge of the limb here, they're doing actually a randomized controlled study. They're actually finding

people eligible and then randomizing in or out of that program.

DR. NEWHOUSE: But as Glen said, we don't have a drug benefit so we can't identify that way.

MR. KNUTSON: The idea was that they would include that and still show a savings. They might include a drug benefit.

DR. NEWHOUSE: But you have to have some prior knowledge about the drugs that are being used to--I don't want to put you further on the spot but I'd suggest then maybe this is an area we should find out something about. Maybe staff could follow up.

AUDIENCE SPEAKER: I'm actually a CMS staff person and I work in the demonstration group. What you've said so far is pretty much dead on. I also wanted to let you know that a week from now my director will be briefing MedPAC on the demonstrations, specifically the disease management demonstrations. So if you have any further questions she might be able to answer that.

DR. NEWHOUSE: I'm just still struggling with beneficiaries with multiple problems, dealing with multiple providers, many of whom are in very small groups or even

solo practice, with no drug benefit, which affects both the targeting side and the compliance side, how this even starts rolling down the runway, let alone gets in air. But I'd be delighted to be shown how it does.

There's one just point of information I wanted to make which was some data I saw the other day that I found interesting and I thought cast the enthusiasm for disease management is a somewhat different light, although not entirely, which is I think the enthusiasm at least as I hear it stems from the observation that--pick a number--5 percent of the beneficiaries account for half the dollars, and following Sutton's law, go where the dollars are. These people are largely people with chronic disease, et cetera.

The data I saw divided the distribution of people by spending into thirds, so it looked at the bottom third, the middle third, and the top third of spenders. Then it looked at the rate of increase in each of those thirds over time. Lo and behold, they were almost the same, the rates of increase, which is consistent with the notion that the general shape of this distribution doesn't change. That is, for many years it's been the case that 5 percent of the people account for half, plus or minus, of the dollars,

which suggests that disease management may be fine, although as David and others said, the jury is even out on that. But it's presumably not doing much about the two bottom thirds of the people which are some substantial share of the spending. So this suggests it may be an answer but it's not the magic bullet.

DR. NELSON: I also have an observation and a question. To some degree my observation follows what Joe was pointing toward. It has to do with my suspicion that the cost benefit calculation for an employed group may not be transferable to a Medicare population because there is a time window. It's to the benefit of the employer or the insurer to manage the diabetes, defer the renal failure and the other complications until a person retires. But the Medicare patients may not necessarily avoid that expensive crash; it just comes later. And when it comes it may even be more expensive if it involves Alzheimer's disease or cancer instead of a nice clean quick coronary at home. So not being Kervorkian in this, I still think that we have to be cautious lest Congress jump to some leaps in scoring this in overall program savings.

The question that I had for Dr. Knutson drills

down a little further on your statement that these programs shouldn't be physician visit based. What is the most sensible basis for reimbursing these activities? Is it with the team being reimbursed? Or is it capitation plus visits? Or is it just capitation? Or is there some other arrangement that seems to make sense, particularly with respect to the Medicare population?

MR. KNUTSON: Some of the so-called pay for performance methods used now include paying explicitly for education. Medicare already does that for diabetes for recognized providers, but other purchasers are thinking of doing the same thing. Some are measuring a number of quality indicators and then offering a bonus over the top, regardless of how they were paid. If it was fee-for-service or capitation, there's some additional amount that's over and above your regular revenue flow.

I think those are, as I said, good starts in that any targeted approach like that engages, it gets us focused, it indicates a new interest, but ultimately a design needs to be something a little more global and in the fabric of the financing system. I personally think that we're working our way toward--let me give you an example. Even with risk

adjustment, which is something I spent a lot of time on, you're basically coming up with your risk scores by finding the average cost, usual care usually, and it may be inconsistent with your desire to improve or increase the short-term expenditures for a particular--for disease management, per se. We haven't figure out how to build these models on some sort of--not just what is but what ought to happen, and figure out who to stage it.

One of the interesting things going on in Southern California, Robert Wood Johnson funded the Rewarding Results program, a group of health plans and providers are demonstrating a pay for performance approach. One of the things they've done, and this is a theme that I've jumped on is they will pay a bonus for hemoglobin A1C control. But they'll also pay a bonus for a clear improvement in your clinical IT application, which is an interesting thing. They actually have a trajectory and every year they go back and say, can you do this now? Can you do this now?

If they show progress they get a reward for that, and it's because they believe they need to support capacity building. The capacity building then helps prepare them for a time when we're going to run out of specific diseases with

enough prevalence, evidence, money, all that, like diabetes that we can get these good starts based on, and have more of something that's cross disease and built into the fabric of care.

How to finance that in the long run, I've been a fan of mixing fee-for-service with some budgeted amount based on some--instead of what-is, some oughts in there too. So it's a little bit of a nuanced partial cap idea I think in the long run. But the whole world is grappling with that right now. I don't think we really know yet. I certainly don't think that 5 percent based on your hemoglobin A1C controls going to be the long run solution but it's a good start.

MR. SMITH: Thank you, all. This was very useful.

David, a conundrum embedded in your presentation I just want to raise and ask you to reflect on and then a question. You say that disease management can't be visit-based and for obvious reason that makes sense. On the other hand, you report that beneficiary or patient compliance goes up dramatically when this comes from the physician. I suspect that there's more to that relationship and something that would suggest that the visit, or at least the

supervision of the visit, or the place of the visit probably continues to play an important role. I suspect you've thought about that and wonder if you could must on it for a bit.

Second question, you talked about the wild card importance of the patient role and I wondered if there had been any experience with financial incentives for patients or financial incentives that shared savings between the provider and the patient.

Jeff, a question for you. The nursing home pharmacy compliance rate was staggering it seemed to me, that 74 percent of the recommendations were implemented. I couldn't figure out, and if you could talk a little bit about it, who paid for those? Did you pay for them independently? And then, who is responsible for implementing them and why did they? Why would they? What was the incentive that worked? Did you have either a participation incentive or a financial incentive? Did you share the savings? How did you get that extraordinary compliance?

MR. KNUTSON: Regarding the visit-based approach, that statement is based upon the current, the typical visit,

and the 15 minutes and the time spent, even with good rooming, preparation and other things it's still not adequate and therefore a program is needed, one at the organizational level. Now I think there's a broader trend that is also a wild card and that is how many different access points will emerged with Internet and telephone and other sources that will be optimal in terms of the right access point at the right time to get the appropriate care? When one thinks like that, then the visit probably will change itself.

In other words, a lot of visits are simply, in that context, unnecessary and time could be better spent in counseling, coaching, in serving as the good agent if you will, meaning understanding the values, the preferences of the patient, especially when the patient has more economic responsibility for treatment choices. How that all is organized I think is potentially an efficient way to go. So the visit could be the core of the whole thing ultimately. I don't know. But right now, the way the treadmill works you just can't build a chronic disease or a disease management program on it.

The second question?

MR. SMITH: Asking whether you had any experience thought about--your point about the importance of the patient role, and I wondered whether you had experience with financial incentives either directly to beneficiaries or patients or shared incentives with providers.

MR. KNUTSON: The Weingarten meta-analysis actually--and I didn't cover this--included in it some programs that did provide a direct financial incentive for so-called compliance with disease management programs and those actually produced some of the more significant improvements really. So that is an option. There are other kinds of incentives for patients that include--that are more in the choice environment where you have somehow lower coinsurance, for example, or a lower out-of-paycheck deduction if you choose a higher quality provider, ostensibly a provider who's doing all these good things that can be measured and that's going on.

But anyway, I think that's been a limited amount of direct payment. Where it's been done according to Weingarten's study it looks like it's effective.

MR. SIMMS: To answer your question about the nursing home polypharmacy, the major incentive was the $29

million reduction in our budget that we needed to get something in place to really begin seeing--then on the provider side it was a fear of reduction in the rates. So what it ended up being was that partnership again where we got the nursing home long term care pharmacy association to work with the community care providers to implement these strategies. The funding for it was actually taken out of the $2.50 PM/PM. They then invested that money into getting the pharmacist to work along with the provider to implement the program.

DR. WOLTER: Allen and David essentially asked my questions, but just a couple things that have occurred to me through all this. I think there's a bit of a tension in this conversation around the intensive case management versus the more population approach to disease management, and that's normal I suppose. But if you think about the world of quality as it's unfolding, much of what's being discussed is what patients don't get when they should get it, and that in many cases drives outcomes over a long period of time that aren't as successful as they could be. That investment doesn't get you the shorter term cost savings but it may create improved health outcomes and save

you cost in the long run. So that's just something we have to wrestle with.

Also, I could not agree more, I don't think the current model of care which is based around an episodic visit adapts itself very well either to some of the new system approaches that we need for quality or to intensive case management for that example. So to move from what we have now to something else probably would require some type of an investment since we don't have good data right now about how well those things will work, and which models will work the best, and how much money can be saved. If you looked at it in a non-governmental or non-health care model, it would be some investment in research and development is probably going to be necessary to find some models that can create some success.

Personally, I think there's a lot here in terms of where we could go in terms of how health care delivery system could change to attack these problems better. I think the problem we have is we look at adding incentives to the current way that health care is delivered rather than maybe create incentives around newer models of care. I think that slows the whole process down and I think Joe was

essentially making that point earlier.

MR. HACKBARTH: There is a lot that's very appealing to me as a layman in the basic concepts here, but I think that Glen in his presentation is right in saying that a very basic strategic choice for Medicare is, do you try to accomplish these things through the traditional fee-for-service program or through private options that are made available to Medicare beneficiaries? As I understand the research and what I've heard from clinicians, former colleagues deeply involved in these activities is that what we're talking about is changing behavior of both clinicians and patients at a very fine level of detail.

The traditional Medicare program that's free choice and episodic payment has many strengths, but changing behavior of patients and clinicians at that level is not among them. So you're talking about a major, major adaptation of the traditional program to make it even have a fighting chance of doing these things. Once you do that, you don't have the traditional fee-for-service Medicare program any longer. You've so altered its fundamental characteristics that you're going to have something different. Whereas, in private plans, the nature of the

interactions between clinicians and patients and payers, at least on the face of it would seem to have greater potential for being melded in ways that can accomplish these goals.

So that came out a little bit more definitive than I meant. There's a question mark at the end of it, but that's my instinct on the question that Glen raised.

DR. REISCHAUER: I thought the presentations were very good, and along with the others, thank you for coming and sharing your wisdom.

I want to build on Glenn's remark but in a slightly different way. I think the research suggests that physicians and groups don't practice different kinds of medicine for different payers in a sense. I'm wondering if this does spread, become more common among employer-sponsored plans, wouldn't maybe a lot of the benefit from it, without any action by CMS or Congress, spill over possibly? Some of this involves changes in the behavior of physicians. Some of it involves the development of capacities, different kinds of people, different IT systems within the offices of group practices or others. In a sense, some of it is a fixed cost in a way and once you've done if for one group there are economies of scale, and then

there's a small amount that is a variable cost.

If this proves to be a trend that will improve outcomes or reduce costs I think Medicare should move forward in a proactive way, but I'm wondering, if it doesn't whether at least some of the benefit is going to accrue to Medicare anyway.

MR. HACKBARTH: Sometimes he asks these rhetorical questions.

DR. REISCHAUER: I was thinking also, within North Carolina, how many of the folks in the Medicaid system really are involved in this effort? As you said, the dual eligibles are under a different set of rules that constrain you. I didn't know if everybody else in the system was participating in one way or another. You said it was those groups, those physician groups that volunteered and came into this, implying that there maybe are a number of people out there who aren't, and we're dealing with 50 percent, 25 percent, 90 percent, I don't know of the non-dual eligible population. Did this spill over to other people?

MR. SIMMS: Let me answer the North Carolina piece real quick. In the statewide Carolina Access program, which is the one that I was saying is the foundational program, we

have probably about 4,000 primary care providers contracted to participate in that program. So far in the Community Care of North Carolina program with the 13 networks we have over 2,000 providers participating in that. So it's the remaining 1,500 or 1,700 that we're still having to transition into the Community Care of North Carolina. Some of those will be providers who have smaller numbers of Medicaid, so therefore, their investment in this will not be as great of some of the other providers. But the bulk of the safety net providers are already in the program and now it's a matter of going and dealing with the provider who has 100, 250, 300 Medicare patients.

On the patient side, the bulk of the patients are going to be the women and children who are eligible for Medicaid. Now we have some of the elderly population who may be straight Medicaid that we do have enrolled, but the bulk of them are going to be the women and children.

MR. KNUTSON: I think it's true that in my own studies and in others that there's a mode of practice and it's typically common across payers. The question is when did a medical group tip into capitated behavior, this sort of thing. That's actually the theme, or one of the

questions we're asking in Minnesota and Colorado with this HRQ project that I'm co-leading, and that is can we bring purchasers together to so-call align incentives so that it produces not only a coherent signal but the magnitude that can get the attention of a provider group?

One of my favorite mechanisms of financing was the buyers health care action group product and I, along with a lot of others of us in the Twin Cities have studied it and written about it. But it's dying. One of the reasons it's dying, even though these care system, provider care systems have loved it, is that it didn't generate more than a few percent of revenue for any of them.

This was a problem for them to such a degree that they actually invited three years ago CMS in to talk about whether Medicare would be willing to purchase directly from them using the same mechanism. The belief then was, and I think it's still there, that employers can innovate. They're rarely stick with a game plan. These can't. It's just not in the cards. There is progress. Things happen. NCQA comes along. But frankly, they can't stick with a game plan. They can innovate. We watch what they do, but until Medicare does it, it's not institutionalized in this

country. We're working in Colorado and Minnesota on just getting Medicaid and commercial purchasers together with the hope that maybe somewhere down the road we can bring Medicare into the same financing scheme.

So I think you're right, but I think the question is a critical mass of everything.

MR. MULLER: If we're thinking of disease management, case management as a way of trying to dampen those curves on all three thirds of the population, in other words, the whole population that Joe referred to earlier, then I think there's some things going on along the lines you suggest in provider systems and so forth that tries to, for the reasons that Nick mentioned, where people are trying to look at quality efforts that reduce variations in care along the lines that panel, Elliott and others mentioned last month. So there may be some transference from what's going on in the non-Medicare population to the Medicare population.

But if one is looking at trying to reduce the number of high cost cases that occur--I understand in a distribution there's always 20 percent or 30 percent high cost, but if part of this is really an effort to reduce the

number of cases that become high cost cases then I think the evidence is not, as I said today, is not that clear that disease management is making a big difference in causing that to occur. I think one of the questions we have in front of us is that what the people who are trying to control cost in the Medicare program and trying to ultimately target here is to reduce that number of cases that evolve to high cost, and whether it's having palliative care rather than high cost ICU care at the end of life? I think that's one of the questions for us to consider, where the evidence is on what causes those high cost cases to not occur.

DR. WAKEFIELD: Mr. Simms, just a quick question for you. When you rolled your program out did you see any sort of differential successes or challenges in rural versus urban communities with regard to your disease management? Did it play differently? Was it easier to do in rural communities in engaging and developing networks? More difficult? Any sort of differential impact when it was rolled out?

MR. SIMMS: Allen may be able to respond to this. He was in one of the rural communities when we--I guess it

would be considered a rural community. What we were able to--definitely more of the providers there served the Medicaid program or Medicaid population. Where you get into the urban areas, the options are there for them and many of them will have limited enrollment in the Medicaid program.

So I guess that really is the major thing, is that when you begin dealing in more of the urban areas we have the community health centers who were the larger providers and a lot of the outpatient centers were the larger providers, and they're the ones who end up being the safety net providers in those communities. So when you really begin moving outside of that and start tapping into some of the private providers, that's where you really have fewer or limited enrollment, whereas in the rural communities pretty much every provider there serves Medicaid and they serve Medicaid in a large number. So that really is one of the major things that we've seen.

MS. DePARLE: I wanted to follow up on the point that you made earlier, Glenn, about the difficulty that Medicare has in doing some of these things. I tend to agree with you and have certainly had that experience, and it's one of the reasons I've made the argument that private plans

have an important role in Medicare. But I actually heard something today here that I think gives me a slightly different takeaway, and it's from Mr. Simms' experience in North Carolina, because as I understand it that is fee-for-service. You're not talking about managed care plans doing this. So I think in a way I take away from this the argument that many of us have made is that traditional Medicare--fee-for-service is really a misnomer, but traditional Medicare needs more tools to be able to be more effective. We didn't get that granular on exactly how did they do this and whether Medicare could ever do that, but I found this to be somewhat hopeful in that sense that at least in a state they've been able to do some of those things.

MR. HACKBARTH: Jeffrey, my understanding was that in North Carolina that we're talking about a limited network of providers. This is not everybody that serves Medicaid recipients. We're talking about a select group of providers, the so-called safety net community health centers?

MR. SIMMS: No, actually pretty much we have--it's all the providers that we contract with, primary care

providers in North Carolina that serve Medicaid. Now the safety net providers end up being part of the networks, but we're talking about private providers as well that we have contracted with through our primary care case management program which is a fee-for-service program that allows you to link Medicaid patients with a primary care doctors. So it is statewide as far as the number of contracts we have with the doctors. So it's not limited to just safety net providers. These are private providers, family practice, internal medicine, pediatric practices across the state.

MS. DePARLE: Do you have an estimate of what percentage of the total providers in the state you're dealing with?

MR. SIMMS: Actually I would say--let's do it by specialty. Pediatrics, I would say it's pretty much 100 percent. Family practice I would probably say 98 percent of the family practice docs. Internal medicine is where it gets a little iffy because you're going to bring in some of the specialists and stuff as well, but I would say in that arena we're probably dealing with 75, 80 percent of the providers across the state. Pretty much the way the program is established is that if you're going to serve Medicaid in

North Carolina on a primary care provider side, that most of the providers are going to be in the Access program, Community Care of North Carolina, because they realize this is the way to do it, because the program also gives them an opportunity to have some control over how they serve, manage the population, because of the linkage with them they then have control over the referral system and stuff for the patient population.

DR. MILLER: I just wanted to get in on this because it hit one question that I had written down, because I also thought some of the things that I heard in North Carolina were a new twist on this that I hadn't heard in lots of other discussions that I've been involved in, particularly the ED, the pharmacy, and the nursing home. You also mentioned therapies quickly.

I think the question goes like this, can you help us to parse out how what goes on there is different than the standard prior authorization types of activities and how it's more like disease management or case management? Or how would you characterize what's going on in those settings? Because I think it does get to how it works within the fee-for-service environment.

MR. SIMMS: I think it goes back to what I was saying is the fundamental or the foundation that we've been able to establish in North Carolina. That is, first of all, having a strong enough provider network system across the state willing to serve the Medicaid population, and we did that through the ACCESS program. Then what we were able to do is then link the Medicaid recipients through--originally we started out as a 1915(b) waiver program that gives you the ability to mandatorily link certain eligible populations with a primary care provider that you've contracted with that will say, I'll provide 24 hours, seven-day-a-week coverage. I'll refer to specialists. I'll serve as the gatekeeper of the health care services.

Those are really the fundamental things that we did ten years ago that we're now building upon through Community Care of North Carolina with things like disease management, the care coordination, the pharmacy advantage list as well. So really the fundamental thing that had to happen was the linkage of the Medicaid recipient with the primary care provider and having adequate providers and an adequate provider network to serve them.

MR. HACKBARTH: I'm sure we could go on for quite

awhile. Carol, I'm going to give you the last word here.

MS. RAPHAEL: I'm just struggling with how to think about the fee-for-service system because as I look at this four key things have to happen. You have to move to a science of medicine. You have to have clinical guidelines that are widely accepted and diffused. I think, Glen, you said that you saw some sense of more adoption of this.

Then you have to have a notion of individual responsibility for your own health, that it's no longer just vested in the profession but that you as an individual have some clear responsibility. So that's another major change that has to occur, potentially cost-saving change if we shift some of the responsibility off to individuals.

Then you have to think differently about the unit that provides the service. I'm not entirely sure, except that we think it has to be a team. Again, maybe we can do some labor savings here if we move from higher cost professions to lower cost professions.

Then you have to think differently about the time dimension because you aren't only measuring short term outcomes here. You have to really look at longer term outcomes, which led you to think that Medicare had more

opportunity because we have a more stable population and would ostensibly have more incentive to invest.

So what I'm struggling with is where Glenn was, how would you put all of these major changes together in the fee-for-service system, and what are the mechanisms that we have that could effectuate these kinds of changes? I was just wondering if any of our panelists had any thoughts about that.

MR. KNUTSON: All I would say is I think you're on a couple of important tracks right now. I think North Carolina's experiences is very informative. I think there are some other states who in their Medicaid programs are going to move down a similar path with their PCCM program. Colorado, for example, went from eight or nine HMOs down to one and I think it's stopped enrollment right now. So the question is, what can they do to not go back to traditional fee-for-service and yet build care management into their fee-for-service system? There are, from what I understand, a number of states, maybe a handful, looking at the same thing. I would figure out who they are and monitor their progress and follow North Carolina.

The second is, the CMS demonstration projects when

you really get into them are quite interesting, particularly the capitated disease management program. It sounds like you're going to hear about it, but some of those look really promising to me to be informative about what Medicare can do.

DR. NEWHOUSE: This is a suggestion for our chapter actually and it builds on the notion of Alan Nelson talking about employers deferring cost, and Nick talking about underuse and upfront costs in the hopes of later savings, and Carol talking about the longer run view. Jim Lubitz about a month ago published an article in the New England Journal in which he tried to assess the effect of the decline in disability on longer run Medicare costs, and the answer was it was about a wash. That suggests to me that disease management and case management, probably both, ought to be framed on the research side of having very great importance on better health outcomes and quantifying those. That that's where the value is. That probably the costs may be about a wash.

Moreover, it may be a very long time before we actually find out the answer on cost, but first of all that the longer run framework or the lifetime framework is the

right framework to have and that it's very important to get some kind of assessment of health outcomes in these the programs even in the shorter run.

MS. BURKE: The target group may not necessarily be the top third. Part of this issue is that it really may not be about costs and about he drivers for the top third, which are acute short-term episodes at the end, but rather a long-term investment in better outcomes that may affect it but in a different scenario. So I think we have to think about it differently.

MR. HACKBARTH: Thank you very much. It was very informative and I'm sure we could have continued through the afternoon but other things beckon. Thank you.

We will have a very brief public comment period before breaking for lunch, if in fact there are public comments.

MR. ROYWELL: My name Bob Roywell. I'm with the Visiting Nurse Associations of America, and as someone recently introduced me, I'm a recovering CMS employee. In any event, it would be hard to add anything to the discussion we had today but I'd like to just make--if I had a slide up there with five points on it that I would like to

emphasize, the first is that although I think it was said in a different way, is that disease doesn't develop into chronicity in a physician's office or in a hospital. It develops in the home and community, and I think that's where the solution to this problem lies.

Secondly, we really need to have a model that integrates physician and perhaps nurse practitioners into the homes in a home care plan if we're going to solve this problem, particularly the people that we deal with. We're not privileged to be funded very often for prevention. We receive the lion's share of our funding for people who, as someone put it, have crashed and burned, often with multiple chronic conditions. If we're successful in rehabilitating them to the point in 30, 60 or 90 days where they're somewhat ambulatory and somewhat more able, then Medicare funding ends and they're left at the tender mercies of what comes next.

So I think my next slide would be continuity. It is a tragedy to see people leave home care only to return six months or six weeks later because there has not been continuity, whether that continuity is through private insurance or through a Medicaid system which doesn't

integrate terribly well in long term care when people leave Medicare onto Medicaid, not to mention the delicate dance between Medicare and Medicaid cost shifting, which would be amusing if it didn't hurt so many people and didn't exhaust limited resources.

Fourth, I think we have to realize we have to integrate some of the disease management principles into what we have talked about in terms of aggressive or intensive care management. I think one without the other is not going to be successful.

Lastly, I think to be successful this has to reach the fee-for-service population. Unless the system changes more dramatically than it's changed in the last 20 years, for the foreseeable future we're going to be dealing with primarily Medicare in a fee-for-service system. So we have to be able to reach that population and I think the people that reach that population have to be incentivized to enter into these programs, and they also have to know that they deal with people with whom they have some community connection and some confidence.

Thank you.

MR. HACKBARTH: Okay, we will reconvene at 1:00.

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

AFTERNOON SESSION

MR. HACKBARTH: Before we begin this afternoon's presentations I wanted to just yield to Mark for a second for an announcement for the public audience, and then just one follow-up point about our discussion this morning.

DR. MILLER: Because I think there were some people asking in the public audience, Sarah Thomas has been promoted to the deputy executive director. We're going to put a notice out on either Friday afternoon or Monday. It was just the meetings caught up with us and we weren't able to get it out. So if you're wondering why she's sitting up there, it's not because she's done anything wrong. It's because she did something right.

Then in two seconds or less, at lunch there was--I just want to say something about the disease management conversation that was driven by some conversation at lunch. I think it is still an open question on how the physician, the role the physician play, there's the notion at one extreme that the physician is providing the disease management and paid to provide the disease management. But another role is, you involve the physician at the front end, get all your protocols straight and your strategies but that

caring of the disease management is more by social workers, nurses, that kind of thing, and that there's still a continuum there for analysts to explore as we think through how this works.

Then one final statement on fee-for-service versus private plans. I think that, which venue it works in is also still an open question. It's not that it has to be one or the other. I think there's discussion still open on that. From the lunch conversation, I don't think it was entirely clear on that so I just wanted to make that point.

MR. HACKBARTH: Okay, let's turn to our agenda for this afternoon. The first issue is physician payment and specifically bundled payment options. Kevin?

DR. HAYES: Good afternoon. Our plans for the June report include a chapter on use of physician services, and one topic we could consider as part of that chapter is bundled payment for physician services. So we're here today to provide you with an overview as to why the Commission might want to see that topic addressed in the June report and how we would address questions on the topic for a chapter in the report.

When they say bundling, we're referring to the

size of the unit of payment. For physician services the unit of payment is small. It's one of 7,000 discrete services for which there are payment rates in Medicare's physician fee schedule. The question is whether that unit of payment should be expanded in some way.

There are two general approaches to doing something like this. The first would be to group related services that are provided to patients offer a span of time. An example of this comes from the current somewhat limited bundling that is in the fee schedule already and that would be for surgical services where we see a single payment rate for pre-op visits, the surgical procedure itself, and post-op visits.

Another approach to bundling is to group services that are provided together at a point in time. An example of that would come from the way Medicare pays rural health clinics. There is a single per-visit rate that is paid and it covers the visit itself as well as related ancillary services such as lab work.

So we're ready to move on to the topics at hand. Before I do so just let me point out that in the paper that we sent you for this meeting you saw that we made use of

some software that groups claims into episodes of care. Vivek ran the software and he's here with me today so if you have any questions about that you can address them to him.

So as we look more closely at this topic we know that there is some bundling of payments already in the fee schedule. I cited the surgical services example. Another example is the monthly capitation rate that physicians receive for the services they provide in the way of evaluation and management of dialysis patients. What are the other possibilities? At this point it's hard to say where we would end up, but what's left is non-surgical services as well as surgical services and associated non-surgical services provided during the same episode of care but not currently part of the surgical bundle at present.

Reasons to consider further bundling, we've listed three here. The first is that it would broaden the scope of financial incentives for efficiency. Second, it seems that from an administrative feasibility standpoint it's a bit more feasible now to do more bundling than it was in the 1980s when bundling was last considered as an issue. And the third possibility is that it would seem, just on the surface anyway, that it would be easier to link payment to

measures of quality of care. This is a topic that you addressed in this past June's report. So what we'll do now is just go through these reasons here one by one.

Focusing first on bundling and financial incentives, recall that the Commission over the years has spent a fair amount of time considering the major design elements of payment systems and one of those is the unit of payment. With a large unit of payment, the scope of financial incentives includes both the mix and quantity of services and the inputs used to provide services. In the case of a small unit of payment like that in the physician fee schedule, the scope of the incentives is more narrow. It just applies to the inputs used in delivery of services.

So the question here is whether it's time to revisit the fee schedule, the physician fee schedule's unit of payment? One reason to do that follows up on the discussion you had last month. We had a panel made up of Elliott Fisher and David Cutler and there was some discussion there about overuse of services. So reconsidering the unit of payment in the fee schedule might be one way to address that problem.

A disadvantage of bundling, however, is that it

does increase the risk of stinting. So the question then would be, in any consideration of this, whether it's possible to minimize that risk as part of any expanded bundling policy.

Moving on to the next item here which would be the question about whether it's administratively feasible to do this. Here, just as I said, it seems like it's a bit more feasible from an administrative standpoint to do bundling now than it was previously. To bundle services two things need to happen. One is it's necessary to decide what services are in the bundle and when they're bundled. In other words, how the bundles are defined. The other consideration is just that it's necessary to identify these bundles during claims processing.

Looking at these two points separately we can see on the issue of just defining the bundles we have seen the emergence of the availability over the past ten years or so of the software to bundle claims into episodes of care. So that would be one tool that could be used to help figure out how to define bundles.

The other is that there is precedent now for clinical involvement in matters of this sort. CMS and its

contractors currently use coding edits to review the billing codes that are reported on claims for payment. As part of that process there is input from a group known as the correct coding policy committee which is made up of physicians and other health care professionals. So a question here would be whether that process for working on the coding edits could be adapted to consider the bundling of the type that we're discussing here today.

On this issue, I mentioned the coding edits, it would seem like a tool of that sort would be an integral part of implementing any expanded bundling policy. Those edits are in place now used by CMS's contractors who process the claims. It would be a matter of invoking those edits and making payments accordingly.

A third reason to consider bundling has to do with this idea of linking quality measures and payment. Currently the payments for physician services are for services, for discrete services. By contrast, when we consider the research that's going on on development of quality measures, the focus there is somewhat on services but it's primarily on conditions. You could see that this morning in the discussion about disease management, that

that seems to be a hot bed of activity. But on development of quality measures, thereto, it seems like the focus is on conditions.

When we take, for example, the work of the Agency for Healthcare Research and Quality, they have set up these evidence-based practice centers to prepare reports, conduct technology assessments and so on on care for Medicare and Medicaid beneficiaries. If you look at the topics that those centers are working on it's either overall care for patients with certain conditions or it's services but services always in the context of conditions.

So connecting all this idea to bundling, with bundling, there again we're talking about payments for services, but like AHRQ's work it's in the context of conditions. So if that's the case it would seem that it would be possible to link quality measures to bundles according to the conditions that are used to defined them.

So what would we do on this topic for the June report? If we think about bundling and the related concept of episodes of care and where the innovation is these days, some of it is in the private sector in the areas of disease management, provider profiling, and payment. So one thing

we would do is to consult with private sector experts who have experience in these areas and develop an understanding of the strengths and weaknesses of bundling. We would also review the experience with bundling in Medicare. CMS staff have been thinking about this topic for a long time and we would meet with them and get their thoughts on what might work. We'd also review the experience with the centers of excellence demonstrations for lessons learned.

The next issue we would need to address would be identifying alternative criteria for defining the payment bundles. An example of such a criterion would be something having to do with the number of physicians involved and whether it would be necessary to define bundles in terms of just the services that are typically provided by just one physician or whether it needs to be something perhaps larger.

Another issue concerns determining payment amounts for bundles. This ground was covered when decisions were made about the bundled payments for surgical services, so we would review that experience and we would also draw on any relevant experience in the private sector.

Another topic to consider here has that to do with

those coding edits and the extent to which they could be used in an expanded bundling policy. There we would consult with CMS staff and the claims processing contractors that they use. We would also talk to representatives of the AMA's correct coding policy committee.

With respect to quality measures that might be relevant here, we would conduct a literature review and identify evidence-based measures of quality that are relevant to different types of episodes of care and therefore to different payment bundles.

Finally, we would assess options for minimizing the risk of stinting.

So that's about all we wanted to cover here. We're anxious to get your feedback on how to proceed on this topic, and happy to answer any questions that you have.

DR. NEWHOUSE: Kevin, it was hard for me to get my hands around this at this level of generality but I think if we can talk about specific cases where it might be useful we'll be ahead. But let me say I'm generally kind of skeptical about how much gold is in the ore here. We know we have a problem of overuse and underuse. You actually allude to that. At first blush, as you say, this reduces

overuse but at the price potentially of increasing underuse. You talk about a couple of thinks that I wanted to ask you about in that context.

One is, as I understood it, you were going to make the fee dependent on certain things happening. This was the tie to quality-based payment. It wasn't clear to me that we needed to bundle to do that, if we were going to do that. And if we were going to do that, whether or not it's in the context of bundling there's a lot of issues to be addressed like how do you update this. This sounds a little like the FASB updating accounting standards to me. And how do you audited if this was actually done. If it's on the outcome side then we get into the whole risk adjustment issue.

Then the episode issue almost surely would often involve multiple physicians. Then I'm not clear who gets the bundled payment. We don't even, for a lot of reasons don't bundle, for example, surgeons and anesthesiologists payment which clearly would be one of the most obvious things to bundle if you were going to go this route. So I'm not sure what you have in mind when you say, bundle an episode unless it's entirely within the purview of one physician.

DR. HAYES: Let me take a stab at those. With respect to the link between payment and quality, I could see an evaluation, so to speak, of policy in this area where we start out just identifying payment bundles based on criteria that we've alluded to in the general way in this. Whatever those payment bundles are, fine. Then in keeping with the Commission's recommendation about using incentives to reward quality, I could see where on a parallel track, whatever the case might be, that there would be a move also to try and link measures of quality with the payments.

One of the things that we would want to do is to do some research to identify the extent to which there are evidence-based measures of quality that could be used for this purpose. At this point we don't do what the state of play is in that area. I'm optimistic that there are going to be some evidence-based measures of quality that would be useful for this purpose. But in any case, I see some linkage here between a bundling policy and linking quality measures to the bundled payments, but there are some timing issues that would have to be sorted out and it could be that one would happen before the other.

On the other business about multiple physicians,

you're exactly right. It all turns on this question of how the bundles are defined, and to what extent we can identify bundles that are typically provided by one physician. Let's say that there's a decision made that we want to focus only on bundles where usually services are provided by one physician. Then we would look at the claims data and see to what extent it's possible to identify bundles of that sort, how meaningful they would be in the grand scheme of things in terms of spending, to what extent they respond to other criteria that might be relevant.

There could be, I could imagine, a branching here where you say, okay, we're going to focus on episodes that are typically provided by one physician but we need to have some provision in this policy that allows for cases where multiple physicians happen to be involved. That is true with respect to the current bundling for surgical services where it is possible for physicians to provide within a surgical bundle just the pre-op visits, just the post-op visit, and a different physician provides a surgical procedures itself. So in the claims processing there are these payment modifiers that are identified on claims that flag such claims.

So that's the kind of thing that would get sorted out as we work through this, and I see some do-ability here but without going further we don't know exactly what things would look like.

MR. HACKBARTH: Let me just say a word about the context for this discussion, at least as I see it. This presentation is part of a series now that goes back over quite some period of time. We have looked at physician payment issues. We're on record as being unhappy with the SGR as a way of dealing with, if not the actual increase in volume and intensity, the risk that the rate of increase in volume and intensity will grow over time. Medicare more recently has been in a period where the growth in volume and intensity has been relatively low, though in the last year, 18 months there's been now again some uptick in the rate of increase.

I have found myself in the position, in dealing with people on the Hill, of being asked the question, if you don't like SGR, what do you like? We could respond to that by saying, we are simply not concerned about what's happening in volume and intensity, or we can look for alternative approaches that we think would be for compatible

with--

DR. NEWHOUSE: I thought we said we'd like something similar to what institutional providers, the process for setting their update, as opposed to a mechanical formula.

MR. HACKBARTH: In fact we did. What we said was that the initial baseline was to use a measure of input price increase with a productivity adjustment, but then there's also a discretionary factor. But even there you would be manipulating a price to deal with the volume issue and there are other ways that you can go, including bundling to create incentives for controlling volume.

So the implicit premise of this presentation, I think, is that there is some concern, if not about the current growth in volume and intensity, the potential that it will accelerate and pose significant budgetary problems for the program. Maybe before running down that path we need to have some explicit discussion among the commissioners about how concerned we are about that, whether we believe that we need to come up with a proposal to deal with volume and intensity, or alternatively, we think that for the most part the growth in volume and intensity is a

good thing. It's better care for Medicare beneficiaries.

MS. BURKE: Glenn, it seems to me that the other issue that's there but unsaid and is picked up a little bit in the document but I think needs to brought out as well, is the extent to which the payment system moves towards a system where there is a check on quality, where there is a presumption that we can move towards a series of decisions that encourage certain kinds of care. One the questions in bundling that I found here but not here is this question, because there's a presumption that you can't link metrics to individual services but only into bundles and I'm not entirely sure I agree with that, which was Joe's point as well.

But it seems to me that in addition to your question of, do we believe there's a concern about intensity and about volume is also the implicit question about whether or not what we're seeing is in fact linked to quality, and whether in fact is down result in outcomes that are what they ought to be. So I think as we engage that question we need to look at it in the broader context as well. That it ought to be, to what extent can you build a system that presumes to have some linkage to an outcome that is

measurable and is related to quality ought to be part of that fundamental question as well.

DR. NEWHOUSE: Glenn, can I respond to you? The evidence on overuse, and underuse for that matter, is in the cross-section. It's the Miami's of the world. That's a very different issue than the growth over time which is going on everywhere and which may well relate to what beneficiaries ought to be getting. It seems to me very hard to use payment policy that's going to address an overuse and not potentially also affect underuse. But that's all in the cross-section. I just see the issue of the SGR and control on volume growth over time as a very different issue than the issue of overuse and underuse at a point in time.

DR. NELSON: We know that there are variations, but we don't know where within that variation the optimal lies. One of the problems that I had with the tone of this paper in talking about incentives to reduce overuse was the fact that it seems to me that if we decide to look at bundling it ought to be to try and link payment with the appropriate use, and that if there are all of these unrecognized or undertreated hypertensives wandering around out there, we've said that preventive services aren't being

offered at the rate that they should, we say that diabetes is not being managed to the degree that it really should be, that indeed there may be a greater potential for--that is, the underuse problem may be a bigger problem than the overuse problem. It may turn out to be a wash.

What we want to aim for, if bundling has any capacity to do, and I doubt that it does, if we're talking by and large about E&M services, and that's mostly what we're talking about here, it might be possible to bundle EKGs into office visits or something like that, but trying to bundle E&M services in a way to rationalize usage it seems to me is a tough call because we don't know where the optimal lies. We know there are big differences in how often people with chronic conditions see doctors, but we don't know how often they should.

DR. NEWHOUSE: And even if we had the right rate, you've got to get it to the right people. You could have exactly the right rate and if the wrong people get it, you haven't accomplish anything.

DR. ROWE: A couple points. I agree with much of what's been said. First, you've talked in the paper and your comments about consulting the AMA's correct coding

policy committee and I think that's a good thing. The AMA has a view about correct coding and it's not necessarily the only view out there.

You also mentioned consulting with some of the software vendors that CMS has begun to deal with and I'd just point out that this is an issue that health plans have been dealing with for 15 years. This is a very high volume issue for us. My company handles about 800,000 claims a day and we have a vast experience with the question of bundling, in courtrooms as well as out of courtrooms. I think you might consider talking with some health plans, private sector experts, and you might get a group of them that have particularly done some M+C work so that they have some understanding about Medicare as well and get an intersection there.

Secondly, I'm concerned about some of the adverse effects of bundling, unintended adverse effects. Clinically, I think the issue of reducing the use of preventive services is a very, very significant concern. We have to make sure that preventive services are not further reduce in their utilization. We just need, to whatever extent there needs to be some juice in the payment system to

make sure that preventive services are made available to every Medicare beneficiary, we need not to--make sure that we remove that or dilute in some way. I think that's a significant concern.

I think it would be helpful to frame this as it's not just about the money. The discussion is about overuse and cost-effectiveness, but the facts are that if a patient goes into a doctor and has an interaction with a physician that generate five claims, that's five claims that have to be sent in, and five claims that have to be adjudicated, and five checks that have to get sent. It's a very costly experience for the doctor's office and for whoever is cutting the check. Even if the total amount of money was exactly the same that the doctor was getting.

Bundling isn't necessarily just about--it's about making the system much more efficient rather than having necessarily any effect on what the doctor does. The implication of the way it's written is that doctors are doing things they don't need to do because they're getting paid for all of them. My point is, if they were just doing exactly what they should do, which many do, sending one bill rather than five bills makes a lot of sense. So I

would like to see some language about that.

Let me give you a couple examples of unintended consequences of bundling that you have to be careful about. One is a disaggregation of the bundle in time, so that the patient, instead of going in, explaining to the patient what's going to happen, signing the consent form and having the procedure is you come in on day one, you have the explanation, you sign it, you go home, you think about it overnight, you come back the second day and you have the procedure, so you have two visits. Because if you did it all at once it would be one visit and you'd only get paid for the procedure and you don't get paid for any of the extra time that it takes, et cetera. So that's not an efficient system that works that way.

A second is a disaggregation of the services not in time but by person. You wind up involving more providers than you need to provide because if one provider did it all it would be one bundle, one bill. But if I do X and he does Y, then there's two bills. So there are these unintended consequences sometimes that we have a lot of experience with and you can think about how to get things done efficiently.

The last point has to do with disease management.

Somebody mentioned disease management. I think I want to mention that particularly because I put it in the same category as preventive services, although sometimes it's not considered preventive services but it really is, like eye exams for diabetics, or screening for urine protein and stuff like that. These are really important things and they should get paid for, and if we don't pay for them they're not going to get done as often as they are if we do pay for them. They've been shown to be cost-effective things to do. So if in bundling we wind up removing payments for things which are in fact cost-effective things to do, it's counterintuitive. So we have to take all these things into consideration as we formulate the bundling.

The last is, I would emphasize a little more the really long term excellent experience we've had with surgery and with comprehensive care in patients on dialysis, because this is not new to Medicare. This has been going on for a very long period of time and it works, I think, for the patients and for the providers. It's mentioned in your paper but I think I'd talk a little more about the duration that we've been doing this and how well it's gone. Thank you.

DR. MILLER: Can I just try and get one clarification in your comments? You preface your comments by saying that you agreed with a lot of what was said, but some of what you were saying seemed to imply that there was bundling that went on among the programs that you deal with. I think even your last comment--

DR. ROWE: Sure.

DR. MILLER: So can you talk, if there's this much concern about it and all of these concerns have been raised, how does it work and what problems or what successes did you have with it?

DR. ROWE: The major problem I think we had as an industry which varied across plans was that in the eyes of many physicians bundling became synonymous with the concept of automatic downcoding, so that it was just seen as a way of paying less. The views of plans early on was that this unbundling--I remember when I was in academics we used to talk about the concept of the least publishable unit. Instead of having some big paper with a lot of data in it, there were 10 papers that were published. As soon as you got enough data to send this one off to the journal, then you get the next one. The health plan had a view that this

was the least billable unit.

So to give an extreme example, instead of a physical it was examination of the left hand, of the left arm, of the left leg, of the left foot, of the back, stuff like that. That is an absurd example but that's the theoretical objection.

I think we've come a long way from there and I think we have a lot of experience with physicians and with health plans in figuring out what kind of bundling makes since clinically and what kind doesn't make sense clinically. I in general feel that the efficiencies that are raised out it are more important than the fraud and abuse aspect of it. I think we're overemphasizing the fraud and abuse aspect of it in the conversation and not emphasizing the efficiency aspect of it. That's my general feeling about it.

MS. DePARLE: So Jack, to Mark's question, do you now pay physicians for office visits in a bundled way as opposed to paying them for individual.

DR. ROWE: I think it varies for what kinds of services there are, what kind of specialties there are, what kinds of diagnosis there are. I'm not an expert on all of

these things but there has been worked out approaches to doing it.

MS. BURKE: But Jack, it would seem to me that the obvious place to begin that is with chronic conditions where there's a certain predictability about the things that need to be done over a timeframe. Harder to understand--it's improved by the movement to hospitalists which we're beginning to see where you do have these segmentations where they go in the door and they stop. You have the stuff that happens before, the stuff that happens, and the stuff that happens after in fairly predictable pieces, a surgical piece being the obvious.

But on the non-surgical piece, to what extent have you in fact been able to construct a model that allows you to predict and pay on the basis of things that should occur over the long term in the treatment of someone who--I mean, on the episodic, I walk in the door, I have an acute condition and I move out; different issue. But in the obvious question of the chronically ill which is what you'd likely see in Medicare, beyond the diabetics, the hypertensives, how far have you been able to go in that kind of predictive financing, in structuring those kinds of

models?

DR. ROWE: My sense of it is that there's a lot of variability in the industry in how far we've been able to go, and I can't give you exact information on this, Sheila, unfortunately, though when we next meet I'll be prepared to do that and I'd be happy to get my staff in touch with you. But my sense of it is that working with professional groups such as the American College of Obstetrics and Gynecology we've been able to--I'm not familiar with the gynecological oncologist, for instance. They came to us with a proposal for what they thought was a good bundle, because they said, it doesn't make sense the way you're paying, and it doesn't make sense the way some people are practicing. So by the way we, the gynecological oncologists, believe that this is the correct bundle that should get done for everybody who has X or Y. So it's a disease-specific thing but it's done with the medical professionals obviously.

MS. BURKE: I hear what you're saying. That is a good example of a specific diagnosis that is somewhat predictable in the treatment. You have a certain presenting diagnosis. There are certain things that one does that are--

DR. ROWE: They're going to have a biopsy, and they're going to have this treatment, they're going to have that, and let's just pay for the management of this patient with this problem.

MS. BURKE: Which again suggests defined units lend themselves to this, or specific chronic conditions might lend themselves to this, or other things--it is closer to surgery in that sense. It's fairly definable, beginning, middle, and an end, or a long term.

DR. MILLER: I think that somehow we've gotten--I think it's fair--this is the kind of stuff that we're talking about. When we said non-surgical, maybe it wasn't clear that non-surgery can mean a non-surgical admission; might have a clear path of visits that follows it, to follow up on that. So that might be--like a surgical stay in a hospital has a follow-up bundle of visits, you could move that concept to non-surgery. Not non-surgery in the sense of everything on the planet. I think it's more of the notion of a non-surgical admission, and then precisely the exchange between you two on the notion of a bundled payment for ESRD physicians happens now, or for dialysis happens now. But you could expand that concept to other chronic

conditions. This is the kind of stuff--it's not coming across. This is the kind of stuff that was in our mind.

DR. NELSON: The classic example, the one that's talked about in medicine is treatment of a myocardial infarction, where there are a certain number of procedures, there's a protocol that should be followed, and if it's uncomplicated, fairly stereotype length of stay. But there are others that--that stands out because it's one that is so well defined.

But it would really be helpful if--we may not be able to, not having a November meeting, but it would really be helpful to have the kind of panel that we had this morning for disease management with private sector models and programs so we could really drill down on that.

DR. ROWE: We already bundle, the other place we bundle, Mark, that's worth mentioning maybe is in hospital payments. We don't get a bill from the hospital that says, seen by the nurse at 7:30 in the morning; given breakfast. Seen by the physical therapist; transported to X. We get a bill per diem or something, or we pay based on a DRG or something. That's a bundled payment, right?

MS. BURKE: But Jack, we did, in the old days when

we moved from 223 limits to--when we made this progression into a DRG system, the work that went into creating those structured episodes, the DRGs, arguably what we're suggesting here is a comparable kind of analysis on the physician side. The difficulty has always been, I think, is that to the extent that things happen in a building they are more easily defined. That's been our long term problem is, how do you define things that occur outside and all of the players that get involved. The episode in a hospital is a somewhat easily, record kept kind of. But the doc piece has never really been there. The doc piece is arguably a somewhat separate piece.

But I don't disagree with you that's where you'd want to go, but once you move beyond certain predictable, myocardial infarct, certain predictable kinds of things, it does get more complicated. You can imagine for diabetes the things that ought to happen in the treatment of a diabetic patient, how often they ought to be brought in, what are the tests that ought to be done on a routine basis, whether they get their eye exams, whether they get their feet examined, those kinds of things. But my guess is there is a limit to those kinds of things, although maybe as we look at the

pattern of use in Medicare they will be a fairly defined set that drive a lot of it that would be worth looking at.

DR. REISCHAUER: You also have to ask whether they're more likely to occur if you bill them separately or if you bundle them.

DR. ROWE: That's the point.

DR. REISCHAUER: And if you bundle them without any kind of qualitative oversight on this--

DR. ROWE: I'm worried about that too, but you have to trust the doctors at some point. I think that while there may be some stinting of services, I guess one of my points is, when we do the analysis we should also include in the analysis the savings associated with reducing the number of claims that are submitted.

DR. REISCHAUER: That's why I asked to butt in because I thought you gave both sides of the argument here, because I was with you when I read this the other day on, save a lot of administrative costs because you don't have to send in a whole lot of bills. But at the same time you have to remember that each of the services that we bundle together almost assuredly would be also separately billable under other kinds of conditions. You raise the possibility

that rather than have the lab test done by the doctor he'd say, go to my brother down the hall who's running Joe's lab, or something like that. So you'd have to have a whole lot of checks to make sure that you weren't being ripped off in some sense and there would be a back and forth. So the doc would only have to send in one rather than five bills, but he'd get four letters saying, are you sure this isn't part of the episode, did you order this test, or something like that. That might be more onerous in fact.

DR. ROWE: We have all this experience so you can walk around and talk with some folks and they can tell you what specialties and what diseases are most amenable, what conditions, to an approach. You don't have to do everything. We could add a couple to the dialysis and see how it went.

MR. HACKBARTH: We have a number of people who have been waiting patiently.

MS. DePARLE: I just had a small point. I think, like most people have said, the idea of determining an episode of care is very appealing and it certainly has worked well in some other context. But my question mainly had to do with your suggestion that this was

administratively feasible. I think the way you said it was, should be more administratively feasible than it was 20 years ago. One would hope so, and yet when you bring up the correct coding initiative, about which I know quite a bit, I'm a little bit surprised or curious that that would be seen as a building block for this, because it's a pretty primitive tool. To go back to Jack's vernacular, it was Medicare's attempt to make sure that if someone said they did surgery on your hand, they didn't also bill for amputating your hand. It's pretty basic stuff. It was just coding edits.

And the reason there's an AMA committee is because the AMA didn't like what they thought was black box medicine. They wanted to know what the coding edit were. But CMS, then HCFA, couldn't give them the coding edits because we had, at the strong urging of Congress, purchased some off-the-shelf software to do the edits and that company said they were proprietary so we couldn't give them to the AMA. So that's why all that happened. I'm sure it's a very good group of about clinicians who would be helpful in this process, but I don't think the correct coding initiative, unless it's really become a lot more ambitious than it was a

couple years ago is a place to say that we have a building block here.

DR. STOWERS: I just wanted to get back to what Glenn said a minute ago about what we're trying to of accomplish here. I agree with the comments on the tone about stemming or looking at the growth in physician services. But I think when we go back to our chapter on growth in physician services, it's not in E&M, and it's not in following diabetic patients, and it's not in all of the examples that we've been using. It's in the high tech, and all of these kind of things, and yet we're trying to create this tremendously complicated system of bundling in an area that's even had some negative growth in a lot of cases. It may be 1 or 2 percent. So I'm really wondering where we're headed here with that.

And most of those areas that we're talking about, it's more of an underuse problem, if we're going to focus this on quality, instead of an overuse. If we get into looking at these high-end services, then we really get into somebody in the emergency room has ordered the MRI and now how are you going to penalize that physician for ordering an MRI that's going to increase--

So I just really think we're headed up the wrong tree here if we're looking at growth in physician services, or at the very least we link our examples in the bundles that we're looking to to the areas where there are rapid growth in physician services. That even gets back to the drug issue that is penned into that growth rate. So are we going to bundle medications in there too, because that's a huge part of it. So I'm really worried more about the underuse problem than I am the other.

Then I just had another question. I've never read anything that the bundling with surgery, after all of this 20 years of experience, has slowed growth in spending. I think if we're going to--

DR. ROWE: We don't know what it would have been without it.

DR. STOWERS: But the only thing, there again, to be limited was essentially the number of E&M visits that were connected to the surgery to be sure that we didn't have five post-op visits instead of the four. Again, E&M is not the problem. I'm like you, Jack, I've watched the pre-consult to get them ready for surgery, be sure that it happens X number of days ahead of the surgery, so what

normally could have been, arrive that day, get it done kind of thing ends up in a $200 consult three days before surgery. I think it's increased cost and I don't think it's done a thing for the volume of the number of surgeries being done.

So again, I think we really need to connect it to where the growth is, and number two, show that what we've had as a trial over all this period of time has made a difference. So anyway, I'm just a little concerned about where we're headed with E&M visits.

MR. SMITH: Most of what I wanted to raise has been raised several times so I'll try to be brief.

I was struck it looking at the product of the software that you used that it would be easier to link quality measures to the payment system in and unbundled system than a bundled system, and that making sure we understand how we use the quality data, quality information that is now becoming more available, as you point out in here. In an unbundled system it's harder to tell whether it happened or not. So if we want to use the payment system and link it up with quality, I'm not sure why bundling helps.

DR. ROWE: That assumes a fidelity between the billing and what happened. You're assuming that everything that is billed for--

MR. SMITH: That is presented for payment actually happened; right. But that's a different kind of problem. The information and the construction of the episode that the software allows you to do, does allow you to tell whether or not a request for payment was presented for something that should have been done. In a bundled world that's a harder to do.

DR. ROWE: There's a difference between quality of care and quality of billing.

MR. SMITH: I understand.

My second set of questions, Kevin, I'll try to reference them, really had to do with the link between this morning's conversation and this one. It struck me that what was missing from here was an effort to inquire as to whether or not bundling might help us address exactly the questions Jack raised a few minutes ago. That an episode of care bundle or a bundle that incorporated examination, evaluation and preventive services might not be an important addition to the payment system, and how could we think about that

bundle?

I think as several of my colleagues have said, the focus here is on bundling as a way to get docs to do less. As a proposition, I'm not at all sure that that's the one we ought to be embracing. I do think there's a way to think about bundling as getting docs to do more of the right thing. But that's a larger modification of the payment system than a bundle that is aimed at somehow responding to a perception that docs are doing too much, which I think in some cases may be true but I'm not sure a bundle is the right way at it.

MR. MULLER: My comment builds on both Ray's and Dave's, which is what are we trying to bundle? It goes back to the larger unit question, what's the larger unit you want to bundle? We all know that the driver, in many ways, of health care costs, medical costs, is physician initiation. But the actual things we pay for tend not to be the physician services. It's hospitals, it's imaging, et cetera, and so forth, whether it's facilities or devices and so on.

So the question I would raise is, the bundle that one wants if one is looking at both utilization and cost, is

the bundle in that interaction between the physician judgment and the device or the facility used. So whether that's an extension of the APC thinking and so forth--so my question and my comment is, do we want to bundle them more in that way, that gives us an incentive to have the physician use the right technology, the right facility, the right drug, the right device and so forth? The discussion so far has been very much on how one thinks about putting together discrete physician services so that you have three visits, or four, or five. But I would say it's the interaction of the doctor with the physical thing that Pete likes so much that we have to think about in terms of the facilities, the drugs, devices, and so forth. That's the larger unit that I would suggest we look at.

DR. NEWHOUSE: This all leads me to wonder how much effort should go into this for the June report. If we come down to we're trying to find instances where it's sensible to bundle that are confined to within single-doctor services, I'm not persuaded that there's a lot of value there, but I could be wrong. I certainly don't think there's enough value that it responds to the concerns, as Glenn framed it, that are raised around the SGR that more

bundling somehow relieves the pressure on physician spending.

I want to close with a couple comments on the stinting issue. One is just an example of how pervasive I think it is. In effect, coordination and counseling are bundled with the visit fee in the sense that there's no separate payment for them. I think we all think that those are probably under-provided, and certainly when you talk to physicians they will tell you they don't take the time to tell smokers to stop because they don't get paid for that, and they don't get paid for coordinating the care to any greater degree, and in effect that's a bundled payment.

Now I agree with the comments about the ESRD system but in the ESRD system we have gradually moved so where we have, compared to much of the rest of the system, some reasonable outcome indicators. We have things like KT over V that we monitor and act upon, I think, if they're unsatisfactory. Again, given the concerns about potential underprovision, it's not clear to me we want to go the route of more bundling without something analogous to that, which I think for much of what we're talking about we're not likely to have.

So again I would be happy to be proved wrong but I'm not sure we're the group, or the staff is the group that ought to work on bundling. People have been thinking about coding for a long time in terms of what CPT codes makes sense to be put together. Are we going to really add to do? Maybe we are, but I think that's where we're at.

DR. NELSON: What's KT over V?

DR. NEWHOUSE: We should ask the nephrologist.

DR. ROWE: It's a measure of dialysis effectiveness. It's essentially a clearance rate kind of measure. It's a blood test.

DR. MILLER: Glenn and I were talking and he wanted me to wrap up and summarize what we're heard. I think all that went really well.

[Laughter.].

DR. MILLER: Actually, I've heard a couple of things to perhaps run to ground, and also to give Kevin credit where credit is due. Kevin has been saying that he wants to bring a panel in in December to talk about how this works and I told him that I wouldn't promise him that because I didn't know how much work we would have to grind through in the December meeting. So credit where credit is

due, he had that idea and has been pushing me to make sure that it happens in December and I just wasn't sure we would have the time to do it. The certainly will look for that time a lot more aggressively now.

I also heard two things that are hard to reconcile. Remember, we did talk about technology and growth and some of this flowed from the last conversation we had where some things were taken off of the table and it was, see how far you could get on this. Notionally, if you listen to Jack and some other comments, the notion of bundling for limited circumstances, perhaps for efficiency--and we really weren't trying to convey the tone of fraud and abuse--but efficiency and administrative savings that might be a path, although fully acknowledging that it's not going to capture large blocks of dollars. I don't think we thought that this was going to capture large blocks of dollars either.

A little more complicated is the other comment, drawing together Ralph and Ray's comment, the notion of can you put something together with the physician and the piece of technology that gives an incentive to use the right piece of technology, if I'm following those comments. The notion

of trying to focus, Ray, your comment, on where the growth is occurring; high tech imaging and those kinds, and then I think it was Ralph's point on putting together something with the physician and the technology, if I followed your point. We could try and look at that a little bit.

I think those would be the three blocks of things from this I could hear that we could take another look at based on what I heard. I guess the thing I would just draw your attention back to, and maybe this is what the panel would be about, this does go on. People do do this. It's just, I think, a question of what its intent is and what its purpose is. I really think it does create the building blocks to move towards a quality measurement. I think it is, and I must be crazy but I think it is difficult to track it service by service. It's true that in ESRD you do have all of those measures, but you also have an event that you can track and look at quality relative--

DR. REISCHAUER: No, just the opposite.

DR. MILLER: Like I said, I must be crazy.

MR. HACKBARTH: What I hear Mark saying is, it's not just the bundling in and of itself. It's a way of thinking about the care that needs to be provided. It's not

discrete visits. So the idea is, you bundle these things together and say, for this particular condition you need kind of a course of treatment. It's not enough that you pay on that basis alone. You also have to have the quality measures and assess what happens.

DR. REISCHAUER: But you have at least the claim that the service was delivered when you keep things unbundled.

DR. NEWHOUSE: Under penalty of law.

DR. REISCHAUER: So why is this an advance?

MS. DePARLE: You could say the same thing with hospitals though, with DRGs, the services may or may not have all been delivered, and we don't do anything about that right now.

MS. BURKE: But the point is that it was easier when you bundled and I think my reaction is it isn't necessarily easier, which is not to suggest that bundling doesn't make sense for certain things, and that you will have to have a check on the system to ensure that in fact that predictive group of things occurred. But it does not a priori suggest that it is better or easier to do it by bundling, because it is not. It's easier to track it per

unit because then either you did it or you didn't, you billed for it or you didn't, presuming the bill reflects what actually happened.

But I don't think one's easier than the other. I think bundling is more complicated but it doesn't mean it's a bad thing to do.

MS. DePARLE: Can I just make a suggestion too? If we pursue discussion of this, I think it helps--there is a table, Table 1, that talks about frequent episodes of care. If we could have this be a little more concrete as to what we'd be talking about. When I think of it as hypertension your points, Mark, make more sense to me and I can see why you would say that a bundle helps. When I'm just thinking about physicians, I'm thinking E&M visits, the way Ray was, so I have a hard time understanding how we would actually do this.

So if we bring in a panel or whatever, it would be helpful to be pretty concrete about what exactly they did and how they did it. Maybe like these 10 episodes of care, that's 31 percent, that's a lot. If you really think you could that, that might be worth doing.

MR. MULLER: I would say based on what I'm hearing

here and perhaps what I think I heard Joe say is, I think it's a very important topic but not quite ripe in terms of where we are, because I think there's quite a different set of views around the table as to what we're bundling, and what the virtues of bundling and unbundling are, and the effects on quality and so forth. So I'm also thinking about all the things we have to do in December without the November session, so we've got a lot of big topics there. So whether we could take three hours--this is more--scheduling thing is whether we could take three hours on this when we're not quite ready on this.

MR. DeBUSK: Should we even be pursuing this?

DR. STOWERS: I think the very least we need to do in the chapter is, if we're going to link bundling to quality is that we need to make the point, in most cases the more we bundle whether it be in an HMO model or whether it be in a DRG, whatever, brought on the great necessity of greater monitoring to make sure that the quality or no stinting was occurring. So really when you come to quality, the more you bundle, the less you usually assure quality.

A good example of that is bundling the E&M service. When I see a patient I'm responsible for the

patient until the next visit all for that one E&M service. That's managing the home health care, that's managing getting therapy, that's managing--and yet what we're talking about is those things are not occurring. So when the management services came out of the AMA process to go, we're not paying and separating out a payment for management. I think we'd have been a lot better off unbundling the E&M to include some of the management things in between so the we were getting this quality, coordination of care, that kind of thing. So I think we at least need to look at the flip side of that in the chapter.

MR. HACKBARTH: Okay, we need to move on to the next item, so thanks, Kevin.

Next up is Medicare supplemental markets.

DR. BERNSTEIN: Good afternoon. I'm going to briefly walk through the summary document that we sent you about the site visits that we did over the summer with the help of Mathematica Policy Research. Bob Hurley from Virginia Commonwealth University who worked on that project is also here and if you have any questions later about specifics on the site visits any of us has an equal chance of being able to answer them.

The objective of the site visits was to help us understand the factors that shape the different markets for supplemental insurance that we have seen across the country. We were looking for the sources of variation in order to understand what the implications of the variation in these different markets might be for Medicare beneficiaries and for Medicare policy now and in the near future. The sites that we went to were Atlanta, Long Island, Minneapolis-St. Paul area, the entire state of in Nebraska, and San Diego. These areas have approximately the same number of beneficiaries although their size varies considerably, and the distribution of different kinds of supplemental coverage also varies tremendously across these three areas.

Although Medicare is a national program with standard benefits, the array of products that beneficiaries use to supplement Medicare are shaped in large measure by local factors. For the purposes of summarizing what we learned on the site visits we have divided these into four sets of issues which I'll talk about briefly. One is state regulation and oversight. Second is the organization and history of the local systems. We also looked at the nature and concentration of employer-sponsored retiree health

benefits in each of these areas. Finally, we looked at the interaction of privately-funded supplemental products with publicly-funded products, particularly for low income beneficiaries.

We discussed the issues of state and local regulation with a variety of people in each of these sites, and I'm going to move from specific issues up to more general issues. A major topic that comes up, particularly in states that have not made changes in excess of the National Association of Insurance Commissioners model regulations is access to supplemental insurance for disabled beneficiaries under the age of 65. To of the states we visited don't have any special provisions for extra open enrollment or guaranteed issue. Three of them do.

This is an issue which is still in play. California only increased protections for beneficiaries under 65 a couple years ago. They had a special open enrollment period and they're going to have another one starting in January because evidently no one was aware of the first one. They were kind of concerned about that.

As it turns out, the Medicare+Choice program is what brought this issue into special light in a number of

these states. There was some hope on the part of the beneficiary advocate community that M+C programs would provide an option for people who couldn't get supplemental insurance. This turned out not to work out very well. In the two states that didn't have special provisions the M+C market never really developed all that much and there was never a great deal of enrollment for people under 65. Now that the availability of M+C programs in both Nebraska and the Atlanta area is quite limited impact, we're back to the same position we were at before which is an issue of some concern for the beneficiary community.

Moving to the next area, there are really basic differences in the way Medigap insurance in particular looks in states. Minnesota is a waiver state and its products are actually quite different from the national products in some substantive ways. In particular, the structure of the drug benefit that's available in Minnesota Medigap is a little bit more generous than anything that's available under H, I, and J. It's expensive, but there are also differences in the way Minnesota Medigap is structured in terms of the select policies so that there are options available to beneficiaries in Minnesota for coverage which includes drug

coverage that are more accessible, evidently, than they are nationally. Twice as many people who buy Medigap in Minnesota get a drug coverage version than is true for the benefit in the other states.

DR. REISCHAUER: But isn't that because it's one of the three states that was excluded from the requirements--

DR. BERNSTEIN: Right.

DR. REISCHAUER: --and they have to keep the plans that were defined as of the early 1990s?

DR. BERNSTEIN: They made the reforms right before the OBRA reforms and they basically went through the same process, they just came up with a slightly--they believe that their structure was superior to what NAIC came up with so they didn't switch to the NAIC option. Their actuaries have some very interesting insights into what they think they did, although they're not taking credit for it being entirely on purpose but it seemed to have worked out pretty well.

Medigap is the basic form of coverage in Minnesota. The M+C rate is not that high and there's very little employer coverage there compared to some other urban

areas that would be comparable to Minneapolis. So it is a big deal there.

New York is also a heavily regulated state under the regular system but New York has pure community rating and open enrollment and guaranteed issue. There are less policies sold in New York, and they're not cheap but we didn't hear any complaints when we were there about the availability of Medigap from beneficiaries or from regulators.

We also saw differences in the regulatory climate that affects supplemental products. Some states are very happy with the existing set of standardized policies and don't want any changes to it and are very resistant to the introduction of innovative benefits. Other states are much more laissez faire and believe that the basic rules cover the options and if it's okay with the national system, it's okay with them. California is the prime example there. There are a lot of different things going on in California and I'll come back--but the insurance options in California are more diverse than they are in other standardized states.

In the broadest level, some of the state regulations actually affect who can participate in the M+C

market and what insurers can do. In Minnesota for-profit organizations can't find health plans, PPOs or M+C or any kind of managed care plan, so there are contracting arrangements with commercial vendors that have established contracting intricacies there that have affected the way they go forth with things like PPOs.

New York has a rule about insurers not doing out-of-state business which would be an issue, and California's prohibition of corporate practice of medicine has had an effect on the way physician groups have organized themselves there, which in turn has an effect on who participates and what kind of managed care arrangement or insurance arrangement.

Moving to the local delivery systems. It's kind of obvious to say that managed care and M+C options look different in markets where integrated care and HMOs are a way of life versus markets where they're not, but they're more fine-tuned differences that stem from that kind of basic difference across the places that we went to. The four metro areas that we visited are about the same size in Medicare population but they have very different kinds of health care provider organizations, physician groups,

relationships with hospitals, et cetera. M+C options fit in some of them and they don't fit very well in some of these other places.

Both Minneapolis and San Diego have strong managed care organizations and have had high penetration rates in managed care in the commercial market for decades. In Minneapolis, pretty much everyone we talked to told us about the region's strong commitment to integrated care and to quality initiatives and to strong relationships between providers and health plans and so forth. In San Diego, the physician groups are clearly committed to contracting with health plans and capitated arrangements still actually work there, and there are a lot of people who are committed to sustaining those relationships. Beneficiaries also are very loyal to managed care in San Diego even though the quality of the M+C benefits has deteriorated somewhat over time.

Some of the points that are listed in the sub-bullets there are--contrary to popular opinion, rules of thumb don't always apply because of these differences in local delivery systems. As I said, in San Diego some provider organizations really like capitated arrangements. In Minnesota we talked to plans who said they had put

together rural networks and they planned to put together more rural networks in adjoining states. In other urban areas it seemed to be virtually impossible to put together networks that could participate in PPOS or in MedicareSelect plans. Atlanta was one example and Long Island is another.

Finally, history and cultural or whatever you want to call it, makes a difference in some of these areas. Beneficiaries in some of these markets were very happy about the coming of managed care, M+C programs, and very unhappy when things didn't work out the way they wanted them to and the plans, particularly in Atlanta, just disappeared. It's almost personal. People are very skeptical, including the people who work in the counseling organizations about managed care and its ability to ever serve these people's needs so they're going to be skeptical when anything new comes along.

The issue of employer-sponsored insurance came up a couple times this morning. Again, despite the fact that it is clearly true that there's a decline in retiree benefits, it's still important in some of these markets, in Long Island in particular, there are big variations across the industry groups and the public versus private sector

with regard to these benefits, but across all of them we heard very mixed views about how--on the one hand these things remain important. They're important to the beneficiaries. They're important to the employers. All of them are concerned about cost. All of them are concerned about, in particular, prescription drug benefits and the cost of those plans.

One thing that we heard about that's important is the extent to which, in an effort to reduce costs or liability in employee benefits in general, employers in both the public and private sector can move retirees into their own risk pool, which reduces the increase in cost for the working population but leads to fairly steep premium increases for the retirees and may cause them to drop coverage.

So we have to be very skeptical now when you look at the offer--percentage of employers who say they're offering coverage to retirees masks the fact that, first of all, some of the retiree premiums are very, very high in some of these programs, and in some of these programs employers are no longer able to contribute at all to the retiree population. They offer the plans because they're

group plans and group plans have distinct advantages, mainly in terms of being able to craft benefits more flexibly than you can in the individual market. In many cases, the retiree plans are the only--provide a way of offering a much better drug benefit than you can buy through H, I, or J and there isn't much else out there except for some generic-only plans.

Finally, employer-sponsored insurance still has a big effect in some areas on local health plans. In some markets contract plans for M+C through employers constitute one-third or more of the business that some of the M+C plans are involved with.

Another unique example is the TriCare for Life program which is an employer-sponsored plan from the Department of Defense which covers supplemental benefits and offers an optional free--it doesn't cost anything to join it--drug program for military retirees. When that came online a little over two years ago in San Diego it affected about 14 percent of the Medicare beneficiaries living there. Thousands of people left their existing plans, dropped either M+C coverage or Medigap coverage. A major insurer in Atlanta also told us 10,000 of their members dropped Medigap

when TriCare for Life came online. So these organizations do affect each other.

On a sadder note, in Minnesota--it doesn't affect Minneapolis as much as the state as a whole, large declines in coverage for iron and steelworkers as a result of plant closings has led to really interesting competition among Medigap and M+C plans in that state as well.

We also talked about some of these low income programs this morning so I'll just go over this really quickly. The supplemental coverage offered through the full Medicaid program varies substantially across states; has a big impact on beneficiary access to coverage. The income limits in Georgia are less than half of the income limits in Minnesota, which has the highest. Asset levels vary considerably across these states as well.

For the Medicare savings programs, that would be QMB and SLIMB, QI1 program, the income is set nationally so those are the same but again the state asset requirements come into play. There's even more variability when it comes to the prescription drug benefits available for low income beneficiaries. Georgia has a program which basically helps people get private sector drug assistance, whereas Nebraska

has no program at all; New York has a very popular program called EPIC which many of you know about, which provides coverage to people of low and moderate income levels. It's a very large program, and given the support that it has in the state and the commitment that the state has made to us, we heard a lot of people there say that they were actually concerned that changes in national policy could be detrimental to the people of New York because it could leave them with something worse than what they have now.

The last thing I'll mention even more briefly is that the dual eligible issue is clearly important in all of these areas. In most of the states, dual eligibles are not generally in managed care because it's optional and it's very difficult to coordinate benefits, particularly drug benefits. However, the MSHO program, Minnesota Senior Health Options in Minnesota is a fully integrated waiver program that combines Medicare and Medicaid benefits into a single funding stream, and a lot of folks there are actually in managed care. The plans that are participating in that think there's a tremendous potential for better care and more coordinated care and efficiencies, and later this year other staff will be getting back to you on some of the

issues regarding dual eligibles and some of what's going on with them.

Looking to the future. One common theme that we heard and what we emphasized in the report is that generally across all the five sites we went to, as different they were, the Medigap market is seen as a stable thing. The insurance regulators, the insurance companies and beneficiaries know what the rules are. They generally understand them. They had very few complaints about regulation, and it was striking to us that this is just as true in New York or in Minnesota as it was in places where there was very little regulation in comparison. Knowing what the rules are with these products is very important to people.

There's a growing tension, however, as some of the forms of Medigap and different sorts of Medicare+Choice products evolve, as benefits have eroded and cost-sharing has increased Medicare+Choice plans begin to look a little bit more like Medigap products. Medigap providers for their part, particularly in places where they're being more innovative or trying to come up with ways of addressing the prescription drug needs of their clients and also trying to

deal with cost by using high deductible plans.

They're also adding benefits like homeopathic medicine or the prevention programs or exercise programs that attract different groups of beneficiaries so that in some places like California it's really hard to figure out what these products are, whether they're Medigap or whether they're Medicare+Choice. Those differences are important because they're regulated differently. The open enrollment season issues are different, and the community rating provisions are different, and the re-entry into the market are affected by different federal and state protections.

A number of the beneficiary folks we talked to in California were really beginning to have trouble trying to figure out what to tell their clients. In terms of Medigap alone, the SHIP was unable to provide price information on alternative Medigap products because the system is so complicated, there's so many different options and they're so hard to compare to each other that they had basically lost the ability to help the people that called them to get that kind of information. It's also not available on the state insurance department web site, the pricing information, because they can't keep track of it either.

I just want to go through one really quick example of how some of this plays out by using an example that was raised with us a number of times in different states and that has to do with the regulation of private fee-for-service plans, which are very, very much like other Medicare+Choice plans with a couple of unique distinctions. Like Medicare plans, you can't deny people entry based on any kind of personal--age or health or whatever. No difference for smokers or nonsmokers like there can be in other insurance. They have the same open enrollment, guaranteed renewal rules as other M+C plans. They are M+C plans. They have benefits similar to other M+C plans. To the extent that they have--you can set up a different systems of copayments. They cover some non-Medicare services. They offer some kinds of discounts for things like sometimes hearing aids, sometimes prescription drugs, out-of-area coverage. They look a lot like other M+C plans. They also look a lot like some of the Medigap plans that are available out there.

Currently none of them have networks, which does make them different from other M+C plans. But the other difference that has insurance regulators concerned is that

nobody reviews their rates. CMS by law doesn't review the rates of private fee-for-service plans, and states are preempted by federal law from reviewing the rates that are offered by these plans.

The concern of the regulators is that these are insurance products that are licensed to do business in their state, beneficiaries buy them the way they would any other Medicare product but it looks more like they're buying Medigap than M+C. But if the plans raise their rates substantially over time but don't leave the area, then the beneficiary might be in a difficult situation because they don't have--if the plan still exists they don't have the same rights as they would if the plan just disappeared and they would have automatic reinstatement rights for Medigap under federal law--I mean, M+C under federal law.

If an M+C plan disappears and there are no other M+C options, a person has certain rights to reenter the Medigap market, which is true of these plans. But if the plan is still there but offering a very high rate, this puts them in a different position. In a state like Minnesota where they are very careful about regulating everything, this is causing a great deal of consternation.

DR. ROWE: Can you say that again? I got a little confused.

DR. BERNSTEIN: I think I said it wrong. If you're in an M+C plan and it disappears, it withdraws from your area, there are federal protections for reentering the Medigap market. You're allowed within certain number, a 60-day window or something, you're allowed to reenter the market and buy certain of the Medigap plans without underwriting. Since private fee-for-service is an M+C plan it counts in there, so in many rural counties of Minnesota it's the only M+C option--actually Minnesota is a bad example. They have M+C everywhere. In many areas of many rural states it's the only option that's there. So if one private fee-for-service plan comes in and it's charging $70 a month for a benefit and then it leaves--

DR. ROWE: You can't afford that so you drop that but you don't have this reentry eligibility.

DR. BERNSTEIN: Right, because there's still an M+C plan. You can go back to regular Medicare but you can't get Medigap.

DR. ROWE: Why can't you buy Medigap? Is there a law against it?

DR. BERNSTEIN: It depends on the state rules. After the 60--

DR. ROWE: You can never buy back in?

DR. BERNSTEIN: No, you can buy it but there are different rules in every state. You don't get guaranteed issue. In New York it doesn't make any difference because it's community rated and open enrollment, but other states you can't.

DR. ROWE: Tell me about the exceptions.

DR. BERNSTEIN: This is complicated, but the bottom line is, private fee-for-service looks like M+C but you don't have the same--nobody is reviewing the rates. That's what gets people upset and that could have an impact on beneficiaries if that's all that's available.

DR. ROWE: I don't understand. It seems to me that you are implicitly suggesting--you're kind of a born regulator. You're implicitly suggesting that what you should do is have some people review these rates. Why don't you solve the problem the other way and put in a regulation that gives these people the right to access Medigap at those rates, rather than create another bureaucracy reviewing all these rates? Wouldn't that fix the problem a little easier?

DR. BERNSTEIN: I'm not sure that the states want--I'm not proposing or was not building to a recommendation that they review the rates. I'm saying that the regulators don't know what to do with these products that look sort of like Medigap and sort of not like Medigap, and kind of like M+C but not exactly like M+C. They have a lot of questions.

DR. ROWE: And they want to review the rates. You're saying, why can't we review the rates for these policies in this state that people are buying? I'm just saying there's another solution to the problem that would be much simpler and less bureaucratic.

DR. BERNSTEIN: I don't think the regulators in other states will want to review them. I think Minnesota like to review things. In fact they review things they're not even allowed to review.

MS. BURKE: Jill, can I just ask one further question on the structure of these plans? You indicate that there's no rate review. Are there similar to the normal insurance structure in most states as to reserve requirements or any of those kinds of issues?

DR. BERNSTEIN: They have to be licensed by the

states so it depends on the state's rules.

MS. BURKE: So it's just a function of that. So it may or may not.

DR. BERNSTEIN: Right.

MR. FEEZOR: Indirectly it may.

MR. SMITH: Purveyors are subject to normal insurance department regulations. What they're selling isn't but the sellers are.

MR. HACKBARTH: So the finances of this particular plan, is the premium appropriate for the costs, are not subject to state review but the overall financial stability of
XYZ health insurer is because it's a state-licensed entity. That's a threshold requirement for participating in Medicare is that they're a state-licensed--

DR. BERNSTEIN: Right, they have to qualify to be a Medicare contractor, so they have to meet those requirements.

So as we develop--we're going to give you a final report on the site visits and we're going to look at some of these other issues further, so I just basically have two questions for you. One is whether there are particular

topics that were raised in the material we sent, or elsewhere, that you think we should be pursuing? And secondly, whether you would be interested in us looking at potential policy changes that might improve beneficiaries' ability to meet their supplemental needs.

MR. SMITH: Jill, thank you. I found this fascinating at the last meeting when we looked at the site visits and the mailing materials. I found it fascinating but not very satisfying, in that the question, so what, never got raised in any useful way. Does the structure of the supplemental market end up costing beneficiaries differentially out-of-pocket? Does it affect utilization? Does the structure of the market affect health outcomes to the extent that we know?

It's interesting that Minnesota and New York continue to be heavy-handed regulators and Jack would prefer to be in Nevada, but so what? Is the experience of one of Jack's policyholders in New York significantly better, significantly worse, significantly more expensive? Do they buy less supplemental health care than folks in a difficult market? It's hard to even begin to think about answers to the questions you raise at the end without knowing whether

or not this stuff matters.

DR. BERNSTEIN: One of the reasons that we did this is because when we did the national overview it was clear that it did matter. There a lot more people in some of these states that don't have any supplemental coverage than in others. In previous work we've tried to look at whether having different kinds of supplemental insurance makes a difference in terms of the way people use services. We haven't done that again recently, but that was going to be part of what we'd like to do in the future.

We're particularly interested in looking at what the decline in employer-sponsored benefits actually means, and where do these people go, and what are their options, but haven't yet figured out a good way of getting the data to track some of that. So those are all really important issues that we'd like--and that's one of the reasons that we wanted to talk to you today is to get some ideas about what particular directions you'd like us to go in.

MR. SMITH: In general I'd be more interested in what kind of services do they consume and how much do they have to pay for them, rather than what the architecture of their supplemental choice is.

DR. BERNSTEIN: Every year in the context chapter do an analysis of out-of-pocket spending and we do that by different type of supplemental coverage.

MR. SMITH: Incorporating some of that in here would be--

DR. BERNSTEIN: We did that last year and we're doing that again for the context chapter this year. We're also developing a chapter for the June report looking specifically at beneficiary resources and liabilities, basically looking at what they're spending for health care, and how they're paying for it, and how that's changed over time.

MR. SMITH: Looking that in terms of the differences in supplemental marketplaces?

DR. BERNSTEIN: That will be one of the things that's in there.

MR. HACKBARTH: Whether the different regulatory regimes are good or bad depends in part on who you are as a beneficiary and what you're expected expenditures are, what your health status is.

DR. BERNSTEIN: Actually, one of the things that will be in the report that we haven't had a change to talk

about is the natural experiment in San Diego when almost 50,000 people went from having just military retiree coverage, which wasn't very good, to having TriCare for Life coverage, which is very good and has a very good drug benefit. We have yet to figure out how to get hard data on this, but there was a lot of anecdotal evidence that their use of services has changed dramatically as a result of having different kinds of supplemental. They're using a lot more services.

So it is an issue. Again, on Long Island more than 60 percent of the people, according to CPS, have supplemental coverage through their employer. Utilization patterns there are very difficult than they are in San Diego or Minneapolis.

MR. HACKBARTH: One of the interesting things that I read on this subject, I think it was Kaiser Foundation report that looked at different markets and looked at the options available to certain hypothetical beneficiaries with different conditions and associated health care costs, and said, what are the total health care costs for this hypothetical 80-year-old frail female, or a 65-year-old healthy male in different markets, when you take into

account the premiums plus the out-of-pocket expenditures? It was very interesting and enlightening. Huge differences; huge differences.

MR. FEEZOR: Glenn, I think you and Dave probably at your last question framed what really we should be focusing more on in our analysis of this. I bear some responsibility because Jill and Scott had asked my opinion from my days 15 years ago as a regulator about what were the right market and some of the nuances.

In retrospect, I am concerned about two or three things about our work thus far. Out of the five sites we picked, three are in notoriously unique states in the terms of the regulatory environment. That is Minnesota, that is New York, that is California. Two, I think three of those are out of the four or five who maintained a duality of regulatory oversight for a long time. Basically said that HMOs were not in the insurance business and that sort of thing. So in retrospect I worry about that.

Also in retrospect as I look--we looked largely at urban markets, with the exception of all of Nebraska, and we got all of Nebraska in order to get equal numbers I guess, or equal size markets.

DR. BERNSTEIN: No, we wanted to go to a state that was rural; someplace that was rural.

MR. FEEZOR: In retrospect, even that one I worry a little bit about the presence of Mutual of Omaha being so very, very strong early in the supplemental market, though they may not be anymore. So you may want to just touch base or do a couple of quick and dirty conversations with some other less urban states to see if there's some--to verify what you found in Nebraska.

By the way, parenthetic, I think what will be interesting, Jill's point on the evolution of a lot of the Medicare+Choice products to look more like Medigap and Medigap to mimic some aspects of some of the Medicare+Choice products despite different regulatory--Jack may bear it out and I'm sorry Alice isn't here, but an awful lot of the--because of what seems to be the intransigence of the division of managed health care in California almost every HMO that I know is in fact filing dual license. They in fact are filing HMO look-alike products under a department of insurance license in order to have greater flexibility in their benefit design and so forth.

Then just one other observation. Because it is

probably a more static market now maybe this is not as important, but I think it's hard to look at what happens in the Medicare supplemental market generally without looking and giving some credence--and it's very tough thing to do market by market--by looking a little more carefully at the distribution mechanism by which those products are sold, looking at the compensation or the reimbursement, whether it's a captive sales force, independent agent, does that commission pan out over two years? Even though some of the Medigap reform efforts limited some of that variation, I think that's important. Then ultimately, and the point was made in this paper, how the regulatory construct fits with where there are some regional or local payment and physician network practices and attitudes are awfully important.

Two other just quick points. There was a new study that's just been released. I haven't had a chance to see it on public entity retiree.

DR. BERNSTEIN: I've got it.

MR. FEEZOR: Okay, just wanted to make sure you'd seen that.

Then finally, I don't know who's doing the actuarial work for TriCare for Life, but the future cost of

that--I see a lot of snickers. I may be stepping into it, but it won't be the first time nor the last. But the unfunded liabilities, not only--Jill's point on the number just in San Diego, but even within the CalPERS program when people began to say, when we move to just a 10 or--in fact most of our retirees in the CalPERS program pay very little; certainly the state retirees. But even when we start talking about a pay increase out-of-pocket on premiums for the retirees, I had a significant number, hundreds that actually bolted from an almost free retiree coverage in CalPERS to TriCare for Life. If I could have been a little more selective about which ones left me that wouldn't have been all bad from my perspective, but I really do worry about who's tracking that from the federal government standpoint.

DR. REISCHAUER: By the time the bill comes in Arnold will be president and he'll handle that issue.

[Laughter.]

DR. BERNSTEIN: I just wanted to mention that the full report has a lot of the detail that we haven't been able to talk about including the agents. There's much more richness but it was hard to--we'll get a lot of that stuff

to you.

DR. WAKEFIELD: I take the point that some of these examples might be little bit on extreme ends or atypical examples, but frankly, I liked that read. I agree, if you can, to deal some maybe more run-of-the-mill markets or circumstances into the mix might be helpful. But I thought this was pretty illuminating. The variation was striking to me, and I found that to be helpful. I did have the same reaction and why I asked to be called on was because I wanted to raise David's point, which he already raised and that was, I had some difficulty connecting this to the beneficiary at the end of the day. But you answered that. If we can deal that content back in here, I really interested in, recognizing all of this then, what's the link to out-of-pocket expenses, for example, to beneficiaries? How are they impacted by these kinds of variations? Because I actually found this quite helpful, but that was the piece I was still missing. And I heard your answer, you're coming back and that's going to be dealt back in again. So basically that question was already raised.

I do have a different question though on--I also had a second question on private fee-for-service. Is it

still the case, Jill, that these tend to be primarily in rural areas? At least the first one out of the box was. Is that still the case or are we seeing them equally distributed in urban and rural areas? Just out of curiosity.

DR. HARRISON: Next presentation will have a table that will show you that.

DR. REISCHAUER: When we do whatever we do in this area I hope we don't lose sight of what I think should be the message of MedPAC, and that is because employment conditions and health markets and the regulatory framework and Medicaid policy vary tremendously from area to area or state to state, the availability of supplemental insurance will be unequal and it will be inequitable with respect to cost, availability, structure, generosity, everything.

The right way or only way to solve this problem is to expand the basic Medicare package so that it constitutes a package that the vast majority of the elderly and disabled regard as adequate and they don't need two health insurance policies. We two years ago wrote something about that, about how one could do that. But we'll be here 50 years from now talking about the strangeness and the inequities

that exist and how you might tinker around the edges and make some of it, the repercussions a little better than they otherwise would be, but you'll come nowhere near to solving the basic problem unless you expand the coverage of the basic Medicare benefit.

DR. HARRISON: The one thing that we really found was the search for drugs was very important in all of the markets. People stay in retiree plans where they have to contribute lots of money only because they're going to get drugs out of it that they can't get elsewhere.

DR. REISCHAUER: But as soon as we cover drugs we're going to worry about catastrophic.

DR. HARRISON: Right. I'm just saying, an example of what we found from the case studies is that drugs are swinging a lot of the decisions that are going on here. I don't know that we have a lot else that we saw.

DR. ROWE: Just three quick points. One is, I thought the stuff at the end of the chapter on how the Medigap policies seemed to be turning into M+C and M+C seemed to be turning into Medigap and it was getting to be a blur of the distinction yet they were regulated very differently was interesting. One of your questions is, are

there particular topics, and you didn't talk about that much in the presentation but I thought that was interesting. Maybe if there was some sort of a table or something that showed the direction that each product was going and how they were trying to get--they seemed to be converging, I thought that was interesting.

Second is, I think you should say something to distinguish corporations that are putting in policies that individuals who are not yet hired or who may be hired but not yet retired will lose certain benefits versus actually reducing the benefits of currently retired people, because they're two very different things. There are a lot of companies that are saying, no more X for retirees after next year or something like that, or two or five years from now or a sliding scale, because they don't want people to rush out and retire. But that's not influencing the market now because that company's retirees still have benefits. That's one subset.

Then there are the subset of people who actually are having their benefits reduced in retirement while they're retired and I think it's not obvious from what you presented about that.

The third is just a quick question. When you were in Minnesota, whether the proximity to Canada had any effect on the search for drugs. We hear a lot about people going to Canada get drugs, and I just wondered if you had heard anything about that or saw anything in the market up there that was different than in North Carolina or something like that.

DR. BERNSTEIN: Yes. There's a very large program run by a nonprofit consumer group there that has a very large drug importation business going on. I think they're having a little bit of legal--

DR. ROWE: Are they licensed--

DR. BERNSTEIN: A little bit of legal issues going on there now, but it's a very big program. They sort of invented--they've one of the driving factors behind the entire national movement. It's a huge organization.

MS. DePARLE: When you say very large, Jill, what do you mean?

DR. BERNSTEIN: It's the Minnesota Senior Federation and has like 80,000 people who belong to it in Minnesota plus others. They have a professional full-time staff and it's a real place.

DR. ROWE: I was hoping that wasn't going to be the answer, but given that it is then I think Minnesota is particularly inappropriate for us to draw any conclusions from with respect to--while we're comparing, we're picking three different markets or four different markets and we're trying to see what's going on. Here we've got this one market with this huge drug importation--

DR. WAKEFIELD: I think more states are doing that. There's probably at least three or four states.

DR. ROWE: Three or four out of 50.

DR. WAKEFIELD: Ralph's saying 16 or 17 states.

MR. HACKBARTH: We need to keep moving here, I'm afraid. Carol has the last comment and then we need to move on.

MS. RAPHAEL: This is something I'd like to have you focus on. It's on the road to tinkering, to make this better in the interim. That's the young disabled, because we know they're growing in the Medicare population. We know there are real issues about access to Medigap. I think you highlighted last year or the year before. You make some very brief reference to it, but I'd like to really understand the Medigap market for the young disabled under

65.

DR. BERNSTEIN: I didn't do it this time because we had talked about it in some earlier sessions. There's data--we've been looking at it and it will be discussed in the report.

Actually, if I can make a really brief comment about the site visits and where we went. Site visits are really--you can't generalize from them but they're really good at looking at things that are different. I think the methodological advantage we had here is, in a sense looking at extremes to get a sense of how things could play out. We will be very careful in trying any conclusions from these five weird places about national--we need national data to do that. We can't do that from these five places, but you can see some really interesting nuances that can play out in very different ways which we thought would be helpful.

MR. HACKBARTH: Thank you.

Next up is Medicare+Choice. Scott and Tim.

MS. DePARLE: While we're changing tables I just want to say, I think that it's commendable that the staff went to the effort to make these site visits, because I know do with the limited staff how much extra effort and energy

it takes to go out there. But as we're seeing more and more how different markets are I think that's an important perspective that we need to have so I want to thank them for doing that.

DR. HARRISON: In this session we're going to focus on payment rates and plan availability in the M+C plan for next year. In its May announcement of the M+C rate increases for 2004, CMS announced that expected fee-for-service growth in Medicare for beneficiary will be 3.7 percent in 2004. The payment formulas feed off this number, and running that through the formulas we get the following updates.

Payment rates in floor counties will rise by approximately 5 percent. Rates in non-floor counties will increase by the legislatively set guaranteed minimum of 2 percent, plus 0.2 percent to account for increased coverage responsibilities from national coverage determinations, so the total increase there is 2.2 percent. Combining the effects of these rate changes, the average base payment rate for M+C plans will rise by 3.2 percent for next year. On top of these increases CMS is raising all county rates by 4.89 percent as part of the introduction of the new risk

adjustment system in 2004. I'll get into this in just a couple minutes.

As you may remember, there are two absolute floors that vary with the characteristics of a county. One floor applies to counties in large urban areas, defined as metropolitan statistical areas containing more than 250,000 residents. The other floor applies to all other counties. The large urban floor was introduced in BIPA, and BIPA also set the floors at $525 per month for the large urban areas and $475 in the other areas. The rates are growing at the rate of per beneficiary fee-for-service spending growth, and the floor rates for 2004 are $592 per month in the large urban areas and $536 per month in the other areas.

Now note that as the floor rates increase at rates higher than the 2 percent minimum guaranteed increase more counties will have their rates raised by the floor. For 2004, about 7 percent of Medicare beneficiaries live in the counties that will be newly affected by the floors in 2004. In other words, they were not affected by the floors in 2003. These are some big counties; Montgomery County, Maryland and Denver, Colorado, for example.

Approximately 63 percent of Medicare beneficiaries

and 40 percent of the M+C enrollees will live in floor counties in 2004. Back in 1998 when there was one national floor only 15 percent of beneficiaries lived in floor counties, and as recently as 2001 when the second floor was influenced 49 percent of Medicare beneficiaries lived in floor counties, and now we're up to 63 percent.

As a greater share of M+C payments are determined by the floor rates, payment policy moves farther from the Commission's stated objective of Medicare paying the plans equivalent to spending that would occur on those enrollees under the traditional program.

So how are M+C payments related to Medicare fee-for-service spending now? While the increases in M+C rates have been below growth in spending in the fee-for-service Medicare program over the last several years, we estimate that for 2004 M+C plans will still be paid on average at rates higher than per capita spending in the traditional fee-for-service program. For 2004 we estimate that across all counties Medicare is paying Medicare+Choice plans an average of 103 percent of what it would cost to cover the current mix of M+C enrollees under the traditional fee-for-service program.

Medicare pays 110 percent of fee-for-service for enrollees in floor counties in the large urban areas and 113 percent of fee-for-service in other floor areas. By contrast, in non-floor counties Medicare pays 100 percent of average fee-for-service spending which just happens to match Commission preferences.

All these estimates though assume that the average health risk of M+C and traditional enrollees are the same, other than differences accounted for by the demographic characteristics. However, CMS has found that M+C plans enroll a less costly population than would be accounted for by demographics and, therefore, on average Medicare is paying M+C plans more than 103 percent of Medicare spending under fee-for-service.

Let's get into the effects of the risk differences between the two parts of the program.

CMS has estimated that plans enroll beneficiaries that are, on average, 16.3 percent less costly than demographically similar beneficiaries in the traditional program. The new risk adjustment system was designed to correct for this risk difference. I really should say that this 16.3 percent figure is based on simulations of plan

data that was submitted--the diagnoses that were submitted by plans specifically for these simulation purposes. If plans were not successful in collecting all the diagnostic data then the difference will not turn out to be that large, but we don't know yet.

In 2004, plans will be paid a blended rate based 30 percent on the new risk adjustment system and 70 percent on the old demographic system. However, CMS has decided to compensate plans so that total payments under the new system in 2004 will be the same as if all payments were made under the old demographic system. CMS has chosen to accomplish this version of budget neutrality by increasing all county rates in 2004 by 30 percent of the total 16.3 percent, or 4.89 percent for 2004.

MR. HACKBARTH: Scott, can we go back to the first bullet because I saw a couple puzzled looks on what that meant? Let met see if I understood you correctly. So what CMS did was, based on data submitted by plans, compared to riskiness, if you will, of the current enrollees--

DR. HARRISON: Expected cost.

MR. HACKBARTH: The expected cost of the current enrollees with the fee-for-service population. Using this

risk adjustment system they said that there's 16.3 percent less risky, or lower expected cost than the fee-for-service. However, this may overstate the difference. To the extent that the plans do not have all of the information properly coded, the patients may be sicker, if you will, than what this information suggests so the gap could narrow somewhat as coding improves. Is that correct?

MR. FEEZOR: Narrow or increase.

DR. HARRISON: I think it's unlikely to increase. It would probably narrow if we thought that the plans didn't have all the data in from their different providers. I guess it would be unlikely to think that they had more data, more diagnoses than--

MR. HACKBARTH: When they're not paid to code correctly they tend to undercode and there's less complete information, which leads the patients to look healthier.

DR. HARRISON: Correct.

MS. DePARLE: Although you said this was a specific sample that the plans submitted for this purpose, right?

DR. HARRISON: Yes.

MS. DePARLE: So we assume they had every

incentive to code properly.

DR. HARRISON: It only gave them an example of what the impact would be. Payments are still based on a model completely calibrated by the fee-for-service data.

MR. HACKBARTH: I guess the other important point is that even if Scott is directionally correct; namely, that the difference would tend to narrow, it's hard to say how much it would narrow. It probably doesn't account with the full 16.3 percent.

DR. HARRISON: Probably not.

MR. SMITH: Glenn, if I could just stick with this for a minute to make sure I have my arithmetic right. Would it be right to say that the effect of the CMS decision to rates by 4.89 percent is the same thing as having put off the blended rate?

DR. HARRISON: Not doing anything for risk adjustment, right..

MR. SMITH: The math is the same.

DR. HARRISON: Right.

What they did was they didn't touch the 70 percent, and they did touch the 30 percent but then they gave it back. The point is that this treatment of risk

adjustment would most likely push M+C rates further from the fee-for-service level at which the Commission had recommended the M+C rates be set.

Now I do want to note that these higher payments based on risk differences between the plan enrollees and fee-for-service beneficiaries is not a new problem, however, we didn't have a number to pin this to before. Also, the 4.89 percent portion has now been made explicit. That portion will grow if the adjustments continue to be made as risk adjustment is phased in fully. I should also note that CMS has not committed to paying the budget neutrality factor to plans after 2004, and if they do not then payments will get closer to fee-for-service levels.

MS. BURKE: Scott, can I ask a question? I just want to be sure that I understand what the impact of the neutrality provisions are. In making the adjustment, the 4.89 in order to--essentially to recover the amount that would be lost as a result of the blending, the impact will vary by plan. So that it's not absolute neutrality by plan, it's neutrality against the system.

DR. HARRISON: That's correct.

MS. BURKE: So you may still have, presumably,

variances and there may be plans in fact who do less well as a result of the transition.

DR. HARRISON: Yes.

MS. BURKE: In which case, what are the expectations that we're going to end up with a series of appeals to be more specific in the neutrality adjustment? You're going to have winners and losers.

DR. HARRISON: They vary by plan.

MS. BURKE: That's my point. So having had to set floors and do a variety of other things to protect people, one could only assume--

MR. HACKBARTH: So 4.89 percent is the right increment for the plan that has a selection of risk that matches traditional Medicare, normal selection of risk?

DR. REISCHAUER: No, it's average for all Medicare+Choice plans.

MS. BURKE: It's the average, so there will be big winners and losers potentially.

DR. HARRISON: Yes.

MS. BURKE: So one could only imagine that there may well be attempts to further correct for this temporary period, correct? If history repeats itself, one could

imagine that we're going to be asked to go in and save somebody.

MR. HACKBARTH: If everybody is interpreting budget neutrality as budget neutrality for me.

MS. BURKE: Theirs; correct.

DR. REISCHAUER: These guys have been playing around with this for a couple of years now. They all know this was coming and we haven't heard, I don't think, any big screams about it.

Let me ask you if I'm right here. This 103 percent wouldn't change at all if we completely phased in risk adjustment and gave another 11 percent increase, right? It offsets.

DR. HARRISON: No.

DR. REISCHAUER: The 16 is--beyond the 4.89. Two more slugs of 4.89, but then we reduce the payment because we put in risk adjustment fully, so that would lower everything. Then that we lower it back up. If we do the calculation it would still come out to 103.

DR. HARRISON: That's my next point, if that were the case you'd end up paying about 120 percent on average because you'd be paying the 103 just for the base rate

differences and on top of that you would have given back 16.3. We have 103 percent that we talked about before, and that's just the base rate differences. That assumed that everybody was--

MS. BURKE: That's the floor.

DR. HARRISON: That's right. Now on top of that--

DR. REISCHAUER: But then if you did not do budget neutral risk adjustment it would lower it down. You'd lower it down and with the extra money you bring it back up.

MR. SMITH: You'd end up at 103.

DR. HARRISON: -- but that's adding the 4.89, and twice more.

DR. REISCHAUER: What I'm saying is, we're at 103 and we're at 30 percent risk neutrality, we go from 30 to 100 percent risk neutrality which lowers the payment so we're way down below 103. Then we add the money back up and we're at 103, not 120.

DR. HARRISON: We'd be at 103 but for different populations then, because the M+C population would be less costly. The 103 ignores any risk differences. Now if these risk differences really are there, then you would be paying 16 percent above the 103.

DR. ROWE: I'd like to point out that I believe the discussion has an implicit assumption in it, or at least the material does as you read it, when we make all these comparisons as to what the health plans are getting paid versus what CMS is paying in the traditional plan. It's 103, it's 105, it's 120, it's 130, et cetera. The implicit assumption is that the health plans' cost are the same as Medicare's cost and therefore this is profit or they're being overpaid or something. It might be worth having a sentence in the chapter that says, that the health plans are paying--

DR. REISCHAUER: So less efficient--

DR. ROWE: --are paying 130 percent of Medicare to the hospitals and 108 percent of Medicare to physicians nationwide, or something like that that at least give a little sense of fairness, because otherwise the whole conversation goes on without any reference to these higher costs.

MR. HACKBARTH: I think it ought to be explicit in saying that the private plans cost more than traditional Medicare.

DR. ROWE: I think that would be fair, because of

contracts with the providers.

MR. HACKBARTH: They pay providers more.

DR. ROWE: We pay the rural hospitals more, we pay the physicians more.

MR. HACKBARTH: Even after you adjust for the difference in benefit package they cost more.

DR. ROWE: But there's nothing in the chapter that I saw about benefit package differences or contracts with providers. I think it's the other side of the coin.

MR. HACKBARTH: I agree with that. I think different people will interpret that differently and draw different significance from it. Plans, we're being underpaid; it's not covering our costs, and proponents of traditional Medicare will say--

DR. ROWE: That's not our problem.

MR. HACKBARTH: Right. They can't do it as efficiently.

DR. ROWE: I understand that. I just think it would provide a little balance.

MR. HACKBARTH: That is the bottom line.

DR. ROWE: Could I make another comment which you may or may not want to include? I might want to quit at the

point that I got something in.

If you're going to talk about why people didn't pull out, which in the main they didn't. I think Wellpoint pulled out Atlanta and otherwise basically nobody pulled out.

DR. HARRISON: Right. That's coming.

DR. ROWE: That's basically what happened this year. Why did that happen? I think one of the answers is that health plans are waiting to see what's going to happen in Congress with the Medicare bill, and if the new Medicare proposal, the administration's third pathway proposal doesn't get passed or that people think that people might go back and put some more money into Medicare+Choice because they want to continue to preserve the option. And that as a consolation prize or whatever there may be--but no one was interested in putting that extra money in now because they didn't want to distract people from this new proposal that they wanted to draw attention to and support.

So many of the health plans, looking at what was going on said, we really have to wait another year to see what's going to happen to the Medicare+Choice funding, so it would be premature to pull out, but we don't want to go into

more counties either because we're not sure. So I think that's an explanation, one man in the street explanation for what may have been going on in people's minds as they were looking at this.

MR. HACKBARTH: Just the average man on the street.

DR. REISCHAUER: Is that Wall Street, Jack [Laughter.].

MR. HACKBARTH: We need to press ahead, so Scott, lead the way.

DR. HARRISON: Jack got a little ahead of me, but how are plans responding and how will they be participating under these rates for 2004? As far as plan participation goes, I guess the interpretation is up to the individual. The M+C program has stabilized. Less than 1 percent of current Medicare+Choice enrollees will be affected by plan withdrawals this year. Of those enrollees who will lose their coordinated care plan, only about 1,000 live in areas not served by another Medicare+Choice coordinated care plan.

Also since the start of the year new plans have entered the program and expanded their service areas. Currently CMS lists four plans with pending applications

into the program and another 15 non-demonstration plans seeking service area expansions. Beneficiary participation in the program has been flat over the last year and, unfortunately, we don't yet know how benefits and premiums will change for 2004 and, thus, we can't suggest how those changes may affect beneficiary enrollment for 2004.

Here's a chart on the availability. The chart includes the effects of pullouts for 2004, but we do not have any information on how new plans may affect availability. But at least 63 percent of Medicare beneficiaries will have a coordinated care plan available in 2004, up from 61 percent at the beginning of this year. Although a new private fee-for-service plan joined the M+C program this year, Sterling, which is the largest fee-for-service plan is reducing it's service area by withdrawing from over 500 counties. As a result, only 32 percent of beneficiaries will have access to a private fee-for-service plan compared with 34 percent earlier this year. However, CMS does list two plans as having new M+C private fee-for-service applications pending, so we could have some more next year.

So for 2004, 77 percent of beneficiaries will have

an M+C choice available, down from 78 percent at the beginning of 2003. Beneficiaries living in floor counties are much less likely to have a coordinated care plan available than those beneficiaries living in non-floor counties, although they are more likely to have access to a private fee-for-service plan available. Those differences have narrowed, although a good portion of the changes are really attributable to counties shifting from non-floor to floor state.

Despite the overall increase in coordinated care plan availability, rural areas continue to lag with only 16 percent of rural beneficiaries having a plan available. Also virtually all of the loss in the private fee-for-service availability occurred in rural areas.

Some of the other work that we plan to complete includes examining the benefit packages and premiums of the M+C plans and then examination of the enrollment in the PPO demonstration plans to see how those plans are affecting the overall M+C program. Of course, we will report on any legislation that comes along that would affect the program.

MR. FEEZOR: Scott, good work, and despite how hard we tend to make your job around here. I wondered, just

reading this excerpt itself, I had a little problem drawing the conclusion looking at the same facts that you did that the plan has stabilized. It's sort of like saying that you've got plans that are making application--that's sort of like intentions. Execution is different. I guess I'd bit a little more cautious. I think we need to do two things. Either we need to be a little more cautious in our judgment, as perhaps rather than stabilized that it's in a period of uncertainty, particularly when you give the fact that there seems to be a rather flat enrollee choice. That, after all, is the most important measure, I would argue.

Otherwise we might want to, in some of our charts, show a longer period of history which does show that there has been a significant decline for a lot of understandable reasons that we've opined on and analyzed in the past. This does seem to be a leveling out. But to say that it has stabilized on the evidence that we've presented, I have little trouble with that language and I think we need to soften it a little bit. I would argue that probably just by what Jack said, there really is, because of some other potential policy changes, there's a lot of uncertainty around it, both from enrollee and from probably the insurer

side.

DR. ROWE: I think, Allen, one point relevant to what you said is, one way to look at the lack of increase in enrollees is that there isn't any marketing out there. That if people are really going sideways and it's a wait and see, then this is not the time when you're going to be expending a lot of resources on marketing because you may be getting out of--you're waiting and seeing. So you wouldn't have marketing, and when you don't have marketing you don't have as much enrollment. So I think it's consistent with what I was saying.

MR. SMITH: Picking upon Allen's point and offering at least a competing explanation, Jack, is it's not the same product, and it's more expensive. So we're not comparing the same thing that people were selling in 1999 to what's being sold today, and talking about stabilization it's important to make that point as well.

DR. STOWERS: Scott, I had a question if you just had a concept of this. It may be silly. But if we were to take the areas where Medicare+Choice is not available and we added on the benefits that are additional in Medicare+Choice, primarily the drug benefit, what would the

plus be? Would it be a plus three to add on those benefits in traditional Medicare or would it get up to a plus 20?

DR. HARRISON: You mean the actuarial of an M+C plan?

DR. STOWERS: Right, and adding it onto base fee-for-service. In other words, I think there's where you'd start seeing the efficiency of the delivery systems. Just curious. In other words, we've got this package that's out there in certain areas where Medicare+Choice is available and then we have the fee-for-service areas where it's not available so there's a difference in the benefit package essentially in Medicare+Choice and in traditional because there's no--how much would it take to add on to the traditional Medicare fee-for-service payments to get the rest of the population up to the same benefits?

DR. HARRISON: In other words, how much would you have to raise rates by in some of the rural areas to get plans to come in?

DR. STOWERS: Yes, rural or urban. Just areas where there's not the Medicare+Choice plan available. How much more would we have pay in fee-for-service to get that benefit out there?

DR. HARRISON: I think there was a study--

DR. NEWHOUSE: Yes, there's an old ProPAC study.

DR. HARRISON: There was a simulation done a couple years ago that suggested you're talking lots and lots of money.

DR. REISCHAUER: But I don't think that's relevant now because the Medicare+Choice drug offerings have shrunk very, very significantly and virtually all of them or a very high percentage are charging premiums now. What you want is the net benefit of the actuarial cost of the drug benefit minus the premiums that people are paying that's over and above. I don't think it would come out to be much money. But it wouldn't offer much protection either.

DR. NEWHOUSE: You'd have to also add in the value of copay reduction.

DR. ROWE: It wouldn't offer protection for a population but it might for individuals, right? It might be a net--

DR. REISCHAUER: An awful lot of these things now have limits that are relatively low, $1,000 or less, and they're broken down by quarters so you don't get more than $250 a quarter something like that, so you really aren't

offering people with large drug expenditures the catastrophic protection that they would expect.

MS. BURKE: Scott, in terms of your plans going forward and the things that you anticipate doing what's not noted is looking at the implementation of and the impact of the payment change; essentially the phasing in of the risk adjuster and shoring up for a short period of time and how that differentially impacts. Is that something you would imagine doing? Again it's the question of neutrality will hit people differently. In some places it won't in fact be neutrality. So is that something that you anticipate coming back and telling us how that works since they're only proposing to do it for a year, presumably it's something of a predictor in terms of who's going to be--

DR. HARRISON: I believe CMS has at least done the simulations. I don't know whether I've seen any results of what the distribution would be in terms of plans. We can ask and find out.

MS. BURKE: The reason I ask the question is at least historically when there were--literally when we were going county by county and determining what rates were going to look like it became the focus of a lot of activity,

depending on where geographically they happened to be located. So it might be of interest to us to have anticipated where you're going to see big shifts, if you are. Maybe the impact won't be great but it will be instructive, I believe. One might want to look going forward at what that has looked like, because if they're only proposing to do neutrality for a year, I assume they've also done the rollout in terms of what those numbers, what the allocation and the impact is going to be in the outyears of fully phased in--

DR. NEWHOUSE: If they have a sample they probably don't have enough to do--

DR. HARRISON: I assume hey have the full impact analysis.

MS. BURKE: My guess is they do.

DR. HARRISON: But it's not clear whether they're going to do it past 2004. We're in this gray area. There's been differences of opinion about what the law says about whether they're supposed to be doing this, how the budget neutrality is supposed to work.

MS. BURKE: But I could lay odds, if Mark hasn't already heard, that we will begin to hear the patter of

little feet around issues of the predictions of what those allocations are going to look like and what the impact is going to be geographically.

DR. REISCHAUER: The law says that they have to phase the risk adjustment in in two more steps, right?

DR. HARRISON: Yes.

DR. REISCHAUER: But the question of whether they make the positive 4.9 judgment is still up in the air. The patter of little feet probably won't be to the Hill, it will be to the executive branch which made this decision before.

MS. BURKE: Perhaps. But it could also be to the Hill.

DR. REISCHAUER: But also these plans have had a pretty good idea of how their payments weren't going to be affected I think for the last six months and my guess is when they submitted their rate increases for 2004 they built in what they had to charge to compensate, if they were hurt or if they were benefitted. If they didn't, they'll be out of business and they probably should be.

MS. BURKE: I don't doubt that, but I think just for instructive purposes it will be interesting to look at what those shifts are going to be like and the phase in.

DR. HARRISON: I will request that from CMS. I don't know whether they'll give us stuff we can break down geographically.

MS. BURKE: That's fine. Because we used to literally get it by county. I could have told you exactly who was going to get what in what county for what plan.

DR. NEWHOUSE: This would also change sometime as enrollment changes.

MS. BURKE: Absolutely. It will change for a variety of reasons but it will be a base against which you can anticipated if Florida is differentially, or Iowa would strike me as being of interest.

MS. DePARLE: Just as a point of information, Scott, you referred to the dispute about budget neutrality in this which I remember quite well, but I thought Congress in the end in a law--I guess it would have had to have been BIPA--instructed CMS to not make it budget neutral. I thought--or to make it budget neutral. CMS when I was there our position was--

DR. HARRISON: I believe the language resides in a conference report somewhere.

MS. DePARLE: Okay. But when I was there our

position was that it was not intended to be budget neutral. Then I thought after that there was some congressional mandate--intervention.

DR. HARRISON: Right, and the intervention was not in statute. I believe it was in the form of conference language or something.

MS. DePARLE: So that's why they're saying that they may not do it in the future, or they have not opined--

DR. HARRISON: I think they haven't decided whether it cost them budget money or not.

MS. DePARLE: It depends on what you use as the baseline, which I would think it probably does.

Are we going to make recommendations on this?

MR. HACKBARTH: We actually took this question up in the abstract, I guess it was: how do you do the budget neutrality? How do you phase in the new risk adjustment? The position that we took was that you should not make this sort of budget neutrality adjustment. What we're striving for is to have our payments to health plans be equal to traditional Medicare after risk adjustment. So you shouldn't be throwing in new money to offset the fact that they have lower payments due to healthier enrollees. I think

that was two years ago that we took that position, and I personally think it was still the right policy.

DR. REISCHAUER: And you can see what an impact it had.

MR. HACKBARTH: We've got to move on. Thank you.

Next up is long-term care hospitals. Sally.

DR. KAPLAN: The purpose of this presentation is to bring you the latest results from our research on long-term care hospitals. In June 2003, we reported that patients in market areas with long-term care hospitals had similar acute hospital lengths of stay whether they used long-term care hospitals or not. Long-term care hospital patients were three to five times less likely to use SNFs, suggesting that long-term care hospitals and SNFs are substitutes. LTCH patients had higher rates of mortality and Medicare paid more for their episode of care. Higher mortality might have indicated unmeasured severity of illness.

Today I'm presenting results from analyses designed to answer the three research questions on the screen and in your handout. The first analysis is to answer the question, what is the effect of certificate of need on

long-term care hospital beds? We investigated whether the presence of a certificate of need, or CON program, for hospitals reduce the number of LTCH beds in a state. Twenty-six states and the District of Columbia have a CON requirement. The other 24 states do not.

As you can see from the table on the screen and in your handouts, half of the eight states without any long-term care hospital beds are CON states, half are not. Half of the eight states with 100 or more beds per 100,000 beneficiaries are CON states, half are not. States without a CON requirement have 11 percent more long-term care hospital beds per 100,000 beneficiaries compared for CON states.

We can conclude that having a certificate of need requirement for hospitals has little effect on long-term care hospital beds. Since CON programs can vary in their strength, we plan to look at this issue further by examining the relationship of long-term care hospitals and the strength of the certificate of need.

Now we turn to the question of how long-term care hospitals differ by age, ownership, freestanding versus hospital-within-hospital. To answer these questions we

analyzed the same 11 DRGs used for the June report. Old long-term care hospitals were established before October 1983, new hospitals were established in or after October 1993, and middle long-term care hospitals were established in the decade between.

The volume of cases is very different. For example, new long-term care hospitals account for 66 percent of cases in the 11 DRGs, middle long-term care hospitals account for 22 percent, and old LTCHs account for 12 percent. For-profit long-term care hospitals account for 60 percent of cases, non-profits account for 34, and government long-term care hospitals account for 6 percent. There's a lot of overlap between new and for-profit long-term care hospitals.

When we looked at differences in case mix we found mostly similarities with about a 12 percent difference among long-term care hospitals by age group and a 5 percent difference by ownership. When we went inside the 11 DRGs and examined acute hospital length of stay, use of SNFs, mortality, and total episode payment, controlling for DRG and severity level, the only substantial difference was that total episode payments were less for old long-term care

hospitals. This appears to reflect the TEFRA payment system that was in effect before PPS. Remember that this data is 2001 and the PPS did not start until October 1 2002. Under TEFRA old long-term care hospitals were paid more than new ones.

To answer the question, what factors predict beneficiary use of long-term care hospitals we used multivariate analyses. The unit of analysis for the multivariate regressions is the beneficiary's episode of care. Beneficiaries discharged from an acute hospital alive in the first six months of 2001 were the universe studied; 5.3 million observations. Episodes began with acute hospital use and ended with death, readmission to an acute hospital, or no post-acute care services for 61 days.

The first regressions were to try to predict first post-acute care setting after discharge from the acute hospital. We used clinical and demographic factors, acute hospital characteristics, and beneficiaries' proximity to a long-term care hospital. We used Dartmouth Atlas hospital referral regions and hospital service areas as proxies for a beneficiary's proximity to an LTCH. An HRR without a long-term care hospital was the furthest away, an HRR with a

long-term care hospital is closer, and a hospital service with an LTCH is closer still. Being admitted to an acute hospital that has a hospital-within-hospital is the closest.

Our preliminary results are, a diagnosis of tracheostomy is the strongest predictor of long-term care hospital use. Some other diagnoses predict LTCH use, such as respiratory system diagnoses with ventilator support, acute and subacute endocarditis, amputation, skin graft and wound debridement, and osteomyelitis. Severity level four quadruples the probability of long-term care hospital use regardless of diagnoses.

As proximity to an LTCH increases, the probability of LTCH use increases. For example, a beneficiary living in an HRR with a long-term care hospital has twice the probability of using a long-term care hospital compared with a beneficiary living in an HRR without one of these facilities. A beneficiary living in a hospital service area with an LTCH has four times the probability of using an LTCH compared with a beneficiary living in an HRR without such a facility. Being admitted to an acute hospital with a hospital-within-hospital quadruples the probability that a beneficiary will use a long-term care hospital.

To predict post-acute care setting we divided beneficiaries into four clinical groups using a clinical complexity model that predicted probability of long-term care hospital use. The four clinical groups ranged from very low to very high. We then compared regression coefficients by proximity to an LTCH and clinical complexity group.

First we found that the clinical model we used worked to predict discharge destination. The other results we found are the probability of beneficiaries using LTCHs increases as clinical complexity increases in each geographic group or proximity to LTCH group. The probability of using LTCHs increases as clinical complexity and proximity to LTCH increase. For example, the probability of using LTCHs is 10 times greater for beneficiaries in the very high clinical group if they live in a hospital service area with an LTCH rather than HRR without an LTCH.

Two other findings from putting the beneficiaries into four clinical complexity groups are that, first, the probability of using an inpatient rehabilitation facility increases as clinical complexity increases and proximity to

an LTCH increases. Second, the probability of SNF use increases as clinical complexity increases and decreases with proximity to an LTCH. For beneficiaries in the very high clinical complexity group, the greatest probability of SNF use is in areas without long-term care hospitals.

In our continuing research on long-term care hospitals our next step will be to focus the quantitative work on answering the question about where patients clinically similar to those using long-term care hospitals are treated in areas without these facilities. This will be a multivariate regression analysis. On the qualitative side we have two studies. First, we have a contractor conducting structured interviews in market areas with and without long-term care hospitals. Second, we are making site visits to long-term care hospitals.

DR. NEWHOUSE: Sally, thanks for all this analysis. This has been a difficult area for a long time.

On this last step of where are patients treated, what we'd really like to know is something about costs and outcomes. It strikes me that we're going to wind up in the position we're in, that knowing Miami costs more than Minneapolis, but while people are prepared--some people are

prepared to make judgments about that, ultimately we don't have a lot--I mean, the recent Fisher stuff helps there. But do you have any plans to do anything on the outcomes side?

DR. KAPLAN: Yes, we do.

DR. NEWHOUSE: Do you want to say anything about that?

DR. KAPLAN: We do plan on looking at outcomes. We are including in outcomes--is that what you want to know, Joe, what kind of outcomes we're looking at?

DR. NEWHOUSE: What kind of outcomes.

DR. KAPLAN: We're looking at total episode cost. We're looking at total episode length of stay. We're looking at mortality at different periods. In other words, mortality at 30 days post-admission to the acute hospital, 60 days post, 90 days post, 120 days post, as well as death in the year 2001. These folks were admitted to the acute hospital in the first half of 2001.

We also are going to be looking at readmissions to the acute care hospitals as well.

DR. REISCHAUER: Sally, I think this is all very interesting but I'd like to have a little more context.

Maybe you provided this context in previous material that you've given us, but I was just wondering, for people with these diagnoses what fraction of them end up in a long-term care hospital? Is it 80 percent of the level four tracheostomies, or 10 percent?

DR. KAPLAN: I actually can give you a general ballpark figure out that. The probability of being admitted to a long-term care hospital never exceeds more than 3 percent.

DR. REISCHAUER: You mean even very high probability?

DR. KAPLAN: I'm sorry, I need to go back and check on this then and get back to you with this, because a tracheostomy is really high up there. So, yes, you're right.

MR. HACKBARTH: When you say never more than 3 percent, you're talking about in an area where there is one.

DR. KAPLAN: Yes, I'm talking about in a hospital service area with a long-term care hospital.

MR. HACKBARTH: So even with tracheostomy it's --

DR. KAPLAN: No, I don't think with--no, that's for the very high clinical group but I'm not specifically

talking about any particular diagnosis. I'm talking about very high clinical complexity group, the odds are never greater than 3 percent.

DR. REISCHAUER: So for the threes and fours across this average of DRGs it would really be that low. Then I think the questions that Joe asked are very important.

DR. KAPLAN: Exactly.

DR. ROWE: I think if you try to get the quality of care or outcomes it's going to be very difficult using the measures you suggested, Sally, because these are fatal diseases in many of these cases and everybody is going to die. If these are patients with amyelotropic lateral sclerosis or some other, you know. It doesn't mean it was bad care if the patients don't survive. You're going to have to find some other measures, and lengths of stay is--which is good, short or long? If we're talking about hospice, if this were care at the end of life, long length of stay is good. It's not bad.

So I think it would be nice to try to find some other measures like infection rates or nutritional status or family satisfaction. I don't know enough about what the

case mix is here, but I'm just a little concerned that people might jump to conclusions about some of these outcomes that really don't reflect the underlying nature of the clinical situation. Nick used to run ICUs. You populated places like this with some of your patients. Do you have some sense of what kind of outcomes would be worth looking at?

DR. WOLTER: In our part of the world they don't exist so we take care of these patients either in the acute care setting, in a SNF, or in some other way.

DR. NELSON: The people that are there to get six weeks of IV antibiotics for endocarditis or osteomyelitis, they'd have a pretty good outcome, a lot of them.

DR. NEWHOUSE: Also these long-term care hospitals are very heterogeneous on the whole, so who gets cared for where is actually very important here. They're much more heterogeneous than acute care hospitals.

DR. MILLER: I think what we would be trying to do is take a look at these outcomes--and I realize that they're crude. One of the problems is, unlike some of the other post-acute care areas, there's no assessment instrument going on here, so there's something to grab onto. One of

the places that we might want to go to as we look at this, because as you think about it these outcomes are very crude. You look across relative areas, SNF, hospital, whatever the case may be, then start asking yourself, are there certain diagnoses and severity levels that do well here? And then, would you want to be thinking about an assessment instrument to try and get inside a little bit to see pre, post, and how patients do here? That's kind of the direction we're trying to push in. Not kind of. That is the direction we're trying to push in.

MR. FEEZOR: Sally, I sent you running after this certificate of need thing and I owe you a piece of document in follow up, but just in talking to a couple of folks in the CON world I don't even think this has hit their Richter scale. It's been just below the radar. And in one other instance I spoke with a lot of the excess beds that have been authorized that have been taken out of service by some of the merger mania in the late-'90s now seem to be being brought back online in this form, so again it is probably is flying just below the radar screen.

MR. DeBUSK: Let me ask you, Sally, how do you define the acuity level here with these sick, sick patients?

DR. KAPLAN: We have 400 APR-DRGs, which are the 400 most frequent, severity level, risk of death, or risk of mortality, ICU use, which basically is ICU or CCC days. We have hospitalization in the 90 days prior to this particular acute hospital admission. That's it.

MR. HACKBARTH: Okay. Thank you, Sally.

DR. KAPLAN: Are you ready for the next one?

MR. HACKBARTH: Yes. Inpatient rehab.

DR. KAPLAN: The prospective payment system for inpatient rehabilitation facilities, better known as IRFs, at least by some people, began on January 1, 2002. The research I'm presenting today begins our examination of IRFs and the PPS. At then end of the presentation I'll talk about some questions we plan to research and I'll ask you for significant issues you'd like addressed in the June chapter.

IRFs are generally characterized as specializing in intensive rehab; physical therapy, occupational therapy, and speech therapy. To be eligible for this care in the Medicare program, beneficiaries have to be capable of sustaining three hours of therapy per day.

Inpatient rehab facilities are defined as distinct

from acute hospitals by a series of requirements. The most important requirement is that 75 percent of an inpatient rehab facility's cases have to be in 10 diagnoses that are believed to require intensive rehab. One of the 10 diagnoses, polyarthritis, has become very controversial. It is the condition by which patients with major joint replacements have been counted in the 75 percent for IRFs. When major joint replacement cases are not counted, few of the IRFs are in compliance with the rule. As you'll see in a moment, major joint replacement is the most frequent diagnosis treated in IRFs. CMS's new proposed 75 percent rule make it difficult for IRFs to admit beneficiaries with joint disease or major joint replacement.

Before I talk about what changed between 1999 to 2002 I'd like to explain why I'm talking about 1999. Most of the information you'll see today is from RAND's research. They designed the payment system using 1999 data. Although we cannot say that these changes between '99 and 2002 were caused by the PPS, some of the changes are consistent with changes we saw in response to the acute hospital prospective payment system.

In addition, in 1999 the BBRA mandated a per-

discharge payment system for IRFs so these facilities were aware of the type of PPS they would have and may have changed behavior in preparation for the PPS.

The number of Medicare cases increased 6 percent per year between 1999 and 2002. Other changes include the distribution of diagnoses, the inpatient rehab facility length of stay decreased, the case-mix index increased, and the acute hospital length of stay decreased for patients discharged to an IRF.

Now let's look a little closer at most of these changes. As you can see on this chart, the largest changes in distribution of cases by RIC, or rehabilitation impairment category, are in stroke and major joint replacements; the two biggest RICs in 1999 and 2002. The other changes were small. In some RICs the share of cases didn't change and I've not shown them. Between 1999 and 2002 stroke and major joint replacement changed places as far as number one and number two.

In the acute hospital in these years there also was a big change in these two groups of patients. For example, stroke cases decreased by 28 percent over the three years and major joint replacement cases increased 17 percent

from '99 to 2002.

It is also possible that payment policy may have driven the changes in distribution. Although the payment rate was the same for the lowest level of impairment and no comorbidities for the two diagnoses, the rate increases faster as comorbidities increase for major joint replacement cases.

On average, the decrease in IRF length of stay was about 5 percent per year. Decreases in length of stay are consistent with a per-discharge prospective payment system. This decrease is similar to the 4 percent decrease in length of stay we saw in the first year after the hospital PPS was implemented.

Changes to the case-mix index may include reach changes in case mix in addition to improvement in coding and upcoding. The national IRF case-mix index increased about 1 percent per year from '99 to 2002. To compare, the acute hospital case-mix index increased 4.4 percent in the first year of PPS alone. Earlier transfers from acute hospitals probably would result in real case-mix index change. Because comorbidities increase payments, IRFs are more likely to code comorbidities under the PPS. This would

result in coding improvement.

Almost 90 percent of IRF patients are transferred from acute hospitals. It is surprising that the acute hospital length of stay and the IRF length of stay both would decrease at the same time. Unfortunately, we'll be unable to directly assess the effect of these length of stay decreases on patient's outcomes because the measurement of functional status and cognitive status in IRFs changed from '99 to 2002. We will be able to examine whether discharge destinations changed pre and post-PPS. In the future, if length of stay continues to drop we will be able to assess the effect of the drop because we will have more than one year of data.

As you remember, in the June 2003 report we recommended that CMS conduct a demonstration on payment for quality and we pointed out that IRFs were a good place to start because they have a data collection system that is robust, well accepted, and standardized. Payment for quality might reduce decreases in length of stay that implicate quality.

There are many things that we could examine in our research on IRFs and the PPS. Some of them are on the

screen now. The question for you is, are there other significant issues you'd like addressed for the June 2004 report?

DR. ROWE: Sally, just a comment about the change in the proportion of cases, the stroke and major joint that you commented on. First of all, I think this is fabulous. This is the best news I've heard. I've been sitting here five years. A 28 percent reduction in acute hospitalization for stroke between 1998 and 2002 is fabulous. If that reflects better anti-coagulation of people with atrial fibrillation or more rapid intervention in patients with evolving stroke, which I think it may, I think it's great.

In fact the 28 percent reduction is so high that it would explain this whole thing. It's almost not worth going into the payment issues. You do mention this could be due to the fact that there are 28 percent fewer strokes, and then you go into all this stuff about how the payment mechanism might be causing it, when in fact you may have already explained it. But that's because this is MedPAC and we're into payment. If this were the American Society of Neurologists we wouldn't go to that second level.

But in the first level I think perhaps even more

important than the number of strokes in hospitals is the severity of the strokes, which you don't comment on. If we're getting more effective in treating stroke and treating it more rapidly, then for any given group of patients admitted to the hospital with stroke there will be fewer very severe strokes, and those are the ones that are likely to go to the inpatient rehabilitation facility. And there will be more people with less severe strokes, and they're more likely to go home or get home care or visiting nurse care or something else as they get rehab.

So I would mention something about the severity, and I would see if there are any data with respect to severity within the population of stroke patients because it may be that in fact there's been a shift, in addition to the number of patients.

DR. REISCHAUER: Sally, you were talking about the decline in the length of stay, and then noting that it was surprising that the length of stay in acute care hospitals declined at the same time as the IRF length of stay. The explanation may be, if you look at your Table 2, over those two years or three years there was a 58 percent increase in the number of people going to IRFs. What might have

happened is those that would have been discharged somewhere else who were the less severe cases ended up going to the IRF, and that would have lowered both of these length of stay at the same time. Just the existence of more beds and more facilities in effect produces a result that on the surface looks like good news but in fact it could be troubling news.

DR. NEWHOUSE: This is a second-order question but since the transfer payment DRG issue is likely to be around, I wondered if this differential length of stay in IRFs--I'm sorry, if the length of stay decline was differential by the transfer DRGs versus the non-transfer guarantees?

MR. HACKBARTH: Anyone else? Okay, Sally, thank you.

The last item for today, hospital margins and their uses.

MR. ASHBY: In this presentation we are going to review two types of hospital margins that we routinely in our payment policy work; that is the overall Medicare margin and margins for components of that overall Medicare margin. Then we'll talk briefly about one other margin used for context; the total margin.

The overall Medicare margin includes costs and payments for the largest six Medicare services that hospitals provide plus costs and payments for graduate medical education. You see the six services listed here. Its primary use is in assessing payment adequacy for the acute inpatient and outpatient payment. Specifically, this margin, or the cost and payment components of it, forms the basis for estimating our current payments and costs, which is one of several factors that we examine in drawing conclusions about the adequacy of payments.

We assess payment adequacy for the hospital as a whole because we suspect that the allocation of costs is biased in the Medicare cost report. Prior to the late 1990s hospitals had the incentive to allocate as much of their costs as possible to services other than acute inpatient because all of these other services were paid at the time on the basis of cost. As a result of that phenomenon we believe that the inpatient margin is overstated and all of the other margins are probably understated. Unfortunately, we don't know how much difference this bias makes, and we also don't know whether it has been reduced over time as the other services have come into their own respective PPSs.

Turning to the component margins, we have calculated margins for all six of the components of the overall Medicare margin, but we make primary use of the inpatient and outpatient margin. Their use is, for the most part, analyzing the distribution of payments within a specific PPS, including estimating the impact of policy options that the Commission has considered at various points along the way.

The overall Medicare margin does not work well for that purpose because it reflects payments and costs outside the PPS under consideration, which confounds the analysis. If we assess the analysis the impact of an outpatient option, for example, with this measure with outpatient comprising only 15 percent of hospital payments, large changes in outpatient payments would appear as small changes in the overall payments, and the distribution of changes would be different as well.

When it comes to comparing hospital margins to those of other sectors we have to remember that because all six hospital component margins are likely over- or understated, none of them can be compared with any confidence to margins in other sectors. The overall

Medicare margin provides a much better comparison to other sectors, and by other sectors I'm referring to freestanding SNF, home health, rehab, dialysis. The overall Medicare margin provides a better comparison to those sectors because it is netting out the overstatement and understatement of its components.

Comparing the margins of a hospital-based and a freestanding service with the same sector, like freestanding and hospital-based SNF is also difficult. If a margin for a hospital-based service is thought to be understated then a weighted average of the hospital-based and the freestanding is still going to be understated, but obviously to a less degree.

The last margin is the total margin. This covers revenue from all payers as well as non-patient sources. Non-patient sources include non-patient services like cafeteria, parking lot, that sort of thing, and also donations and investment income. The total margin does not play a direct role in MedPAC's policy decisions primarily because the Commission concluded that Medicare payments should relate to the cost of treating Medicare patients. To the extent that beneficiary access to care is an issue we

would like to develop direct measures of access to care rather than relying on overall financial condition as an indirect indicator.

There's also some question as to whether total margin even provides an accurate indicator of overall financial condition in larger organizations given that it is limited to the hospital corporation and does not encompass all components of complex corporate structures that have become commonplace in the field.

The difficulty of attempting to affect total margins through Medicare policy is exhibited in this scatterplot by the lack of any consistent relationship between overall Medicare and total margins. Hospitals with negative and positive overall Medicare margins are roughly equally likely to have positive total margins.

DR. ROWE: Is there an R value for that?

MR. ASHBY: It's 0.06 which is roughly like nothing.

MS. BURKE: Jack, just for illustrative purposes, can you give me an example of an institution at the extreme, one that might have an overall Medicare margin of plus-40, or some variation, and a negative overall margin? Give me

an example of what would end up in that kind of an array.

MR. ASHBY: More than anything else there are a number of academic medical centers, major teaching hospitals in that category--

MS. BURKE: Because of GME.

MR. ASHBY: --that do have very high Medicare margins because of the policy adjustments that Medicare gives them but don't fare as well in other payers and uncompensated care.

MS. BURKE: What about the reverse?

MR. ASHBY: But I want to point out that there are major teaching hospitals that are on the other side of this matrix as well, that have very high Medicare margins and still have high total margins as well.

DR. NEWHOUSE: The big public teaching hospital would be--

MS. BURKE: That would make sense to me. What about the reverse?

DR. NELSON: InterMountain Healthcare.

DR. ROWE: Pediatric hospitals where the overall Medicare margin was negative but a very small portion of the patients were Medicare--

MS. BURKE: Let me ask that question. Tell me what's included in this array. Would it include, for example, pediatric hospitals?

MR. ASHBY: No, it actually would not include pediatric hospitals, because these are PPS hospitals.

MS. BURKE: These are all PPS hospitals.

MR. ASHBY: That in the group, right.

DR. ROWE: How about the disabled patient who's a Medicare beneficiary who goes to a pediatric hospital?

MR. ASHBY: It certainly counts as Medicare but it's not a hospital that's under the prospective payment system so we don't include it in this.

MS. BURKE: Jack, give me an example of the other extreme, which is a very high overall margin and a very low Medicare margin.

MR. ASHBY: This would be a community hospital that has a large private payer business and has negotiated well in that private payer business, has limited uncompensated care and fills out nicely in its revenue.

DR. REISCHAUER: I think, Jack, you've already answered my question in that you knew the answers to these questions. But I was wondering if you had ever run a simple

regression of overall Medicare margins as a function of the relative importance of these various other types, inpatient, outpatient, Medicare, nursing home, et cetera?

MR. ASHBY: As a function of their mix of other services?

DR. REISCHAUER: Yes, the mix of other Medicare services. The overall as a function of the mix excluding inpatient. And then maybe adding onto that, percent of total revenue from Medicare and percent from Medicaid as two other--

MR. ASHBY: Right. We have not run that precise analysis. However, we did put together a similar scatterplot of the proportion of Medicare business covered by this and the total margin and it is a very similar blob, if you will. That varies all over the map too. So one of the key variants here is the amount of Medicare of all types they have. We have not really looked at it by those service components as you suggest, so we would have to go back and take a look.

DR. NEWHOUSE: I had three comments. The first was actually quite similar to Bob's. I thought we should try to explain variation in the total Medicare margin with

the product mix to tell us something about--which would give us an estimate of Medicare margin by service. Also, the second point is, if there is variation there, it doesn't make sense to compare hospitals with different product mixes in their total margin because it's comparing apples and oranges.

MR. ASHBY: When you say product mix, do you mean Medicare product mix now or the mix of Medicare and other--

DR. NEWHOUSE: Yes, I mean a mix of product lines. Do they have an IRF? Do they have a SNF? Do they have a home health agency, et cetera? So what are the product lines that are contributing to this margin?

My second question really goes also to the component margins, which is at some point in the past you were talking about trying to get a handle on these margins by using certain hospitals' cost allocation mechanisms. Where does that stand? Is that still going forward?

MR. ASHBY: That project is absolutely going forward. We have awarded a contract and the project just started just in the last couple weeks.

DR. NEWHOUSE: When will we hear something of what it found?

MR. ASHBY: That's always a risky question. We're shooting for next spring for the spring meetings, but there are a lot of unknowns in the meantime and it's a little bit hard to make any promise on that.

DR. NEWHOUSE: I understand.

DR. MILLER: We're not even sure how much hospital participation we're going to get in it.

MR. ASHBY: That's one of the biggest unknowns is how well we're going to be able to recruit hospitals, let alone the right mix of hospitals that we'd like to have, into this study.

DR. NEWHOUSE: Then a third question is, you've made the point several times in the past that the level of margins depends on what costs count as cost for the purpose of calculating the margin, and specifically the disallowed costs. I wondered if you have any plans to go into that.

MR. ASHBY: No, we don't. All of the hospitals in this scatterplot are treated equally in the sense that we're looking Medicare-allowable costs, as we always do, in our financial performance analysis. So all of them have some level of non-allowables and we're not looking at that.

DR. REISCHAUER: When we do the total margin do we

include those unallowable costs?

MR. ASHBY: Yes.

DR. REISCHAUER: That's interesting.

DR. NEWHOUSE: That is interesting.

MR. ASHBY: The total margin, you're using the financial data that the hospital generates, and they have no interest in dealing in allowable or non-allowable costs. Obviously we're on their platform when we do this measure.

DR. MILLER: It's not identified. It's just a total number.

DR. NEWHOUSE: For purposes of trying to translate, shouldn't we try to do some kind of crosswalk then?

MS. DePARLE: I think we should because that's something that they always raise, not only with respect to hospitals but others always raise, but you haven't counted the costs that you won't allow. Sitting here, I'm not even sure I could tick them off, so at least I think we ought to be clear about what they are.

DR. REISCHAUER: Do we have the ability to look at the ratio of unallowed to allowed Medicare costs by hospital and do a scatter diagram of that? And relate that to how

much Medicare business they do relative to all business? Because the ones that are most upset about it, it could be a relatively minor thing in their overall book of business.

MR. ASHBY: The amount of non-allowables is not a readily available number actually. There's a very complex set of reporting and calculation that backs that up, so it's not something we could easily run and do.

MS. BURKE: Jack, what's the biggest category of non-allowables?

MR. ASHBY: We don't have complete data on that but we're told that one of the most major, if not the major category, has to do with home office costs with chain operations, because the chains are doing a variety of different things and some of their costs are not necessarily applicable to providing inpatient and outpatient care and the like.

MR. MULLER: This is along those themes. Since we know from our prior years' work that not the DSH, where we put in the whole revenue but don't put in the whole costs, therefore overstates the Medicare margin considerably. In the calculation we don't have the Medicaid costs in that, if you follow me. So the DSH hospitals always have a higher

Medicare margin just by definition, but probably have, because they're DSH hospitals, a lower total margin. It would be good to break that one out without the DSH payments because I think you might see a different plot, given how much the DSH payments affect those base. I seem to remember--I'm trying to remember now from our books in the last couple years, I think of the overall--the 14 or 15 that we show for inpatient doesn't about four to six of that come from DSH or so, some fairly high number?

MR. ASHBY: Right, it does. We have all of the cost of treating Medicare patients in the numerator or denominator here, depending how you--

MR. MULLER: We have the costs in. But we have DSH revenues in that therefore make the margin look bigger because some of the DSH revenues are for Medicaid patients.

MR. ASHBY: They're really not for Medicaid patients, per se. This is a Medicare payment. It's in the Medicare program as it stands now. The distribution of those DSH payments is determined heavily by the hospital's Medicaid penetration. But it's never really been offered as payment for Medicaid. There is a Medicaid DSH separate from--

MR. MULLER: No, I'm talking about the Medicare DSH which is calculated on Medicare and Medicaid. Therefore, in a sense, you get payment for your Medicaid patients even though you don't have the cost of those Medicaid patients in there. Am I accurate in that?

MR. ASHBY: The Medicaid costs are definitely not in there as it stands now.

MR. MULLER: But the payment is.

MR. HACKBARTH: Jack, correct me if I'm wrong, or Sheila, somebody correct me if I'm wrong. My understanding was that originally the notion behind DSH was that Medicare patients that were low income patients might have higher costs and we were trying to find an adjustment that would reflect the higher cost of treating low income Medicare patients. Over time, however, the rationale for the DSH adjustment and the amount of money involved in the DSH adjustment has changed. So now we've got a sum that is actually, I think, quite a bit larger than the amount that would be required to pay for the higher cost of low-income--

DR. NEWHOUSE: The higher costs were based on a study of Massachusetts only and didn't hold up a couple years later when you went to the nation. They aren't higher

cost.

MR. HACKBARTH: So now we have a payment adjustment that increases payments for Medicare admissions based on Medicaid and SSI volume without a clearly defined rationale of what we're compensating for. Is it the higher cost of Medicare patients? Is it for uncompensated care patients? It's, frankly, I think murky at this point.

MR. MULLER: I'm just saying, by definition it overstates the Medicare inpatient margin because in a sense you get credit for patients that aren't in the cost base. So in the ratio you get credit in the numerator for costs that aren't in the denominator.

DR. MILLER: But you can also say that the adjustment is supposed to be for a more expensive Medicare patient. This was the best proxy at the time. That relationship didn't show up, but the money is still flowing through. You're technically right about the Medicaid cost is not in there, but there's a whole different way to look at this transaction in terms of the dollars hitting the hospital.

DR. REISCHAUER: If you really want to be tough you could say this is just the same thing as the excess

payment in IME, over and above the justifiable payment.

DR. WOLTER: One other clarification on total margin that might be useful, at least as many institutions use that phrase includes investments, unrelated business income, subsidiaries that might not be really related to the operation of health care. I don't know whether we're using it that way here or not, but that would be important to know, because I think that really then muddies the picture. Some people use the phrase operating margin to refer to the operations of direct health care services.

MR. ASHBY: No, an operating margin is not necessarily restricted to health care services either.

DR. WOLTER: Not necessarily, but it's closer than the phrase total margin. That's all I'm saying. Total margin might include activities that are really quite separate, and it certainly would include your investments, for example, Jack.

MR. ASHBY: The main thing that a total margin includes that's an operation margin doesn't is investment income and donations. But all of the services, even if they have virtually nothing to do with health care--they could be operating a restaurant or a senior citizen living

arrangement, would still be in an operation margin.

DR. WOLTER: That may be true for some institutions, Jack, but I'm not sure that's universally so. The point I'm making is, total margin in any way is a less-good comparison to overall Medicare margin than something that's a little bit narrower than that. Maybe we can't get to that, but when you include investment income and donations--and many places would some of these other things you just mentioned in their total margin but not in their operating margin. But maybe not all. Maybe there's some imprecision there.

One other thing I just wanted to mention that's in the body of the paper, I'm not sure I would say that the overall Medicare margin is a good comparator to some of the component margins. It may give us some comfort when we look at--

MR. ASHBY: To margins in other sectors.

DR. WOLTER: Yes, but it's perhaps not a good comparator because it does lump many things together, whereas, in the other sectors we're just looking at one set of services. So that might be a slight overstatement.

MR. ASHBY: Right. Nick, that was a reference

primarily to the problem I was trying to explicate about the upward and downward bias in the component margin.

DR. WOLTER: I understand where it's coming from, but it's probably not a good comparator.

MR. ASHBY: So I used the word, better measure, in that sense because it's not hit by this bias problem. But that doesn't make it a good measure on all fronts, as you say.

DR. WOLTER: A minor point.

The thing I've wondered about this, I think this presentation describes fairly well what a cloudy lens we look through when we make update recommendations about individual component sectors, at least I think it describes that pretty well. I've wondered, if you were to say, where would the Commission want to be in three or four years, what course would we get on? Do we think that the individual sectors should have reimbursement that covers the cost of an efficient provider? Because we've talked about that framework. If we thought that, we would clean up the cost reports, we would get information that we don't currently have, and we would have a system that would do that.

Although we have gravitated to using the overall

Medicare margin to give us some comfort, the fact of the matter is that at times we dip to the level of the individual DRG to try to create reimbursement that covers the cost of an efficient provider. When we get into bundling conversations we're looking at another level of reimbursement that might or might not cover overall cost.

So I think it would be helpful for the Commission to decide what principles it would like to have, and then see if we could design a course to get there, recognizing that it would take several years. Because covering the cost of an efficient provider for each of the component sectors is different than having this somewhat cloudy feeling that at the end of the day that overall Medicare margin at least seems to be in whatever shape it's in. I'm not really sure what our goals are on this. I've thought about it a lot over the past year.

DR. NEWHOUSE: Nick, I think that's a great question and at the end of the day it's probably impossible because the reason these costs--one reason the costs differ is that the hospitals are allocating their joint costs. So in terms of how Ralph's salary is getting allocated at Penn is ultimately arbitrary. I mean, it follows accounting

conventions, but the conventions are arbitrary.

But beyond that, what that implies is that to cover the cost of adding a SNF unit, if you did the incremental cost of everything, you wouldn't cover the joint costs, unless you want to say something like, there's always going to be an inpatient unit so I'll put them there. But then I'm paying more than the operating cost of the inpatient unit. So we're stuck with that inherent issue in operating a hospital that does several different things.

DR. WOLTER: I haven't really presumed an answer to my question because I know these are difficult things, but we have said that our goal is to cover the cost of an efficient provider, and we have applied it to things like DRGs as well as component sectors as well as total margin. But then sometimes we go into other reasons for not getting there, such as the reasons you just gave.

I think some clarity about how we might want to look at all these things would be useful. The achievement of getting to something better would be very difficult. It seems to me we've moved to a great deal of PPS in recent years. There's much less in terms of reimbursement that's currently dependent on the cost reports. I don't know how

that is or isn't changing behavior around cost reports.

I also know that in our case our staffs spend so much time on filling those cost reports out, and there are some very specific requirements, so in theory you could imagine a cost report that tries to answer some of the questions you just outlined.

I just don't know whether it would be worth our while to define where we'd like to be and then decide whether it's worth the effort to try to get there. But we do have a pretty cloudy lens that we look through when we make specific payment updates, I think.

MR. MULLER: We do use basically the inpatient margin to cover the other five sectors over and over again, and our data has shown that what we'll call the product mix of these services does, first of all, it varies quite a bit in terms of scale; there's quite a bit of distribution, so not everybody has the same proportions of inpatient to outpatient to rehab, et cetera, and so forth. So a hospital that, in a sense, in theory had only an inpatient program could have a significantly high margin, and those that do a lot of outreach, do a lot of rehab, have broader needs to-- have a broader role in the community, whether it's a rural

community or urban community and so forth, in a sense one could argue have a broader social role, get dragged down because we don't give them as much money in those other sectors and so forth, financially. So in a sense, one is punished financially for playing a broader role.

So I understand the discussion between Joe and Nick, but I do think understanding exactly, or trying to better understand--not exactly. I concede Joe's point, it can't be exact, but trying to better understand the components make a lot of sense. Because I remember when we went through the SNF discussion last year or the year before and we had margins of minus 70 and minus 30, and so forth, and we just said, oh well, it gets covered by inpatient and so forth. That's a lot to cover through inpatient. So I'm just hesitant to keep saying that the inpatient margin will cover all these other components for the foreseeable future.

MR. HACKBARTH: To the extent that the inpatient margins are inflated because of allocation of costs, the hospitals that haven't had the other lines of business never went through the practice of allocating the costs out. So presumably, I guess, all other things being equal, they would have lower inpatient margins.

MR. MULLER: I think that's what we want to know.

DR. NEWHOUSE: My regression is going to get the incremental costs.

MS. DePARLE: My question went to the same kind of issue that Nick was raising that we were just discussing, which is the quality of the data that we're relying on. I just wanted to be clear, am I correct that none of what we're looking at when we establish Medicare margins relies upon, or is influenced by, hospital charges? We had a discussion in July about charges and how that was something that did obviously affect--

MR. ASHBY: No, it very definitely is influenced by charges.

MS. DePARLE: Then it seems like we should have some discussion of that, because we had a long discussion in July, or fairly long, about the extent to which that had affected outlier payments in the notable case, and just what a house of cards it might all be. I wasn't clear that it was part of what you were relying on here. It affects the cost reports.

MR. ASHBY: It is part of what we're relying on here because charges are used in the cost report process for

allocating costs among services for ancillary costs. So we are at the mercy of hospital's charge-setting practices and the consistency of their markups.

MS. DePARLE: In the cost-to-charge ratio?

MR. ASHBY: Exactly. So we are affected by that, by all means. Now the study that we are undertaking is going to examine the charge-setting practices of hospitals to try and better understand what they take into account in setting their charges and what implications that has for the allocations that we do. In addition to, for a sample of hospitals, measuring the allocation of costs that they with their sophisticated cost accounting systems think is correct, which is not based on charges, or to a very small degree. So we'll have a comparison in that way of how much difference all of this charge problem has.

DR. REISCHAUER: How about a regression that related overall Medicare margins to the fraction of Medicare payments that were represented by outlier cost payments. It could be that a subgroup is doing quite well because it's gaming--

MR. ASHBY: I think CMS has pretty well announced that there is a subgroup that has been doing well.

MR. HACKBARTH: Any others?

Okay. We will have a brief public comment period.

[No response.]

Okay, thank you. We reconvene tomorrow morning at 9:00 a.m.

[Whereupon, at 4:44 p.m., the meeting was recessed, to convene at 9:00 a.m., Friday, October 10, 2003.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, October 10, 2003
9:02 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA D. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Good morning, Karen.

Our first item for today is access to care. Karen?

* MS. MILGATE: This session is a session on talking about what we see about the beneficiary perspective on their ability to obtain care in the Medicare program.

Last year, the Commission developed a framework for monitoring access to care and there were three dimensions of that. One is to look at the capacity of the system to deliver care. The second was to look at the ability for beneficiaries to obtain care. And the third was to look at the ability for beneficiaries to obtain the appropriate care. So this provides us some information on the second one, which is the overall ability for beneficiaries to obtain care in the Medicare program.

The information presented here is at a very general and high level because it's intended to be included in the context chapter that Anne Mutti described at last month's session that will go in front of the March report, giving a context for the update recommendations.

There will also be other information on access

that will be included in the specific setting chapter, so this is not all you will see on access to different types of care. But today what I'm going to do is present data from the beneficiary perspective, and essentially that's going to mean presenting data from three specific surveys of beneficiaries.

The first slide here is a bit busy but fairly straightforward. This is data presented from the Medicare Current Beneficiary Survey. You see here three types of questions that are asked on that survey. One is whether beneficiaries delayed health care due to costs. Secondly, whether they did not see a doctor if they needed one. And thirdly, if they had trouble getting health care.

You can see from 1991 to 2001, on the top two measures of delayed health care due to cost and did not see a doctor when they needed one, the trends have been good since 1991. And then trouble getting health care has been fairly stable over that period. However, you can see that 8 percent really is -- that in 2001 less than 8 percent of beneficiaries reported any problems, for example.

In 2001, the largest problem reported was in the delay due to cost, and that was 7.9 percent of

beneficiaries. Those that said they did not see a doctor when they thought they needed one, 5.5 percent of beneficiaries. And those that reported trouble getting care in 2001 was 4.3.

The only thing I'd like the point out other than that is that there did seem to be kind of a bottoming out on the top indicator of delayed health care due to cost in 1998 of 7.0 percent. In it's inched up slightly since then. None of those differences in each of those years are statistically significant. However, the difference between 7.0 and 7.9 is. So it looks like something we might want to watch over the next coming years.

MS. DePARLE: Karen, did the word health care include pharmaceuticals?

MS. MILGATE: It isn't clear from the question, I mean that's all the question asked. But there are other questions actually on the MCBS that do look at that. I didn't look at those at this point in time in detail, but that's something that could be reported.

MS. DePARLE: I was just wondering if that significantly significant increase could be what we're observing also in the pharmaceutical area?

MS. MILGATE: Yes, it could include that. It certainly is not clear that it excludes that.

MS. BURKE: Although, there is actually a statistic that suggests that there was little difficulty getting prescription medicine which I found odd.

MS. MILGATE: We'll certainly have that discussion at the last slide.

MS. BURKE: I thought it was bizarre.

MS. MILGATE: I can say a few things about that because yes, that was an interesting finding in the CAHPS survey.

This next slide is data from the National Health Interview Survey which is actually not a survey specific to Medicare beneficiaries but it's asked of all persons. So here we're really talking about a subgroup of Medicare beneficiaries, those that are over age 65 and are on Medicare. So this does not include the disabled, for example, and the 65-plus.

Here, the question was whether the person failed to obtain care due to financial barriers in 2002. I only have one year shown here because the last couple of years were fairly stable so there was no real change to report.

But it may be interesting to note that there was some stability in the last couple of years.

Again, what you see here is the Medicare beneficiaries, or at least those over 65, seem very satisfied with their ability to get care and report few financial barriers. The national average is 4.7 percent suggest that they have failed to obtain care due to financial barriers. Those 18 to 64, the number is higher at 6.2 percent. But then those over 65 report only 2.5 per cent.

DR. REISCHAUER: You don't have the answers for these questions for those who have insurance who are under 65, do you?

MS. MILGATE: Those who have insurance under 65 versus others.

DR. REISCHAUER: You know, to compare two populations that are in a sense similar because they have insurance. Do people with Medicare have greater problems than others or less problems.

MS. MILGATE: Does NHIS have that, Jill? I don't have them here but that is something we can look at, yes.

MS. BURKE: The disabled are included in the 18 to

64s?

MS. MILGATE: Yes, I believe they are. That would be right, the disabled under 65? Yes, because this is just an age break down, so this would include all persons.

MS. BURKE: So the Medicare disabled would be covered in the under-65s?

MS. MILGATE: Yes, so it would include all kinds of coverage under 65.

Interesting enough, I don't have this on here, those under 18 also have a lower level of reporting failure to obtain care. So it seems like for children and for folks over 65 that's the best category. And then in between I think you're seeing all the mix of different types of insurance and lack thereof.

Another question that's asked on the National Health Interview Survey that we reported on last year and wanted to update was whether people have a usual place to go for care in 2002. The difference isn't quite as stark here as the previous question, but you see once again that those over 65 report a higher level of having a usual place to go for care than the national average and than those who are of a closer age. Here I chose the 45-to-64 population to

compare to rather than the whole 18-to-64.

MS. BURKE: The usual place to go could be an emergency room.

MS. MILGATE: It could be.

MS. BURKE: So it doesn't qualitatively give us an indication of where they think the usual is.

MS. MILGATE: That's true. The CAHPS data that going to now says a little more about whether they see a doctor or a nurse routinely. But this is general in saying a place to go.

The MCBS also asks it generally and then breaks it down. And you'll see that the rates that are in CAHPS on going to doctors and nurses actually are very similar to the rates of those on the MCBS that say they have a regular doctor. And then there's a difference on top of it that people go to EDs or just don't have one.

DR. REISCHAUER: Not to be jumping all over this about the limitations of this kind of information, but there's also the problem that something like 12 to 15 percent of Medicare participants don't go to a doctor during a year. And something like a third of the rest of the population doesn't go. It would be hard to have a problem

accessing care if you were healthy and never wanted to go.

MS. MILGATE: If you didn't try to go.

DR. REISCHAUER: And so if you were really doing these you would want to do the subset of people who wanted to see a doctor who then had a problem.

MS. MILGATE: Actually, the CAHPS data in some way does that because it asks if you needed to did you on most of the different questions.

DR. REISCHAUER: So is this a subset of that?

MS. MILGATE: No, I'm just getting to that.

DR. REISCHAUER: No, but you could do it.

MS. MILGATE: The next few sides are going to be from that, so that will give us a little more information. But you're right, that's true.

And I think it's important to note that these are questions that individual people are answering. So there is a lot of subjectivity. It's designed into the survey process. It's important information but it's unclear how much to act upon just this information.

The next three slides are data from the CAHPS survey and I want to just stop for a minute to say a couple of words about the CAHPS survey. This is a new tool in our

too kit of access and quality information. It's a survey that was originally designed for commercial health plans and then was altered a bit for Medicare+Choice. And then, in an attempt to make sure that they had information on fee-for-service beneficiaries as well, was again modified somewhat for fee-for-service.

This is one of the first times that I know of that these data that been reported publicly, so I just wanted to stay that this is kind of new and interesting information. It provides some of the same types of general information you see on the other surveys but digs in just a tad deeper. So it's kind of an interesting one to take a look at.

CMS is clearly continuing to change and modify. We found some questions we couldn't compare over years and that kind of thing, just to try to get a better handle on what beneficiaries were perceiving when they were answering these questions.

It's a large sample as well. There's 100,000 to 120,000 beneficiaries are surveyed every year. So it's a nice large sample.

What the beneficiaries said in answer to the question that was presented on necessary care, and here's

the question just so we understand what they are thinking when they answered it, if you or your doctor believed you needed care, how much of a problem was it to get this care? So it's a little bit better than do you think you got care and whether you tried or not. We're going to presume they tried, because the doctor or them thought they needed it.

You can see here that for all three years 97 percent or more of beneficiaries reported it was a small or no problem getting their necessary care. And then a very small percentage reported it was a big problem.

That's sort of an overall question, and then they broke it down by urgent care and routine care. So here you see the data for routine care. And again, here's the question. The question is if you needed care right away for illness or injury, how often did you get it as soon as you wanted? So it puts a bit of a timing issue in there. It's not did you get it, it's how often you got as soon as you wanted. So again, a little bit of subjectivity there.

Most beneficiaries in all three years, 92 to 93 percent, said they usually or always got the urgent care that they perceived they wanted or perceived they needed as soon as they wanted.

However, you'll see that is a slight increase in those that said they never got urgent care and also sometimes did not get urgent care as soon as they wanted between 2000 and 2002. So it's a very small increase but it might be something to watch as well, as they keep using the survey.

For routine care, the question here was if you made an appointment for regular or routine care, how often did you get an appointment as soon as you wanted? So again, it has that timing aspect in there. Here we see that between 2000 and 2002, 90 to 92 percent of beneficiaries reported they always or usually got an appointment as soon as they wanted.

Again, you see a slight but statistically significant increase in those that reported never or sometimes. So again, it might be something to watch. This is a larger increase than you see in urgent care, so there may be some beginning of an issue here in the obtaining of routine care.

Another aspect of access the CAHPS survey gives us some information on is continuity of care. It's asked on other surveys as well. Here the data show that 89 percent

of beneficiaries have a regular doctor or nurse. So here they don't ask usual place. They say specifically do you have regular doctor or nurse. Almost 80 percent -- and I found the second bullet particular interesting -- of beneficiaries said they have seen their regular doctor for two or more years. And in 2002, 60 percent actually reported seeing the same doctor for over five years. So for a significant portion of beneficiaries, they have a regular doctor or a nurse and they actually have known them for some period of time.

50 percent of beneficiaries have actually been seeing the same provider since before they entered the Medicare program.

In addition to asking some general questions about access to physicians, they asked about specialists and other types of health services. The services they asked about were specialists, prescription drugs, home health, durable medical equipment, and PT/OT/ST or physical therapy, occupational therapy, and speech therapy.

Clearly the numbers of beneficiaries seeing these different services varies. That doesn't necessarily mean it's unimportant if a small percentage need one service or

the other, but I wanted to just put those numbers out there. Those reporting that they sought prescription drugs were 90 percent of beneficiaries. Those reporting they sought care from a specialist were 48 percent. And then durable medical equipment was 16 percent. PT/OT/ST, 13 percent. And those reporting they needed home health in 2002 were 7.9 percent. So there's a difference of how many beneficiaries actually needed the different services.

What you see from the charts that were included in your background materials is that access to all types of these services appear as good. Almost 90 percent report no or a small problem for any service. However, there are some differences and I wanted to highlight a couple of them.

First of all, as Sheila noted before for prescription drugs, 96 percent of beneficiaries reported that they had a small or no problem obtaining prescription drugs. This number is similar to other surveys and also -- is similar to other surveys that asks question in this way. And it's always been hard to interpret is what I've been told in talking to several folks about what does this mean.

You'll see this number when it's asked generally whether beneficiaries have access to prescription drugs.

However, other data show a higher level of beneficiaries are actually skipping doses, splitting pills, replacing drugs for other goods that they might otherwise have bought.

The other thing to note is this number is different for different types of beneficiaries. A recent Health Systems Change Survey found actually higher levels for both whites and African-Americans when the question was asked in the last year how often did you delay getting a prescription because of cost. So that's a little different than this question. That survey found that whites were 6.8 percent more likely to say that and 16.4 percent of African-Americans said they were likely to delay at least one prescription due the cost.

So we have some conflicting data here on prescription drugs and it's important to understand this number in the context of those different surveys.

Specialist, 94 percent of beneficiaries said that it was a small or no problem to obtain a specialist. And then the other, I think, interesting number and particularly interesting to the Commission because of update recommendations was the home health number. And that number was relatively good -- I don't know relatively, it was a

fairly high level, 88 to 89 percent of beneficiaries said it was a small or no problem obtaining home health services.

But again we wanted to dig into this number little bit, to say of those who said they had a big problem, did they actually get it eventually? How big was the problem, of course, becomes the question.

So we looked at 2000 data, which was the most recent we had, of how many beneficiaries actually obtained home health services. We looked basically was there a claim for that beneficiary for home health. And found in 2000, 7.5 percent of beneficiaries had a claim for home health.

And concluded from that that most of these beneficiaries are seeming to get home health because those in 2000 on this survey who said they sought home health care were 7.7 percent. So there's a .2, 7.7 minus 7.5, difference between those who actually entered a claim and those who said they sought home health care. It appears, at least from those data, that there may be a reported big problem but they do eventually get home health care.

So it doesn't mean there's not necessarily an access problem, but they are actually obtaining home health care. The barriers aren't so high that they aren't actually

getting the care.

In summary, I think what we see from these data, at least, that beneficiaries perceive they have good access to care. Clearly, these are national data so they can obscure important differences for certain types of beneficiaries and perhaps differences across geographic areas. But this gives us a good general overall picture.

DR. WAKEFIELD: Karen, I know these data are the aggregate data and you are providing them, they be included to provide context it sounds like. Because you mentioned that there will be some more precision around breaking these data down when that's relevant in subsequent chapters. So this is sort of a front-end piece?

MS. MILGATE: Exactly. Yes. It's intended to be, as you saw all the different charts that Anne Mutti showed last time of looking at the economy generally, Medicare trust fund, that sort of thing. And in that broad chapter, we say here is broadly what access to care looks like for beneficiaries.

DR. WAKEFIELD: I'm a little bit concerned about what this might wash out in these averages, but I also understand what you're saying, you're trying to do the big

picture view. Will there be any place where you might be breaking this down by, for example, difficulty obtaining care, didn't see the doctor, cost a factor? Are you going to try and break that down at all by minority status, income, age, region? Is any of that kind of cut on this data going to be included to give us a little bit more precision, in terms of what we're looking at?

MS. MILGATE: We hadn't planned on doing it broadly, but there might be particular places like what I just described for explaining prescription drugs, that it might be useful. So I guess that's the eye I would use is where it seems like it would be really useful, if it's seems like the averages are not necessarily giving a good enough picture, that we might include some information like that.

DR. WAKEFIELD: There's a level of specificity that a person will never get to because the data won't support it I'm sure, and the sampling is not going to support it, in some ways. So I think the case that I'm thinking about, but we'll never see it here, is I was just doing some visits to travel reservations talking with people about their care for elders among American Indians in my region of the country. And gosh, access is just a huge

issue for them and they are Medicare-covered. This is the program that pays for their care.

Now you're not going to get to that level of detail. You're not sampling at the level, and so on. But I'm wondering, somewhere between this, the big picture, and that, which you're not going to get to, can there be any slightly finer cut?

If this goes as it is, it suggests to me that by and large things are good in Medicare-land from a beneficiary perspective. And that may well be true. But I'm concerned about pockets. Again, minority pockets, age, income in particular, especially as we start to see changes in copays and so on, which maybe we're not picking up yet. But if the data will support that, it seems to me that would be a useful thing to do.

MS. MILGATE: Okay.

DR. REISCHAUER: What kind of identifiers are on these people? Is there a rural identifier?

MS. MILGATE: The CAHPS survey, which is really -- well, you could do it --

DR. REISCHAUER: Because 100,000 is certainly big enough to do some cuts like that.

MS. MILGATE: Yes, and we are actually -- let's see, how should I say this?

The CAHPS data, and the analysis they have, are somewhat new. And so I am now talking to both CMS and the contractors they have worked with on the various things that we might be able to do with the data. They are identified at the county level, which means there are a variety of different ways we could cut it, urban/rural. And we're discussing with them the possibility of doing that.

I hate to promise it by the time of the next meeting or the next report, but we are talking to them about being able to look at urban/rural breakdowns and some racial breakdowns.

I would just say that CAHPS, in the future, provides us a lot of different possibilities that we could build on.

DR. REISCHAUER: I think what Mary's suggesting is just even a paragraph that said preliminary analysis suggests that in rural areas the number might be higher and over time we'll be able to hone in on this.

MS. MILGATE: The other thing that Sarah said that we should point out is that we do have some information by

supplemental insurance status. So that's one thing we could include in there.

DR. ROWE: This is the CAHPS fee-for-service survey, right?

MS. MILGATE: Right.

DR. ROWE: Is the a CAHPS M+C survey?

MS. MILGATE: Yes, there is. This was modified from that, essentially.

DR. ROWE: Are those data available now, also?

MS. MILGATE: They are available in a different way and I should have said that. I am planning for us to include some comparison because we do have some comparisons. What they've done with the M+C is create composite rates from a variety of different questions. So we could certainly compare the scores on the composite rates. I found the level of detail included in individual questions in some ways more useful and interesting for fee-for-service, but there is a higher level comparison that could be done.

DR. ROWE: Also, it would be interesting with respect to the race and ethnicity information whether or not there have been any improvement over time, rather than just

the differences these disparities seem rather intractable. None of us are going to be surprised by finding another disparity, there's one under every rock and behind every tree. But it would be nice to see if we're making progress, since you now have longitudinal data here.

And I think it would be interesting to compare those changes over time in the M+C versus the other, the fee-for-service.

MS. MILGATE: I don't know if they've broken the M+C by race, but I suppose you could.

DR. ROWE: Yes, they have.

MS. MILGATE: Okay.

DR. ROWE: The data that we get from the CAHPS survey for our beneficiaries includes race and ethnicity.

MS. MILGATE: We will also be able to compare -- I should say this, there is another set of indicators we're running for quality purposes that we will use also probably for some access information, and that's the ACE-PROs that we've talked about before that looked at the provision of clinically necessary services in the ambulatory setting.

And there we are looking at a racial analysis, as well as urban/rural breakdown, that will give us some

information both for quality and access purposes.

DR. ROWE: The interesting question here that everybody is familiar with, but when these disparities were found in the fee-for-service population and people looked at the M+C population, it helped in answering the question of whether or not it was the lack of a primary care physician that was part of the limitation in access. Because in the M+C program, by definition everybody has a primary care physician. In fact, it made no difference. People still had the access problem.

So here they were. They were insured and they had access to primary care physician and still report -- I think the Commonwealth Fund supported some work that was published that show these rather significant reductions in Medicare beneficiaries, in getting beta blockers after a heart attack, getting follow-up after mental health admissions, et cetera.

So I think that one of the values of comparing the datasets is that in one dataset we know there's a primary care physician, and certain other services are provided. In another dataset it isn't. And we can start to answer some questions.

MR. HACKBARTH: Karen, my recollection from my previous life at Harbor Community Health Plan was that we tended to get different results based on the type of survey. For example, an annual member satisfaction survey versus a visit-based survey. So if you asked people to reflect back over the course of the past year consistently we tended to get higher satisfaction levels than if you asked them right after a visit.

I don't know what explains that. It could have to do with at the time of the visit maybe they have a health problem and there's a higher level of anxiety, whereas if you asked them to reflect back over longer periods. But there is some -- biases isn't the right word, but there are some real tendencies depending on the type of measure you're using. It was our experience that you tended to get the most favorable results when you asked these sorts of questions.

The other thing that was striking to me in that experience was how different the response of different population groups would be. Seniors tended to have the highest levels of satisfaction. So even if you asked a senior and a younger population using the exact same

facility, controlled as closely as possible, they had the same access, the same physical facilities, that the seniors will always give higher scores to everything.

MS. MILGATE: Just a couple of comments on your second one. The older you get, the better it seems actually, also. On some of the surveys that break down Medicare beneficiaries by age you'll often see high rates of satisfaction for those over 80 than those 65-to-74. And that's kind of interesting.

MR. HACKBARTH: So in the chapter, when we talk about comparisons across groups, we may want to have something that reflects the fact that there are some.

MS. MILGATE: I would just say one thing though, about the CAHPS survey. It's sort of in between what you describe because they do at least six months. They don't ask the whole year. I don't know if that was by design or it made it more convenient for their administration. So they do do it by six months, but I don't know that that means that there's any difference really.

And then the other thing is that in the future, when they get the hospital CAHPS, because they're also working on a CAHPS that will be okay now you were just in

the hospital, tell us about your experience. That might give us some other really interesting information, because it is right after the event occurred.

MR. SMITH: (off microphone) On the visit-based stuff they pick up the Newhouse computation.

MS. MILGATE: The Newhouse computation. I don't know about that phenomenon....

MR. HACKBARTH: I don't think Joe was ever a member.

MS. BURKE: Karen, a terrific job, it's fascinating stuff.

I am, however, as concerned at the point that Mary has raised, and that is that we may leave a false impression of living -- if you'll forgive me -- in Lake Woebegone, that everybody's above average and all is well. When in fact, if you begin to differentiate among the populations, there are significant differences in how they experience treatment and how they access it. And so I think a paragraph that notes that is critical.

But I also wonder, particularly around the issues around income and around race. I mean, there are certainly geographic issues as well that we're well aware of,

particularly around certain services. But the generic impact of income on access and the difficulty of gaining access and around race because of the disparities issues, I feel that to the extent that we can, we need to highlight that because a lot of the work that suggests that in fact the low income elderly are incurring greater and greater out-of-pocket costs, larger percentages of their income go towards the purchase and access to care, their difficulties in accessing.

And I would worry about appearing -- I mean, the drug number sort of underscored that sort of disconnect with at least the reality that some people face.

And to the extent that we can do that with a paragraph, suggesting that these are averages in a sense. But to the extent that we have any data that allows us to begin to separate out some of those groups, I think would be a very important for the overall context of the debate.

MS. MILGATE: I think we can certainly add some more context to the context. But we also have already planned to do some on the cost-sharing levels for different types of beneficiaries. So we'll meld that together more directly with the access piece, as well.

MS. BURKE: Okay, great.

MR. MULLER: On the same theme that Mary and Sheila have raised, looking at the subsets, we probably don't have any language markers and so forth. But when you start looking at -- I think for L.A. County there's like 100 languages or more, something like that, some enormous number. I know that my experience has been that a lot of times people will travel a long way, three or four or five hours, to go to a physician. a nurse, et cetera, who can speak the same language because of the difficulty of communicating a lot of the technical aspects of medical care, having somebody that precisely knows the language as opposed to just generally is very helpful.

So I don't know whether we have any kind of indicators of that, but I think in certain pockets you would find that. That's one theme.

Another one is, to go back to some of the supply questions in some of these pockets, where there are indicators of physicians per thousand or beds per thousands and so forth have any kind of impact on access. Because I think that we're going to find the access problems -- again in these subsets -- that 4 or 5 percent can capture a lot of

variety. And while it gets lost in the overall samples with people being okay at the 90 to 92 percent level, I think there's a lot of action in that 7 or 8 percent.

So the question is how to try to identify that how much of that is supply-based, how much is on the classic factors of disparity that Jack and Sheila have mentioned, and so on.

So since we have a large enough sample here to keep looking for what some of the indicators of the difference may be, it's helpful.

MS. MILGATE: Geographically, also.

MR. MULLER: I think there's a lot of suspicion that supply could have an effect, whether the supply numbers of CAHPS have a small enough granularity to -- if it's at a county level, then you really won't notice the difference. It really has to almost be below a county level, and so forth.

MS. BURKE: This goes back to Bob's earlier point. Do we have the capacity to test these questions against people who actually sought out and accessed care? Or does this number include those people who did not, for whom there's no problem because there was no problem.

MS. MILGATE: It depends on the survey. CAHPS I feel like did about as good a job as you can.

MS. BURKE: But just in the way the survey is structured, does it survey --

MS. MILGATE: Who does it survey? It surveys randomly. So it would be those who wouldn't have tried and those who would have. But what they do before every question is say did you seek. So if you didn't seek a doctor or a specialist or you didn't seek prescription drugs or you didn't seek home health, then you're not --

MS. BURKE: You wouldn't get picked up as someone who didn't have a problem?

MS. MILGATE: Right. Necessary care. Did you or your doctor think you needed necessary care and you tried to get it? If you did, then how much of a problem --

MS. BURKE: So hopefully, the way it's structured will sort out those.

MS. MILGATE: On CAHPS, yes.

MS. BURKE: Because I do worry, there are a huge number of people who have no problem.

MS. MILGATE: Right. Now some of the other surveys aren't as granular, but the CAHPS survey I think

they did a pretty decent job at that, yes.

MR. FEEZOR: Just to pick up on a comment that Sheila made, that I think our readership interest would be significantly higher if we could have some sub-national numbers and geographic. Not just urban and rural. but if there are some significant regional variations, I think picking that up, if not this time at least subsequently I think would be very helpful to some of our decision makers.

MR. HACKBARTH: My understanding is, at least in the non-Medicare population surveys I've seen, there are significant regional differences in satisfaction.

MS. MILGATE: Possibly.

MR. FEEZOR: If there are.

MS. MILGATE: It's possible to do. I haven't looked at it, so I don't know what it looks like for this.

DR. STOWERS: I was just going to make a comment, it sometimes brings it home, like Sheila was talking the variance in come, that Medicare is only picking up 55 percent of the total health care bill there. So there's a huge part that is out-of-pocket or coinsurance or whatever. So sometimes I think they need to be reminded of that, that Medicare is not picking up the majority of that.

MR. HACKBARTH: Karen, could you go back to the initial graph on difficulty in obtaining care?

MS. MILGATE: Yes. You want me to put it on the screen?

MR. HACKBARTH: To me the big news there is the long-term decline in the percentage saying that they delayed health care due to costs. I was sitting here trying to figure out why, what happened over this time period that resulted in this very significant improvement.

MS. BURKE: I'm still trying to figure out what's going on in 1991.

DR. NEWHOUSE: A depression was going on, or a recession. The economy is getting better.

MR. HACKBARTH: Good for Medicare people.

DR. REISCHAUER: Another hypothesis, which is relative to private payers, Medicare becomes a better payer during this period.

DR. NEWHOUSE: This is delayed health care due to costs which sounds like it's a beneficiary.

MS. BURKE: But is this a Medicare population?

MS. MILGATE: Yes.

MR. HACKBARTH: So Medicare hospital payments went

up but beneficiaries never see that anyhow.

MS. DePARLE: The only policy change was the physician fee schedule during that time really, wasn't it?

DR. NEWHOUSE: [off microphone]

MS. DePARLE: And you had the outpatient coinsurance going up, up, up. So I think beneficiary income went up.

DR. REISCHAUER: This is the period of the huge increase in HMO participation and the overpayments, and so people fall into a kind of insurance that they don't have copays or very low copays.

MS. DePARLE: Not really, though, Bob. That really didn't start occurring until like '95, '96, '97. The peak was 1998.

MS. BURKE: You may be looking at 3 percent in '91, maybe 3 or 4 percent.

MR. HACKBARTH: We could sit here for several hours generating notions. But to me, it sort of gives me pause when I look at these results when there are patterns like this that I can't readily explain, it just sort of puts my antenna up about everything else that comes afterwards.

MS. MILGATE: I can give you a couple of thoughts

but this is not based on any serious analysis.

DR. REISCHAUER: [Off microphone.] As opposed to ours.

[Laughter.]

MS. MILGATE: Yes, I know. I thought they would be much more intelligent on this than I. But I'll jump in a bit.

M+C enrollment went up during that time. I don't know about income of the elderly, but that was a fairly significant increase in the -- the economy did pretty well during that time. So I'm wondering if the income of the elderly simply went up.

And then Sarah was saying that the QMB/SLIMB programs went in around that time, for more lower income. So there could have been more on the side of the beneficiaries' ability to cover these costs than having to do with payment. That's the lens that I would suggest might be more directly involved.

DR. NEWHOUSE: So did Medicaid expand in these years?

MS. MILGATE: Yes, not for the elderly, though.

MS. BURKE: [Off microphone.] That's a lot of the

kids --

MR. FEEZOR: [Off microphone.] The private sector market at this time in the late '80s and early '90s was --

MS. DePARLE: That's what I was going to say. This is the Clinton health plan period when it was the response of all those health care plans and Congress was really looking at it. It makes you wonder if the beneficiaries were just reflecting some of that insecurity.

And then, as we all know, it disappeared in the early '90s. And maybe that's where Joe's explanation comes.

MS. BURKE: [Off microphone.] But just on the face of it, it seems counterintuitive to me that you delayed care due to cost but you didn't have trouble getting care.

MS. MILGATE: That's what I found interesting, too, Sheila. I said wouldn't it show up in your trouble getting health care. They delayed it but eventually got it, I guess.

MS. BURKE: [Off microphone.] It's a huge bell curve.

DR. REISCHAUER: [Off microphone.] But a delay isn't trouble.

MR. SMITH: [Off microphone.] A delay may mean

you didn't seek it, so the answer to the second question is no.

MS. MILGATE: No, you needed it, but delayed it is...

MS. BURKE: [Off microphone.] Delay means you sought and delayed. It didn't mean you didn't ask.

MS. MILGATE: Yes.

DR. ROWE: [Off microphone.] It was delayed, it wasn't cancelled.

DR. REISCHAUER: Could we have a panel of respondents to this at the next meeting?

DR. MILLER: What I was going to suggest is I think it would make sense for us to look at the supplemental trends at the same time for Medigap, M+C, Medicaid coverage, as it relates to the Medicare population and see how those are tracking at the same time.

MS. MILGATE: And we can include some discussion to the extent we feel we learn something that we can conclude on this because it is an interesting question.

MR. HACKBARTH: Any other questions? Dave.

MR. DURENBERGER: All the good questions have been asked, but it may not be a question or thoughtful responses

given, as an observation. That is when you read this, you say well everybody's really happy with the Medicare program. And whether it's Lake Woebegone or some other place, people ask can you see a doc? Do you regularly see the doctor? Can you get to a hospital? Do you get whatever you need? People will say yes.

But if you ask people if they're happy with the system, if their doctor is pleased with the system, if they have to take a relative into the hospital with them, those kind of questions there's a lot of unhappiness in the system.

And if you push on it with the providers of care -- you don't even have to push on it. They will volunteer and they will say the problem is Medicare. And the private payers will say the problem is Medicare.

And I don't mean what they mean is -- they don't mean the adequacy of the benefit structure. They mean the adequacy of the financing. Or the way in which the financing is provided.

So if I have a question it's simply so what? What value does this particular piece of analysis add to our consideration of appropriate financing of the various parts

of the health care delivery system? Do you understand my question?

MR. HACKBARTH: I think I do, yes and so much of what we do in Medicare payment policy is designed to insulate the beneficiaries from that. And so it either works to their advantage by reducing out-of-pocket payments, coinsurance, and the like, or they are not exposed to it at all, in the case of say hospital services. But these are clearly not measures of system satisfaction, system health. It's much more narrow than that.

I think one of the themes of all of the comments has been that we want to be careful in how these are presented. We don't want it come across as oh, everything is okay. And I know you appreciate that. And some of the questions and the sensitivities -- wait, wait.

We don't want it to be a simplistic statement that this shows that everything is just fine. There is a lot of good things happening but there are also real issues. So it's a careful balance that needs to be struck.

DR. REISCHAUER: And now the other side of the argument. This is a problem of is the glass half full or 90 percent full or 10 percent empty? The fact of the matter is

I think most of us at this table were surprised by these numbers, the degree of satisfaction and the lack of -- well, you aren't because you saw them before.

MS. DePARLE: Beneficiaries like Medicare.

DR. REISCHAUER: But we're looking at this in general. There might be pockets of problems. In general, the thing is working pretty well from the standpoint of access. And we've gone through a decade of turmoil and it doesn't seem like the turmoil has upset the apple cart tremendously. And I don't think we should shy away from the fact that it's working pretty well on this dimension.

Can things be better? Yes, they can. Are there specific problems we should focus on? Yes. But you don't want to look at something where 92 percent of people were satisfied or they're getting what they want and say oh, god, 7 percent, let's change the system.

DR. NEWHOUSE: I'm with Bob. If the numbers had come out triple in terms of problems we would have said it shows that what we thought was right. I agree with Bob, I think these are somewhat surprising and there's a sort of reluctance to accept that there might be some good news.

MR. DeBUSK: There's a regional issue here that

could come into play.

DR. NEWHOUSE: We have to see those data.

MS. BURKE: [Off microphone.] I don't think there's a reluctance to agree --

DR. REISCHAUER: Turn on your microphone when you say that.

MS. BURKE: And I absolutely agree with Bob but I think -- I mean, we would all agree that Medicare has done an extraordinary job. Having said that, I think we do need to be cautious about not masking that there are these pockets.

So I would not suggest that we say oh, whoa, it's only 90-something. But I think we say great, it's 90-something but there are still pockets that we need to be concerned about. But I don't disagree with you at all. It's the little engine that could. The big engine that could.

MR. HACKBARTH: I think that's well put, Sheila?

Any other comments? Okay, thank you.

Next up is outpatient PPS and specifically the outlier policy.

DR. WORZALA: Good morning.

We're back in the details of the outpatient PPS. Hope I don't -- never mind.

My presentation will have three parts this morning. First, a conceptual discussion of the rationale for outlier payments cutting sort of across systems. Second, a presentation of the outpatient PPS outlier policy as it was implemented this year, 2003. And finally, a discussion of some policy questions that the Commission may want to consider for the March report.

Outlier payments provide additional funds to providers when the services they furnish are exceptionally costly compared to Medicare's payment rates. Conceptually, the outlier payments serve as a kind of insurance protecting hospitals against unexpected large losses. By providing these additional payments, the program takes away some of the incentive to avoid costly patients and thereby helps to promote beneficiary access to care.

If we look at outliers as a form of insurance, that suggest two situations where you might want an outlier policy. First would be when there's considerable variation in the cost of providing the services included in the product that Medicare is paying for, such as the inpatient

case or the outpatient APC. This is because Medicare sets payments based on average cost. Thus, if a payment group has great variability around that average, the provider is more likely to treat a beneficiary with extraordinarily high costs. This variability in costs is likely to be linked to the product definition. Is the product defined broadly or is it defined narrowly?

A little bit of contrast to get that concept across, the inpatient, of course, is a very broadly defined product covering the entire stay. If you look at the outpatient PPS, it's a much more mixed product definition. There are some broad APC groups such as pacemaker implantation and others are very narrow, an x-ray, an electrocardiogram, a drug.

The other situation where you might want an outlier payment is when the potential losses are great. In that situation providers would be at increased financial risk so you would want to diminish that risk through an outlier policy, both to help the provider and to protect beneficiary access to care.

Of course, when these two things coincide and there is a lot of variation in the costs and the potential

losses are great the need for an outlier policy is magnified.

I would note one additional situation where you might want an outlier policy and that's when the risky cases or the expensive cases are not randomly distributed across providers. If one set of providers is more likely to treat the costly beneficiaries then the outlier policy would shield them from financial losses.

This chart shows what the outpatient payment system looks like when it comes to the size of the potential loss. What we've got are the APC groups and their payment rates. We see that most of APC groups have low payment rates per unit. So two-thirds have a payment rate of less than $500 and 75 percent of the APCs have a payment rate of less than $1000.

There are, however, some highly paid services. For example, insertion of a cardioverter defibrillator as a payment rate of $17,000. What this chart shows is just the distribution of the APC groups. It doesn't have the volume in there, but much of the volume is in the lower paid APC groups.

MR. DeBUSK: [Off microphone.] Does this have the

C-code information in it?

DR. WORZALA: Yes, it does. This is 2003, so most of the devices are packaged.

MR. DeBUSK: [Off microphone.] Packaged? Okay.

DR. ROWE: The $17,000 includes the device?--

DR. WORZALA: In the case of the cardioverter defibrillator, I would have to go back and double-check whether that's still a pass-through in 2003 or not. I apologize, I don't know that detail.

DR. ROWE: That would be a very high rate just to insert it.

DR. WORZALA: It probably does but I would have to go back and double-check.

A number of payment system have an outlier policy and they do have certain elements in common. The first is eligibility, which services can qualify for an outlier payment. The second is the cost threshold, how high must a providers costs be to qualify for an outlier? Third, the marginal payment factor. If you're eligible for an outlier payment, how much additional payment will you receive? What share of the costs above the threshold will be covered by Medicare? Finally, the target amount. What percentage of

total payments will be set aside to fund the outliers?

The outlier policy for the outpatient PPS is required by statute. Like the outlier policy in other settings, it is budget neutral so CMS reduces the payments for all APCs to fund the outlier payments. Congress set an upper bound on the outlier payments of 3 percent. CMS has so far targeted outlier payments below that limit. In 2003 the set aside was 2 percent. If actual payments exceed or fall below that target of 2 percent, no effort is made to modify the conversion factor to try and recoup or return those funds in later years.

In 2003, the outpatient PPS provided outlier payments to all APCs except for pass-through drugs and devices. This includes both the broadly defined APCs ---

MS. BURKE: I'm sorry, can I just ask a question? If you could go back to the prior, just remind me. If, in fact, the adjustment is made, is it made prospectively?

DR. WORZALA: Yes.

MS. BURKE: Essentially if there's an overpayment in the following year, they essentially adjust downward?

DR. WORZALA: No, they never try to adjust. They set the target, they reduce the conversion factor, but

there's no look-back. There's no look-back to say I paid too much last year, therefore I'll reduce the conversion factor more.

So in 2003 we had outliers for everything except pass-through drugs and devices. This includes both the broader bundle such as the surgeries and very narrowly defined groups such as a x-ray or an electrocardiogram. And CMS estimated that a cost threshold of three-and-a-half times the payment rate for the APC and a marginal payment factor of 45 percent above the costs of the threshold would meet their 2 percent target. So to qualify for an outlier payment, the cost must be three-and-a-half times the payment rate. Any costs above that threshold are reimbursed at 45 percent.

You do have a detailed example in your briefing papers of how the outlier was calculated. Here I'm just going to review the process that's followed. Outlier payments are, of course, based on the estimated costs and the FIs estimate costs by taking the current charges submitted on the claim and multiplying them by a cost-to-charge ratio that comes from the most recent tentatively settled or settled cost report.

But even using the most current tentative settled cost report generally results in a time lag of one to two years between the date of the cost-to-charge ratio and the submitted charges. So you come up against the situation where charges have increased at a faster rate than costs in the intervening period. The CCR will result in an estimate of costs that are higher than the actual costs.

And we have seen some evidence in recent years that charges have been increasing faster than costs on average, and for some hospitals at a much faster pace.

There are, of course, may reasons to increase your charges faster than your costs. But no matter what your motivation, the pattern will result in unwarranted outlier payments and those payments will be paid for by other hospitals. So since the outliers are budget neutral that can, of course, have a distribution affect which we'll look at in this slide.

This shows the distribution of outlier payments among hospitals across three different groupings, location, teaching status, and ownership type.

DR. ROWE: This is just the outpatient?

DR. WORZALA: This is just the outpatient outlier

payments. I didn't put that in the title, I apologize.

The percentages in each cell should cum to 100. They don't exactly due to rounding and also an inability to classify hospitals.

So you can see from the table that in each group one type of hospital received a disproportionate share of the outlier payments. It doesn't however tell us why. This could be explained by differences in either costs or charges.

So if you look at it by location, hospitals in large urban areas received a greater share of the outlier payments, 57 percent, than they did of the APC payments, 46 percent. If the outliers were completely randomly distributed, or the cases really and the outliers, we would expect those two numbers to be the same, 46 percent of APC payments and 46 percent of outliers. But you see a disproportionate share of the outlier payments going to hospitals in large urban areas. Of course, for hospitals in other urban and rural areas, the share of outlier payments was lower than the share of APC payments.

If you look at it by teaching status, the major teaching hospitals received a greater share of outlier

payments than APC payments. And looking at it by ownership, the for-profit or proprietary hospitals received a disproportionate share of the outlier payments, as well.

MS. DePARLE: Chantal, how did you define other teaching?

DR. WORZALA: It is defined by the resident-to-bed ratio. And so it's the exact same definition as we would use in our inpatient hospital analysis.

MS. BURKE: Chantal, I was just interested in your comment that the disproportionately is in fact driven by the issues around costs and charges. Is there any impact of the acuity of the particular patient? The distribution of APCs may be what they are, but is there not an impact among APCs and their allocation based on the acuity of the patient that may drive the charge?

DR. WORZALA: Yes, I think that would be where you really are seeing this driven by differences in cost structure and the cost could be a function of the patients that you see. It could very well be that the risky patients, the more expensive patients, are not randomly distributed across hospitals and certain hospitals may, in fact, see more costly patients.

MR. MULLER: [Off microphone.] We know that.

DR. WORZALA: Exactly.

MS. BURKE: So I would only caution you about the use of the term disproportionate because in fact, it may be appropriate. That's my only concern, is that the resulting allocation, the share of the outliers, may in fact track the acuity of the patient and not simply a function of some people are bigger piggies than others.

DR. WORZALA: I didn't mean for disproportionate to be used that way. It was just a different in proportion of the APC payments versus the outlier payment. I tried to predicate all this with the explanation it could be charges, it could be costs, and we can't disentangled that from what's in front of us. And hopefully additional analyses that we do over the next few months will help us disentangle some of that.

Here are some policy questions that we might want to ask. The first would be does the outpatient PPS need an outlier payment? I think there are a number of arguments supporting a no response to that question. First, many outpatient services have a narrow product definition, and this includes a lot of ancillary services and inputs that

are paid separately which would suggest that the variability in costs will not be great.

I haven't shown you any analyses by service type because I want to make sure everything is right before I present it, but our initial results are suggesting that some of these sort of fairly simple ancillary services are receiving a fairly high share of outlier payments, which I think poses some questions.

Secondly, as we saw earlier, the APCs generally have low payment rates so the size of the potential loss is not that great. Third, I think there are some equity issues here. This is a budget neutral system, so the base payments are lowered to find the outliers, but we know that the outlier payments themselves are not evenly distributed.

In addition, there is the potential for outlier payments to be made in responses to increases in charges not necessarily increases in costs. Again, I think that's an equity issue.

Finally, the outpatient PPS is the only ambulatory setting with an outlier policy. However, many of the services provided can also be provided in physicians' offices or ASCs. So when you have an outlier policy in one

setting and not the others, you have just one more difference in how the services are paid for across settings.

I do believe that Ariel has heard from some ASCs who would like an outlier payment.

However, there are also arguments supporting a yes answer to the question of does the outpatient PPS need an outlier policy. There has been a shift toward more sophisticated and more costly services being performed in the outpatient setting. That's a pattern that's likely to continue in the future.

Second. this is a pretty new payment system and we know that CMS has had some difficulty setting the payment rates given the data they have available. So some would argue that the outlier system provides a cushion in the event that rates really are just too low.

Of course, it would be best to fix the payment rates but in the interim maybe there is a role for the outlier.

And third, as we've been discussing, I think the distribution of cases across hospitals may not be random. And so if you're routinely seeing more expensive cases, the outlier helps to compensate you for those additional costs.

Finally, if we decide that the outlier is appropriate for the outpatient PPS, are there any changes to the design that are warranted? Currently most services are eligible for outlier payments, including electrocardiograms, x-rays, setting a cast. These all can be given an outlier payment.

Does that makes sense or should we limit the eligibility to certain types of APCs such as surgeries or more broadly defined products?

Second, currently the threshold is set as a multiple of the payment rate regardless of the actual dollar amount. So if we go back to the example of electrocardiograms, they have a payment rate of $19. Does a low-cost service like that provide a sufficient financial risk to warrant an outlier payment?

Other outlier polices do have an absolute dollar threshold that must be met before an outlier payment is received. Is that something that might make sense in the outpatient setting as well?

And of course, changes along these lines may have implications for the target amount as well. If fewer services are eligible for outliers, then you need less funds

taken out of base payments to fund outliers.

And very quickly, over the next few months I will bring you additional data to help inform these policy questions, looking more at the distribution of outliers by hospital to look at some of the distributional issues. And then looking at outlier payments by APC to inform some of these discussions of design.

And finally, I'm planning to bring you data from 2002 although I've come up against some data issues so we'll see what happens there.

DR. NEWHOUSE: Chantal, you could do some analysis that would help me think about this, which is for the higher paying APCs what is the coefficient of variation? That is, you pointed to a narrow bundle being a reason not to have an outlier scheme. And in the narrowest of bundles there would be one service and there would be no variation at all so he wouldn't need an outlier scheme. And we have outlier schemes when we think there is variation as in PPS, and I think also in home health.

So what is it here and how did the variability compare to these other systems?

That seems to me also would inform us in thinking

about how much should be set aside for outliers because if it was say somewhere in between the one extreme of the physicians system and probably the hospital system or the home health system, we'd have a payment percentage that was in between.

And then on a separate issue, if there is an outlier scheme I think as a matter of principle we would want to fix dollar threshold as in the hospital PPS.

DR. REISCHAUER: How do you calculate the coefficient of variation?

DR. NEWHOUSE: A standard deviation over the mean.

DR. ROWE: [Off microphone.] [Inaudible.]

DR. REISCHAUER: Thank you, Professor.

DR. ROWE: Even I know that and I'm a doctor.

DR. REISCHAUER: I can get my Ph.D. taken away from me by Professor Newhouse.

What's the data that you use?

DR. NEWHOUSE: But you have the threat of taking my professorial title away.

DR. REISCHAUER: Don't you have to use the stuff that the hospitals are submitting, which maybe is biased?

DR. NEWHOUSE: Yes, that's right. What do we use

in the hospital system? I'd still like to know what.

DR. MILLER: Can I ask one question on this, and I want to be clear on this which is why I'm asking. In some instances, isn't your point that it is effectively coming down to one service? But I wanted to also just make sure that that point was clear to everyone, that often it is one service that we're talking about that the calculation is being taken on.

MS. DePARLE: I'm sorry, can I just ask a contextual point? It's been a while since I looked at this and I thought it was in the paper but it isn't.

How much is Medicare spending? What's the 2002 data on outpatient spending? And what has the trend been over the last few years, I guess since '98?

DR. WORZALA: We had a really sharp increase in 2001 that took us up to $18.6 billion under the outpatient PPS. And the projections are for continued rapid growth. There was real growth in the '80s and the early '90s and there was a little bit of a slowing down in the mid- to late-'90s with real acceleration since the implementation of the outpatient PPS.

DR. MILLER: [Off microphone.] Chantal, I thought

the last COACT number was --

DR. WORZALA: That is for 2004 protected.

MR. DeBUSK: I've got two or three points here. In assessing the outlier policy under the outpatient prospective payment system I notice in the last bullet point we're looking at using data from 2002. Do we have access to any more recent data? Isn't there some claims data that CMS has access to?

MS. BURKE: We were using '96.

DR. WORZALA: I've presented data from 2001. We have up and running the 2002 CMS data but we're having a few data issues and we may have to go back and get a new dataset.

MR. DeBUSK: Yesterday I got out of the penalty box because Nick took up the issue about my normal complaint about the availability of data. I guess we're right back at the same place, the data is not current enough to even discuss the subject hardly. But anyhow, let me go to the next piece.

Eligibility, all APCs except pass-through of drugs and devices. Last year, we were talking a lot about the implantables and the costs and the overrun, the last two

years. Now that we're into full-blown use of stents and what have you and drugs, do we have any idea what this looks like? Is there any data out there to tell us?

That is outside the budget neutral piece, is it not? These C-codes that still exist.

DR. WORZALA: No, the pass-throughs are also funded budget neutral.

MR. DeBUSK: The drugs?

DR. WORZALA: The reason we don't have outlier payments on pass-through items is because pass-through items are paid 100 percent of cost. And so there's not a fixed payment rate to compare the costs against.

DR. MILLER: But to Pete's point, if the pass-through payments exceed the budget neutral amount, then there's a pro rata reduction. And I think we're not a position at this point to calculate whether it's going to exceed that; is that a fair statement? Is that what you're driving at, Pete?

MR. DeBUSK: Yes, it is. Is that set at 2 or 2.5 percent?

DR. WORZALA: I'm going to be honest, I'm struggling in my mind whether it's 2 or 2.5 percent. It's

2.5 in 2003 and 2 percent in 2004 is my recollection, but I would need to double-check that.

But is your point that in 2002, for example, when there was a pro rata reduction that pass-through items should have been able to receive outlier payments?

MR. DeBUSK: I was just wondering, when I look at being neutral, we actually spent more money. Wasn't there an overrun of about $600 million in 2002; isn't that right?

DR. WORZALA: In 2001, we know that there was considerably more spent, almost four times -- well, three times what was set aside. In 2002, I don't think we know yet. We need to look at the data to tell me.

MR. DeBUSK: There was a projection though of $1.7 billion right, initially? Isn't that right?

MS. BURKE: On pass-through.

MR. DeBUSK: On pass-throughs. But that was never actually reached. It turned to be something more like $600 million dollars.

DR. WORZALA: I honestly don't think we know yet. That number was the 2002 projection and I haven't seen any data from the 2002 claims to see how much was actually spent on the pass-throughs.

MR. DeBUSK: The biggest thing here, I guess, is we don't have any ability to look at what's happened after the program memorandum of January in regards to the statewide averaging?

DR. WORZALA: That's true. Yes, we don't have any 2003 data on the outliers although potentially we could get the first three months or something of 2003.

DR. MILLER: Or to put it differently, to the extent that that problem was still in play it would be reflected in this data. To the extent that the program memorandum -- corrected anything, we have not seen the data to see what the effect is. I think that's your point.

MR. DeBUSK: Yes, that's fair enough.

MR. FEEZOR: Thank you, Chantal, a good presentation. A couple of things.

I guess I would echo Joe's comments that if it does look like we're going to be proceeding on this, some staff work around a dollar threshold, I think would be very helpful prior to going into that.

Secondly, when you breakout more information on a hospital-specific basis, my first instinct would be I'd love to know which are the financial or billing systems the

entities are using. That's probably not feasible. But perhaps hospitals that are under common ownership might be an interesting array. I won't say anything more.

And then third, follow up I guess on Mark's observation that it's largely maybe one or two procedures or issues we're talking about here. I wonder if some effort to sort of look into the future in terms -- and I mean near future, next three of five years -- of what might be evolving to the outpatient basis, so that we would have some idea whether it's going to be that limited.

And then the final thing is, I shared with one my colleagues on the Commission here that your back ground must have been with Aetna or an intermediary and the financial example that you used, you're off about $100 that you have, the example used was not calculated properly. So you probably need to correct that.

DR. ROWE: I object.

[Laughter.]

MR. FEEZOR: And as a payer, I used to appreciate those.

DR. ROWE: That was the old Aetna.

DR. WORZALA: I apologize. Feel free to pass

editorial comments on paper.

DR. ROWE: A couple of points. One is I think my answer to the question of whether there should be an outlier for this is yes. I'm concerned about the fact that we don't want to have any payment policies that influence the site of care in a way that has care take place in other than the best place for it to take place. And if we have an outlier policy in the hospital and we don't have an outlier policy out of the hospital, and if some of these hospitals that are having a "disproportionate" share of outlier payments now because of the kind of things they're doing in the outpatient setting, which we think is the direction we want to go, it would start relocating those back into the hospital in order to get this protection. Then we would have set a policy up that was in the wrong direction.

So that's my concern. Maybe that's included in your reasons that you articulated and that you have in the paper but it's not said quite that way. I think that we should make sure that we're not setting policies that have that unintended effect. I don't know how big an effect that would be.

MR. HACKBARTH: Jack, but it may be that having an

outlier is conceptually reasonable for some types of outpatient cases but not others.

DR. ROWE: I would say so. After I would say yes to that, then I would certainly say yes to certain types of cases. I think that outliers for some of the simple things, like putting a cast on, might not be costs or patient-specific characteristics. They might be provider-specific characteristics. I mean, if they're particularly bad at doing something and they have to redo it over and over again. Or it may be another way to pay for medical education or something else. I don't know what would be driving the outliers in some of these fairly simple things.

So I would say what we want to do is we want to point out certain.

MR. MULLER: Was that a [inaudible] -- slur there?

DR. ROWE: No, I'm just imagining. I'm remember when I was a resident, I kept doing it. You're going to run this play until you get it right. So I would pick some complex things or look at the last payments in the past and choose the most important ones.

The other comment I would make while I have the microphone is I would not support the idea of taking Bob's

Ph.D. away. I think we might revisit his role as Vice Chairman of the Commission but not...

[Laughter.]

MR. MULLER: I'm also in favorite having an outlier policy. Remind me again, the loss on the patients was about the 15 to 17 percent range?

DR. WORZALA: You're talking about the margins?

DR. WORZALA: Yes.

DR. WORZALA: Yes, -15.

MR. MULLER: So to have a component, or whatever we called it yesterday, that on average has a negative margin of 15 percent, with all that caveats of Joe's about the cost allocation process, but still it's one in which there are considerable losses on average.

Secondly, in the example you gave of how the outlier works, even after the outlier payment in that particular case the hospital, the place was getting less than 50 percent of cost. So in a sense it mitigates some of the extreme losses but doesn't mitigate it very much the way the formula is calculated with that 2.5 times threshold and then the 45 percent of marginal cost. It's really a pretty modest payment for the wide variation in costs that could

occur, probably due to acuity and other things that we're going to understand more fully.

So to both have a program area in which there are considerable -- let's say there's a pretty high negative margin -- and the outlier policy doesn't go very far towards mitigating that loss in extreme cases. So from my point of view, this is a pretty damp outlier and it doesn't do much mitigation, especially if we're in favor of limiting the number of APCs to which it applies and perhaps not have some of the more narrowly defined APCs put into outlier policy. That's even more reason perhaps to focus the outlier on the ones that have more bundling going on, that have more variation and more range.

The examples you gave in the document that you sent us I think was very well done. It does indicate that some of these APCs are a little closer to DRG bundles. And I think focusing on the ones that are a little closer to that makes a lot of sense.

And so if we could, as we elaborate on this work over the course of the year, to get a little bit more information on the ones that have the more variation -- I think that's when Joe was asking in his initial comments --

I think would be very helpful. But I think we should keep reminding ourselves this dampens very modestly a program in which we already have considerable losses. So it really doesn't -- unlike the inpatient outlier policy where there's some evidence that CMS has responded to that considerable margins can be achieved through the outlier policy, positive margins can be achieved through the outlier policy, this just dampens a pretty considerable loss. It doesn't really , it strikes me from the evidence we have, put certain of these APCs into a high margin.

To go back to Nancy-Ann's point about the growth, the grown again, as we've shown over the course of the last few years, is much more technology driven and utilization driven and so forth. I don't think the evidence is as clear yet, if there's evidence at all, that there's high margins per procedure on this, as opposed to a considerable increase in utilization. So that the 18 or 20 percent increases that are going on, I would suspect are more utilization driven rather than high margin per case driven.

MR. HACKBARTH: Ralph, help me out. I think of this is as a distributive issue. These dollars wouldn't disappear, they would go back into the base. So with regard

to the overall average margin of hospitals for outpatient services, this is a neutral policy. Whether you have the outliers or not, or constrained or not affects the distribution of payments among types of hospitals, but not the overall margin.

MR. MULLER: Correct, but if in fact, if the outlier does what it's intended to do, which is act as an insurance policy on some cases in which there is extreme variation, then in fact having some kind of appropriate payment for those cases I think is an appropriate distributional effect. And therefore, having some of those APCs or the patients in those APCs have some of fair approximation of costs, I think is a fair way of thinking about it.

Even though in some of these cases the provider may be losing 80 or 90 percent on that, and that's not a good policy to have to be losing at that level. Because even as I say, in the case that Chantal gave, they were still losing about 60 percent or so, a 60 percent loss. So to have APCs that are that far off coming closer to break even, I don't think is a good distributional policy to have.

I follow your point but the reason that we have

outliers and have circuit breakers and so forth is to take into account the fact that they're still -- and since it's based on averages, there can be some considerable variation and there should be some accommodation for that variation.

MR. HACKBARTH: And I agree with that and I think that leads you to thinking about outliers in terms of the APCs where there is a potential for large variation in case costs.

MS. DePARLE: I just wanted to respond to that. Based on everything I've heard this morning, I'm not convinced there is such a strong rationale for an outlier policy here. If there is to be one, I think it should be more limited and specifying some dollar thresholds, I think that's what Joe and others have said here today. And I would hope if there's anything we can contribute to a policy that would help CMS to avoid the kind of problems that have occurred in the inpatient area, I would hope that we would do that.

I'm also troubled by the fact that we do not -- that this is not available in other settings, where these same procedures are being performed. And we have said before that we wanted to create a more level playing field.

And so I like to be convinced that that's fair here.

DR. WORZALA: I just want to mention one thing that I didn't put in my presentation but was in the paper. In the proposal rule for 2004, CMS points out the case of the community mental health centers that provide partial hospitalization services. They did find pretty significant evidence that a subset of those providers were, in fact, gaming the outpatient outlier system. They found charges -- well, it ended up that a subset of providers received as much in outlier payments as they were receiving in their base payments for these services. Then they were finding that the charges for the services for some of these providers were actually higher than an inpatient psychiatric stay.

So there's potential on the outpatient side, and it apparently has been acted on by some providers. And CMS has responded by proposing to set a higher threshold for that particular set of providers than for hospitals because they felt like it was a sufficiently isolated case.

MS. BURKE: I agree with much of what Nancy-Ann has said, although I do fundamentally believe in an outlier payment policy. I think the nature of a reimbursement

system that's based on averages suggests that in fact there are legitimate variances that must be dealt with if they are extreme, which suggests that -- has been proposed -- I think it is not only a question of a threshold amount which puts an institution at risk but it is also the variance that exists in the individual cases that I think has to be tracked.

So I think we would be well guided to look at both what a threshold would be, that in fact is a significant risk, where there is in fact variation, going to Joe's early point, what can we track in terms of those particular instances where this is warranted and reduce substantially. I mean, to suggest that it ought to be applied to all treatment is crazy by the nature of what goes on in those settings.

The other question, however, is this question of whether it ought to apply outside of an institutional setting to non-hospital based programs. And I don't know that I know what the right answer to that is.

I do think we have to be worried about setting different incentives, which is something we've talked about repeatedly over the last couple of years, that depending on

the setting we essentially -- by the nature of how we pay -- lead people in certain directions. Although I was quite concerned, I noted that description of the mental health provider was frightening in terms of what the risks might be.

But I do think there needs to be some analysis of whether or not it should legitimately apply, particularly if we're able to narrow the types of cases that are, in fact, where there are huge variances that we may be able to control that in an environment that's not in the hospital-based environment. So I think all of those things ought to drive us in terms of further analysis and whether we can narrow it down. But I do fundamentally think we ought to have an outlier policy.

DR. REISCHAUER: I basically agree with Nancy-Ann also on where we should go with this.

I was wondering whether we had any information about how private plans pay for outpatient procedures and whether they have outlier types of mechanisms or a payment system which in practice makes adjustments for acuity and other kinds of things?

The other comment that I'd make is looking at this

outlier payments by hospital group chart, I wondered if we could do some more refined analysis here. Because the thing that leaps out at me is the proprietary line and the knowledge that few of those hospitals are major teaching, and many of them are in other urban locations.

And if you do your mental arithmetic here, you might find that the gap is really very, very large which then would raise a set of questions because of what we know about the inpatient abuses that have taken place with respect to outlier payments.

DR. WORZALA: I should note that charges are set for all payers by law and so you don't have a different charge for an refer ancillary service when it's provided on the inpatient side versus an outpatient side. So when you're talking about escalating charges, a lot of those charges apply on both sides of the line.

DR. REISCHAUER: Isn't the real question who pays charges? I mean, you know, Saudi princes?

MR. MULLER: The allegation in the inpatient was that some providers had doubled their charges overnight.

DR. MILLER: Also, with respect to Medicare, it's which services you choose to increase your charges on.

MR. MULLER: No, to take advantage of the cost of charge calculations.

DR. MILLER: Even if you have to charge it similarly, it's which ones you choose to set the charges high on, if you're trying to have an impact on Medicare. Although, in some of the stuff that went on, really the sense is that the charging practices that they were engaged in were actually to drive both Medicare and private pay outlier type policies.

MR. MULLER: Bob, the privates do have outlier circuit breaker-type policies. They are more inpatient focused than outpatient focused and they have different thresholds but they do exist.

DR. ROWE: You're referring to stop loss?

MR. MULLER: Yes. There's various kinds of circuit breakers. But I think one of the questions that we're starting with, to use the inpatient analogy, is when people inappropriately jack up prices 100 percent. I mean, one can make arguments that charges should go up two, three, four, five. It's a lot harder to say that when somebody takes over the hospital you have to increase the charges 100 percent, as some of people did and the stuff that hit the

pass this summer. There's probably not much warrant for that, in terms of a cost structure, to increase your charges 100 percent.

Then given how some of the modifications that CMS has made in the inpatient policy, tries to take that into account. Also there was some room to play with the hospital-specific cost-to-charge ratio vis-a-vis the state cost-to-charge ratio. So there clearly gaming going on there.

I agree with Nancy-Ann, we shouldn't have policies that invite gaming that quickly and unfortunately, one shouldn't necessarily throw out the whole policy just because there might be some people who game it. And obviously, having cost-to-charge ratios does invite that kind of gaming to go on whether one does it by looking at settings in which charges blow up by some unreasonable number and how do you define unreasonable and so forth, might be one way of dealing with it. But certainly that was, I think, what happened on the inpatient side.

DR. ROWE: Can I ask Nancy-Ann a question? Do you find my concern just unpersuasive or you don't think it's -- you have so much more experience than the rest of us here in

this about relocating stuff back into the inpatient in order to protect themselves on outlier side. You don't think that's going to be a problem?

MS. DePARLE: I guess, in looking at the data that Chantal has presented, we have now what 600 APCs? This is more granular than any other payment system we have now. And you start to wonder are we even really bundling anymore. I guess I just have some questions about where we're going with this in general.

DR. NEWHOUSE: But then there won't be much variance.

MS. DePARLE: And therefore I don't find it as compelling, Jack, that we need an outlier policy in this setting as I do certainly in the inpatient setting. I didn't say that I -- I just said I wasn't convinced. I don't find it is convincing, especially when we look at some of the examples that Chantal gave. Obviously, we have to look at all of them. And an example of setting a cast for $19, I hope she's going to tell us that she did not find any evidence that CMS paid outlier payments for that.

DR. REISCHAUER: But doesn't an inpatient one have a dollar threshold that's very high and so it eliminates

virtually all of these.

DR. ROWE: It's a stop-loss.

MS. DePARLE: I was there when we implemented this, so perhaps I should have seen that then, but I'm just saying it seems to me clearly that we need some sort of threshold for this. I don't think, even if you find Jack's arguments more compelling even then I did, you would not say that it should apply to everything, I think. You didn't say that.

DR. ROWE: I didn't represent that.

MR. MULLER: There is a threshold in there.

MS. DePARLE: Not in the outpatient. That's the problem, so it could apply to this setting a cast APC for $19.

MR. MULLER: Well, 2.75, I'd call that a threshold.

MS. DePARLE: But that's a threshold of the payments. That's not a threshold of which things it should apply to. I guess I think that's what the outlier policy should be designed around.

MR. HACKBARTH: Nancy-Ann, what I hear you saying is if we do Joe's analysis and find for selected APCs that

there is a lot of variation, you wouldn't be opposed to an outlier policy in those limited cases. But you want specific -- not just across the board.

MS. DePARLE: I would be interested in a dollar threshold, as well, although if we find -- I mean, it's quite interesting, at least to people at this table I guess -- if we found that for something like the example the Chantal used, the $19 procedure, there was that much variation, I would want to bring Karen and the equality people up here and say what's going on in some of these hospitals.

MR. HACKBARTH: We use variation and that's shorthand for variation beyond the control of the provider, so it's variation in the patient and the needs of the patient as opposed to just variation of what they're doing is ideally what we want.

MS. DePARLE: That's what we'd be looking for but I'd be very interested in knowing that, if that's the case.

MR. HACKBARTH: That's exactly the problem.

DR. WORZALA: I can just tell you, just as a cautionary tale, and I will certainly bring you back things that show the coefficient of variation by service. But as

Bob pointed out, this is all dependent on the data that the hospitals submit. And so all of these motivations are in there.

And I will tell you that there are electrocardiograms where the charges are $140 in my dataset and that will be picked up as part of the coefficient of variation.

So in theory, we think that a small bundle should have lower variability, but I don't know that that's going to show up in the data because of all the motivations that are in play right now.

MR. SMITH: Very briefly, I found Jack's argument persuasive but persuasive at a very high level, which seemed to me that there ought to be a pretty high dollar threshold and perhaps some APC limitation. You're going to have distributional data both on amount and APC. That will give us some sense of how to constrain it. But it does seem to me that we have an access issue and we have a site of treatment issue if we don't have an outlier policy and there's no particular reason to do that if we can figure out how to narrow the universe to which it applies.

And I suspect that also argues for a similar

outlier policy in other outpatient settings. I doesn't seem to me we can argue that we're concerned about shifting treatment back into the hospital if we get rid of the outlier policy but we're not concerned about shifting stuff back into the outpatient department if we don't apply the outlier policy more broadly. So narrow it and expanded it.

DR. ROWE: Let me give you an example of what I was thinking about, just to be specific. I think it was at Duke University where some really fabulous guys developed an outpatient bone marrow transplant program, which is just a terrific idea because these patients are at risk for infection. You want to keep them out of the hospital. When you put them in the hospital you have to create an environment around them which makes believe they're not in the hospital, et cetera, et cetera. And I may have the details wrong, but I think it was at Duke. And I think their results are excellent.

The last thing you want to do is stem that kind of innovation because these are very sick patients and they may have some whatever, and have a bad experience and have the hospital say look, we can't afford this anymore.

So I'm thinking of this very high end stuff and I

don't know what the threshold is, but I'm trying to foster innovation is what I think we need to do with the policies. That's where I was coming from.

MS. DePARLE: I agree and I think I remember that.

Remember, there's also an issue though, and Chantal mentioned this, as to which procedures are appropriate for the outpatient setting and that's a separate issue. You talked about it a little bit in the paper. We didn't talk about it here.

DR. ROWE: [Off microphone.] We should let tomorrow's doctors decide that.

MS. DePARLE: I was going to say my view is that CMS has expanded it, perhaps not enough. Perhaps, both in the hospital outpatient setting and in the ASCs, there should be more flexibility there. That's a separate issue.

But also remember we're not talking about taking these dollars away from the outpatient hospital setting. We're simply saying, at least it's my belief, that they should be targeted towards truly appropriate cases. And what we're talking about here is defining those. And I just don't think that they have been defined adequately so far.

MR. HACKBARTH: I have Joe and then Ray, and then

I think we need to move on.

DR. NEWHOUSE: I certainly agree with Jack's intent, but to the degree there is an issue it's a much bigger issue than outliers. That is, there could be no variation within each APC, in which case there would be no need for an outlier scheme. But there could be quite different reimbursement for the outpatient setting than the inpatient setting. In which case payment policy could conceivably influence site of care. Whether it did or not is another matter.

Maybe at some point staff wants to look at the different payments for things that could go back and forth. We've seen the practice expense on the office, the ASC, and the outpatient department and the non-neutrality there. And we've seen some non-neutrality in the post-acute side. Maybe we should also look at it here. I don't recall seeing any data like that for inpatient/outpatient.

DR. STOWERS: I think I'm kind of saying what Joe was saying, but Jack, I see your example more as setting an appropriate APC for outpatient bone marrow rather than a variance between the cost of doing that from one patient to another.

DR. ROWE: Sure.

DR. STOWERS: I think that's where the innovation has to come, as in quickly bring in new APCs to cover new procedures. But I think it's important in this chapter not to get that confused.

DR. ROWE: Okay, I accept that. I think that's a good addition. I do think that when you're innovating, the variability in your experience is greater and it gets really hard, until you have a lot of experience, to set the right price. And so you're making it up as you going along. You're innovating and you really don't know.

So I agree with you that if you get the right price, then if you get enough cases and a reasonable variation around it, everybody will be okay. But early on you're putting some people at risk and that was really what I had in mind.

MR. HACKBARTH: Thank you, Chantal.

Next up is the work plan for ambulatory surgical centers.

MR. WINTER: Good morning. I'll be providing a brief update on the ambulatory surgical center payment system, discussing the factors we use to assess payment

adequacy, and presenting preliminary data on growth in the number of ASCs.

Medicare uses a fee schedule to pay for facility services provided in an ASC. The fee schedule divides procedures into nine payment groups and the rates for these groups are based on cost data from the 1986 survey of ASCs.

CMS conducted a new survey in 1994 but rates based on the survey were never implemented due to congressional action. The agency recently said that it has developed a new survey instrument, however it has not yet been fielded. CMS also said that it is exploring ways to revise the ASC payment system so that ASC rates are better aligned with hospital outpatient and physician office rates. This does not necessarily mean paying the same rate in each setting. It could mean using similar relative weights for services in each setting.

The annual update for ASC rates is based on the increase in the consumer price index for urban consumers. In March, the Commission recommended that the update for FY 2004 be eliminated. The House Medicare bill would reduce the update by two percentage points from 2004 through 2008. The Senate bill has no such provision.

A full update of 2 percent recently went into effect for FY 2004. Medicare payments to ASCs totaled almost $2 billion in 2002, the second consecutive year in which payments increased by 17 percent. This amount is less than 1 percent of total Medicare spending.

In March CMS published a final rule that updated the list of procedures eligible for Medicare payment when performed in an ASC. The rule added 300 new codes and deleted 144 for a new total of 2,400. The list had last been updated in 1995. CMS expects that these changes will expand the volume of ASC services and increase Medicare spending by $5 million a year.

CMS assigned new procedures to one of the nine ASC payment groups by matching new codes to codes that are currently on the list based on their clinical similarity and use of resources. As I mentioned earlier, the current rates for these groups are based on fairly old cost data.

It is worth noting that CMS thought about ways to minimize disparities between ASC and outpatient rates for the same services when developing this rule. For example, they considered assigning new codes to the ASC payment groups that were most similar to the outpatient payment

rates for these codes. However, they decided not to use this approach because it could have resulted in new ASC procedures being paid different rates than similar procedures currently on the list.

In addition, CMS found that certain procedures met the criteria for inclusion on the list but would have been paid much more in an ASC than other ambulatory settings, even if placed in the lowest ASC payment group of $340. Because adding these procedures to the ASC list could have created financial incentives to shift these services to ASCs, CMS excluded them from the list.

As we did last year, we will again assess the adequacy of Medicare payments for ASC services. Although we lack recent date on the cost of ASC procedures, there are several other factors we can use to judge the adequacy of payments which are listed here. We will look at the recent entry and exit of ASCs from the Medicare market on the next slide.

But before we get there, I want to mention that we have a research project underway with RAND that we hope will shed light on the quality of care provided in ASCs. One of the project's goals is to development measures that will

allow us to compare outcomes for services provided in ASCs, outpatient departments, and physician offices. These outcome indicators could eventually be used to assess changes in the quality of care provided in ASCs. Although this project will not be completed in time for the March report next year, we hope to be able to use the findings in the update process for FY 2006.

Our preliminary analysis of new data from the provider of services file shows that there is continued strong growth in the number of Medicare-certified ASCs. At the end of 2001, there were almost 3,400 centers. As of June 2003, there were over 3,700. The number grew by 6.7 percent in 2002 and at an annual rate of 7.7 percent in the first half of 2003.

During 2002 over 300 ASCs entered the Medicare program while 83 closed or merged with other centers. Most of the new centers are freestanding for-profit entities located in urban areas. This is also true of existing ASCs. ASCs tend to be geographically concentrated. Over 40 percent of centers are located in five states that account for 26 percent of beneficiaries.

As part of our study of specialty providers which

we discussed at last month's meeting, we will analyze the market factors that are associated with ASC location. The factors we plan to look include the presence of certificate of need rules, population growth, household income, and the supply of hospital beds and physicians.

This concludes my presentation and I welcome any questions or comments.

MR. HACKBARTH: Ariel, remind me where we stand on getting cost data? Is anything in progress or imminent on that?

MR. WINTER: In the rule this past March, in which CMS updated the list of procedures on the list, they said that they've completed a survey instrument but there's no information about when they plan to field that instrument. They do say that, based on prior experience, it takes about two years to field the survey, collect the data, audit it, and analyze the.

DR. REISCHAUER: This is a general comment about the way we structure these analyses, so this is to Mark as much as to you, Ariel. That is, I think we should preface always our discussion of entrance and exit into the importance of Medicare to that type of provider's business.

And if 5 percent of ASCs' business is Medicare, it's clearly not the Medicare tail that's wagging this dog, it's something else. And lots of people coming in and going out isn't really relevant, and access to capital is another thing that you should do the same way.

MR. WINTER: That's a good point and we estimated last year that Medicare accounts for about 20 to 30 percent of ASC revenue, but that's going to vary by the kind of ASCs. So ASCs that specialize in cataract procedures are going to much be higher, endoscopy could be lower.

MR. FEEZOR: Ariel, the factors again you're going to be analyzing in the market, CON, bed supply, physician supply, and there were a couple of others.

MR. WINTER: We talked about household income, median household income, population growth which could be a factor in where they decide to locate. Faster growing areas might be more attractive. We would also look at demographic factors, percent of non-white residents.

We're also going to look at the presence of other kinds of specialty providers like specialty hospitals and freestanding imaging centers.

DR. ROWE: [Off microphone.] Ariel, I think the

time has come to look at this differently. In the beginning, when there weren't that many of these it was fair to lump them. But now we're up over 3,000 and this is not one of these you've seen one redwood you've seen all the redwoods. They are very different kinds of facilities, some of them specialize, as you say, in cataracts, others in other kinds of procedures. They vary in their size. They vary in their ownership.

I think it would be helpful maybe even working with the professional organizations that represent these facilities, maybe they have a classification of them. Maybe the literature includes -- I don't follow this literature. But rather than just show us the volume blame changes in the 3000, let's see if we can develop some subcategories that tell us something about what's really happening here from a policy point of view if we're going to try to make some suggestions.

I don't know what that categorization would look like, but I think it would be worth trying to develop one.

MR. WINTER: We did publish a table in last year's report on the breakdown of ASCs by their specialty based on industry data. What we're planning to do now is actually

look at what the distribution is based on their provision of Medicare services. So using Medicare data, what are those that specialize in ophthalmology procedures, endoscopy, et cetera. We also want to look at them by the number of ORs, which is provided in the provider services data and other characteristics.

MS. DePARLE: I feel like a broken record on this because I've said many times that I'm very uncomfortable with basing our assessment of the adequacy of Medicare payments to ambulatory surgical centers on 20-year-old data. I think it's really bad that CMS hasn't done the survey and that we don't have better data.

But that sad, if we are going to use other things as proxies, which we did last year, and it appears we're headed in that direction this year, I agree with Bob that we should try to be a little more precise about exactly what we're looking at. And to the extent that it's possible -- I don't know if it is possible Ariel -- but among the new entrants to the market, you've described several things that you're going to look at. I might suggest -- I don't know if you said physician supply as one of the things. Did you say hospital beds, too, in patient hospital beds?

MR. WINTER: Yes.

MS. DePARLE: So I might suggest that if there's any way to look at not just the importance of Medicare to ASCs in general, which you seem to indicate we have some data on, or on average what the ASC revenue is and how much of it is attributable to Medicare. But is it possible to look at that based on the new entrants, whether they are in fact following that same trend?

Because I've seen information at least anecdotally that would seem to indicate that they're not.

MR. WINTER: I'll look into that, whether we can address that.

MR. HACKBARTH: I share your concern, Nancy-Ann, about the lack of data. We really do not have much here on which to base a recommendation. The fact of rapid growth, in and of itself, is not necessarily a bad thing. It reflects changes in medical practice and may be good for patients, physicians. I'm not biased in anyway against doing more in ambulatory surgical centers. What makes it suspect is the fact that these rates are based on such old data. And then there was the added fact of the disparity in payment between what we pay for the hospital outpatient

department in an ASC. That's what sort of raised the potential flags about this.

MS. DePARLE: But it's not all in the same direction. Remember, we had that discussion before. Some of the rates are higher in an outpatient setting. Not all of them, but we did have that discussion before.

MR. HACKBARTH: And so it's frustrating to hear that we're going to be in essentially the same position in terms of hard information for at least the next couple of years. I wish there was something we could do about that.

DR. REISCHAUER: Do we have any information about how many of these ASCs, either new ones or existing ones, are not Medicare-certified? Because they don't have to be to serve Medicare folks. And a test of whether payments are adequate is whether they choose to serve them, particularly the new ones. And if they do, it would suggest that Medicare payments are at least covering marginal costs.

MS. DePARLE: [Off microphone.] For some procedures.

DR. REISCHAUER: Yes. But you either do or you don't, I would gather. So it's sort of on average.

MS. DePARLE: By an ASC doesn't have to do every

procedure. So it could be that you'd make the decision that for some things it's adequate, so you want Medicare certification. But I agree with you.

MR. WINTER: If I could just address that, the list we have is only for Medicare-certified ASCs. I don't have a list of those that are Medicare-certified and those that are not. I've heard from the industry that many of them, even if they're not serving any or many Medicare beneficiaries, do get certified because private payers require that or give some incentive for doing so.

Our numbers track pretty closely to numbers that have been published by an industry survey, so they not -- they track very closely to that. So that would suggest that most, if not all, ASCs that are serving private payers exclusively are also Medicare-certified.

MR. HACKBARTH: Any others?

Thanks Ariel.

Next is a preliminary review of the information on SNFs, market factors.

DR. SEAGRAVE: Hello. Today I will present some preliminary information on recent trends in SNF market factors. I'm going to cover these five market factors that

we always look at.

First, I want to quickly address Bob's earlier comment, and just clarify something on this slide. When we look at SNFs entry and exit, we're looking at the entry and exit of Medicare certification only. We don't actually look at Medicaid-certified facilities. We look at Medicare only certified and Medicare/Medicaid. So we're looking at entry and exit into the Medicare program in this case.

With regard to SNFs entry and exit from the Medicare program, the 2003 data indicates that the trend that we've seen for the last few years continues. In the period 2002 to 2003, in the far right column of this slide, we see that the number of hospital-based SNFs participating in Medicare decreased by about 9 percent between 2002 and 2003. And the number of freestanding SNFs participating in Medicare increased by about 2 percent for an overall increase among all SNFs of about 1 percent. These percentages are essentially the same percentages that we saw for the period from 2001 to 2002.

In 2003, the number of hospital-based SNFs participating in Medicare is about the same as it was in 1993, I just wanted to point out. Part of the reason for

that, even despite the rapid decline in these facilities in recent years, is as you can see the percent change in the number of these facilities from 1992 to 1998 was 61 percent.

I also just wanted to show you that there has been some entry of hospital-based SNFs into certain areas as well. The numbers in the far left column represent the number of hospital-based SNFs in 1997 in hospital service areas. The numbers across the top represent the number of hospital-based SNFs in those the same hospital service areas in 2001. As you can see, about 92 hospital service areas that didn't have a hospital-based SNF in 1997 did have one by 2001. So there has been some entry.

As well, when we look at the number of beds by freestanding and hospital-based in these areas in 1997 and 2001, we also find that freestanding SNF beds have perhaps substituted for some of the loss of hospital-based SNF beds. For example, in the 308 hospital service areas where there was one hospital-based SNF in 1997 and none left in 2001, the average number of freestanding SNF beds in those areas increased from 336 to 352.

Recall from the last meeting that a disproportionate number of hospital-based SNF withdrawals

from the Medicare market since 1997 have occurred among for-profit SNFs operating in urban areas. In addition, this chart shows that per diem cost tended to be higher among hospital-based SNFs that exited the Medicare program. The reported aggregate per diem cost in the hospital-based SNFs that left the Medicare program at $321 a day in 1998 were about 43 percent higher than those of the hospital-based SNFs that remained in the program.

Moving on to our second market factor, the volume of SNF services, we can see that the volume of SNF services increased in 2001, the most recent year for which we have data on this factor, with total payments to SNFs increasing by about 22 percent, total number of discharges increasing by 6 percent, covered days increasing by 8 percent, and average length of stay increasing by about 2 percent.

We are still collecting information on recent trends in beneficiaries access to SNF services for 2003. OIG studies in 1999 through 2001, and the focus group of hospital discharge planners we held in October 2002 you may remember, all suggested that beneficiaries needing rehabilitation services generally had no problem accessing SNF services, but that certain patients with complex non-

rehabilitation therapy needs may have experienced delays and accessing these services. These patients may have stayed in the hospital longer in some cases, although it's uncertain whether this is a worse outcome for some of these patients.

I did want to mention the fact that we are still collecting information on this for 2003 and I hope to bring that to you in subsequent meetings. Also, the OIG now plans to do a study on access to SNF services, to be released sometime in fiscal year 2005. This is very good news for the future, although obviously it won't help in our analysis this year.

I wanted to bring you some preliminary information from our analysis of readmission rates on quality. As you can see, it doesn't look -- the measures that we have seen so far don't indicate big changes in the quality of care delivered in SNFs between 1999 and 2001.

I wanted to explain these five categories of SNF readmissions to the acute care hospital were analyzed by researchers at the University of Colorado Health Sciences Center and found to be the types of readmissions that were most preventable if SNFs were delivering quality of care to patients. We used the Colorado methodology and analyzed the

SNF readmissions for these years ourselves and we found that if you adjust -- I wanted to point out too that these are all adjusted for the case-mix of patients and based on the national average rates across all SNF admissions for these years.

We see small increases in the rates of readmissions for two of the five conditions, electrolyte imbalance and congestive heart failure, but virtually no change in the other three measures.

Finally I want to briefly discuss our preliminary findings on access to capital. As you know, the nursing home sector is a fragmented industry with only about 16 percent of the beds accounted for by the top 10 largest chains. The nursing home industry is also dominated by for-profit companies, about two-thirds of nursing homes are owned by for-profit.

Access to capital for some has always been limited, particularly for small and nonprofit providers. In addition, equity issuances have been a source of capital for the nursing home industry in the past but there were no issuances in 1999 through 2001.

Publicly traded bonds were a source of capital for

this industry in the past and still are today but at lower levels. Furthermore, debt ratings have been downgraded, leading to higher interest rates charged to nursing homes for debt. Still, despite all of this, the stronger nursing home chains may still have continued access to capital.

Other sources of capital for this industry include bank loans, real estate investment trusts, and federally guaranteed loans of which about $1.2 billion in fiscal year 2002 were issued.

The bottom line for all of this is that the situation with SNFs' access to capital has worsened recently due in large part to reduced Medicaid nursing home payments. However, it was also due to the expiration of two temporary Medicare payment increases mandated by BBRA and BIPA and the increasing costs of liability insurance for nursing homes. Still, financial analysts continue to view Medicare SNF payments in a positive light. Fitch Ratings, for example, said in its recent analysis of the nursing home industry that it "views Medicare reimbursement favorably as Medicare is generally a profitable payer for most nursing homes."

I just wanted to mention that in the chapter and the next time, we will be discussing more about the

proportion of Medicare that's accounted for in nursing home payments.

This concludes my presentation. I welcome any questions the Commission might have.

DR. MILLER: If I could just say one thing quickly, your point about the Medicaid, the expiration, and the increasing costs of liability insurance, this is what the financial analysts are saying are driving their conclusions on capital?

DR. SEAGRAVE: Yes, that's right.

MR. SMITH: It might be useful to note, or at least ask the question, of whether or not the huge increase in SNFs between 1992 and 2003 has something to do with the decline in activity in the capital market in the past year. This is an industry which one might conclude had expanded too rapidly, there was overcapacity, and the capital market is reacting to that, or that and the changes in the payment system.

DR. ROWE: I have a general question but one small point first. Most studies, I think, of the admission rates showed that, in addition to congestive heart failure, hip fracture is a diagnosis that has a traditionally very high

readmission rate. Did that come up? I noticed that wasn't on your list.

DR. SEAGRAVE: Yes, the researchers in the University of Colorado very carefully chose these five admission rates.

DR. ROWE: These weren't necessarily the five highest?

DR. SEAGRAVE: No, they were chosen specifically because these were deemed if a nursing home could implement processes or perform their care and monitor the patients in such a way that they would have a pretty good chance of keeping these people out of the hospital for these five conditions.

DR. ROWE: Thank you, Susanne.

The question I had has to do with how do we approach a situation where the Medicare margin is positive or favorable, the overall institutions aren't doing well for other reasons, you know, Medicaid payments are down, access to capital is down, their ratings are down, their interest rates are up, whatever is going on, but if they go away, then access to their services is diminished for Medicare beneficiaries?

We don't want to go down a pathway of just paying more and more and more to keep them alive. On the other hand, there is the other hand. It seems to me it would be interesting, I know we dealt with this before, but here's a stark example. If you start with Bob's suggestion at the beginning of the chapter about how important are these, yes or no, it's going to be small proportion of their budget but it's going to be a big proportion of their margin if they have any, right?

MR. HACKBARTH: I think, Jack, you're actually restating a point that Dave made last year when we talked about the SNF update, expressing very similar concerns about access. The problem that we face is that given Medicare's low share of the total revenue base of SNFs, about 10 percent as I recall, is that right Susanne, 12 percent?

DR. SEAGRAVE: 12 percent, yes.

MR. HACKBARTH: That's a very small base on which to rest the financial stability of a whole industry. But even more problematic than that from my perspective is that the tool that we have at our disposal is to increase Medicare payment rates. And it doesn't get the money to the right places. So the most money would go to the SNFs that

have the largest Medicare patient loads and the lowest Medicaid patient loads, and have the highest margins.

And so it is a very --

DR. ROWE: [Off microphone.] If you're talking about access, that's most -- --

MR. HACKBARTH: So it's a very poor tool to deal with what is perhaps a Medicaid problem principally. I'm sort of old-fashioned. I think if you have a Medicaid problem you ought to fix it in Medicaid as opposed to try to fix it with Medicare add-ons.

DR. ROWE: If you have a Medicaid problem, from the point of view of the budget of the institution. But we're here to serve and protect the Medicare beneficiaries.

MR. HACKBARTH: We're here also to --

DR. ROWE: So I'm a Medicare beneficiary and I can't get in a SNF and I call you. Are you going to say well, call the governor?

MR. HACKBARTH: We're also here to advise the Congress, that's our principal purpose, on what is the best policy for dealing with problems facing the Medicare population. And I don't think the best policy is to try to balance the books of a whole industry through Medicare

updates.

MS. RAPHAEL: I was just going to say, this is certainly a very, very important issue. But 19 states actually cut the Medicaid rates that they pay to nursing homes in this last fiscal year. So there's clearly great stress in the Medicaid system that finances nursing homes in this nation.

MR. HACKBARTH: And I wonder what would happen if Medicare says we'll assume responsibility for the welfare of the industry. If you're a governor facing a deficit, that seems like an invitation to further cut.

MR. DURENBERGER: The point would probably not -- and I did not know it when I raised it and you re-raised it, the point in not is the Medicare program the answer? The point is are members of Congress an important part of the answer to the problem of adequate access?

It's more in how we deal with this issue in the advice that we give people where we see capacities strained or capacity declining that we can make a contribution with the kind of information that we've developed as it relates to all of these factors that she has laid out here.

I mean, I agree with you that it is difficult if

not impossible to use Medicare policy directly to accomplish it. But I think the members of Congress need to understand it isn't 19 governors or 19 legislatures alone who create problems in the decline in Medicaid revenues going to subacute or to nursing homes and so forth. It is a combination responsibility of policymakers at a national and a state level.

MR. HACKBARTH: Just one additional point. In the one area where we did have some reason to be immediately or more immediately concerned about access to care for Medicare beneficiaries is in the more complex patients. And in that instance we made a specific recommendation how to deal that particular problem, mainly reallocating the add-on dollars.

Now in fact, it wasn't accepted, but where there is a problem we tried to make a specific concrete recommendation.

DR. REISCHAUER: I basically agree with you, Glenn, on this issue but it is a bit more complicated because, of course, many people enter the nursing home as a Medicare patient and the benefit is of limited duration or their private sources decline and then become a Medicaid person in terms of being paid for. But they are still a

Medicare person when they go to the hospital or have a doctors visit or anything else as the primary payer. So it is a little bit more complex. If they don't have the care through Medicaid in the nursing home Medicare's spending on acute care services might rise.

MR. HACKBARTH: Others on this issue?

Okay, thank you.

Last is a similar update on home health.

MS. CHENG: Hello. This presentation is the first of three to develop our update recommendation for the home health sector for this year. Today I will cover three factors, beneficiaries' access to home health services, entry and exit of agencies from the program, and the agencies access to capital.

In my next presentation I'll be adding information on the volume of services and the relation of payments to costs. I also planned, in my next presentation, to add a new indicator of quality which I'd like to introduce to you today.

By way of context, I'd like to start with a description of the home health sector. This table shows you the composition of the 7,000 or so Medicare-certified

agencies in terms of the number of agencies. The categories refer, in the first case, to whether they are freestanding or whether they are based in a hospital, SNF, or other health care facility. In a second case it refers to the location of agency. And in the third case to the type of control of the agencies.

As you can see, most agencies are freestanding and many of them are in an urban setting. Many agencies are proprietary in this sector but not a majority. A small but significant number are operated by state, city, or county health agencies.

As part of our work on volume, what we can do is break the episode volume down into these categories if you'd like to see data on that kind of breakdown.

We have two questions regarding access to care for beneficiaries. First, are there providers in beneficiaries' communities, and can beneficiaries access those providers. This map is an indicator of the answer to the first question. It indicates that 99 percent of Medicare beneficiaries lived in an area that was served by a home health agency in the past 12 months as of May, 2003.

This suggests that access for beneficiaries, in

terms of whether there is a provider in their community, is very good. Some of the largest white areas on the map, indicating there were zero home health agencies, include deserts, swamps, and timberland.

The map is based on the zip code area of the beneficiary residents. In most cases, zip codes allow us to look at a sub-county level, although in some cases there are zip codes that will encompass more than one county.

The data is based on the zip codes as reported by the nurses or the therapist in the field as part of their patient assessment. Some providers have identified some discrepancies in the data as such as field reported. The database administrator at CMS has listened to these providers and received this data and eliminated where possible obvious discrepancies such as a provider in Florida who cared for a beneficiary in Nebraska.

This map may tend to understate the areas of service because it can only reflect where an agency actually delivered service. So if there was an area that it would be willing to serve but did not have a request to do so in the past 12 months, then it wouldn't show up as a service area for that agency on this map.

On the other hand, it may tend to overstate the service area of an agency because if an agency is only willing to serve a quarter or a portion of a zip code, then this map would reflect the entire zip code area as having been served. But that's a limitation of any time we try to describe service areas with a geographic unit.

MR. HACKBARTH: Sharon, on the first point that there simply was not a request for service, you may be able to deal with that a little bit by looking at multiple years? Is that possible? Are these data available for more than one year?

MS. CHENG: This is the first year we have this zip code level data. We could look at county level data and we could then use multiple years. One of the features that they're trying to maintain this database is to make it current so it actually rolls. So the 12-month period will roll forward, so it actually will contract that a little bit rather than expand it, as this database is developed.

In addition to most beneficiaries having access to one home health agency, as the map showed, we also found that most beneficiaries have a choice of providers. 97 percent of beneficiaries lived in an area served by two or

more home health agencies.

Our second access question is whether beneficiaries can obtain care from the providers in their community. Our indicator for this is the most recent CAHPS surveys of beneficiaries. The proportion of beneficiaries who sought some home care and reported little or no problem with home health is about the same as the proportion who report they usually or always can make an appointment for routine care with a doctor or nurse, about 90 percent.

Of those who said they had a big problem, we do believe it appears that the problem was not an inability to obtain care because it seems that almost all beneficiaries who sought home care did receive it. We know that 7.5 percent of the beneficiaries used home care in 2000 and this is very close to the number of beneficiaries who sought home care in that year. According to the CAHPS surveys, 7.7 percent of beneficiaries sought some care, and we don't know how many of those beneficiaries were eligible for the benefit.

Our next indicator is entry and exit of agencies. In 2003 the number of agencies showed a very slight uptick. This year there will be about 7,100 agencies certified to

serve Medicare beneficiaries. Along with evidence that mergers and acquisitions have picked up pace, this suggests that there are more and possibly larger agencies in the program than there were at the beginning of the prospective payment system. The composition of the agencies certified, as described earlier, has remained essentially the same for the past four years.

This time series shows how the number of agencies has changed over the past 10 years. Today's number is about the same as it was in the early '90s before the pace of entries became quite rapid.

The final indicator I'll discusses this morning is access to capital. Access to capital is not a strong indicator for the home health sector. Access is determined more by the size of the industry and perceptions of risk than seems to be determined by the adequacy of Medicare's payments for this sector. The sector is small and the players in it are small compared to many that seek investors' dollars. Total expenditures in 2001 for home care services was $33 billion, compared to $450 billion for hospital care or even $100 billion for nursing homes. The largest publicly traded home care company has only a 2 or 3

percent market share.

That said, Wall Street has a positive outlook for the industry, predicting that will outperform the S&P 500 over the near-term. However, the publicly traded agencies have moderate ratings despite good margins and growth potential, usually due to perceived high risks for the sector from legal challenges such as subpoenas or legislative uncertainty related to the copay or a reduced updated in legislation. Medicare is noted in several of these industry reports as being the higher payer margin payer in the industry.

My final slide is a starting point for the national quality score we plan to bring you in the next presentation. The trend you see here is based on the scores for several activities of daily living and instrumental activities of daily living from a proprietary database of about 2.5 billion patient records. The score captures the average improvement or stabilization in a patient's functioning on each of these activities. Thus, if a hypothetical patient were to improve her ability to get around, stabilize her ability to dress her lower body while her ability to dress her upper body became more difficult,

the score would be one. This is the average of two points given for the improvement, one point for the stabilization, and zero points awarded for the lack of improvement on the third ability.

Since this score is an average of all of the patients in the database, and the goal of care for many patients is the stabilization and their ability to perform these tasks, we would expect the scores to cluster around one, which they do this chart.

MedPAC staff is working with the creators of this score and we plan to do a couple of different extensions. First, we're going to extend this trend back into time and look at 1999. That's before the implementation of the PPS. We're also going to take it forward to 2002, so that we have a year of PPS experience. We'll also expand the database from the proprietary database that this trend is drawn from to a national OASIS database. We will also review the outcomes that you see in this chart and we will make sure that the ones that we choose are policy relevant, clinically appropriate, and operationally sound.

With that, I'd like to take your questions on the data and especially your reactions to this score and any

changes you'd like to see to it. Thanks.

DR. NELSON: Sharon, I think that's very important, but there's a dimension that hasn't been dealt with with respect to the impact of payment policy on what the beneficiary can access in terms of home care. And that is the contraction of the menu of available services that agencies have adopted under financial pressures. Whereas they may have offered diabetes education, ventilator care, other labor-intensive services in the past, some of them have modified the services that they offer in order to maintain a positive bottom line.

What that results in obviously is an impact on the beneficiary that has to be taken into account in addition just to whether there is an agency available in their area and what their access to capital and so forth is.

MS. CHENG: I tried to nip at that a little bit in the paper to suggest that when we think about access there are really three dimensions. Is there a provider in your community? If there is, can you access that provider, can you get through their door -- or in this case can you get them through your door? And then the third would be once they're there, are you getting what you need? Do you have

access to the services once they're through the door?

The access measures that I have here, I really to think we're looking at the answers to question one and question two. And I guess what I'd like to do is run down the third question by looking at outcome scores like this to say all right if they're getting what they need then hopefully we're going to see a good outcome for that care. So let's look at changes in the outcomes. We're certainly going to have to adjust it for the severity of the patient because we think that the product is changing. But let's make sure that they've got a good outcome when they're gone.

DR. NELSON: But there may be a dimension of that in terms of what's desirable and not being provided, socially desirable, desirable from the standpoint of well-rounded care or whatever. When I'm suggesting is that it maybe that the trade associations or others can give you some information on services that formerly were provided when times were better and that no longer are being provided even though there may be a need or a perceived need for those services.

And the substitute for some of those, such as ventilator care, may be nursing home care. That is there

may be more expensive substitutes. And that needs to be taken into account with respect to our payment recommendations.

MR. HACKBARTH: Alan, have you seen some data on agencies reducing services or is this just your personal experience?

DR. NELSON: No, I've seen data but not across a broad universe. I've seen reports from an integrated system that has a home care presence. And whereas two years ago they were showing red ink, it's a well-run outfits so that they've made changes. The changes they've made have been to contract the menu of services that they offer in their home health product. And so now it again is in the black. But it's been at the expense of a reduced menu of services.

Now, how generalizable that is, I don't know. That's the reason why I raised this as a question. But it may very well be that the trade associations have collected data on how the menu of offered services has changed.

MR. HACKBARTH: In some ways, this takes me back to our conversation yesterday about bundling of physician payment, in that if you're talking about a bundle and a prospective system that creates an incentive to reduce

costs, even if an agency has a high margin and they think that this is a service that they can reduce without damaging their position in the market or reducing quality, they have the incentive to drop it anyhow even if they have a lot of money.

So it goes to the question of how important is it from a quality standpoint? And do we have quality measures refined enough to detect that sort of reduction in quality?

DR. NELSON: [Off microphone.] You may not be able to detect it in the short-term. That's my point. I mean, diabetes education is a case in point.

MR. FEEZOR: Alan asks exactly the question I was going to, and from my narrow geographic perspective, a similar observation and actually some -- as I look over the operation sheets of a couple of regional home health I have seen a significant contraction in the array of services. And I was just going to urge that we try to see if we can get any sort of measure on that.

MS. RAPHAEL: I think we have seen some site shifting because we see an increased in admissions to nursing homes, I believe, at the same time that admissions to home care were declining. So there may be some site

substitution, although I don't think we know enough to reach that conclusion.

I was going to make two points. One is that I would like to see some of the data broken down by type of agency because home health care is a very heterogeneous field and you have very small agencies and large public companies. And Wall Street is focused on the large public companies.

I think it is important to look at the whole array of agencies and how their faring, because I think what Glenn was commenting on before it is an issue that home health care agencies face in tandem with nursing homes, although a larger share of home health care payments come from Medicare. That is, those agencies that tend to serve Medicaid patients or the uninsured tend to have very low total margins although their Medicare margins are good.

And their survival or their ability to provide the whole panoply of services is at risk as Medicare payments begin to decline. So I think we need to keep that in mind because that can ultimately affect access in some of these areas where you don't have too many agencies currently available.

DR. STOWERS: I think a thought too, needs to go a little bit into changes in the package that came from CMS. The no IV drugs at home and that kind of thing now.

I've got actually a family member with osteomyelitis following a knee replacement that is going to have to spend six to eight weeks in the hospital getting IV drugs.

MS. RAPHAEL: We're the only ones in New York City still providing infusion nursing. Everyone else has left the marketplace. And we're doing it at a loss.

DR. STOWERS: So there's some other of those related access things, too, that might need to be looked at that are tremendously inefficient for the system.

MR. HACKBARTH: Is it on this point?

MS. DePARLE: Not on this point. I wanted to ask Carol her view of this quality measure and whether you think we're going in the right direction.

MS. RAPHAEL: Well, I am concerned about using this as sort of the benchmark for quality even though it's a large database. There are two areas where we're seeing some sort of patterns that I think are cause for concern. One is rehospitalization rates. Our rehospitalization rates have

gone up and our emergency room visit rates have gone up. Now we may be aberrational, but I consider those very important indicators.

And also, this has to do with the refinement of OASIS. We just believe that OASIS, and understandably, is very geared to what's measurable and very task oriented. And it doesn't pick up a lot of things that have to do with functional ability, cognitive impairments, that really can make a huge difference in whether you can rehabilitate and restore functioning.

So I just think there needs to be the next level of refinement of OASIS. I think it's done a very good job but we can't rest here and assume that it's really capturing all of the variables in terms of recovery and restoration of function.

DR. WAKEFIELD: Just a comment, Sharon, that I shared with you on the side the last time that we met. And that is I really like the use of the zip codes this time around because it gives us a sharper focus on one hand in some areas of the country than we had the last time we were looking at this data.

On the other hand, we lose some precision to the

extent that zip codes, as you indicate here and so I'm really pleased to see that recognition, we lose some precision when zip codes cover larger areas than a county.

For example, when you go out west -- notwithstanding the fact Joe that yes, you do have Teddy Roosevelt State Park there on the western part of North Dakota, notwithstanding that -- some of our counties in the western part of the state are over 1,900 square miles. That's a pretty large area.

So if you've got a home health agency that's five miles over the border or 10 miles in or 15 miles in, just as an FYI, we lose the rest of the picture there. So you've got it identified but we do lose the rest of the picture.

And probably not a whole lot of folks out there maybe, but we don't know. And we don't know what proportion of folks that are out there are Medicare beneficiaries, for example, as opposed to 30-year-old ranchers, or whatever.

So it's just so important, I think, to have that -- I kind of like this western talk here.

So I think it's really important that we've got that caveat there because I look over here and I see 99 percent of beneficiaries covered and that's terrific.

That's great, good news. And on the other hand, we don't really have the complete picture because we might just have parts of counties and even less than a county almost, now that we're using zip codes, reflected.

And we do have the home health add-on that's expired now, that provided some protection for rural home health agencies. And so I think it is going to be important, all of these things coming together, to track on that what impact that might have, if any.

I think in one of our earlier reports, for example, and I don't know where it's at now, but we saw that there were longer lengths of stay in rural hospitals. And I think we thought in part that might be attributable -- we didn't know for sure -- but in part that might be attributable to a lack of availability of post-acute care.

So we're casting abroad our net, in some instances. We've got a congressionally legislated add-on that's expired. And we know that there was something going on, at least historically, with those longer lengths of stay but we don't know exactly what they were due to. So it's just making sure that this is reflected to be as tentative as it is.

And at some point in time, maybe we can go back and look at what's happening to lengths of stay to give us a measure. I don't know. Maybe we could look at a couple of counties and drill down in a case study sort of a way and see what is really happening there. But I just wanted to make sure that those issues are adequately reflected at some point.

Then the question I've got for you is, we've got 99 percent of beneficiaries covered and on our table one we've got a big problem for 12 percent for beneficiaries that sought access to home health care services. And that's statistically significant, a slight increase, but it is statistically significant. Do we know anything but that subset, that 12 percent? Do we have any characteristics of that population? It's small but the rise is statistically significant. Can we know anything about them?

MS. CHENG: I'd have to double check with Karen. This is the CAHPS data that we were talking about this morning, and I know we talked a little bit about how much you can slice and dice that. To the extent that we could, we'll give that a shot. I don't know what we'll be able to find out about that subset.

DR. WAKEFIELD: If you'd look, that would be great. Thank you.

DR. REISCHAUER: I wonder if we have spent too much time looking at institutions. This applies to the home health area, the SNF area. Do I really care whether the number of agencies has gone up or down? Or do I really care about where services are provided or available, and the number of services per unit of need over time?

I look at these things and you don't know if they're big or small, or are all the hospital-based SNFs 10 beds and all the other ones 50 beds? What's happening to the total volume of services? And should we be really looking at a chart that shows the fraction of Medicare beneficiaries who receive this kind of service over time? And is it rising or falling? And maybe you could adjust it for the changing age composition of the Medicare population.

But in a way, the number of institutions doesn't really make any a difference at all, I don't think, to what we're concerned about.

MR. HACKBARTH: And I think in the past we've noted that that's a particular problem with home health because the elasticity of the units. What I hear you saying

is at some point the qualifications are so many that we ought to just stop doing them.

Others?

Okay, thank you, Sharon. We will now have a brief public comment period.

MS. FISHER: Karen Fisher of Association for American Medical Colleges.

I have four hopefully brief points. First, we appreciate the discussion on the outpatient outlier payments. In our comment letter submitted on the most recent proposed rule, we also pointed out the fact that with the current threshold the amount of absolute dollar costs that very high cost items would have to achieve to even qualify for an outlier payment is vastly different than a high-cost item. So we feel similarly to where the Commission is on that.

We also believe, though, that I don't believe was discuss this morning, that if you believe in the merits of an outlier payment policy then not only should you look at the threshold, but we believe the Commission should give some thought and discussion to the payment percentage for those services that meet the threshold. It's currently at

45 percent of cost above a threshold and CMS is proposing to move that to 50 percent. The inpatient payment percentage is 80 percent.

We believe if these are legitimate high-cost, extraordinarily high-cost, services that merit an outlier payments and the hospital has to eat the cost up to the threshold, that to be consistent with the inpatient system -- and it's just a matter of fairness -- that that payment percentage should be increased.

On two related but separate items, we're concerned about the expiration of the transitional corridor payments that occur at the end of 2003. Our look at the data, those transitional corridor payments were meant to be a three-year set of cushion payments so that no hospital would fare extraordinarily poorly when the PPS was implemented. Our analysis of the data and hearing from some of our members, they are relying a fair amount on those corridor payments and are concerned about what will happen when those corridor payments end at the end of 2003.

I think it would be useful for the Commission to examine those payments for multiple purposes. I think it was a useful mechanism at the implementation of a new

payment system and then to see what goes forward.

Finally, in terms of the suggestion about encouraging innovation in the outpatient system, I'd like to raise an issue to you that has perplexed us over the past several years. That is the outpatient payment system contains an inpatient only list. And that is a list of services that CMS has determined will not be paid for by Medicare if performed in an outpatient setting. They are deemed to be provided for only on the inpatient setting.

We have had problems with this list from the get-go. First of all, we believe that there are other checks and balances for determining when care can appropriately be moved from the inpatient to the outpatient setting. So we believe the role of CMS even in this setting is not necessary.

That being said, the criteria for which CMS determines when a service moves from the inpatient setting to the outpatient setting is perplexing. Because this area issue arose to me at the meaning I don't have the exact detail, but as I recall the criteria was a significant number of hospitals had to be performing the service on an outpatient basis in order for it to be moved from an

inpatient to an outpatient basis.

That doesn't make sense when you're looking at it from a major teaching hospital perspective where these services will first be performed. They have to start somewhere, the outpatient setting, before they can be defused to other places. So for basing your criteria to move it off of the list that you have to have a significant number of hospitals providing it, doesn't make sense to us and we think could quelch innovation in that area.

So we think that is a straightforward type of a potential recommendation for the Commission that we'd like you to consider. Thank you.

MS. SMITH: My name is Elise Smith, and I'm with the American Health Care Association. I have just three points.

First, a comment on the issue of the possibility that skilled nursing facilities are actually increasing. Our association has somewhat different data. We have OSCAR data that seems to suggest that, in fact, the certified facilities are decreasing. We have a number of about 17, 014 from June '99, going down to about 16,347 in June of 2003. We will provide our data and hopefully discuss this

issue with the MedPAC staff.

But I bring it up here because I just want to remind you of the phenomenon out there that if you think you are seeing an increase in certified units or beds, it may be in great part due to the increase in dual certification. There are states out there that are on an increasing basis requiring Medicaid nursing homes to provide Medicare and vice versa. So we believe that this phenomenon, if indeed it exists as an increase, may be in part due to that. We just bring your attention to that and we're going to try and find out more information about that.

My second point is the issue of capital access. It doesn't really matter who might, in numbers, dominate this industry. I simply wish to bring your attention to the fact that the capital access problem is widespread throughout the entire sector, affecting multis, affecting SNF freestanding facilities, both for-profit and nonprofit.

Just one sentence out of the CMS market report, the outlook for the smaller and not-for-profit facilities may be bleaker compared to the larger for-profit facilities. That starts on page 21. And if you want some pretty bleak details and a bleak picture, you will find it --

unfortunately, you will find it there.

Last, but not least, the issue of total margins. Ms. Raphael's comments on trends in Medicaid rates regarding nursing homes is crucial. It is an increasing problem, as you all know. You only have to look at the latest Kaiser report to see some pretty bleak trends. Not a day goes by on Capitol Hill that there isn't a hearing involving the increased Medicare crisis.

What is the bottom line with all of this? Well, as you probably would see it coming, what I want to emphasize is that the focus should be on the health of the entire sector, and that requires looking at total margins. I believe Jack Ashby yesterday said that you have looked at total margins in the hospital arena for context. At a minimum, we would appreciate the same contextual approach. But really, we believe that the time has come to try somehow to move towards an analysis of total financial health not only of the SNF sector but all of the provider sectors.

Thank you for your attention.

MR. FENIGER: Randy Feniger with the Federated Ambulatory Surgery Association. We're the largest trade group of ambulatory surgery centers. And just a few

comments and observations on the work plan that was discussed earlier.

First, as you look at reasons for growth in the industry, I think it's very important to look at the change in medical technology and anesthesia techniques over a period of time which has certainly contributed to the ability to move things from more complex inpatient settings to settings of outpatient ambulatory surgery-type arrangements.

Look at the efficiency of the ASC versus the hospital for the same service. If the hospital takes an hour to turn around the endoscopy suite for the next patient, and you can turn the same room around in your ASC in 10 minutes, the efficiency will drive the doctor and the patients into that environment. So I think that's a very important issue to consider as you do.

Also, from the point of view of the physicians, their control over the quality of the service that is being delivered. They have control over staff, other kinds of things that they think are important, that they may not have in a hospital setting. So I think those are issues that should be incorporated as you go forward and look at that.

The regulatory environment at the state level is extremely important in the distribution of ASCs, and it's critical that you look at that very carefully. And also, measure -- since Medicare is a static rate across the country, distribution is going to be driven in large part by the private insurance climate in given parts of the country. Those that favor ASCs, you're going to find more use of them. Those that tend not to, you will probably find a different distribution. So we would encourage you to incorporate some of that analysis within your work.

As you look at access to capital as a measure, and I know we went around on this issue last year as a proxy for determining why the industry was growing, there really are two different capital markets you have to look at. One is publicly traded companies like AmSurg and some of the others who are essentially going to Wall Street to get their money. But a group of doctors who finances something locally, through the local bank, that's a different capital market. And I think you really need to look at both.

I think that gets to the point was made earlier about not considering ASCs as a lump, as one thing. They

are different. They're different in their structure. They're different in their specialization. All of these are factors that I think should be incorporated.

We are more than happy to work with your staff to offer up what information we have that may assist in that differentiation, so you get a clearer picture of what's going on in the various sectors within the ASC industry.

Once again, we come back to gee, we have no data. We had none last year. We don't have any this year. And that complicates your analysis. The analysis is also complicated because you have an archaic payment system with a very limited number of buckets for payment compared to hospital outpatient department, inpatient DRGs, or any of the others.

This has prompted the industry, and Mark and Ariel were at this meeting, to talk to Congress and the conferees and now make a proposal to actually identify a way to collect data. We don't think the survey is probably ever going to get done. We have to find some alternatives.

And then, using that data and subsequent analysis of that data, to have CMS make recommendations to Congress

for changes both in the payment structure for ASCs as well as the coverage rules.

So this is a proposal that we, as an industry have put forward to Congress. Time will tell if they accept it, but we think that there is general agreement across the industry that what we have today is not working as well as it should. It needs to be changed. The fact that it hasn't been changed over these many years, well there's nobody to blame for that. It just hasn't changed.

But I wanted you to know that we have made this recommendation as an industry and we look forward to working with your staff again and with the members of the Commission. We invite all of you to visit your local ASC, and not as a patient, but as a visitor on a guided tour. We will arrange that for everybody, even in those most rural parts of America. I'll find one.

DR. WAKEFIELD: [Off microphone.] Or build one.

MR. FENIGER: You know I can find anything in a rural area, if I have to.

And we appreciate your consideration of these comments and look forward to working with you and the staff.

Thank you.

MS. ST. PIERRE: Mary St. Pierre with the National Association for Home Care.

I just wanted to let you know that we would be very, very happy and pleased to work with MedPAC on analyzing the data and looking at those areas within zip codes where there may not be the appropriate access to service that the beneficiaries need. We have close contact with the state associations and they are always ready and willing to help with projects like that.

I also want to let you know that NAHC has analyzed over 6,000 home health agency cost reports and we have that information that we're very happy to share with you. This is a project that we will continue to engage in for an indefinite period of time.

I think that the information that we have obtained in analyzing these cost reports shows a potential growing problem as far as margins for home health agencies that there is a large number of home health agencies that are in the red and an increasing number in the next year that will be in the red with the reduction in payment and we're

particularly concerned about the loss of the rural add-on.

I also wanted to mention that as the OASIS queen at the National Association for Home Care, I receive questions every day about how do I answer this particular OASIS item. And so I would be very pleased to volunteer my services to help in identifying which of the outcome measures may be more appropriate, where you're getting better input from the providers, more accurate input from the providers, that give a better management to the outcome and the care that they're given.

Thank you.

MR. HACKBARTH: Okay. Thank you very much and we meet next in December.

[Whereupon, at 11:59 a.m., the meeting was adjourned.]