MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, October 28, 2004*
9:32 a.m.

COMMISSIONERS PRESENT:

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NICHOLAS J. WOLTER, M.D.

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1 P R O C E E D I N G S

2 MR. HACKBARTH: Good morning. The first item on
3 our agenda today is the mandated reports on benefits design
4 and cost sharing in Medicare Advantage plans.

5 DR. BERNSTEIN: Good morning. The MMA mandates
6 that MedPAC submit a report on the extent to which cost-
7 sharing structures in MA plans affect access to covered
8 services or result in enrollee selection based on health
9 status, together with any recommendations for legislation or
10 administration action that the Commission things are
11 appropriate. The report is due December 31.

12 In September we presented background materials and
13 some analyses that suggested that while benefit designs that
14 would contribute to selection or access problems are not
15 systematic or widespread, there is evidence that practices
16 of some plans could lead to high levels of cost sharing for
17 certain services that are less discretionary, for example,
18 chemotherapy.

19 Today we're going to briefly discuss some findings
20 from additional analyses and present policy options the
21 Commission may want to consider to help beneficiaries make
22 more informed choices and to limit practices that contribute
23 to access problems or biased selection. The first slide
24 addresses an issue raised in discussion in September. That
25 is, do plans offer lower Medicare cost sharing in return for
26 a higher premiums?

27 Looking at benefit data from the plan files that

1 we got from CMS and at the literature, it seems pretty clear
2 that beneficiaries are choosing to enroll in plans that have
3 a prescription drug benefit. You can, for example, that 73
4 percent of all plans, 34 plus 39 on the chart, the first two
5 rows, offer a drug benefit. And 44 percent of the plans we
6 looked at, 34 plus 10, have no additional premium or they
7 offer a rebate.
8 For the plans with a drug benefit, the first two
9 rows, we don't see a lot of evidence that additional
10 premiums are related to lower cost sharing for Medicare-
11 covered services. Each cell on the chart shows the percent
12 of each type of plan that requires what we have categorized
13 as higher cost sharing for four types of services. It ends
14 up meaning generally the cost sharing is comparable to fee-
15 for-service with no supplemental coverage.
16 Although fewer plans that charge a premium have
17 higher cost sharing for inpatient services -- that's the 22
18 percent up there versus 39 -- cost sharing for the other
19 services in the plans that have a drug benefit are generally
20 about the same.
21 You can see a difference for plans that don't have
22 a drug benefit, the bottom two rows. For example, only 4
23 percent of the plans that charge a premium have higher cost
24 sharing for inpatient services compared to 24 percent with
25 no premium. How the introduction of the new drug benefit
26 will change all these dynamics in 2006 and after is
27 impossible to predict.

1 Now we're going to turn to the question about
2 whether the benefit structures that have evolved in these MA
3 markets creates selection or access problems.
4 The question we were asked by Congress was, is
5 there evidence that plan benefit design leads to selection
6 or access problems. The notion behind the question is that
7 plans can use high cost sharing to avoid sicker
8 beneficiaries. But market competition and beneficiary
9 preferences also shape benefit design.
10 To look for selection, we wanted to look at plan's
11 risk scores to see how healthy their enrollees are and then
12 compare the scores to their cost-sharing requirements.
13 However, we were only able to get information on risk scores
14 for each MA plan contract. This information combines the
15 risk scores for all the individual plans that operate under
16 a single contract, which is usually in a market area.
17 CMS is working on developing accurate and reliable
18 plan-level risk score information that can be used to review
19 the plan proposals and evaluate possible issues of risk
20 selection, but we don't have those data yet. Instead, we
21 used available information to identify market areas where
22 there is wide variation in enrollee risk scores among
23 participating plans. In those markets we used information
24 from the Medicare personal plan finder on the Medicare.gov
25 web site to look for relationships between contract-level
26 risk scores and plan cost sharing.
27 Our analyses did not uncover any consistent

1 relationship between contract level risk scores and cost-
2 sharing requirements for Medicare-covered services or other
3 services. This chart shows that on average the same person,
4 in this case a 70 to 74-year-old person in poor health, what
5 they would have to pay out-of-pocket in most of the plans --
6 we couldn't fit all of them on the chart -- in one of the
7 counties we studied. This is a county where we saw among
8 the widest variations in contract-level risk scores where we
9 thought we'd be most likely to see a relationship between
10 cost sharing and risk.
11 The out-of-pocket estimates from the Medicare plan
12 finder, which Medicare beneficiaries can download themselves
13 but we made them a little bit easier to read in this chart
14 so you could compare them. We left off the information on
15 premiums from the plan finder. All of these are zero
16 premium plans except for one. The height of the bars
17 generally indicates the plan's cost-sharing structure.
18 The bars showing average out-of-pocket costs are
19 arranged by contract-level risk scores with the lowest on
20 the left. The chart divides the plans among three groups,
21 those with risk scores under 0.9, those 0.9 to 1.0, and
22 those 1.0 and higher. So you can look across the chart left
23 to right, you see the plans under the contract with
24 enrollees with more health risk as we move across the chart.
25 The bars don't show a consistent pattern of higher cost
26 sharing for contracts with higher risk scores. Some plans
27 under contract with the highest scores, like plan 9A, have

1 no cost sharing for inpatient care, while others with nearly
2 the same risk score have been relatively higher cost
3 sharing, like plan 7B.
4 However, until we have plan-level risk scores we
5 can't determine whether cost sharing is associated with
6 significant enrollee risk.
7 So to illustrate how a person who becomes
8 seriously ill might be affected by cost-sharing provisions
9 we looked even more closely at how things might work in
10 different plans in one market if a person developed a
11 serious health problem. In this example we show what the
12 out-of-pocket cost would be a 70-year-old man for a year
13 following initial diagnosis of stage 3 colon cancer. We
14 provided additional information and context in the
15 background materials which, in summary, confirm that cancer
16 care is expensive.
17 Based on the information we got from cancer
18 experts in various places, including the National Cancer
19 Institute, we have devised a prototypical set of services
20 for the typical 70-year-old male patient. We included in
21 this chart only the costs related directly to the treatment
22 of cancer care. We also note that new treatment regimens
23 coming online now are substantially higher for chemotherapy
24 than those indicated in what is now the standard treatment
25 that we used in the example.
26 As we noted in the last meeting and in your
27 background materials, cost sharing for beneficiaries

1 enrolled in MA plans is generally lower than in fee-for-
2 service for most services. The point here, however, is to
3 look at a relatively infrequent but serious possibility.
4 The three plans included on your chart are large plans in
5 another county in a different market are that also has a lot
6 of plans. In any of the plans that we've looked at here,
7 the beneficiary would incur at least a couple thousand
8 dollars in out-of-pocket costs for Medicare-covered services
9 for cancer care. The cost of hospital care for this person
10 would exceed the Medicare fee-for-service hospital
11 deductible in plans one and two, but not in plan three.
12 But clearly, the big difference is in coinsurance
13 for chemotherapy. 20 percent coinsurance in two of the
14 plans, which is what it would be in fee-for-service without
15 supplemental insurance, is $5,600. Now this beneficiary
16 knows that with appropriate treatment he will probably
17 survive for a number years, probably many years. Data NCI
18 shared with us indicates that his out-of-pocket costs in
19 subsequent years would be less. But if there is a
20 recurrence they could be substantially higher than those
21 shown here. Whether this prospect affects his decisions
22 about enrolling in a plan or disenrolling from a plan will
23 depend on a lot of factor, but one will be whether he's able
24 to get the information he needs to compare benefits and
25 cost-sharing options.
26 What kind of cost-sharing information is
27 available? As we already saw, the Medicare personal plan

1 finder on the Medicare web site provides information on
2 estimates out-of-pocket cost for beneficiaries. A person
3 can enter his or her information on age and health status
4 and get estimates for each plan where they live. The
5 estimates are for four general categories that we showed
6 before, inpatient care, other medical care, outpatient
7 drugs, and dental care, and also premiums. In addition,
8 there are estimates about the average out-of-pocket cost for
9 people with three different high-cost conditions.
10 The plan finder also has information on how many
11 people left the plans that they are considering joining, and
12 some information on the reasons why they left.
13 We used this information from the surveys
14 ourselves, as Rachel will tell you in a few minutes, to look
15 a little bit more in detail at the cost sharing, but right
16 now I just want to focus on some of the general issues.
17 This is an example of plan finder information on out-of-
18 pocket cost for beneficiaries with the three high-cost
19 conditions that CMS illustrates on the plan finder. The
20 table shows the same three plans that were used in the
21 cancer example. You can see that for those three plans,
22 out-of-pocket expenses are lower in plan two by a similar
23 magnitude to what we saw in the cancer care example.
24 However, the average cost shown on this part of
25 the plan finders are for all beneficiaries with these
26 conditions regardless of age or other health care problems.
27 For diabetes, for example, the averages shown here include

1 very high costs for some diabetics with serious comorbid
2 conditions who may experience multiple hospitalizations per
3 year and diabetics whose disease is well controlled. The
4 estimates for high-cost conditions. also don't break down
5 the cost by type of service that we saw earlier so we can't
6 tell from this chart whether the costs reflect cost sharing
7 for inpatient care, for other Medicare-covered services, or
8 for uncovered services such as prescriptions drugs.
9 This is an example of information the beneficiary
10 can find on how many members have left the plans in their
11 areas and why. The beneficiary could, for example, check
12 out the reasons why people left the three plans we've shown
13 in the last two slides, the data on the plan finder from
14 2002 and their contract-level data.
15 We see here, however, that in plans one and three,
16 which have the higher out-of-pocket costs, a higher
17 proportion of beneficiaries disenrolled than in the other
18 plan. The reasons they cited were also more likely related
19 to issues to premiums, copayments, or coverage than in plan
20 two, or in the plans in the state or nationally. While the
21 specific reasons that people left the plan is not clear, the
22 beneficiary interested in might get some sense of the issues
23 he might want to dig into before selecting a plan at the
24 next open season.
25 DR. SCHMIDT: We looked at data from the CAHPS
26 disenrollment reason survey to see whether cost sharing is a
27 main reason beneficiaries cite for leaving MA plans.

1 Ideally, if we had plan-level disenrollment rates, that
2 could then provide a potential signal to CMS of the plans
3 that it might want to take a closer look at. However, a
4 limitation of this approach is the survey is conducted at
5 the contract level and is still described, often times many
6 distinct plans with different benefit designs are operating
7 under one contract.
8 Nationwide an average of 10 percent of plan
9 members disenrolled voluntarily in 2002. For historical
10 comparison, we found references in the literature to
11 disenrollment rates of 14 percent in 1994 and 12 percent in
12 1998, but those might not have been calculated in precisely
13 the same way. In the last two years it's been roughly
14 around 11 percent, 13 percent in 2001 and about 10 percent
15 in 2002.
16 CMS groups disenrollment reasons into the five
17 categories that are shown on this slide. You can see that
18 the largest proportion of disenrollees fall into the
19 category called issues with premiums, copayments or
20 coverage. When we looked at the individual responses that
21 fall within this category, most are related to concerns
22 about cost and best value. The category also includes
23 concerns that beneficiaries had when their plans began
24 charging or raised premiums. Since we are particularly
25 focusing on whether cost sharing has led beneficiaries to
26 disenroll, this category probably overstates the rates of
27 disenrollment that we are particularly interested in.

1 In addition, many of the responses are ambiguous
2 to the survey. They could be referring to dissatisfaction
3 with cost sharing, with premiums, with both, or some other
4 features of the plans. Very few of the responses are
5 unambiguously associated with cost sharing.
6 We also took a look at the distribution of plans
7 and enrollees by their rates of voluntary disenrollments
8 that are associated with cost and value concerns. This
9 slide shows you how many plans fall into the groupings of
10 disenrollment rates that are on the bottom of the slide.
11 These are just for the largest category from the previous
12 slide, which was issues with premiums, copayments and
13 coverage.
14 So 107 of the MA contracts had zero to 5 percent
15 of their enrollees leave for those reasons. Another 31
16 contracts had 5 percent to 10 percent leave, and so on.
17 Combined, about 90 percent of the plans had rates of
18 disenrollment associated with cost concerns of 10 percent or
19 less. Likewise, most enrollment is in plans with very low
20 disenrollment Roman rates.
21 The bottom line of this slide is that the vast
22 majority of plans and enrollees have relatively low rates of
23 voluntary disenrollment associated with cost and value
24 concerns. I don't mean to dismiss the situations of
25 beneficiaries who disenroll. They may have experienced some
26 very real problems with the benefit design or cost sharing
27 in their plans. But we're trying to get a sense of how

1 widespread a problem discontent with cost sharing is, and
2 these data seem to suggest that it is not widespread.
3 Remember that this chart includes people do left because
4 they were unhappy with premium increases and other reasons
5 in addition to how a plan designed their cost sharing.
6 This does not directly measure whether access to
7 care of beneficiaries is affected by benefit design but it
8 does give you a sense that most plans do not have large
9 numbers of people leaving because of cost.
10 Here's what I think we've learned from our
11 research so far. On the left-hand side of the slide you can
12 see some summary points. As we started out with and we told
13 you, these are similar to what we found from the meeting of
14 our expert panel back in March, it seems as though the
15 benefit designs to contribute to selection or access
16 problems do not appear to be very widespread. However, we
17 did see some evidence that are plans that do have some high
18 cost sharing for some types of services that one might
19 consider non-discretionary in nature.
20 Another issue that we had highlighted is that we
21 think helping beneficiaries to understand their options, the
22 financial and personal implications of them, is quite a
23 challenge.
24 So we would like you to turn to some categories of
25 policy options that are described further in your materials.
26 The study's mandate says that our report is to include
27 recommendations for legislative and administrative action,

1 if you as a commission consider it appropriate to do so.
2 Your mailings materials included some discussion about the
3 categories of policy options that appear on the right-hand
4 side of the slide. I'll go into them in a bit more detail.
5 One thing that we found in doing this research is
6 that the quality of information submitted to CMS on benefit
7 designs, particularly the plan benefit package data, are
8 sometimes not accurate or coded consistently. That's not
9 surprising because MA benefits are complex and it's hard to
10 provide that detail to CMS. But the same data that we
11 looked at are used to develop the personal plan finder and
12 the out-of-pocket estimates in that to help consumers choose
13 among their options, and unless a plan catches its own
14 mistake those data may not get fixed.
15 Another issue is that while the personal plan
16 finder provides more useful information than has been
17 available in the past, it is not as tailored as what other
18 plans and programs offer. It has estimates of average out-
19 of-pocket cost for a beneficiary who is in the same age and
20 health status as the consumer who is interested, or in some
21 cases has the same type of chronic condition. But it still
22 averages people who have less use of services together with
23 people who have more. Other approaches, such a some web-
24 based tools offered by private plans, or even the Consumer
25 Checkbook guide to FEHBP provide particular scenarios of use
26 of services along with an indication of how likely the
27 scenarios are to occur, and that might give some more

1 tailored information.

2 CMS considered that approach when it developed its
3 current method for showing out-of-pocket cost in the
4 personal plan finder, but at the time it considered that too
5 burdensome to beneficiaries to be entering a lot of
6 information about their use of services. The agency is now
7 reviewing options for more sophisticated softwares, wizards
8 and those sorts of things, for consumers who would like to
9 get more information.

10 CMS is considering a range of options but it has
11 not yet decided what sort of estimates of out-of-pocket it
12 will be able to provide in the plan finder for 2006. It has
13 some concerns about being to estimate out-of-pocket spending
14 for the new Medicare drug benefit that's going to begin in
15 that particular year. Yet information about cost sharing it
16 seems would be particularly important for beneficiaries in
17 that year.

18 While are mailing materials focused on the plan
19 finder, we thought we should remind you that there are other
20 channels to provide consumers with information about MA
21 plans, and those include the 1-800 Medicare line and the
22 state health insurance assistance programs. Those approaches
23 involve more one-on-one discussions or conversations with
24 beneficiaries which may be a more effective means of
25 communication for some people. So we think providing
26 counselors with training and information about benefits
27 design and potential out-of-pocket costs is another avenue

1 for helping beneficiaries make informed choices, but it
2 would also require greater resources.
3 At our September meeting we described the process
4 that CMS uses to review and approve plan proposals. We also
5 described the fact that under the MMA CMS gained authority
6 to negotiate with plans over their bids in a manner similar
7 to that of OPM for administering FEHBP. So it seems that
8 the agency has some authority to steer plans away from
9 benefit designs that encourage enrollment by healthier
10 beneficiaries or encourage disenrollment of sicker ones.
11 CMS anticipates that its workload will increase with this
12 new negotiation authority but it does not yet know the
13 magnitude of that increase but it's not clear how many plans
14 they'll actually need to be negotiating with.
15 There's also uncertainty about what level of staff
16 resources CMS will have for these reviews and negotiations.
17 The Center for Beneficiary Choices has some dedicated
18 personnel. The Office of the Actuary will also participate,
19 and I think there are some plans perhaps to pull in some
20 contractors to help during the months in reviewing plan
21 bids.
22 It's hard to make precise comparisons but we found
23 that the number of staff who are involved in CMS's oversight
24 functions may be smaller than what OPM has for negotiating
25 with plans under FEHBP. This raises the question of whether
26 CMS has sufficient resources and as much flexibility as it
27 might need to manage those resources well.

1 FEHBP has a larger number of covered lives than
2 does the Medicare Advantage program, but CMS has more plans
3 to review and its negotiation and approval function or
4 arguably more complex than OPM's. The reason it's more
5 complex is that for most FEHBP plans OPM compares changes in
6 premiums to what those same plans charged similarly-sized
7 groups in the commercial market. By comparison, CMS will
8 need to review MA plans more closely and negotiate over
9 benefit designs that are more likely to be different from
10 those available in the commercial market.
11 There may be ways to provide CMS with more
12 flexibility to better manage the resources that it has or
13 build in some surge capacity for those months in which it
14 will be reviewing bids and negotiating. It may also be a
15 challenge to coordinate staff within CMS because several
16 parts of CMS play a role in this function.
17 Finally, we have several mutually exclusive
18 approaches that the Commission might want to consider to
19 help prevent benefit designs that are discriminatory among
20 potential enrollees. It's probably important to keep in
21 mind something that we pointed out in September and that is
22 there's a lot of uncertainty surrounding the MA program at
23 this particular point in time because there are so many
24 changes underway, including the phase in of new risk
25 adjusters, moving to a system of bidding, the introduction
26 of Part D, and regional PPOs as some example.
27 But let's forge ahead and discuss these options.

1 One approach would be for CMS to develop a few standard
2 benefits packages that plans would have to use. The main
3 advantage of this approach is that beneficiaries would find
4 it easier to compare plans and assess their value than they
5 do today. This option could also ensure that plans do not
6 have relatively high cost sharing for services that are less
7 discretionary in nature.
8 The disadvantages of using standard benefits are
9 that they may not suit the market conditions and preferences
10 of all parts of the country, and they could make it
11 difficult for plans to develop new products that better suit
12 beneficiary needs. If this approach were used, CMS would
13 need to modify standard packages periodically to keep up
14 with market innovations.
15 Another approach would be for CMS to propose the
16 use of certain benefit structures. If plans use those
17 benefit designs, CMS would not subject the plan to as much
18 oversight as it would get otherwise. This is similar in
19 approach to CMS's current policy of recommending that plans
20 use an out-of-pocket cap. The advantage of this approach is
21 that it could lead to less confusion for beneficiaries
22 without directly requiring a standard benefit. It would
23 also potentially reduce CMS's workload because the agency
24 could focus on the plans that are using a different benefit
25 structure. But plans would only adopt the proposed benefit
26 design if CMS's oversight process placed significant
27 barriers on using a different design.

1 In a third approach, CMS would identify certain
2 types of services that would be subject to standardization.
3 This approach could range from having modular benefit
4 designs for all parts of service to just picking out a few
5 categories, such as some that seem less discretionary in
6 nature. Keeping some of the current flexibility that plans
7 have would allow them to adjust cost sharing in areas where
8 there's arguably overuse of services yet would protect
9 beneficiaries in situations where they have less discretion.
10 A final option would let plans keep most of the
11 flexibility they have today except that they would have to
12 adopt a catastrophic cap. CMS currently suggests an out-of-
13 pocket cap but it is not required. After 2006, regional
14 PPOs are required to include a cap, but the MMA does not
15 specify at what level. This approach may not simplify
16 things much for beneficiaries but it would provide enrollees
17 in some plans with greater protection than they have today.
18 At this point we would like to turn to you all and
19 get your feedback on this.
20 MR. HACKBARTH: This report is due December 31 and
21 given that after this meeting we will increasingly have to
22 spend time at our meetings on the update issues that we have
23 to address in the January report I'd really like to conclude
24 this discussion at this meeting. You'll notice that there
25 are not any draft recommendations. Staff, I think correctly
26 felt, that we didn't quite crystallize the discussion enough
27 at the last meeting to bring draft recommendations to this

1 meeting. What I'd like to get out of this discussion right
2 now is some clear direction for staff that could be
3 overnight formulated into draft recommendations that would
4 come back tomorrow that we could vote on. So that's my
5 objective.
6 So what I'd like to do is, maybe a little bit more
7 than usual, try to have a quite structured discussion here
8 today. I think one way to do that, if you would put up page
9 11 from the overheads, we've got the three categories of
10 policy options, help beneficiaries make more informed
11 choices, bolster CMS's negotiating role with plans, and
12 prevent discriminatory benefit designs. What I'd like to do
13 is just go through those in order and get your thoughts so
14 we can't formulate recommendations. So let's begin with
15 helping beneficiaries make informed choices.
16 DR. REISCHAUER: Is anybody against that?
17 MR. MULLER: Thank you for the excellent report.
18 I read this to say that the question being asked of us in
19 terms of how access is affected by the cost sharing is that
20 neither the plans nor the beneficiaries use it in any kind
21 of linear or authoritative way to drive choice. Given the
22 other analysis that we've done, it strikes me that the fruit
23 is still in terms of understanding the total cost per
24 beneficiary and that the real gain to be made in the program
25 is as plans select "right beneficiary" that has lower cost.
26 Therefore, to me that strikes me that having CMS understand
27 more fully what the costs are per beneficiary and try to

1 keep plans from selecting the lower-cost patient is the
2 right way to be thinking about this.
3 Also in my own experience, and I think the
4 evidence here is, getting people to understand the cost of
5 medical care is very complex. On a running basis, cost
6 sharing, figuring out every month -- we all have our stories
7 of helping Mom or Dad figure out their EOB every Sunday
8 morning, but figuring out your premium once a year is about
9 as much as people can figure out in terms of making choices.
10 Trying to do it on any kind of concurrent basis may be
11 beyond the capacity of any of us to understand. So that
12 leads me to think about how one sets premium levels and how
13 one looks at total cost rather than cost sharing. That's
14 how I read this.
15 Is that a fair evaluation of what you have come up
16 with?
17 DR. SCHMIDT: I suppose so. In terms of ascribing
18 a motive to plans, I don't think that there is evidence to
19 do that well. I'm taking this from your initial comment on
20 how you were interpreting the results of what we wrote up.
21 It seems to me that selection, there's a component that's a
22 two-way street. Beneficiaries try to look for what's in
23 their best interest in a plan, and plans may in fact need
24 to, for example, raise revenue in some cases by charging
25 higher copays, or they could be engaging strategically. We
26 just don't know if many circumstances. I think the evidence
27 that we saw was not compelling to put it squarely in the lap

1 of plans, I would say.

2 DR. MILLER: I might have heard something
3 different over here. Ralph, tell me if this is what you
4 were saying. Was the paper directing better information for
5 the beneficiary to be pitched at the premium and total cost
6 level as opposed to helping beneficiaries understanding the
7 cost-sharing structure?

8 If that's what you're asking, I would say I felt
9 like the paper wasn't headed in that direction. That the
10 paper was saying there were ways to present potential out-
11 of-pocket impact for the beneficiary in the way that gave
12 them a clearer idea of what they might incur. That rather
13 than a big, lumpy average you could say, average cost
14 sharing for somebody with a hospitalization and without and
15 then tell the beneficiary the probability of a
16 hospitalization. So break it down a little bit for them.
17 But I may still misunderstand your question.

18 MR. MULLER: I obviously wasn't very clear so let
19 me try again. I read this to say that neither the
20 beneficiary nor the plans seem to use cost sharing very
21 effectively to drive choice. That the beneficiaries don't
22 understand it as well as they might, and the plans don't use
23 it as effectively as they might. So therefore there must be
24 some other vehicle, some other lever they use.

25 I would surmise that, based on incentives, that --
26 certainly employers do this in the non-Medicare market ,
27 they try to figure out the total cost of care, and the

1 evidence we see of people dropping dependents and so forth
2 from coverage is a function of the cost of coverage and so
3 forth. So I would assume inside the Medicare plan as well
4 the total cost of covering a beneficiary is what plans would
5 look at and that's more of a driver of their behavior, the
6 total cost, in terms of enrolling people or not.
7 Then one obviously can use premium information as
8 well. But I read this to say in cost sharing, despite
9 hypotheses that we might have had, does not seem to have as
10 much effect either on beneficiary behavior or how plans
11 behave.
12 MR. HACKBARTH: Certainly cost sharing as opposed
13 to premiums is more difficult for beneficiaries to get a
14 grip on, which is the challenge. It's more difficult for
15 them to comprehend the implications of the cost-sharing
16 structure for them.
17 MR. MULLER: It's more difficult for plans to get
18 a grip on.
19 MR. HACKBARTH: I think they've got more
20 information and way more skill.
21 MR. MULLER: But they don't seem to use it
22 consistently to drive behavior.
23 MR. HACKBARTH: There are others around the table
24 more expert in that than I am. But just to focus on the
25 beneficiary point for a second. The challenge that I think
26 we have is that beneficiaries tend to focus on premiums
27 because that's easier to compare and understand, and

1 comparing premiums that are missing very important
2 differences potentially in the benefit structure, the cost-
3 sharing structure, that could have dramatic implications for
4 them depending on their circumstances. So the challenge is
5 can we find ways to help beneficiaries analyze that complex
6 choice?

7 At the last session, Arnie for one and perhaps
8 others as well, said that Medicare right now is -- these are
9 my words, not Arnie's -- lagging behind the state-of-the-art
10 in decision-support tools, and there are software tools out
11 there that help people make these comparisons and choices.
12 Is that a fair statement, a fair summary? So that would be
13 one type of approach.

14 A second big category is more resources, more
15 telephone-based help through SHIP or some other mechanism so
16 people can be talked through these decisions. I think those
17 are the two major approaches that are being discussed. So
18 if we could get some feedback on what can we recommend, what
19 should we recommend, those two categories. Are people in
20 favor of more resources, or is there another major option?

21 MR. BERTKO: Just a quick comment again to thank
22 the staff for a very good report on the issue. I'd strongly
23 support this first recommendation of more communication and
24 note that in addition to perhaps coding errors, the current
25 format that CMS records plan decisions on is fairly rigid,
26 in which case there is sometimes difficulty inserting in the
27 actual benefit decisions, which probably limit how people

1 look at this. So more resources by CMS, perhaps whether
2 it's better decision-support tools or more flexibility in
3 terms of recording the actual cost sharing could be helpful
4 and I think would reduce errors and help explain better.
5 MR. HACKBARTH: Could you just explain for me the
6 more flexibility in recording?
7 MR. BERTKO: Sure. I'm not sure if this is an
8 example but on the Part A first-day deductible, fee-for-
9 service is $876, and as you insert there, is it a copay, is
10 it a copay per day, is it a copay limited by a certain
11 amount? As you begin inserting more complicated versions of
12 that, because plans in pre-MMA days were managing to the
13 amount of revenue available, those ways to structure the
14 Part A cost sharing became more complex. It's my
15 understanding from at least a year ago that it was difficult
16 for us as a plan to report in to CMS in the prescribed
17 format the variations of that. So a little bit more
18 flexibility, saying free-form text, would be useful.
19 Then CMS has the second problem of getting that
20 into plan finder, which I think is a pretty good tool but
21 could serve also to be improved in the future.
22 MS. BURKE: Let me focus specifically on the
23 question you asked in terms of the information for the
24 beneficiary. On page 26 of the document -- and my thanks
25 for the work the staff did on this -- there is a suggestion
26 in the last paragraph that CMS currently plans to remove
27 projections of out-of-pocket payments from the plan finder

1 in 2006. That's a little further ahead than where we are
2 today but let me use it as a jumping off point.
3 I think as a general matter, the more information
4 that we give to people the better if it's in a form that in
5 fact can be useful. I think one of the messages that I
6 would suggest that we as a commission want to send is that
7 it is incumbent upon us to make as much information
8 available as possible, and suggestions that they simply drop
9 whole categories out rather than try to deal with the issue,
10 which is how do you accommodate the fact that there will be
11 a drug benefit, I think is the wrong direction. So I think
12 we ought to make it very clear early often that our goal
13 here is in fact to provide information.
14 To the point that Ralph was making and also Glenn
15 has made, and that is the issue as to whether or not
16 people's decisions are more clearly driven by premium as
17 compared to out-of-pocket, because it's a much more clearly
18 articulated number. You can look and you can look behind
19 the plans. It's obviously an inadequate measure from a
20 beneficiary standpoint because the impact of the cost
21 sharing can have such an extraordinary impact on them as
22 compared to premium. If as we saw in the plans that you
23 compared, it can have a substantial difference on an
24 individual if in fact there's cost sharing on drugs, or cost
25 sharing on any number of other things.
26 So I would err on the side of giving more
27 information in both forms, both in the sense that you have

1 it available to you in a plan finder, that we adjust the
2 plan finder as necessary to make it more readily available
3 to an individual to look at it. You made some suggestions
4 in terms of doing a variety of options so that it's not
5 simply the average person, that there are different ways to
6 construct the plan finder. I would encourage us to say that
7 we think that is a useful tool that ought to be improved
8 upon, that there will be people who will find it more useful
9 than others. There are always going to be people who are
10 only going to look at one thing, or who are incapable of
11 managing that kind of a system.
12 But I think it ought not discourage us from having
13 it available. Whether it's the child of a parent utilizing
14 it or the parent themselves, I think we ought to have it
15 available, it ought to be modified to the extent it can be
16 to make it a more realistic test of what expectations would
17 be: if I'm healthy, if I am chronically ill, what my
18 expectations of use would be.
19 So I guess my concern is that we ought to
20 discourage them from pulling stuff out because they're not
21 sure how to deal with it, that we ought to certainly
22 articulate a strong view that more tools ought to be
23 available to the beneficiary in making decisions, and I
24 think it ought to be not only the premium but in fact the
25 extent to which we can improve the information on cost
26 sharing so it is a more useful tool for folks to manage, I
27 think is going to be critical.

1 I think anything short of that would be a real
2 disadvantage for beneficiaries. It isn't perfect as it is.
3 It isn't easy to use, but at the moment it's the best thing
4 we have and it can be improved upon. So I would send that
5 message very strongly in any report that we would have.
6 DR. SCHMIDT: We'd like to clarify one thing that
7 was in the mailing materials. That is, after the mailing
8 materials went out we had other conversations with CMS and
9 it's not so definitive that they plan to drop the out-of-
10 pocket estimates in 2006. They're still considering their
11 options.
12 MS. BURKE: Let's make that clear.
13 DR. MILSTEIN: First I want to reinforce my prior
14 suggestion that informed beneficiary choice of plan I think
15 could be very much improved if it took advantage of current
16 best available tools of predictive modeling. We have made a
17 lot of progress, actually primarily in other applications of
18 predictive modeling, than improving a beneficiary's ability
19 to know how much enrolling in a particular plan is going to
20 cost them personally in the subsequent year. But those
21 advanced predictive modeling tools are not currently part of
22 the Medicare program, the Medicare plan finder.
23 If you then take the next step and say, what would
24 it take for Medicare beneficiaries when choosing plans to be
25 able to access or get the benefit of current advanced
26 predictive modeling tools? It would require Medicare
27 beneficiaries to be able to authorize the pushing of their

1 personal prior 12 or 24 months worth of claims history into
2 the predictive modeler. Now that in turn would require CMS,
3 for its fee-for-service database, to mobilize it and have it
4 available such that if a beneficiary said, I'd like to know
5 for me personally, given my personal health history, what my
6 likely expenses would be in Plan A versus Plan B. There's a
7 fair amount that Medicare would have to do with the
8 traditional Medicare database to get a ready for use in a
9 customized and fresh feed into best available predictive
10 modelers, but not undoable.
11 MR. HACKBARTH: Do employers do that currently or
12 does that have a direct feed into the software so that --
13 DR. MILSTEIN: More advanced. Not all by any
14 means.
15 If you think about it, once somebody was in a
16 plan, if they wanted to model what the implications would be
17 of switching plans, that same easy availability of personal
18 claims history would also be something that would be their
19 entitlement when they're in a Medicare Advantage plan.
20 They'd be able to take their current history and then run it
21 through the modeler.
22 DR. REISCHAUER: Can I just ask a question on
23 that? That is, to the extent these plans are offering
24 benefits that are in addition to the Medicare required
25 benefits and that's a very attractive aspect of these plans,
26 might not this particular methodology that you're suggesting
27 provide them with a biased set of information? Because it

1 will say, of your Medicare-eligible costs you'd do a whole
2 lot better, but the person is really interested in their
3 vision and dental costs. So you'd be steering them maybe in
4 the wrong direction.
5 DR. MILSTEIN: There's no question that your
6 accuracy in predictive modeling would be higher if you were
7 modeling future health care use based on a plan that had
8 identical benefits as the plan you had been in. But that
9 said, you could still get a lot of predictive power, even if
10 you were coming out of a plan that had a different and more
11 lean set of benefits than the one you were thinking about.
12 So a predictive modeler would still work, just it's accuracy
13 would go down by a certain number of percentage points. But
14 it would still be a much more accurate predictor than what
15 we currently do which is, how old are you, what's your
16 gender, and please answer the following short list of
17 questions about what you can remember about your health
18 status. Your ability to then anticipate what a plan is
19 going to cost you out-of-pocket is going to be far reduced
20 relative to what a really good predictive modeler,
21 interacting with your claims data, even for a plan that had
22 a different benefits schedule, would be able to accomplish
23 today.
24 The second point I want to make is, if we think
25 about such a world in which Medicare beneficiaries would
26 have something better than their sons and daughters to try
27 to figure out which is the best deal for them, as it were,

1 you would also want to be able to think about a modeler that
2 would distinguish between what a plan would cost you if you
3 did and did not accept the plan's preferred option.
4 So for example, if it's a Medicare Advantage PPO
5 plan and I go out of network, I'd like to know -- you'd have
6 to have some ability for people to know how much of it would
7 cost them if they stayed within their plan's recommended
8 formulary and recommended network versus if they strayed,
9 because that would in most Medicare Advantage plans have
10 significant, different implications.
11 So those are my two comments. The first is the
12 one I wanted to emphasize, but these are things that are
13 easily within current technology and I think that we'll look
14 back on the current period in which people were asked you --
15 we gave people predictions based on age, gender and then
16 filtered it through their sons and daughters and say, how
17 did we ever accept that, because I think we can do much
18 better.
19 MS. BURKE: That would be a great thing to get to
20 when we could get ticket to it. It occurs to me, Social
21 Security currently does an analysis and we each get a letter
22 -- maybe it's age-based and only some of us get the letter -
23 - each year that calculates what it is that our retirement
24 benefits would be. It's actually quite a useful sort of
25 document.
26 Similarly, you could imagine, to the point that
27 you would have available or an outside contractor could have

1 access to the Medicare files, a similar letter that would go
2 out that would say, last year you used X in terms of your
3 benefits. That might allow people to use the current model
4 even if we begin to have access to the more advanced
5 predictive modeling. But to the extent that Medicare could
6 do that in is similar form, there's history there in Social
7 Security. Whether there's a similar kind of opportunity
8 with Medicare as at least a first step it might well be a
9 useful tool for someone to say, this is what happened last
10 year. You used the following services.
11 To the extent that we could have access to that
12 might at least move us in that direction, which I think over
13 the long term would make a lot of sense.
14 MR. HACKBARTH: Given the nature of this report,
15 this commission, obviously we don't have the wherewithal to
16 review specific tools and say, this is the one you ought to
17 use. So we're simply pointing in a direction and realizing,
18 I think we need to reflect in the attached language that we
19 know that there some issues to get from where we are today
20 to where Medicare ought to be in the future.
21 So the message that we want to convey is there is
22 a different way out there, it's being used in the real
23 world. This is very important, and we urge that you move in
24 that direction with some dispatch. I don't think we can go
25 too much further than that.
26 DR. MILSTEIN: I just want to reinforce, most
27 people who are in a plan may well not realize, based on last

1 year's change in health status, there's a lot better value
2 plan for them in their community available now. So I really
3 want to reinforce Sheila's notion of it being something that
4 is actively made available to beneficiaries when, based on a
5 fresh review of their health status there is a plan that
6 represents a better value in their community.
7 DR. SCANLON: Following up on the last couple of
8 comments, I think that we do need to emphasize what the
9 short-term recommendations we want CMS to consider versus
10 the longer term. I have no issue that it may be ideal to
11 get to a point where beneficiaries have actual information
12 about their experience and that they can put into some
13 system or some model and get some recommendations.
14 Nancy-Ann can probably tell you better than I, but
15 Medicare is not there today in terms of getting that
16 information on any kind of a timely basis, and the kinds of
17 system changes that would be required to do this are really
18 quite dramatic. Social Security is a piece of cake in
19 comparison to Medicare. We have had about a decade of
20 trying to modernize Medicare's information systems and we're
21 still very far from being anywhere close to what you might
22 think of is reflective of today's technology, because all
23 over the world things are happening amazingly with respect
24 to IT. But Medicare is still not there.
25 So I think we need to emphasize for CMS the short-
26 term changes are also critically important in terms of what
27 kinds of things to highlight in plan finder, what kinds of

1 things to highlight in other materials. I think some of the
2 suggestions in the report are very good.
3 Distributional issues are big. Diabetes, the
4 number there surprised me in terms of, we've got a lot of
5 people with a diagnosis of diabetes who are not going to
6 occur necessarily that much expenditure. But we've got in
7 extreme who are going to incur a lot, and people need to
8 know about that.
9 The other thing I would say, and this is in part
10 in reaction to Ralph's comments. I don't think we know a
11 lot about cost sharing either by plans or beneficiaries, and
12 that's appropriate because our question was, are plans using
13 cost sharing to skew their populations? I think we
14 basically found that they're not for the most part. There
15 may be some exceptions. So that question is answered.
16 But in the process of doing this we discovered the
17 difficult that consumers will have in terms of trying to
18 pick a plan, and that's an area where we need to try to make
19 some progress. So I think moving in that direction is a
20 positive step and goes beyond the narrowness of the original
21 question that we got from the Congress.
22 DR. REISCHAUER: Following on what Bill said, it
23 strikes me that the bottom line of this is that our
24 examination found that there was no evidence or no
25 conclusive evidence of egregious benefit design to skew the
26 risk pool that a plan has. This might be because CMS does
27 have the authority to look over their shoulders, and maybe

1 you want to strengthen that authority a little bit. It
2 could be because any commercial plan would be foolish to get
3 itself in a position where CMS announced or the public
4 announced this plan has maliciously designed its benefits to
5 screw the sick, and they wouldn't be able to market for
6 years in that area.
7 Given that situation, we should look at these
8 options and dip into the least intrusive it strikes me.
9 More information for beneficiaries, better, more modern
10 tools for making these estimates, fine. More resources for
11 CMS if it feels that it needs them or we think it should.
12 If plans and CMS thought it would be beneficial,
13 the existence of safe harbors I think makes sense, just to
14 ease the burden, unless plans say we really don't care about
15 that and CMS says it really wouldn't reduce our workload
16 very much. But going much beyond that really at this point
17 isn't necessary, given what this analysis shows.
18 While I'm sympathetic to Arnie's world, I do see
19 that it's somewhat in the future and I think that there
20 really are limits to the extent to which Medicare
21 beneficiaries are going to rely on these kinds of
22 information and tools. All the evidence we have about the
23 way Americans make decisions with respect to consumer items
24 and even things like health suggest that they aren't
25 extremely analytical. Even when they have all the tools in
26 the world and all the analytical information they could have
27 they turn to their neighbor and say, what do you have and do

1 you like it?

2 When you think about this kind of decision, lots
3 of people who are making these decisions are basically
4 healthy. If they are halfway through treatment for an
5 episode of cancer they usually aren't looking around for
6 alternatives. If they are in a plan and they have developed
7 cancer and are halfway through the episode, they often are
8 more concerned about their perceived quality of care that
9 their receiving and their relationships than they are with
10 the cost sharing.

11 So even if we provide lot of water here, it's not
12 clear the horses are going to drink, I think. That's not an
13 excuse for not doing it so that 30, 40 years from now when a
14 new generation of beneficiaries who are analytically
15 oriented and all have engineering degrees comes of age, this
16 will be useful.

17 DR. MILSTEIN: I certainly agree with a lot of the
18 empirical findings you cite today that given the challenges
19 of being an informed consumer that most consumers opt not to
20 do it. But I think my enthusiasm for the version that both
21 Sheila and Nancy alluded to is precisely because it would
22 not require any energy or analytic effort on the behalf of
23 the beneficiary. That is, what I'm envisioning here is
24 something analogous to a blue light special at Kmart where
25 essentially on a periodic basis, based on a beneficiary's
26 personal health history, if there is a plan available to
27 them that would represent a lot better bargain, the blue

1 light goes on and they are alerted to it. They can turn it
2 down or not turn it down. But you don't have to be an
3 engineer in order to respond to a blue light special.
4 DR. REISCHAUER: But you talked about better value
5 and better value seemed to be cost-sharing premiums. But
6 there are a whole lot of other dimensions to health care
7 that people are concerned about; their relationship with
8 individual providers, the distance to those providers, the
9 range of providers and all that, and you can't bring goes
10 in.
11 Now that doesn't mean you shouldn't provide this.
12 But the blue light special is usually a product everybody
13 knows all the dimensions of and what people are comparing it
14 on is relative cost.
15 DR. MILSTEIN: I think that Bob's point is
16 absolutely right that there are certainly a lot more
17 dimensions to which plan I pick than price only. But that
18 said, I think we can do a lot better than we're currently
19 doing to help beneficiaries anticipate what the out-of-
20 pocket cost to them would be of a given plan option which is
21 the scope of what I was addressing.
22 The other thing is this comment about we know that
23 Americans default to what the person over the back fence
24 tells them they should do with respect to health care. I
25 think that is a default and I think it remains to be seen
26 whether or not if we made it easy and transparent and
27 trustworthy whether or not a lot more Americans wouldn't

1 feel comfortable with alternatives to what their neighbor
2 tells them over the back fence.
3 DR. WAKEFIELD: Just a comment and a question,
4 staying with Bob's horse and water analogy. My comment is
5 an interest in ensuring that all the horses that choose to
6 drink have the option to get to the water and they know
7 where the water is. So following up on that my point is, it
8 seems to me it might be worth mentioning somewhere in this
9 report a comment about any extra effort that individuals
10 view as necessary to ensure that vulnerable populations
11 within the larger beneficiary pool have access to
12 information.
13 So for example, I think having web-based
14 information is a terrific thing and knowing that plan finder
15 is there, it sounds like that's an excellent resource. Some
16 limitations, but overall an excellent resource. But I'm
17 concerned about those minority groups, rural populations
18 that at least today and for the near-term foreseeable future
19 may not have access to information that way. True, there's
20 a 1-800 out here. How do we ensure that as many people as
21 possible know that that exists, for example?
22 So just a nod to recognize that perhaps some
23 particular attention needs to be paid so that everybody who
24 wants to avail themselves of information is aware that.
25 Maybe there could be that sort of a comment made in the
26 report, because I'm not sure that this information is going
27 to diffuse out in as smooth and organized a fashion as we

1 might hope it would.

2 The question I've got for you is, in terms of
3 avenues for providing information, this function carried out
4 by SHIPs at the state level, are those functions funded
5 purely through Medicare or is there any responsibility for
6 the state to pick up some of this pushing information out
7 the door to senior citizen centers and so on?

8 DR. BERNSTEIN: Most states, either through their
9 offices of aging or insurance provide additional support to
10 the SHIPs. The last survey I saw there was huge variation
11 in the extent to which they received help from either the
12 states or from other organizations that they partnered with.

13 DR. WAKEFIELD: So this is not a fully Medicare-
14 funded activity then when people are trying to move
15 information out to beneficiaries?

16 DR. BERNSTEIN: No.

17 DR. WAKEFIELD: That's a concern from my
18 perspective in terms of equal access to information for
19 those states that have the resources to put on the table to
20 support this information on a federal program versus those
21 states that either choose not to or don't have the
22 resources.

23 DR. BERNSTEIN: They definitely need help from
24 other organizations. In some states you can go to a SHIP
25 and you can sit down with a counselor for hours who will
26 pour over this stuff with you or help you over the phone.
27 Other states have much less support to the SHIPs.

1 DR. WAKEFIELD: It seems to me highlighting that
2 as a potential problem in terms of access to information
3 ought to be part of this report as well.
4 MR. HACKBARTH: We are at the end of the allotted
5 time so I really want to try to, as quickly as possible,
6 bring this to a conclusion and provide some direction for
7 the staff on the issues of CMS negotiating authority and
8 preventing discriminatory benefit designs, the other two
9 components here.
10 I agree with a Bob's summary that on the immediate
11 question we were offered, is there a lot of this activity of
12 discriminatory benefit designs, the answer is no, based on
13 what we've been able to find.
14 Having said that, it was not zero. There were
15 some instances, so I think what I'd like to see us say along
16 those lines is that if it were to increase, it would be a
17 problem. But because it isn't a problem right now we don't
18 want to, as Bob recommended, go into the excessively
19 regulatory restrictive options. They are simply not merited
20 based on the facts we have in front of us.
21 I am personally concerned that if it were to
22 proliferate, if we would have more plans with low cost
23 sharing for everybody except for cancer patients, that that
24 is detrimental to the Medicare program, to Medicare
25 beneficiaries, to the other private plans in the
26 marketplace. I think maybe a way to strike the appropriate
27 balance by assuring that CMS has in fact that negotiating

1 authority and isn't limited to simply pleading with plans or
2 threatening to put their names in the newspaper but can say,
3 this is an unacceptable discriminatory design.
4 Now I have a question about that. When we were
5 discussing this issue, briefing congressional staff on it,
6 at least some of them thought that the existing MMA language
7 which grants CMS authority on discriminatory design for drug
8 benefits actually was broader and covered local MA plans.
9 DR. SCHMIDT: It does. The language basically
10 says that CMS has authority similar to that of OPM for
11 administering FEHBP, and OPM's authority is quite broad. It
12 includes setting minimum benefit standards.
13 If you look, however, in the proposed rules that
14 CMS has written about the MA plan, they're interpreting
15 this, similar to, to mean that the Medicare benefit is a bit
16 different. That there is a defined A, B fee-for-service
17 benefit and they don't think that they have authority to
18 negotiate about that.
19 However, when we move into a world in which there
20 is bidding, plans are bidding on the A, B benefit, there's
21 some rebate money that may result and CMS thinks it does
22 have authority to negotiate on the level of benefits
23 provided with those rebate dollars.
24 DR. MILLER: The point is, although the
25 legislative language implies it's very broad, FEHBP-like,
26 the regulation could be read to mean that they're going to
27 negotiate on a much more narrow platform, which is the

1 rebate that the plan is giving. Glenn, to your point, if
2 you want to be clear that the Commission thinks that the
3 authority should be broad, we could make a statement that
4 the interpretation might track more closely to what we think
5 the law says. Is that fair?
6 DR. SCHMIDT: I think that's a fair comment.
7 MR. HACKBARTH: Let me advance to two other
8 specific ideas that have been discussed. So we think CMS
9 ought to have the authority. Now are there additional steps
10 that ought to be taken? One idea that has been suggested
11 multiple times is the idea of a safe harbor. If you don't
12 want to be subject to CMS's discretion about this you can go
13 into a safe harbor, which is clearly defined as non-
14 discriminatory, and be okay.
15 I'd like to ask our plan people their reaction to
16 that concept. John and Jay and everybody else who wants to
17 leap in.
18 MR. BERTKO: Going to page 14, I think that the
19 bottom three, the safe harbor, possibly the
20 standardizations, and then the last one, which is the
21 catastrophic cap which I view as a subset of the safe
22 harbor, would all be workable types of things.
23 MR. HACKBARTH: The catastrophic cap was going to
24 be the next one that I go to, whether we ought to recommend
25 that there be a catastrophic cap.
26 MR. BERTKO: The first one I would make two points
27 on. I think I made one a while back and the staff here have

1 acknowledged this, if you have standard plans, they tend to
2 become obsolete after a while. I would also suggest that in
3 the context of January 1, 2006 there's a lot of uncertainty
4 on the new programs, and rather than introduce additional
5 uncertainty, using two, three, or four of these options
6 would allow permission but not require it.

7 So for example, the safe harbor in my
8 interpretation says, if you're in the safe harbor you go a
9 quick pass through. If you decide to do your own you have
10 then the possible burden of defending that, and to me that's
11 quite acceptable.

12 MR. HACKBARTH: That's helpful. I was taking
13 number one off as maybe a bit of an over-reaction to what we
14 have seen to this point. I was focused on two, and four on
15 this list as opposed to designing the modular benefits,
16 which I think is a lot of work to do to set up that system.
17 So I was really --

18 DR. REISCHAUER: The catastrophic cap could be an
19 alternative element of the safe harbor. Choose this benefit
20 design or you have a catastrophic cap.

21 MR. HACKBARTH: Exactly. It could be a choice for
22 the plan. Jay, did you have any thoughts?

23 DR. CROSSON: Similar thoughts. I agree with
24 Bob's analysis here that the narrow question that the
25 Commission was asked, is there evidence that plans are using
26 benefit design to drive selection? The answer is there does
27 not appear to be much evidence.

1 But in the analysis, as well as the initial
2 intuitive look at this, there's been a concern that while
3 that may be true, in a small number of plans there may be,
4 advertently or inadvertently, an effect on a small set of
5 vulnerable individual beneficiaries who happen to find out
6 that they have a disease for which the burden then in a
7 particular plan would be beyond their ability to manage.
8 So I think I also agree with Bob that whatever we
9 recommend as a fix, given the answer to the narrow question
10 being negative, often to be narrowly designed. It also
11 ought to be effective and we ought to have the sense that it
12 probably will work.
13 Now as I looked at these, I think I agree that the
14 first one seems to be as over-reaction. I also agree with
15 John that probably any one of the other three would work. I
16 was actually most attracted by number three, not so much
17 that I think we ought to go hog wild and design modular
18 benefits well beyond the problem identified, but I wondered
19 about whether a narrower approach, one really focused in on
20 a smaller subset of non-discretionary services, might in
21 fact be an approach that is more tailored to the problem
22 identified. I don't know whether the right term then is
23 modular benefits. It might be something more, a targeted
24 beneficiary protection standardized benefit.
25 MR. HACKBARTH: I think you and I see this in a
26 quite similar way. I am quite concerned about
27 disproportionate cost sharing on people with serious

1 illnesses where the services are basically non-
2 discretionary. I have little tolerance for that. I think
3 that's for one purpose and for one purpose only, which is to
4 skim good risk or eliminate bad risk. But we don't want to
5 over-react. We're not seeing wholesale evidence of that.
6 I think the modular benefits concept is an
7 interesting one, but I am reluctant to recommend something
8 that I don't really fully comprehend how it would work.
9 Maybe what we could do is have some text language that says,
10 there are some particular areas of concern. Based on our
11 last discussion, I think there was general concern about
12 high cost sharing or disproportionate cost sharing on non-
13 discretionary service. We could include reference to that
14 in the text and say that maybe one thing that CMS could do
15 in the exercise of its discretion is focus in on those
16 sensitive areas and define the safe harbor idea for those
17 particularly sensitive areas. Would that meet your --
18 DR. CROSSON: Yes, I think that's essentially what
19 I was saying.
20 MR. HACKBARTH: We are 10 minutes over right now.
21 I don't want to cut off any important comments but please
22 keep them brief.
23 DR. SCANLON: I'd like to suggest that we think
24 about this catastrophic cap, because in part it's only an
25 extension to the local plans since we already have a
26 catastrophic cap in law for the regional plans. I think
27 that's probably one of the most important things you can do.

1 It's the thing that's missing in traditional Medicare. You
2 talk about a person who has non-discretionary services, in
3 traditional Medicare they're also incredibly vulnerable.
4 MR. HACKBARTH: So you're arguing in favor of the
5 catastrophic cap?
6 DR. SCANLON: I'm arguing in favor of the cap.
7 MR. HACKBARTH: Just to be clear, what I would
8 envision is that we would recommend two and four. So we
9 would recommend that a catastrophic cap be established as
10 there is proposed to be, or legislated to be for the
11 regional PPOs.
12 DR. SCANLON: I think this is a recommendation to
13 the Congress as opposed to CMS. You do it within your
14 negotiation authority but you do it --
15 MR. HACKBARTH: Yes, that is a legislative
16 recommendation.
17 DR. REISCHAUER: Are you suggesting that this
18 would be a requirement or an option for a safe harbor?
19 DR. SCANLON: I think it should be a requirement.
20 The Congress has already said that for regional plans there
21 needs to be catastrophic cap, and that the same kind of cap
22 could be applied in local plans. I don't understand why it
23 wouldn't be, especially given the evidence that we have
24 found, that there are plans for which there can be extremely
25 high expenses for certain individuals. It's not a lot of
26 plans, as we have shown, and it would be protecting a
27 relatively small number, but extremely affected individuals.

1 MS. BURKE: Nancy-Ann and I were just chatting
2 about this. There's an interesting question here. The
3 Congress has historically talked about catastrophic caps in
4 the broader context. This is a relatively narrow context.
5 Query how it will be perceived. We're talking about it
6 solely in the context of the plans. Bill is right, they've
7 just done it in the context of the regional plans. We would
8 now be saying it in the context of the Medicare Advantage
9 plans. Query the historical discussion around fee-for-
10 service and the whole context of a catastrophic cap. It has
11 some interesting political overtones that we may want to
12 reflect on. It's an interesting set of issues.
13 DR. REISCHAUER: I just have two short comments
14 related to what Jay was talking about. One is that as we
15 fully phase in risk adjustment, some of the incentive that
16 existed when we were collecting this data should be even
17 smaller than it is now.
18 The second comment would be with respect to option
19 three there. I have the feeling that when we're looking at
20 cost sharing we're talking about the front door of the barn,
21 but we're leaving the back door open, and does it make any
22 sense to close the front door? Cost sharing is certainly
23 one way to affect the attractiveness of different risk
24 groups to your plan, but so is the nature of your provider
25 group, the geographic location of the facilities. Plans
26 have all sorts of other tools they could use if they were
27 perniciously interested in affecting this besides cost

1 sharing, which is in a sense, the most overt and easily
2 detectable one. So we shouldn't put a lot of effort into
3 closing the front door of the barn if we're going to leave
4 the back door open.
5 MS. DePARLE: Just a small point. We do need to
6 clarify the authority because I agree with Mark, the way
7 I've understood it is that they were thinking of their
8 authority to negotiate almost as an actuarial exercise. It
9 probably needs to be clarified that we think it should be
10 broader.
11 But in addition to that, I think we need to make
12 the point that CMS also needs to have the capacity, the
13 oversight capacity here to do what it needs to do. While
14 OPM is being held up as a standard for this, I at least
15 recall when I was the budget person at the Office of
16 Management and Budget responsible for OPM, hearing from them
17 multiple times and actually having the impression myself
18 that they really didn't have adequate resources to do what
19 was being advertised on their behalf, and what they're doing
20 is much different than what we're expecting CMS to do for
21 the plans. So I'd like us to make the point about capacity
22 too.
23 MR. HACKBARTH: Anybody else?
24 DR. WOLTER: Just real briefly, just to put a
25 minority opinion on the table.
26 I think the issue of simplification is an
27 important issue. I think the complexity of the choices is

1 very high. From the provider standpoint, the intersection
2 between the plan benefit design and the copay, et cetera,
3 and the billing done by providers is a huge source of
4 dissatisfaction to patients and comes through very strongly
5 in patient satisfaction surveys and other things. I worry
6 about that piece of this.
7 There's also a fair amount of cost on the provider
8 side because often it's the provider who becomes the source
9 of information to the patient about benefit designs. We
10 have found this, for example, in the drug discount card
11 where there's huge dissatisfaction with the complexity of
12 the choices and we become the resource, so there's a fair
13 amount of cost and time spent there. So I wouldn't discount
14 the first choice up there entirely. I think this is an
15 issue for seniors and it's an issue for providers.
16 MR. HACKBARTH: Anybody else? Arnie, last word.
17 DR. MILSTEIN: The option for catastrophic cap,
18 that can be interpreted in a variety of ways. Some ways of
19 interpreting it could work very much to the disadvantage of
20 efficiency improvement in the Medicare program and in the
21 American health care industry overall. We don't have time
22 to discuss it, but maybe in our recommendations we could
23 take that into account.
24 I want to refer to my earlier comment, are we
25 talking about, for example, if Jay's plan or John's plan
26 offers a PPO Medicare Advantage option, would we want the
27 catastrophic cap to apply to out-of-network care, non-

1 formulary drugs?

2 MR. HACKBARTH: We need to move on for right now.
3 I anticipate that we'll have some draft recommendations for
4 tomorrow that we can consider at that point.

5 Thank you very much. Good work.

6 Next up is imaging services and strategies used by
7 private plans.

8 MR. WINTER: Good morning. I'll be talking about
9 our research on strategies used by private plans to manage
10 the volume and quality of imaging services. This work arose
11 out of a chapter of the June 2004 report in which we
12 explored tools used by private plans to improve the quality
13 and reduce the cost of health care services. In that
14 chapter we discussed ways in which plans are trying to
15 control the use of imaging procedures while ensuring access
16 to appropriate care. Since the June report, we've talked to
17 several plans to gather additional information about these
18 strategies and to find out how effective they have been.

19 There are a couple of reasons why we've pursued
20 this issue. One is our general interest in helping Medicare
21 become a more prudent purchaser. Another is that we're
22 seeking options for reducing growth of services paid under
23 the physician fee schedule without reducing access to care.
24 Today, we'll summarize what we learned from our interviews
25 with plans and highlight similar approaches in Medicare
26 where they exist. Our goal for the March report is to
27 recommend ways for Medicare to better control growth in

1 imaging services while improving their safety and quality.
2 Before we get to the private plan approaches, I'd
3 like to start off by reviewing trends in the use of imaging
4 services by beneficiaries.
5 On a per capita basis, imaging services paid under
6 the physician fee schedule have grown by an average of 9
7 percent per year between 1999 and 2002. This compares with
8 3 percent average annual growth for all fee schedule
9 services.
10 The fastest growing imaging procedures were MRI,
11 nuclear medicine and CT. Total spending for imaging
12 services paid under the physician fee schedule was $6.5
13 billion in 2000 or 14 percent of total fee schedule
14 spending. Radiologists accounted for about half of imaging
15 spending and cardiologists for about one quarter.
16 Independent diagnostic testing facilities or IDTFs
17 accounted for 7 percent of imaging spending but payments to
18 these facilities doubled between 2000 and 2002. IDTFs are
19 facilities that are independent of a hospital or physician
20 office would provide diagnostic tests under physician
21 supervision. They're paid fee schedule rates and are
22 subject to special rules set by Medicare which we will touch
23 on later.
24 The findings I'm going to present are based on the
25 following sources. We interviewed medical directors and
26 other staff at eight private plans and two radiology benefit
27 managers, which are companies that contract with plans to

1 provide radiology services to enrollees. We also spoke with
2 organizations that develop accreditation programs for
3 imaging providers such as the American College of Radiology.
4
5 Finally, we reviewed literature on programs used
6 by insurers to manage imaging services. However, we did not
7 find many of these studies.
8 The plans are generally seeking to address similar
9 issues. They are concerned about the proliferation of
10 imaging equipment among ambulatory providers, which they see
11 as stimulating demand. They note an increase in the use of
12 imaging services by physicians who place equipment in their
13 offices, particularly non-radiologists. There is a concern
14 that many of the non-radiologists ordering or performing
15 studies aren't familiar with the clinical guidelines for
16 when a particular test is appropriate. The plans also want
17 to protect their enrollees from unsafe or low-quality
18 providers. And finally, they are seeking ways to counter
19 rising consumer demand, driven in part by direct to consumer
20 advertising.
21 Here is a list of the main strategies that plans
22 are using to address these issues. Most plans have
23 implemented at least a few of these policies. Some plans
24 have been relatively aggressive in their choice of
25 strategies. Others have been less so. We will summarize
26 each strategy and focus on how effective it has been.
27 Plans were often unable to quantify reductions in

1 volume or spending related to individual approaches. In
2 many cases, multiple programs were implemented at the same
3 time. Although we're still analyzing how feasible it would
4 be for Medicare to adopt any of these approaches, we'll
5 mention parallel policies in Medicare where they exist.
6 Several insurers said that they require outpatient
7 imaging providers in their networks to meet basic safety and
8 quality standards. These relate to the quality of the
9 equipment used and the images they produce, the
10 qualifications of technicians performing the tests, and the
11 physicians who interpret the images and patient safety
12 procedures including monitoring of radiation exposure.
13 Plans may develop their own criteria or require
14 providers to become accredited by private organizations.
15 Providers that fail to meet the standards are dropped from
16 the network.
17 The goals of this policy are to ensure basic level
18 of safety for enrollees, to reduce the need for repeat tests
19 caused by low-quality images, and to weed out unqualified
20 providers.
21 In terms of effectiveness, one plan that
22 implemented standards did not experience reduced volume. On
23 the other hand, a radiology benefit manager claimed that its
24 programs achieved savings of about 5 percent. According to
25 two studies, plans that combined facilities standards with
26 physician privileging were also able to reduce spending.
27 Currently the government sets standards for some

1 types of imaging facilities. However, these standards are
2 sometimes not comprehensive or well enforced. Although CMS
3 does not regulate imaging services provided in physician
4 offices, it has set minimum standards for independent
5 diagnostic testing facilities. These these relate to the
6 qualifications of non-physician staff, the equipment and
7 supervising physicians.

8 However. CMS does not review the quality of the
9 images produced in these facilities or their safety
10 protocols. It also appears that the standards are not
11 vigorously enforced. For example, each facility is subject
12 to an initial site visit but there are usually no follow-up
13 visits.

14 Another Medicare example is that many carriers are
15 providing that providers of vascular ultrasound either be
16 accredited or use credentialed technicians. Outside of
17 Medicare, the FDA regulates mammography facilities. It sets
18 standards for the equipment, technicians and the physicians
19 who interpret the images and it also conducts annual
20 inspections of each facility.

21 The Nuclear Regulatory Commission licenses nuclear
22 medicine facilities. However, there are no federal
23 requirements for MRI or CT imaging that would apply across
24 all settings.

25 I will move on now to the next private-sector
26 strategy which is physician privileging. In privileging,
27 plans limit the payment for performing and interpreting

1 certain procedures to qualified specialties. In most cases,
2 privileging programs permit or restrict payment to an entire
3 physician specialty based on the training a specialty
4 receives in residency programs. In some cases, privileges
5 are linked to individual physicians based on their training
6 and credentialing. Privileging, we noted, is often combined
7 with facilities standards.

8 In the more restrictive version of privileging,
9 radiologists are allowed to provide most services consistent
10 with their training. Other specialties are more restricted,
11 however. For example, cardiologists would only be permitted
12 to provide nuclear cardiology and cardiac ultrasounds. Some
13 programs we heard about are less restrictive and , only
14 place limits on primary care providers and podiatrists.

15 The goals of privileging are to prevent poor
16 quality studies that lead to inaccurate diagnoses or repeat
17 tests. Plans report that there's often significant
18 opposition to privileging, at least initially. Plans also
19 told us that this approach leads to modest savings due to
20 fewer overall tests. And they also noted that privileging
21 is less expensive to administer that other strategies.

22 Currently in Medicare, physicians are paid for
23 medically necessary services provided within the scope of
24 practice for the state in which they are licensed. In other
25 words, Medicare generally does not restrict what services
26 physicians can bill for as long as they are medically
27 necessary. However, there are a few exceptions. CMS

1 recently decided to cover PET scans to diagnose Alzheimer's
2 disease in certain patients with mild cognitive impairment.
3 However, these tests can only be interpreted by physicians
4 in certain specialties with expertise in reading these
5 scans.
6 Another example, Medicare only covers power
7 operated vehicles or scooters if they are ordered by certain
8 specialties such as physical medicine or orthopedic surgery.
9 And finally, chiropractors can only be paid for
10 one type of service and are not allowed to bill for any
11 imaging studies.
12 The next private plan strategy consists of
13 programs to increase compliance with clinical guidelines for
14 the appropriate use of imaging services. The least
15 restrictive of these approaches is educating physicians
16 about the appropriate use of imaging. An example of this
17 would be offering online clinical education.
18 Another approach is to profile the physicians' use
19 of imaging services. In profiling, plans compare
20 physicians' use to peer benchmarks and identify physicians
21 who account for a high amount of imaging spending. Plans
22 then educate these physicians about the appropriate use of
23 imaging.
24 There is an example of profiling in Medicare.
25 Medicare's quality improvement organizations sometime engage
26 in physician profiling to improve the quality of care for
27 some conditions. They analyze variations in physicians

1 practice patterns and provide them with feedback. The next
2 presentation will focus specifically on profiling issues.
3 The most restrictive of these three approaches is
4 preauthorization. Most plans we interviewed require it for
5 PET scans while a few also require it for MRI and CT
6 studies. Two of the plans that require preauthorization
7 experienced initial savings due to denials of requests.
8 However, the denial rates declined over time as physicians
9 learned the criteria for approval. Other plans claimed that
10 preauthorization is ineffective at reducing volume and that
11 it is expensive to administer.
12 We learned about a couple of variations on
13 preauthorization. One plan requires physicians to notify it
14 when they plan to order certain studies. The plan suggests
15 alternatives if another test is more appropriate but does
16 not deny payment. Some plans require physicians to consult
17 with radiologists before ordering studies. And in some
18 cases, the radiologist is responsible for approving the
19 order.
20 We are not aware of any preauthorization programs
21 and Medicare.
22 Many private plans using coding edits for imaging
23 services. One type of edit detects improper billing codes
24 such as unbundling of services. Another type of edit
25 adjusts the payment for multiple procedures done on
26 contiguous body parts. An example would be CT of the
27 abdomen and CT of the pelvis. The first procedure is paid

1 at its full rate while the second procedure is paid at half
2 its normal rate. The premise is that the second procedure
3 takes less time than if it were performed separately because
4 the patient has already been prepared for the procedure and
5 the machine is already set up and running. Usually only the
6 technical component fee, which covers the cost of the
7 equipment and the technician's time is adjusted.
8 Plans emphasize that coding edits should be
9 communicated to physicians so they can bill correctly. A
10 company that develops coding edits for imaging estimates
11 that they reduce spending by about 5 percent.
12 Medicare has developed a system of coding edits
13 for all services called the Correct Coding Initiative.
14 These edits detect improper billing such as unbundling, and
15 claims that include mutually exclusive services. Medicare
16 does pay a discounted rate for multiple surgical procedures
17 provided in the same encounter. However, there is no
18 similar policy for multiple imaging procedures.
19 It is worth noting that 40 percent of Medicare
20 claims for CT services include two or more CT services on
21 the same claim. CT of the abdomen and the pelvis are billed
22 together most frequently. When this occurs, Medicare pays
23 the full rate for both services.
24 Now we'll turn to the remaining two private sector
25 strategies. Some plans have created two tiers of imaging
26 providers, preferred and non-preferred. Providers in the
27 preferred tier are willing to accept lower plan payments in

1 exchange for higher patient volume. In some cases, they
2 must also meet quality standards.
3 One plan charges its enrollees lower copayments
4 when they use a preferred facility. Current law makes it
5 difficult for traditional Medicare to create tiered
6 networks. For example, current law does not permit Medicare
7 to vary beneficiary cost-sharing by provider.
8 Finally, several private plans attempt to educate
9 patients about the risks, benefits and appropriate use of
10 imaging procedures. These efforts are meant to counter
11 demand stimulated by direct to consumer advertising.
12 Medicare has developed several beneficiary education
13 programs in areas such as vaccination, cancer screening and
14 disease management but we're not aware of any education
15 specifically related to imaging.
16 However, the NIH has developed web-based consumer
17 information on various imaging modalities. Perhaps Medicare
18 could target this information to beneficiaries.
19 For our next steps, we plan to analyze how
20 feasible it would be for Medicare to implement any of these
21 approaches. Part of this includes interviewing Medicare
22 carrier and CMS staff to get their feedback on what the
23 legal data and administrative barriers might be. We will
24 also further explore current efforts by Medicare to manage
25 imaging services.
26 We would like to get your feedback on the
27 strategies presented today, which will help us develop draft

1 recommendations for you to consider. This concludes my
2 presentation and I look forward to your questions.
3 MS. DePARLE: In the presentation that we had in -
4 - I think it was either May or March, sometime in the spring
5 anyway, about this subject, there were two things that
6 struck me about it. One issue was self-referral, the extent
7 to which the medical officer from the Blue Cross Plan of
8 Michigan and the administrator from the Tufts New England
9 Health Plan both talked about that as being a problem. You
10 listed that on here as one of the things that private plans
11 are trying to address.
12 So I'm curious, which of the strategies that you
13 discuss here do you think would most effectively deal with
14 that problem of self referral? And have you been able to
15 determine the extent to which that is a big part of the
16 issue in Medicare, the growth of imaging spending that we
17 would consider to be inappropriate? Which strategy would be
18 the most effective in dealing with that? Or would it take a
19 change in the law?
20 MR. WINTER: To some extent, facility
21 accreditation might deal with that. If physicians are doing
22 imaging in their own offices, they may not want to invest in
23 the steps necessary to come up to accreditation standards.
24 But probably privileging is the most effective way to target
25 this because you're targeting primarily non-radiologists,
26 who are the ones ordering the test. So if you prevent them
27 from billing for performing and interpreting the studies,

1 there's less of an incentive for them to buy equipment and
2 install it in their offices.
3 You could also look at tiering of providers as a
4 way to do that, if you create a preferred tier that excludes
5 physicians who are ordering the tests and also performing
6 them. You could limit the providers in the preferred tier.
7 In terms of your second question about to what
8 extent this influences growth of imaging in Medicare, we
9 really don't know. I could actually show you this slide
10 here, which shows you the distribution of imaging spending
11 under the physician fee schedule by specialty. So to some
12 extent, cardiology may be an area where they are actually
13 performing the studies on equipment in their offices. But
14 it could be they are interpreting studies that are done in
15 the hospital. It's hard to tell from this. We have to look
16 at the data in a finer way to get at that.
17 DR. MILLER: I think the third part of the
18 question -- I agree about the strategies that would be most
19 likely to get at it. I think all of them in Medicare would
20 involve a change in law.
21 MR. MULLER: Thanks for bringing up this slide
22 because my question is along these lines.
23 In terms, of what do we know about the cost
24 effectiveness of using things like privileging and
25 authorization and so forth to try to direct imaging towards
26 a limited set of people; e.g., radiologists, cardiologists,
27 versus letting it be more open to all specialties? And

1 especially given that we know that with the -- again, we
2 studied last spring and before that, that imaging equipment
3 technology is getting cheaper -- I shouldn't say cheaper,
4 less expensive -- and probably more miniaturized and more
5 efficient and faster, et cetera and so forth. I would at
6 least hypothesize or surmise that there would be a greater
7 tendency to spread this to all doctors, as opposed to just
8 radiologists and cardiologists and so forth.
9 So if I'm correct in saying the trend will be to
10 spread this out to all physicians, maybe not chiropractors
11 but all physicians, do we think it's more cost-effective
12 based on what we know from the private plans and so forth to
13 try to limit this to several and use credentialing and
14 authorization and so forth as a way of limiting? Or is it,
15 in a sense, cheaper to let internists and others do it who
16 may have a lower fee schedule on this compared to
17 radiologists and so forth?
18 MR. WINTER: The rate of pay would be the same
19 regardless of who's actually performing or interpreting the
20 test. So the internist would get paid the same as a
21 radiologist. That wouldn't vary.
22 MR. MULLER: For example, if an internist reads a
23 CT -- I mean, by and large, at this moment they don't, they
24 let radiologist do it. But if an internist read a CT, he or
25 she would get the same fee as a radiologist?
26 MR. WINTER: That's right.
27 MR. MULLER: So in terms of whether we are better

1 off trying to limit this in terms of cost effectiveness? Do
2 we have any evidence on that? Trying to limit it to a
3 smaller number rather than a larger?
4 MS. DePARLE: It's also quality. I said I had two
5 points and that was the other thing I was going to say based
6 on that panel, is which of these two things goes to the
7 quality, as well?
8 MR. WINTER: They all attempt to address quality.
9 The facility standards are training at the quality of the
10 facility and the equipment and the technicians, primarily.
11 And privileging is trying to get at the quality, the
12 qualifications of the physician who is supervising and
13 interpreting the results, sold, supervising the tests and
14 interpreting the results. So they're sort of getting at
15 different parts of the quality question.
16 Coding edits is more related to paying
17 appropriately. And the physician education, beneficiary
18 education is also trying to drive quality.
19 MR. SMITH: Thank you, Ariel. As I read the
20 material, my reaction to what recommendations we ought to
21 make was essentially all of the above. That for both
22 quality and management reasons there is some reason to think
23 that each of these strategies has some value. None have
24 particularly great downsides and we ought to authorize CMS
25 to employ all of them.
26 One question, Ariel. You mentioned that CMS
27 doesn't have the authority to manipulate copays in a way

1 that would allow it to create tiered networks. It could
2 effectively manipulate copays though, by creating tiered
3 networks with a lower fee schedule, couldn't it?
4 Without a change in the law, Medicare couldn't
5 create a preferred network of providers who are willing to
6 accept a lower fee and, in effect, create a lower copay?
7 DR. MILLER: Not in traditional fee-for-service.
8 You can do that within a plan but not --
9 MR. SMITH: We might want to think about asking
10 Congress to allow Medicare to do that.
11 DR. CROSSON: I'm going to structure my comments
12 using the barn analogy. I'll try to do that all day. So
13 I'll talk about the front door and the back door of the
14 barn, using Bob's barn analogy from before.
15 And again, admitting some difficulty necessarily
16 extrapolating from the model I am in and have been in for a
17 long time, the prepaid group practice model, is a different
18 model. And so some of the tools that we, I think, have used
19 effectively don't necessarily apply in fee-for-service and
20 in small solo group practice models.
21 Nevertheless, I would have to say I think my sense
22 of this is that the preauthorization model is probably not
23 going to be terribly effective. It certainly hasn't proven
24 to be. We use a little bit of that, in terms of radiology
25 consultation, which works in our setting.
26 But I think the experience of the '90s is that the
27 preauthorization approach, in general, is not terribly

1 effective. It's very difficult to do, very difficult to
2 second guess the judgment of the physicians and the like.
3 I would, in this case, much more favor the back
4 door. That has to do with the issue of combining profiling
5 with educational efforts. And even if you don't move toward
6 some particular authority or plan on the part of CMS to
7 intervene on the basis of the profiling, the profiling
8 itself is effective for two reasons.
9 Number one, it often can genuinely be an
10 educational tool for the physicians, particularly physicians
11 practicing in isolation tend to not always understand how
12 their patterns of decisionmaking differ from the rest of the
13 physician community, particularly outside the geography
14 where they are. And so sometimes, physicians are genuinely
15 shocked to find that a pattern of decisionmaking that they
16 have and believe honestly is correct, turns out to be quite
17 different from the standard of the physician community.
18 Secondly, I think physicians are competitive
19 people. They are, for the most part, individuals who have
20 spent their life trying to get A's on report cards, which is
21 not necessarily a bad thing. I don't think most of us would
22 like to have a physician who is satisfied getting C's. But
23 I do think that physicians are competitive, and in that
24 environment will often pay attention to something that looks
25 like it shows that they, again inadvertently perhaps,
26 deviate from the norm. And we tend to see, in that
27 environment, some reversion to what hopefully is an

1 appropriate mean.
2 So we're going to have another discussion about
3 profiling but I would suggest maybe that we focus in that
4 direction.
5 DR. REISCHAUER: Jay, you went to a school where
6 everybody got A's?
7 DR. CROSSON: Everybody was trying to get A's.
8 DR. MILSTEIN: A couple of comments.
9 First, to the degree there is any evidence on the
10 question of whether or not this increasing volume of
11 radiology services is improving health or holding health
12 constant, is improving the overall cost efficiency of
13 Medicare spending, would be an interesting question. We're
14 doing the study because we perceive this to potentially be a
15 problem and so it would be nice to have some evidence pro or
16 con, if there is any, on whether it's a problem.
17 I suspect if Elliott Fisher and Jack Wennberg were
18 here, they would say they already have evidence to suggest
19 that the prior volume was not very cost efficient and
20 therefore it's unlikely that this new increase in volume is
21 likely to be delivering a lot of value. But it's an
22 empirical question and it would be nice to have some
23 information about that.
24 I categorize the problems in three buckets. First
25 of all, we have what I'll call zero-value studies. Studies
26 that are done to the population where there is, as far as we
27 can tell, no health benefit. Secondly, problems in the

1 actual quality imaging themselves so that they're not
2 applied or interpreted correctly. And third is, I'll call
3 it non-competitive unit prices where the unit price you're
4 paying does not reflect the most competitive pricing you can
5 get if there was price competition.

6 If you think about these three problems and say
7 what are the intervention options that match up with these
8 three problems, I think on the first problem, which is the
9 ordering of imaging studies for which there is no likely
10 health value, there it seems to me the unit of profiling is
11 not the imaging center or the radiologist but the referring
12 physician.

13 I think if I were to focus on Jay's
14 recommendation, the profiling with respect to quality and
15 utilization should be for the referring physician not the
16 imaging center or the radiologist.

17 And then the second two problems, that is the poor
18 administration of the imaging study or the incorrect
19 interpretation of it or non-competitive price. For that the
20 unit of intervention and then potentially profiling would
21 also lend itself. It would also be a little bit more
22 tricky, but you could also profile those two past
23 performance. There the unit of profiling, with or without
24 economic reinforcement, would be the radiologist or the
25 imaging center.

26 So I think there's some opportunities to
27 essentially make some more specific our recommendation

1 geared to the two different problems. Problem A is
2 referring physicians, inappropriately referring -- sometimes
3 to themselves -- radiology studies. And secondly, the
4 center or professional receiving the request.
5 DR. WOLTER: I just would emphasize Arnie's point
6 on unit pricing. At least in our experience, imaging is one
7 of those few service areas where there is really a very
8 large bottom line. And I think that that is maybe the major
9 driver of at least the expansion of capacity. I think
10 there's other reasons why volume also goes up.
11 I hesitate to emphasize that because for some of
12 use, we use those dollars to subsidize other services. But
13 almost certainly, the ROI you can drive out of imaging
14 services really is a major driver of what is going on. So
15 we should at least maybe mention that in our study.
16 DR. BERTKO: I just have a quick follow-up to both
17 Jay and Arnie's comment, that profiling physicians with
18 imaging seems to me to offer a great opportunity to do two
19 things. One, within the community, but also across the
20 nation, because everybody recognizes it's quite different
21 and just the education component of this might be a very
22 helpful and straightforward way to reduce costs in the
23 future.
24 MR. HACKBARTH: Anyone else? Ariel, do you have
25 any questions that you need clarified?
26 MR. WINTER: This is very helpful guidance and I
27 really appreciate it.

1 There was one thought that occurred to me that I
2 wanted to add to my answer to Nancy-Ann's question about
3 self-referral which is that studies by the GAO and other
4 groups in the late '80s, early '90s, found that physicians
5 who have a financial interest in an imaging center or the
6 equipment in their offices, order many more tests than other
7 physicians for their patients. So there's evidence of
8 increased volume associated with self-referral. So that
9 could be something that's driving this increase.
10 MR. HACKBARTH: Thank you.
11 Next on the agenda is the related topic, somewhat
12 related topic, of profiling.
13 MS. MUTTI: This presentation builds on the
14 examination that MedPAC did in examining private sector
15 purchasing strategies that we included in the June 2004
16 report. As you may recall, for that report we interviewed a
17 number of plans, purchasers and consultants and asked them
18 what strategies they were using to contain costs. The vast
19 majority reported that they were profiling or measuring
20 physicians, as well as hospitals in some cases, on their
21 resource use as well as quality.
22 A lot of them also mentioned that they were
23 pursuing the strategy, and a large part as a result of the
24 John Wennberg, Elliott Fisher and other research finding the
25 wide geographic variation in practice patterns. And that
26 often the practice patterns that were the most intense did
27 not improve the outcome for patients.

1 So today we are hoping that we're responding to
2 your interest in this topic, I think you expressed it last
3 spring when we talked about it also at our strategic
4 planning meeting, and then just moments ago.
5 So today our question is can provider profiling be
6 used by Medicare to measure relative resource use? And what
7 are those mechanics and issues that are involved in this
8 exercise?
9 We recognize that measuring resource use is only
10 part of the picture. Of course, you need to consider
11 quality measures also, and they really should be used in
12 tandem to determine what kind of efficiency you're gaining,
13 what kind of value you're gaining for your Medicare dollars
14 spent.
15 Our focus today is on physicians. In large part,
16 this is because they provide a lot of the care and direct
17 even more of it. It's also a first place for us to start.
18 We're hoping also to look at resource use measures for
19 hospitals and look at integration of measuring resource use
20 for both physicians and hospitals together.
21 For context, let's start by looking at the
22 definition of profiling and Medicare's role in profiling
23 today. Profiling is a technique that examines providers
24 patterns of care in terms of both quality and resource use.
25 It involves obtaining information from large databases such
26 as claims data to identify a provider's pattern of practice
27 and then compare it with those of similar providers or

1 within an accepted standard of care.

2 Medicare today does not profile its providers for
3 resource use. As Ariel mentioned, we do profile for quality
4 to a certain extent. The QIOs can go out and look at claims
5 data and profile physicians on the frequency with which they
6 provide certain services, like mammograms, flu shots, maybe
7 eye exams for diabetics. These results are shared with the
8 provider to give them some idea of how they are standing,
9 what areas they may have for improvement. But that
10 information is not released publicly.

11 A few CMS demonstrations have encouraged providers
12 to profile themselves. These include the heart bypass
13 demonstration, which is akin to the Centers of Excellence
14 concept, as well as the Large Group Practice Demonstration,
15 which is expected to be launched shortly.

16 Also relevant here is that Medicare does not
17 provide to the public or large purchasers Medicare claims
18 data with unique physician identifiers. As we mentioned
19 last spring, private purchasers have asked CMS to release
20 this information. It would assist them in profiling their
21 providers. It would make their data much more
22 comprehensive. But at least as we've been informed, CMS
23 feels that this violates the physicians' privacy rights.
24 And so they are not able to do it at this point.

25 They are considering whether there's ways they
26 could aggregate this information so that it would be useful
27 to purchasers but still protect physicians' privacy.

1 This slide brings us to the mechanics of profiling
2 and how resources are measured. Over the last few months,
3 as we've talked to plans and vendors of software that's
4 involved in this, we've learned about several main
5 strategies. Common to virtually all are the patient care is
6 risk adjusted and then the patient care is attributed or
7 assigned to a physician or a physician group. Once that's
8 done, the physician can be measured on a number of metrics.
9 I should just note that these certainly can blend together
10 and also can be used in combination with one another. But
11 we thought at this point we would just list them separately
12 to give you a better sense.

13 The first is you could calculate the rate of a
14 given intervention. This could be the number of
15 hospitalizations, the number of emergency room visits, the
16 number of referrals per 1,000 patients.

17 The second is annual patient care spending. We
18 found that this seemed to be particularly used by plans that
19 had primary care providers acting in the gatekeeper
20 capacity.

21 Thirdly, we learned about a metric that measures
22 services used in episodes of care. Those services may be
23 reflected in terms of either spending or standardized units.
24 We also found that this was the most prevalent approach that
25 we heard about. So for that reason, I think we'll spend a
26 little bit more time making sure that you can understand and
27 conceptualize what this approach looks like.

1 First, it's probably important to bear in mind
2 that the scope of an episode can vary. It could be
3 relatively narrow like just the duration of a hospital stay,
4 including both physician and hospital services. Or it could
5 be much broader. It could span across a year or two for a
6 chronic condition if you'd like to measure the services
7 delivered for that. It could be something in between also,
8 all the services surrounding hip replacement surgery or
9 maybe a bout of ammonia from the first visit to a physician,
10 perhaps a hospitalization and follow-up care, that could be
11 the length of an episode.
12 Just to give an example of how the two can
13 interact, once you've defined the episode of care you could
14 look at the rate of a certain intervention, like the average
15 number of lab tests done for somebody with hypertension.
16 To illustrate how episode profiling might work, I
17 will describe broadly the approach of one of the most common
18 products in the marketplace, Episode Treatment Groups. The
19 episode starts with an anchor record, that is a claim for a
20 physician visit or a hospital stay, for example. Then the
21 episode includes related services for the condition until a
22 clean period or a period where no claims are filed is
23 detected. Each episode has its own length of clean period.
24 Different episodes can occur simultaneously. That's
25 entirely possible. And chronic conditions may be considered
26 year-long episodes.
27 The grouper software is key to identifying which

1 claims are related to the same episode. The ETG grouper
2 sorts claims into more than 500 types of vendors. We heard
3 from other vendors where there was a lot more types of
4 episodes.
5 Ideally, the grouper categorizes episodes into
6 clinically homogenous categories that account for different
7 levels of severity and link complications to the underlying
8 condition, recognize the complexity inherent to
9 comorbidities, and also link together related conditions
10 such as hypertension, angina end ischemic heart disease.
11 Once the grouper categorizes the care into
12 episodes, a provider can be measured on the resources used
13 for that type of patient, both the total resources and then
14 the distribution of resources by service.
15 A host of measurement choices also need to be to
16 addressed, however, to improve the accuracy of the
17 profiling. These questions involve what the peer group may
18 be, what type of care you're measuring, are you measuring
19 all the care the physician providers or just a subset of it,
20 what is the outlier threshold. We'll touch on these
21 questions again later, but let me move on to something else
22 first.
23 The idea of this slide is to give you an idea of
24 what an output of resource use profiling can look like. As
25 you can see here, we're comparing a peer group to physician
26 A. We have the average charge per episode. And then we
27 divide it by service category. You can see physician

1 visits, diagnostic and lab tests, et cetera. On the far
2 right-hand side is the overall efficiency score.
3 Here we presented it in terms of standardized
4 dollars. You also have the option of presenting it in sort
5 of relative value units, similar to how we do with
6 physicians in Medicare. And here we also have standardized
7 the spending.
8 Again, this is just an illustration. I actually
9 made these numbers up. So the exercise of standardizing is
10 also a fictitious one here, but the concept is what I want
11 to get across.
12 A plan or Medicare, if they would like to reflect
13 a dollar value, can standardize for differences in payment
14 levels for geographic that we've already built into our
15 system for differences in payment levels for geographic
16 regions as well as special mission hospitals, DSH and
17 teaching hospitals you pay more for. You may not want to
18 penalize them. You might want to try and level the playing
19 field here when you present the dollar value. So you can
20 standardize that and deal with that issue.
21 In this illustration, Physician A uses more
22 services than his peers. That is why he has a 1.20 score.
23 And in particular we can see that Physician A uses more
24 hospital services than his peer group. On other service
25 categories, he or she looks very similar to the peer group.
26 There are at least two critical attributes of
27 effective profiling and really, these are quite common sense

1 attributes, but they still are worth going over. The first
2 is that it needs to produce accurate conclusions. By
3 accuracy, we mean that it needs to reflect differences in
4 practice style, not the relative health status differences
5 of their patient panel, not statistical error, and not
6 incomplete or erroneous data.
7 Unfortunately though, there's little empirical
8 evidence on the accuracy of episode measurement or on what
9 the most appropriate level of resource use is. Instead,
10 most often plans are relying on a comparison to the average
11 resource use of a peer group. which may or may not reflect
12 appropriate use.
13 Private purchasers and researchers also suggest
14 though that profiling might not have to be perfect to be
15 useful. They point out that the alternative is the status
16 quo, which allows for no feedback on the variation and has
17 resulted in an overuse of quite a number of services.
18 Private sector purchasers also note that the
19 accuracy may be improved by using techniques that improve
20 statistical confidence. This may be requiring a very
21 significant number of episodes per physician before you
22 actually evaluate them. It may also involve looking at
23 their resource for only their core services that they
24 provide, really the bread and butter of a given specialty
25 may be the ones that you really want to focus on and may
26 eliminate some of the variation that you see as a result of
27 health status differences.

1 A second attribute of effective profiling is its
2 ability to encourage physicians to evaluate their practice
3 style and modify it when appropriate. For this to occur
4 physicians need to find that the profiling measures are
5 clinical meaningful, that the process of measurement is
6 transparent, and that the results are presented in a way
7 that is actionable to them.
8 By actionable, I mean that the information is
9 sufficient to inform a physician's evaluation of their
10 practice style and suggest a way in which they may be more
11 in line with their peers, if they feel that that's
12 appropriate.
13 A number of design issues need to be addressed in
14 implementing profiling. I'll touch on them briefly but
15 we're hoping that our future work will flesh this out more
16 and we can give you some more information as we do.
17 A fundamental question is how to assign patient
18 care to a physician. This task is complicated by the fact
19 that many beneficiaries see many more than one physician and
20 then who do you attribute their care to? How much and what
21 type of care should a provider deliver before she or he is
22 held accountable for the patient's care? Should they be
23 held accountable for their colleagues decisions?
24 On one hand, I think some people would say yes,
25 that is entirely appropriate. We want a physician to be
26 invested in the total efficiency with which a given
27 beneficiary's care is delivered. Others will point out that

1 in some cases they are not in control of what their
2 colleagues decide for their treatment choices and they're
3 uncomfortable with that kind of designation.
4 Another question as to consider what kind of care
5 is measured. As we mentioned, it could be all the care, it
6 could be chronic care or acute care that you're looking at.
7 It could be care that you find to be particularly high cost
8 care and that would be where you want to start in your
9 profiling. Or it might be care for which we also have
10 quality measures. That's something to think about also.
11 Another question is what is the appropriate
12 benchmark? Are we looking at comparing similar specialties
13 to one another? Are we looking at similar geographic
14 regions? Those are things to think about. Another question
15 is how to integrate hospital and physician measurement, as I
16 mentioned before.
17 On this slide, there's a series of perhaps more
18 technical questions, how to adjust for relative patient
19 risk? I have referred to this so far. Ideally, a grouper
20 adjusts for this health status and severity of illness
21 differences, but we know from experience that risk
22 adjustment is imperfect. Are there other ways to improve it
23 just beyond getting a sophisticated grouper?
24 How do we account for outliers? Outliers are
25 patients that have exceptionally high or perhaps low costs.
26 How do you want to consider those? Do you want to still
27 count those against a physician? And similarly, what is the

1 minimum number of observations that you want to bear in
2 mind? This is how many patients or episodes must be
3 assigned to a physician before you're comfortable measuring
4 that physician on their resource use?
5 Lastly on this slide, is how to adjust for care
6 delivered at special mission facilities? This get at the
7 idea of those facilities that are teaching or DSH hospitals.
8 How do you account for the high costs associated with their
9 missions?
10 I think this is a sampling. I don't think this is
11 an exhaustive list of the kinds of issues that would have to
12 be addressed, but I think it gives you an idea.
13 So at this point, I'll turn it over to Kevin and
14 he can talk about next steps.
15 DR. HAYES: Just to briefly recap, we know then
16 that the private purchasers are often using profiling
17 methods. As you can see from Anne's presentation, we've
18 learned a great deal about those methods already. We're in
19 a position now just wanting to know how they would work in
20 Medicare.
21 So our next steps in this effort involve applying
22 profiling methods with Medicare claims data.
23 Given what we've learned from private purchasers,
24 from consultants, from software vendors, it's pretty clear
25 that these episode-based methods are state-of-the-art. And
26 so we would proceed with using those methods.
27 In doing so, we can then pursue a whole series of

1 interesting questions like which episodes are the most
2 frequent ones experienced by Medicare beneficiaries? During
3 those episodes how does resource use vary, among market
4 areas or whatever other unit of analysis we can pursue?
5 Also, which services are driving that variation? Is it the
6 types of imaging services that Ariel was talking about?
7 The other thing that we would encounter whenever
8 we apply these methods is that we would confront some of the
9 interesting design issues that Anne was talking about. For
10 example, how sensitive are the results to outliers? What
11 about this matter of focusing on all episodes furnished or
12 managed by physicians versus focusing in on just those bread
13 and butter core episodes that physicians are managing within
14 a given specialty?
15 So in short then, what we're trying to do here is
16 to sort of operationalize the methods that we've heard about
17 in the private sector and see how they would work in the
18 Medicare program. This would include exploring the
19 opportunities to try and integrate profiling methods not
20 just for physician services but hospital care and other
21 sectors as well.
22 That's kind of where we are with the project at
23 this point. We realize that the presentation today and the
24 paper we sent you for the meeting covered a lot of material.
25 A lot of it is not all that intuitive and that, too, was
26 part of the motivation for turning now to the data to try
27 and put together some more concrete application of these

1 methods and bring back to you some examples of how the
2 methods work.
3 In the meantime, we would appreciate your feedback
4 on what you've heard so far and your thoughts about what
5 you'd would like to see next on this topic.
6 MR. DeBUSK: On page five, it says apply a grouper
7 that identifies clinical and homogeneous episodes, accounts
8 for variation in severity. Is there quite a selection of
9 software out there that will do this grouper piece?
10 MS. MUTTI: There seems to be one product that has
11 clearly the majority of the market, but there are other
12 products as well, at least other one.
13 MR. DeBUSK: May I ask what is that?
14 MS. MUTTI: The one is the Episode Treatment Group
15 which was created by Symmetry. The other one that we spoke
16 about, that we learned about, was the Cave method. Doug
17 Cave Consulting has its own grouper.
18 MR. DeBUSK: Thank you.
19 DR. REISCHAUER: Most of this discussion has been
20 of the form can you do it? Can you get useful information
21 out of this? And in the back of my mind is always a
22 question of if you could, what would you do with it?
23 In Medicare, there are certain limitations in
24 Medicare and I want to know from John and Jay, what do they
25 do with it? Is it educational only? Is it used to exclude
26 people from networks, which is sort of a much greater
27 problem in Medicare? Is it used to vary payment levels of

1 one form or another?

2 And also, when you begin doing this kind of thing,
3 what do the distributions look like? Do you find in these
4 tables that they are flat, in a sense, that 5 percent of the
5 people? Or are they highly skewed, and you have a few
6 people out there who appear to be extremely inefficient or
7 providing a very different kind of care? And how much of
8 Medicare's total expenditures are in that tail? So if you
9 went through all of this and you aggressively then developed
10 some mechanism for dealing with that. are you going to be
11 saving 2 percent or are you going to be saving 30 percent?

12 DR. BERTKO: Arnie can probably respond to some of
13 this, too, but let me respond with some direct experience
14 we've had. For about three-and-a-half years we used both of
15 the system for a variety of practical reasons. Arnie's
16 colleagues are giving us some emphasis to use one of the
17 systems and we have an interest in the other.

18 To your comments though. First of all, it's a
19 significant amount of money involved. In our commercial
20 populations we think the potential reduction on cost without
21 any reduction in utilization -- that is for appropriate
22 services -- is in the neighborhood of 10 percent. In our
23 experiments in the Medicare data we have, it shows it's an
24 excess of that, perhaps 15 percent or more.

25 Number two, your question, Bob, is what's the
26 distribution on this? Not surprisingly, it varies by
27 specialty. And without identifying the guilty parties, it's

1 as little as 15 percent of docs in the outlier circumstance
2 -- and we're doing that all not clinically but just on a
3 strictly math basis, I don't want to make it anything else -
4 - to as much as 25 percent.
5 We heard a presentation at a meeting that Arnie
6 led by union group in Las Vegas that I think saved what, in
7 excess of 15 percent? 10 to 15 percent by, in this case,
8 eliminating a number of doctors from their network.
9 So to your third question about what could you do?
10 One is to form new networks, which may not work for Medicare
11 fee-for-service but certainly could work in the MA plan
12 scenario.
13 Two, I completely agree with Jay. By far the
14 majority of physicians not only are under the outlier but
15 are clustered toward the mean. And this is not in the
16 closed universe known as Kaiser but in the wide world that
17 is our footprint across the United States. And I think
18 there is, in Medicare, an educational ability to show docs
19 where they are in these things.
20 Number three, on an anecdotal basis only, when
21 we've gotten feedback for a physician saying why am I now
22 not invited into your network, we can show them and say your
23 use of -- in this case, imaging and lab tests -- is 200
24 percent of the norm of your peer group in an area, which is
25 entirely separate from is the area right. But it's way out
26 there. And so the outliers, in many cases, are way up there
27 with, at least on a cost basis, no reason that I can see for

1 that high amount of use. They are severity adjusted in one
2 way or another so we can pretty much toss the complaint.
3 We've had a fair amount of explanation done on
4 transparency. I have used Doug Cave, in fact, to talk to
5 docs and say this is what we did. And we adjusted it for
6 severity this way. And the docs go oh, okay.
7 MR. HACKBARTH: John, when you say 10 or 15
8 percent savings, that is total health care expenditures?
9 DR. BERTKO: In a commercial world we bundle
10 everything, professional fees, lab, imaging, inpatient,
11 outpatient and prescription drugs. And yes, it's all
12 bundled together. It's attached to the episode. Some of
13 the technical questions are still out there.
14 I would also say that, if I can make one other
15 comment here, whether or not Medicare uses this, the ability
16 to either access data or even Medicare's interest on an
17 educational basis I think could be very positive in terms of
18 getting things to work better.
19 When you say that some private organizations have
20 achieved savings on the order of 10 or 15 percent, is that
21 through excluding -- total exclusion of certain providers?
22 Or is that through a combination of education?
23 DR. BERTKO: What most do as far as I know, and
24 this is an industry statement, is change the tier in which
25 the provider is. So you can still go to any doctor, but
26 typically the outlier docs fall into the out-of-network and
27 then they would be higher there. But at the same time there

1 is some amount of education.

2 I know of one other player using this who is doing
3 only education. And presumably they're getting some effect
4 from that.

5 MR. HACKBARTH: So if, for a variety of reasons,
6 Medicare is a payer were unable to go to tiered networks,
7 then the potential saving would be less than the 10 or 15
8 percent?

9 DR. BERTKO: I would assume that would be true.

10 MR. HACKBARTH: Thanks for the clarifications.
11 Arnie?

12 DR. MILSTEIN: A couple of comments. First, if
13 you were to look at the array of options for moderating
14 future premium increase trend in the private sector and say
15 which of these are the -- I will call it the more active end
16 -- of the private purchasers spectrum and their insurers
17 focusing on, it's this area. And it's precisely because
18 there is very few other options that have this magnitude of
19 yield, in terms of opportunity to moderate future premium
20 increase.

21 The second comment is irrelevant to Bob's
22 question. You sort of say once you develop these profiles,
23 how are they being used? They are actually being used in
24 all four conceivable applications. They're being used for
25 performance improvement coaching for doctors, being used for
26 public transparency along the lines of that -- it's not
27 Medicare beneficiaries that only have to pick a plan, but

1 within traditional Medicare, given their out-of-pocket
2 exposure, wouldn't it be nice if they had an opportunity to
3 know which physicians in their community were less likely to
4 burn Medicare benefits fuel and cause them to have more out-
5 of-pocket exposure. So it's used for public transparency.
6 It's used in pay for performance. It could be used and is
7 being used in pay for performance, although it sounds a
8 little counterintuitive to potentially pay providers more
9 for being leaner in their whole resource use. If you think
10 about it more carefully, it's actually not irrational at
11 all. And the third is benefit design, in terms of tiered
12 networks.
13 Some of those obviously would be much more
14 difficult for traditional Medicare to reach than others.
15 But some of them are applicable to traditional Medicare
16 easily.
17 The second point is that obviously the importance
18 of pairing this with best available quality of care
19 profiling so that you're confident you're not pushing people
20 to inappropriately lean physicians or encouraging physicians
21 to be inappropriately lean. The good news is for those
22 insurers and purchasers that have actually gone to the
23 trouble of profiling physicians using best available methods
24 not only for benefits fuel burn but also for quality, is
25 that there are plenty of physicians that score very well on
26 both. The two things have been shown to be not always
27 correlated but sometimes very highly correlated.

1 Another key point I want to emphasize is as you
2 think about any kind of performance measures in health care,
3 whether they're quality measures or efficiency measures or
4 measures of patient experience of care, we know going into
5 it that the methodology is not going to be perfect. And so
6 one of the questions that we will inevitably face is not
7 whether it's perfect but whether it's good enough such that
8 there would be more benefit to the Medicare program than
9 risk?

10 John's point about the importance of the
11 possibility of collaboration between Medicare and the
12 private sector is very important. One of the interesting
13 facets of all of this is the private sector, one of the
14 barriers to them moving ahead is that unlike traditional
15 Medicare, in most private sector insurance plans -- and the
16 same would be true I think of many Medicare advantage plans
17 -- don't have access to a big enough database size to have
18 adequate stability of profiling. Access to the CMS database
19 in patient protected formats would make all the difference
20 in the world, both for Medicare Advantage plans and for
21 traditional plans.

22 In terms of is it good enough, I want to say that
23 for me it's significant that where provider organizations,
24 physician organizations, are bearing any kind of insurance
25 risk, they tend to us it which to me is a signal that
26 imperfect though it may be, it's useful and that providers
27 find it good enough when they themselves at the ones bearing

1 insurance risk.

2 The last comment is that I think this issue of
3 measuring and introducing some way of reinforcing physician
4 conservatism and quality of care at the individual level, I
5 think, will inevitably and hopefully be a part of what we'll
6 call the SGR dialog that will be taking place between
7 Congress and physicians and people who are -- I'll call it
8 taxpayer representatives -- beginning in January. I would
9 hope that we can make our recommendation on a time frame
10 such that we are prepared and active and have a stated
11 position by January because that's when the SGR - if you
12 think about it, the SGR is a way of profiling all American
13 doctors as a big clump and saying we're going to hold you
14 accountable. If you think of it, it's a big pay for
15 performance program. We're saying if you use a lot of
16 services, we're going to cut back on your fees.

17 I think one of the challenges of that has been the
18 unit of accountability. Doctors judged as a national lump
19 are not -- it's one of these things where everyone is
20 responsible and no one individually feels accountable. And
21 it's a very problematic unit of analysis.

22 MR. HACKBARTH: Jay, in particular I'd like your
23 reaction to Arnie's statement that providers, when they are
24 at risk, do this.

25 DR. BERTKO: Glenn, may I correct, I think what
26 Arnie said was that risk takers, namely plans, employers and
27 other things, are the ones doing this, not necessarily the -

1 -

2 MR. HACKBARTH: I thought he was saying that
3 providers -- Arnie, I interpreted your statement as saying
4 that providers, when they're bearing risk, use this tool.
5 And that's an indication, although it may not be perfect,
6 they think it's useful. Did I hear you correctly?

7 DR. MILSTEIN: Yes.

8 DR. BERTKO: Plans maybe a little more than
9 provider groups these days.

10 DR. MILSTEIN: Yes.

11 MR. HACKBARTH: Jay.

12 DR. CROSSON: Thanks. And I was going to make a
13 comment at least tangentially on that. Again, to predicate
14 this, I'm not sure that the model that I'm used to is
15 exactly equivalent to what we're describing here. The issue
16 of profiling, and we don't use that term in the prepaid
17 group practice world that I live in, is a delivery system
18 issue. It's not a plan issue, number one.

19 And it's not necessarily related to stark
20 financial risk. It's predicated, I think, in the group
21 practice culture on the belief that there is a better way to
22 practice medicine. And that is supported by scientific
23 evidence, which admittedly changes over time. But that
24 knowledge of and distribution of that information over time
25 changes physician behavior because physicians, for the most
26 part, are responsive to facts and change their practice when
27 they are given that information. And so that's how we use

1 it essentially. We use it is both an educational and a
2 management tool in the culture of a group practice.
3 We do not distinguish between quality and resource
4 use. We view those as two issues which fall out of the
5 process of organizing scientific evidence to guide practice.
6 It's a cultural phenomenon. It's a management phenomenon.
7 It's actively supported by these patterns of practice are
8 not something that are extrinsic. They are developed by the
9 physician specialists within the group in order to guide
10 themselves and others. And that's how it is.
11 MR. MULLER: I want to echo and endorse that
12 profiling is a good way for Medicare to go, not just because
13 private plans are doing it but because providers use it as
14 well. So I will endorse what Arnie and John and others have
15 said, that providers do use it when they're at risk. In
16 many ways, you can say having a DRG payment puts you at
17 risk, and APCs are more recent.
18 I'm just personally familiar with using it in my
19 organizations for 15 years now, in terms of looking at
20 patterns utilization against DRGs.
21 I think it's fair to say my experience too is that
22 -- I think John said this earlier, there's a lot of cluster
23 around the mean but then a lot of big outliers. There is
24 therefore a lot of fruit to be borne in looking at those
25 outliers.
26 What makes it more difficult is for all of the
27 reasons mentioned earlier, you can get the outliers back to

1 a mean but it's very dynamic. The patterns of practice
2 change so quickly. So let's say if you get some urologist
3 or orthopods or whatever -- it's easier to do in the
4 surgical areas than it is in the medical areas, you get them
5 back to some kind of norm. And for the reasons that John
6 and Jay have mentioned, people want to be within the norm as
7 opposed to being way outside of it.

8 But all of a sudden, some new pattern of care
9 comes up within a year or two, and then people become
10 outliers again within that pattern. So kind of fixing this
11 for a set of practices or a set of physicians doesn't stick
12 very long. So I think one has to think of this in dynamic
13 terms, that you don't fix it in orthopedics or in general
14 surgery, thoracic surgery, for five or 10 years at a time.
15 You may fix a particular issue you're looking at, in terms
16 of putting evidence in front of people. Physicians are
17 evidence-based. They want to do the right thing and comply
18 with it, whether it's regional norms or professional norms.

19 But then some other practice comes up, whether
20 it's driven by innovation or device manufacturers or
21 whatever. The new techniques come out and one has to start
22 thinking again about what the distribution of patterns of
23 care are against that. So I think it's both important to
24 keep looking at this direction, understand how you have to
25 constantly stay on top of it and how dynamic it is. But yet
26 I think it's incredibly fruitful because you do find
27 enormous variation in a small cluster. And if one can

1 change those ways, there's a lot of benefit to be gained.
2 And I think the evidence that obviously that
3 Wennberg and his acolytes have shown is that the quality
4 doesn't necessarily suffer if you put people into those kind
5 of norms. So I do think there's a lot of provider evidence.
6 In many ways I would say there's probably many years of
7 provider evidence on it, if you look going back. Because I
8 think from '83 on people had to start reacting to DRGs. So
9 there's probably 15 years, if not more, of evidence there.
10 Again less apparent on the outpatient side, because the risk
11 wasn't there as clearly until the APCs came in.
12 I think if you want to look at evidence on this, I
13 would look in that area as well.
14 DR. REISCHAUER: This builds a little bit on that
15 point. We do know that there's this huge variation across
16 region in practice patterns. The Fisher and Wennberg kinds
17 of information is a big glom and it's been treated by
18 policymakers as interesting but...
19 It strikes me that risk-adjusted episode-based
20 profiling for physicians or providers in Rochester and
21 Minneapolis versus Miami and Los Angeles could provide some
22 important information to policymakers that would cause them
23 to ask questions and change the nature of the debate on
24 these kinds of issues. And you don't have to have
25 identifications of providers or anything because what you're
26 really looking at is average distribution of docs with
27 respect to this and comparing them across geographic areas

1 for similar risk-adjusted episode of care. And we do know
2 something about health outcomes at the Metropolitan level.
3 And so this could be a very useful piece of
4 information for policymakers, one that they may not want.
5 MR. HACKBARTH: I think this touches on sort of
6 the central question for the Medicare program as we move
7 forward. Our tendency in the past has been to treat all
8 providers as though they are the same. When we have cost
9 problems we squeeze everybody across-the-board.
10 Given the dimension of the challenge that we face
11 going forward from here, personally I think that's a
12 bankrupt strategy. We will do great detriment, great harm,
13 to our health care system, to good providers, to
14 beneficiaries if we insist on this across-the-board, across-
15 the-board, everybody's the same. At some point, although
16 it's hellishly complicated and controversial, you've got to
17 start to dip in and say not everybody is the same. This is
18 just one of many potential ways that you start to get into
19 that conversation. Hence my strong interest in it.
20 I wanted to get commissioner reaction to Arnie and
21 John's statement that even if Medicare felt that for
22 whatever reason it was unable to use the information itself,
23 it could do a service by making the Medicare information,
24 including the provider identifiers, available to private
25 payers.
26 I think, Arnie, I think you were the one that gave
27 me the formulation that Medicare is rich in data and is

1 sometimes hampered in its ability to act on the data by
2 political, legal and other constraints. Private payers have
3 somewhat greater flexibility to act but lack the data. So
4 this is a potential marriage of relative strengths. I want
5 to hear what other commissioners think about that.
6 MS. BURKE: I think it would be a mistake at this
7 point in time. I think, Glenn, you said exactly what I
8 would hope the commission would say was the extraordinary
9 importance of Medicare beginning to develop this information
10 and utilizing it in the context of the Medicare program and
11 how we structure reimbursement, in how we inform physicians
12 about their practice, for purposes of education and
13 ultimately for purposes of reimbursement.
14 I think to provide the information to private
15 payers in advance of our making a decision to use it for the
16 Medicare patient would be an enormous mistake. I think if
17 there are politics in our using it for Medicare patients,
18 the politics of us providing it to payers who will, in fact,
19 use it for purposes of excluding people from coverage, from
20 groups, I think will complicate our long-term strategies to
21 use it effectively for Medicare.
22 I think the political response to that will not be
23 a positive one. But I think we ought to certainly develop
24 it and we ought to state it's importance. We ought to state
25 the value of moving in the direction of using it for payment
26 purposes and education purposes. But I think to allow it to
27 be used for private payers in advance of it being used

1 constructively for Medicare would be a mistake.
2 DR. WAKEFIELD: I can't speak to the timing issues
3 that Sheila just raised but I can say that some of the
4 feedback that I here is that it's difficult, using North
5 Dakota is an example, it's difficult to really assist
6 individual providers in better understanding what's going on
7 with their patient population when they have only part of
8 the data available.
9 So what we hear, for example from Blue Cross Blue
10 Shield representatives, is that they'll feed back their
11 diabetes registry information to individual providers. But
12 they're missing a huge set of information if those providers
13 are caring for a significant -- and in my state it is case -
14 - a significant portion of the patients they see are
15 Medicare beneficiaries.
16 So what gets fed back to the individual provider
17 is what's going on in the private pay side, but they don't
18 have any of the rest of it. It's an incomplete picture.
19 And I think that does a disservice not just to the provider
20 but ultimately to the patients whose care we're trying to
21 assure is high-quality care.
22 I don't disagree necessarily about timing issues.
23 I defer to Sheila on the politics of all of this. But where
24 the rubber hits the road, I think there's an issue there if
25 we're only providing people with half the picture. In my
26 case, in our state, probably less than half the picture
27 right now.

1 MR. SMITH: On Medicare data to private provider
2 question, I think Sheila is exactly right. Turning the
3 politics of this into a fight of what a private provider did
4 with public data could well cramp and eventually inhibit our
5 ability to use the public data publicly. I think Glenn,
6 your formulation earlier that it's time to collect, it's
7 time to figure out how to use this data in Medicare itself
8 is where we should go.
9 But putting our ability to do that at the risk of
10 the political backlash of the way that data is used before
11 Medicare gets to use it by private payers would be a big
12 mistake. Not just a timing mistake but a political judgment
13 mistake.
14 MR. DURENBERGER: I think I'm reacting also to
15 what Sheila said and maybe suggesting by way of example of a
16 way to think about it. I have found, in my own analyzing of
17 the Medicare Modernization Act, in one of my PowerPoint's --
18 I don't know why we're in a barn today. But I've got this
19 little PowerPoint of looking for the pony in the manure
20 pile. For me, the pony is the regionalization. I went
21 through everything that Sheila has talked about. We've all
22 had this experience. When we did RBRVS in 1989, I debated
23 then with Gail Wilensky about the volume performance
24 standards, and when they're applied across the country they
25 penalize the folks in the Upper Midwest more heavily that
26 they will penalize other people. Is there a resolution?
27 Arnie said sure, there's a resolution and we ought to get it

1 in January.

2 But one of the things that is so important, as

3 I've experienced this, about the regionalization potential

4 is not how do we get more benefits to people and things like

5 that. But how do we appeal to the provider instinct that

6 Jay has spoken to and many of us know to do things better

7 and differently if only we have the information on which to

8 do it.

9 While I am sure people tire of the Miami-

10 Minneapolis comparison, let me say Minneapolis is going the

11 way of Miami simply because we haven't dealt adequately with

12 some of these issues.

13 I've observed frequently in recent months that if

14 I had known -- and even though Sheila was there, I didn't

15 know -- if I had known in 1982 or '83 what I know now, I

16 would have done my best to formulate Medicare's payment

17 policy around what became known as the TEFRA risk contracts

18 with HMOs in Hawaii, the Pacific Northwest, Intermountain,

19 the Upper Midwest, and New England. And I would have said

20 everybody else, you take the DRGs because you don't have the

21 cultural capacity to change unless somebody gives you these

22 kind of regulatory incentives.

23 So with that in the back of my mind, I think that

24 what has been suggested by way of applying this to the

25 Medicare claims data is really important. But perhaps

26 contexting it in some suggestions about moving this

27 regionalization process more quickly past the drug benefit,

1 the PPO benefit and starting to think about providing
2 incentives for these naturally occurring regions in this
3 country to use this kind of information to change the way in
4 which we use resources, improve quality and so forth.
5 So it's not a difference in terms of the politics
6 of it? I acknowledge that is a reality, although I think
7 that's changing, too. But I think there's a more positive
8 way in which we could present this.
9 DR. BERTKO: Glenn, may I respond as a quick
10 follow-up to this?
11 MR. HACKBARTH: Very quick.
12 DR. BERTKO: I acknowledge what Sheila said, but
13 there is a chicken and egg element, continuing the barn, in
14 that if there's regionalization run by private plans my
15 comment would be that they will run better and be more
16 likely if, in fact, access is available to this data.
17 MS. BURKE: Let me say the following. I think the
18 extent to which you can begin to provide information that
19 provides guidance, or information that is nonspecific to
20 individual physicians, that is Medicare data that can assist
21 in determining patterns in regional areas, it makes enormous
22 sense.
23 It is the individual identifier that would allow
24 private payers to make decisions on payment based on
25 Medicare data that troubles me in advance of Medicare -- now
26 to Nancy-Ann's concern, there's no question that we have to
27 find a way to get Medicare to move quickly to begin to use

1 this information and gather it. And I think we ought to be
2 a strong as we can be in stating the importance of Medicare
3 moving in this direction for purposes of payment decisions
4 and education decisions. I don't think in any way we should
5 intimate that we don't think this is the direction to go.
6 But actually providing the information on a
7 specific physician basis so private payers can make payment
8 decisions based on Medicare data before Medicare has done
9 so, I think would. in fact, reverse the trend. I think it
10 would, in fact, impede us in moving forward.
11 So I think if we can get regional data, get the
12 information out, show the trends, provide the information as
13 best we can to private payers to utilize it, great. But it
14 is that next step that I think moving too quickly and
15 allowing decisions to be made before Medicare has done so
16 would be a big mistake and would, in fact, create problems
17 that will, I think, impede us moving forward.
18 But I think we ought to be as strong as we can in
19 stating this is exactly the way Medicare ought to go.
20 MR. HACKBARTH: I really need to get Bill and
21 Nick, both of whom have been waiting patiently. Arnie's had
22 his hand up for a while and we are a bit behind schedule.
23 And we have a panel from the outside right after lunch, so I
24 really don't want to keep guests waiting. So we've got a
25 fairly rigid time limit here.
26 DR. SCANLON: I'll pass because Sheila just said
27 essentially what I wanted to say.

1 DR. WOLTER: Since I'm naive about what's
2 possible, I'll weigh in on the side of trying to find a way
3 to actually have the Medicare data be used. I would use the
4 analogy of what's going on the public-private partnerships
5 about quality measures because there's another aspect to
6 this. That is that providers don't want this coming at them
7 from multiple different sectors. They would like it to come
8 in a way that seems consistent.
9 And I think if that could happen, there would be a
10 huge interest actually in responding to how we take this
11 episode profiling and try to make health care better.
12 I'd also say that there's a fair amount of urgency
13 to this. If there's a 10 or 15 percent savings potentially
14 on the table, I don't think we have a lot of time to go
15 after it. That's how I would look at it.
16 And then philosophically, I would also add that
17 there's the 10 or 15 percent that might come from addressing
18 the outlier issue which, of course, gets us to average
19 practice. It doesn't get us to best practice. I think that
20 to get to best practice, that's where we need to think out
21 of the box about how incentives can look at Part A and Part
22 B together, so that we can really drive to best practices.
23 Because I don't think that the skill sets around
24 process and improvement are inherent in training that most
25 physicians get. It takes pharmacists, nurses, quality
26 improvement people, and that's where you really have to have
27 teams working cooperatively.

1 So the incentives need to move beyond the SGR down
2 -- I don't know if it's the individual level. It's
3 certainly at the practice level, in some fashion. But that
4 does involve teams, which means we have to look at the silos
5 of payment and come up with new approaches.
6 MR. HACKBARTH: Arnie, a very brief comment.
7 DR. MILSTEIN: I think Sheila's prediction that
8 the availability of Medicare data at the individual
9 physician level carries major political challenges. But the
10 other side of it is that it is exactly that information set
11 that is the key to unlocking this 10 to 15 percentage points
12 of opportunity to moderate premium trend. And also it's key
13 to what the last two commenters point about building a
14 market in which Medicare and the private sector are a little
15 bit better synchronized in terms of their evaluation of
16 performance and their reward for it.
17 That's really, if you read the IOM Crossing the
18 Quality Chasm Report and you look at their map as to how we
19 might get across the chasm, and move from average practice
20 to very best practices and discovering tomorrow's even
21 better practices, it really is built on this idea of sort of
22 a synchronized market in which private plans, purchasers and
23 Medicare are using the same performance measurement stream
24 and using that to evaluate not just health care
25 organizations but also, to use the IOM's language, patient
26 facing microsystems which could be individual docs in some
27 parts of the country or they could be physician office units

1 in other parts of the country or even bigger units of
2 analysis in the case of Jay's organization.
3 I just think it's one of these things, we have a
4 set of trade-offs here. I think Sheila has correctly
5 characterized it that the politics of doing this in
6 individual physician level of analysis are challenging. But
7 I think it's offset by it being a tremendous leverage point
8 for performance, not just standardization, but by
9 performance breakthrough along the lines of what the IOM is
10 telling us.
11 MR. HACKBARTH: Okay. We'll now have our public
12 comment period with the usual ground rules. Please keep
13 your comments very brief. We are up against a time
14 constraint.
15 If someone before you in the queue makes your
16 comments, please don't repeat the same thing over, just
17 signify your agreement with that.
18 DR. THOR: My name is Bill Thor, I'm a practicing
19 radiologist in North Carolina and immediate past president
20 of the American College of Radiology.
21 We'd like to applaud the Commission's efforts to
22 control inappropriate utilization of imaging services while
23 preserving quality. And we'd like to comment that the goal
24 for Medicare would be to promote that the right test, based
25 on appropriate clinical indications, be done that influence
26 clinical care decisionmaking, but it be performed in a safe
27 high-quality facility by trained professionals, and

1 interpreted by physicians with documentable education,
2 training and experience.
3 I think that bullets one, two, four and six in the
4 options in your brief do address exactly that goal. My
5 concern with option five is that the concept of tiered
6 providers leaves, in fact, providers who are still providing
7 substandard or subquality imaging services. In fact,
8 imaging procedures that are misinterpreted generate more
9 health care costs. They generate repeat procedures, they
10 generate potentially surgery that's unnecessary. So I think
11 the concept of privileging makes sense. The concept of
12 developing tiers, leaving providers doing it that aren't
13 appropriately qualified, would be a mistake.
14 Secondly, the worst outcome for beneficiaries
15 would be that the changes be made via across-the-board
16 reimbursement cuts or inappropriate coding edits that result
17 in decreased quality of current imaging and decreased
18 research and development in the field.
19 The increased imaging realized may result in a
20 decrease in the total cost of episode of care, and there's
21 been a lot of discussion about profiling episodes. Examples
22 are abdominal trauma where now exploratory laparotomy is
23 oftentimes precluded by CT examinations that demonstrate no
24 significant injury.
25 The vast majority of imaging services performed by
26 radiologists is done based on referral from another
27 physician or health care provider, so that the 47 or 48

1 percent that you described and Dr. Milstein addressed, that
2 in fact it's not the radiologist who is responsible for the
3 generation of that test.
4 And that multiple exam efficiencies we were
5 talking about edits with the potential for reduced
6 reduction, may make sense in the technical component side.
7 But in fact, in the professional component side, when I'm
8 interpreting a CT of the abdomen and pelvis, if I find
9 something in the pelvis, it's going to force me to go back
10 and re-examine the abdomen. In fact, in the professional
11 component, there's really no efficiency in doing concurrent
12 exams on the same patient. Many radiology information
13 systems actually require that you bar code in a whole
14 separate accession number, in fact, to go ahead and dictate
15 that second exam.
16 So again, just addressing those specific points.
17 Thank you.
18 DR. GUCCIONE: Thank you. I'm Dr. Andrew
19 Guccione, Senior Vice President of the Division of Practice
20 and Research of the American Physical Therapy Association.
21 On behalf of the Association and its 66,000 members, I want
22 to thank you for looking at the issue of direct access this
23 afternoon.
24 As you know, Congress intended MedPAC to look at
25 the issue. And in August we provided you with this report,
26 which we believe supports implementation of policy. In that
27 report we did provide you with six key emphases which have

1 to do with timely access, the ability for physical
2 therapists without referral to provide safe and effective
3 care, to provide care that's cost-effective, that will
4 improve the quality of life, enhance collaboration among
5 providers, and improve patient choice.
6 Several national associations have supported our
7 request and we hope in your deliberations today that you
8 will recommend to Medicare a change in implementation of
9 policy and would appreciate the opportunity to make some
10 comments again after we hear the staff report.
11 Thank you for your attention.
12 MR. HACKBARTH: Just for future reference, for you
13 and everybody else who's a regular participant in this, I
14 asked that you confine your comments in the public comment
15 period to things that we've discussed in the preceding
16 session. Among other concerns I have as I don't want
17 everybody to come in and say I'm going to do my MedPAC thing
18 for the week right at lunchtime of the first day and we've
19 got a queue going out into the hall.
20 And it's also more useful to the commissioners if
21 you do it connected to the presentation from the staff.
22 Thank you for adhering to that request.
23 MS. MELMAN: Hi, I'm Diane Melman and I'm
24 representing the American Society of Echocardiography and I
25 want to speak to the diagnostic imaging issue.
26 There are a number of aspects of the discussion
27 that are troublesome. Just as a preliminary matter, the

1 statistics that have been put on the board regarding the
2 growth in diagnostic imaging do have a problem with them
3 insofar as they don't take into account shifts in sites of
4 service which has two effects. One is to somewhat elevate
5 the perceived utilization growth which is certainly
6 problematic and should be looked at. But I think that we do
7 need accurate statistics on it.
8 The second impact of that particular anomaly with
9 the data is that it overestimates the extent to which
10 diagnostic imaging is performed by non-radiologists.
11 I think that there was a question raised about
12 what is the problem in Medicare? What's going on in the
13 Medicare program? Where is the growth in the Medicare
14 program?
15 I think that it's important to note that the
16 aspect that two or three modalities that have experienced
17 the largest growth in Medicare are CT and MRI, which happen
18 to be also the more expensive of technologies and therefore
19 have a bigger impact on the Medicare budget. Those are
20 technologies that again are dominated to a very large extent
21 by radiologists. More than 90 percent of CTs and about that
22 of MRIs are actually performed by radiologists.
23 I can speak to the cardiology services, as well.
24 The most recent statistics on nuclear cardiology and
25 echocardiography, taking out of the site of service problem
26 that infects some of the MedPAC data, shows about a 6
27 percent increase from 2000 to 2003 in those modalities,

1 which is higher certainly than the 3 percent overall
2 average, but certainly is not in the double digits.
3 I also want to address this issue of who's
4 referring for what. I think that there is an
5 oversimplification here to say that radiologists do not
6 refer. That's true and not true. Certainly, under the
7 Medicare program radiologists are required to have a written
8 order by a physician. However, what often happens is that
9 the radiologist will then write back to the physician and
10 say we need X, Y and Z test, in addition to what's been
11 ordered. And of course, in this malpractice environment,
12 that's what happens.
13 It is also true that radiologists, to a very large
14 extent, do own their own equipment and benefit from
15 technical component payments. So I think that the issue is
16 much more complicated than it would appear at first. it is
17 extremely politically divisive and there have been and
18 continue to be substantial issues about specialty
19 designations.
20 In echocardiography, in particular, that is a
21 service that actually started out as a war between the
22 radiologists and the cardiologists. It has since become
23 very much a cardiology procedure and very much a part of the
24 practice of cardiology. So I would caution the staff and
25 the Commission not to adopt specialty specific designations
26 in the things that it does. Most of the guidelines, the
27 training guidelines of the American College of Cardiology,

1 for example, are not specialty specific. They have to do
2 with training and education. And I would caution the MedPAC
3 commissioners and staff to also stay away from specialty
4 specific designations and move towards training and
5 education.
6 Thank you.
7 MS. MIROFF: I'm Julie Miroff and I'm here with
8 Dale Seer, Tammy Sloper, and Ann Jones on behalf of the
9 Coalition for Quality in Ultrasound.
10 The Coalition for Quality in Ultrasound is an
11 alliance of 14 leading diagnostic medical ultrasound
12 societies and organizations. They've all come together
13 based on advocating for the implementation of standards that
14 would require the credentialing of technical component
15 personnel and/or the accreditation of the facilities where
16 all ultrasound services are provided.
17 We greatly appreciated today's report by Ariel
18 Winter that examined some of utilization issues in imaging
19 services. We believe that accreditation and/or
20 credentialing are proven means of really ensuring that care
21 of the highest quality is presented to Medicare
22 beneficiaries and that the Medicare program is not subjected
23 to inappropriate utilization that, of course, raises the
24 cost of these services.
25 We submitted comments to MedPAC in September that
26 really established our main arguments supporting these
27 standards. First, we discussed that there is a consensus

1 not only among the relevant medical societies but also a
2 growing consensus among the Medicare carriers to implement
3 these standards to ensure that Medicare beneficiaries
4 receive and that Medicare only pays for the care of the
5 highest quality.
6 Also, we discussed the threat or the risk to
7 Medicare beneficiaries when these services are provided by
8 uncredentialled personnel or an unaccredited facility. We
9 also examined, as Ariel Winter had pointed out, that
10 Medicare does frequently use accreditation and/or
11 credentialing in its program as a means of ensuring
12 appropriate utilization of services.
13 An example that was raised today is with the IDTF
14 component that really reinforced the standards and we'd like
15 to see them implemented more widely in the Medicare program.
16 We've also documented the availability of credentialled
17 personnel and accredited facilities in the area.
18 And we have these three members of the CQU who
19 wanted to just briefly share their expertise with these
20 accreditation and credentialing standards. We appreciate
21 again your consideration of these issues in ensuring that
22 Medicare is a prudent purchaser and ensuring the highest
23 quality of care for Medicare beneficiaries.
24 MR. HACKBARTH: Unfortunately, we don't have time
25 to go through multiple additional people. We do need to get
26 to lunch so we can convene our outside panel promptly on
27 time.

1 Is there anybody else in the queue on a separate
2 subject? If not, I apologize but we are tightly
3 constrained.
4 And actually, I think the most efficient -- I'll
5 repeat something I've said multiple times before, the most
6 efficient way to communicate with commissioners -- there are
7 actually a couple. One, of course, is through the staff who
8 make a concerted effort to reach out to various groups and I
9 gather including yours. A second is to communicate with the
10 commissioners individually via a letter so that people have
11 the time to give it the thoughtful consideration that it is
12 due.
13 This is, frankly, a last resort. This is probably
14 the least effective way to communicate with commissioners
15 just because we have such limited time together as
16 commissioners. We cannot have an extended public comment.
17 So please avail yourselves of all of the available
18 channels. And we are going to convene again at 1:15 p.m.,
19 when we have our outside panel. Thanks.
20 [Whereupon, at 12:26 p.m., the meeting was
21 recessed, to reconvene at 1:15 p.m. this same day.]
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1 AFTERNOON SESSION [1:20 p.m.]
2 MR. HACKBARTH: We are going to begin this
3 afternoon with a panel on clinical IT. Chantal, are you
4 going to do the introductions?
5 DR. WORZALA: Good afternoon. I'm going to very
6 briefly introduce our panel. I want to make sure they have
7 maximum time both for their presentations and your
8 discussion afterward. I know I cannot do justice to their
9 qualifications in a minute or so and I do encourage you to
10 refer to their bios which we put in your binder.
11 Karen, Chad and I worked together to put this
12 panel on, and it's a continuation of our work in IT which we
13 started last spring and plan to continue in this report
14 cycle. You all had expressed an interest in hearing from
15 people who had successfully implemented IT, so we sought out
16 individuals who had successfully navigated this IT maze in
17 three different settings.
18 Our first speaker will by Dr. Omura. He is a
19 primary care physician from Grand Junction, Colorado. He
20 and his partners were really pioneers, choosing to install
21 an EMR more than 10 years ago. He will talk about using an
22 EHR in a small practice environment and look at its
23 usefulness both for quality improvement and also for
24 performance reporting.
25 Our second speaker is Dr. James Walker, who is the
26 chief medical information officer at Geisinger Health System
27 which is located in central Pennsylvania. We've asked him

1 to describe for you the many EHR and IT initiatives that
2 they have going, and asked him to speak specifically about
3 their patient EHR.
4 Then our third speaker, Dr. Clement McDonald, is
5 director of the Regenstrief Institute, which is in
6 Indianapolis. He will be discussing their regional health
7 information network which facilitates sharing of information
8 across providers and has been the premier network in the
9 country.
10 So I'll turn it over to you and thank you. We'll
11 start with Dr. Omura.
12 DR. OMURA: Thank you very much. I guess I'm the
13 example of the little office that could. Back over 10 years
14 ago we started our involvement in electronic records. We're
15 a five-doctor office now with a PA, a nurse practitioner.
16 We do family practice. We're located in rural western
17 Colorado. We feel a little bit isolated out there. About
18 four years ago we did merge with two other primary care
19 offices to make up Primary Care Partners, so we now have an
20 urgent care facility, a diagnostic facility and we have
21 about 30 or so physicians in our group, so we're a little
22 bigger than how we started out.
23 Back in 1993, which was quite a while ago as far
24 as EMRs are concerned, our problem was that we had no
25 further space in our current office for charts. Our chart
26 racks were full. We needed more administrative staff and we
27 had no places for those people to sit. In addition to that

1 we had the paper record dilemma of charts all over the
2 place, and the fact that information wasn't immediately
3 available when it was needed.
4 So we had a front office staff that had grown to
5 7.5 FTEs and personnel costs were starting to become an
6 issue as well.
7 Our options were to build a $200,000 addition to
8 our office, have two chart rooms, add more staff. None of
9 that sounded terribly appealing to us. Or to consider
10 implementing an electronic medical record system. Initially
11 upon looking at that it looked like it would cost about half
12 the cost of the physical expansion. So it was less costly.
13 The future of medicine in our view was not more investment
14 in bricks and mortar, and that information technology and
15 information management was likely to be at the very core of
16 a successful physician in the 21st century.
17 So with these two options we decided to look at
18 programs that were available at that time, and remember in
19 1993 there were many fewer programs out there than there are
20 now. We evaluated a dozen systems and selected and EMR
21 based primarily upon potential efficiency and cost savings,
22 which I would suggest not all doctors do. So if you're not
23 looking for improved efficiency you probably won't get it.
24 We obtained a loan for the purchase of the system
25 for about $125,000 back in 1993, and that's in the ballpark
26 of what we're talking about these days. We implemented the
27 system in 1993 and went completely to a paperless office.

1 We didn't have the resources to be doing duplicate paper and
2 electronic entry.
3 We installed computers and printers in every exam
4 room and at every workstation. Every staff member and every
5 doctor had a computer in front of them at all times. The
6 computer actually ended up being not just the EMR but was
7 also the center for all information flow within the
8 practice. We were electronically connected with both
9 hospitals, so we could look up laboratory results, we're
10 connected to the Internet. So it became a very important
11 part of our day-to-day care.
12 Immediate outcomes. All staff members with the
13 exception of one were able to adapt well to the new system,
14 and the doctor and staff saw tremendous value in the EMR.
15 Our front office staff decreased from 7.5 FTEs to about
16 four. And remember, 7.5 was actually not quite enough at
17 the time. Our transcriptionist dropped from 1.5 FTEs down
18 to one-half FTE, so we actually saved four or five FTEs,
19 mostly in the front office as a result of the
20 implementation.
21 A later office remodel converted previous
22 administrative space, chart rooms and filing areas, to
23 clinical space and I think that was quite helpful for our
24 practice as well.
25 In terms of immediate outcomes, patient records
26 were always available whenever and wherever they were needed
27 including the physician's homes. We're all connected with

1 high-speed lines to the office. Our urgent care facility
2 was connected directly, the emergency room, the hospital and
3 both hospital floors were connected. So we had access
4 whenever we needed to when we interacted with patients.
5 The clinical data was better organized and easier
6 to retrieve. That was a benefit to us. In terms of dollars
7 and cents, our overhead went down 6 percent the first year
8 of use of the EMR. We saved about $60,000 that year, which
9 means we recovered our investment in approximately two
10 years, which was our plan. At that level we probably have
11 saved $500,000 since 1993.
12 Now these numbers are just based on FTEs of
13 personnel and the reduction that we saw. There are other
14 benefits that are not terribly quantifiable, like the
15 efficiency of the doctor or the staff in terms of having the
16 data immediately and not waiting on charts or not looking
17 for charts. Reminders for services and visits; that
18 increased revenue. What I'm speaking about is good revenue.
19 What I mean is we're doing things that we should be doing
20 for the patients and we're reminded of it by the system. We
21 have embedded clinical pathways within the templates. That
22 also means better patient care, but also means higher
23 reimbursement for our practice.
24 The templates in our system reduces transcription
25 costs. It gets information into the system in a more timely
26 fashion. Also the templates allow for delegating
27 information gathering to specially trained nurses, which in

1 my case is quite beneficial to me.
2 There are some non-financial benefits. We have
3 patient satisfaction levels higher than on a paper record
4 system. We can do electronic searches for clinically
5 relevant data, checking on blood pressures, checking on
6 who's on Vioxx and things of that nature and able to handle
7 those types of issues in a very inexpensive and efficient
8 manner.
9 Quality improvement. The program has drug
10 interaction and allergy checking. The program prints
11 prescriptions to eliminate handwriting errors at the
12 pharmacy. Problem and medication lists are 100 percent
13 accurate to reduce mistakes due to oversight of important
14 information. The program prompts doctors and nurses
15 whenever health maintenance services are past due. It
16 prompts them also for chronic disease management services
17 and identifies the parameters that are not met. What I mean
18 by that is, someone comes in for an ear infection, the
19 program will tell me, this person is a diabetic and didn't
20 get their blood test two months ago like they were supposed
21 to. Or they did get their blood test and the test is not
22 optimal. So it reminds us, even in the face of an acute-
23 care visit that chronic disease needs to be addressed as
24 well.
25 Laboratory results flow automatically to letters
26 that are then sent to the patients. They tend to like that.
27 And as is obvious, the information is available outside the

1 office, when you're on the phone on call, either at home or
2 at the hospital.
3 So the electronic record is a very basic tool for
4 comprehensive, outcomes-based management of patient care.
5 That's a lot more than just the day-to-day what you do with
6 the patient when they're in the office. You can efficiently
7 monitor and manage care for all patients and focus on
8 specific disease processes.
9 The future. Our program is set up so that it is
10 Web enabled and it will allow patients to view whatever
11 results we'd like to present to them; laboratory results,
12 major problem lists, current medications, appointment
13 requests, patient education. Those are some of the things
14 that we're thinking of doing though we haven't done that
15 yet.
16 Also into the future, consultants will be able to
17 gain access to the entire patient chart, which I think will
18 be tremendously valuable. It's very difficult to keep on
19 sending copies of this and that to each other and
20 remembering how many consultants may potentially be
21 involved. This way you give them access to the data and
22 they look things up as they need to. As you can imagine
23 it's more timely as well. So a test that was done this
24 morning, the result that came in at 11:00 a.m. should be
25 there, not only in the primary care doctor's office but also
26 the consultant's office if they need it.
27 Outcomes-based reimbursement. We think we're

1 doing a better job in terms of quality outcomes than most
2 other offices in our area and we're working to take
3 advantage of that. In our area we have an IPA that seems to
4 be very cooperative and a local HMO that seems to be very
5 cooperative, optimizing quality.
6 We're actually receiving payments for optimal
7 patient outcomes for various and sundry diseases like
8 diabetes and depression, things of that nature. We are
9 receiving payment for working on patient care management
10 that results in fewer admissions to the hospital, shorter
11 length of stay. These are all good things for the managed-
12 care organization but it's also good things for the patient.
13 Avoiding unnecessary hospitalizations helps everybody.
14 actually, including the doctors. It's a lot more work to
15 take care of patients in the hospital, I think, than in a
16 doctor's office.
17 Our IPA has control of the withholds and incentive
18 money from our local HMO and they're returning these dollars
19 back to the physicians based solely on outcomes, both
20 financial outcomes and quality outcomes. And $8 million
21 divided among 300 physicians is a pretty hefty incentive.
22 That's $8 million assuming we have a good year, which we
23 don't always have. But I would say on the average we're
24 talking about $5 million a year that gets divided in that
25 manner.
26 Clinical data repository. We are working on a
27 community basis to try to develop a health information

1 network and a data repository. Our own program has about
2 50,000 patients in it right now and our community has a
3 population of about 130,000. So as you can see that's
4 potentially doable, especially with the money that our group
5 has invested in connectivity, to simply expand that
6 capability to the whole community. There are all sorts of
7 financial and political issues that have to be addressed
8 though.
9 The Renaissance program. Just a brief mention of
10 that. We're embarking on an ambulatory care redesign
11 program similar to what the Institute of Healthcare
12 Improvement is working on. You really just can't do that
13 without it any more. The HMOs talk about, if we were
14 successful in improving our benefits, to consider
15 adjustments in copays and premiums and things of that nature
16 from there in to promote this type of effort.
17 So in conclusion, we're one of the more productive
18 family practice groups in our area. We have one of the
19 lowest staff to provider ratios. We have one of the lowest
20 cost for patient care based upon the managed-care data in
21 our community. Our five providers are near the very top of
22 the outcomes data for diabetes, for example. And we have a
23 one of the highest take-home salaries -- I don't know that
24 for sure -- in our area.
25 So in conclusion, the EMR has improved the quality
26 of patient care for our patients, has reduced our overhead
27 expenses directly. It has enhanced our revenue and has

1 really helped us to be prepared for health care in the 21st
2 century.
3 The question that was asked us is, would it be
4 easy for others to duplicate our efforts? I would say that
5 we've done a lot that other practices may have some concerns
6 about doing. First of all, it's the cost of implementing an
7 EMR system. $125,000 doesn't sound too bad but as we
8 expanded to three offices we've spent over $1 million now on
9 information technology in a family practice setting, which
10 is a moderate amount of money. Large organizations may be
11 able to better afford these types of investments.
12 The complexity of doing this is not too easy for a
13 smaller office. The reason I emphasize a smaller office is
14 I believe in Colorado the average office has about 2.5, 2.7
15 doctors. So we don't have large quantities of large
16 organizations of physicians, so you're talking about two,
17 three, four doctor offices that would have to undergo these
18 changes. The hassle factor for physicians undergoing this
19 type of change is difficult. And lastly, I think the EMR
20 benefits patients but it also mostly benefits the payers.
21 But there is no increased reimbursement for physicians,
22 which does not provide a lot of incentives for physicians to
23 spend that kind of money to help everyone else and
24 essentially hurt themselves.
25 Our group of five has done well with this
26 conversion but our larger group is financially negatively
27 impacted with the expansion. So that $1 million actually

1 ended up hurting our larger group, and other than saying we
2 have an EMR there is actually not much in the way of
3 increased reimbursement for these efforts.
4 So you get what you provide incentives for, so I
5 suggest that comprehensive care is better than just quick
6 and simple visits. Population-based chronic disease
7 management is better than an acute-care approach even to
8 chronic diseases. That always having patient's medical data
9 available is better than information available only in the
10 office. And electronic drug and allergy checking is better
11 than trying to remember thousands of interactions. I think
12 with IT in a primary care office I think you're going to get
13 a lot more of the first rather than the second.
14 So that's it.
15 MR. HACKBARTH: Thanks, Gregg. Why don't we go
16 through all of the presentations and then have discussion?
17 DR. WALKER: I'm going to go ahead and move on
18 then, talking about what our goals were originally for the
19 EHR and some of the barriers that we have had to overcome to
20 achieve it, some of the results we've documented and take-
21 home lessons about how other groups would use what we've
22 learned and generalize it.
23 The fundamental reason that we embarked on an EHR,
24 in 1993 was when the planning began, is because we cover 31
25 counties in rural Pennsylvania; 23 are officially
26 underserved, 30 are rural. Without electronic
27 communications and an electronic health record we didn't

1 think we could function as a system as opposed to just a
2 collection of practices.
3 So stakeholder communication, and originally that
4 meant clinician communication and more recently that's meant
5 both patient communication and communication with physicians
6 external to our system, was really the primary driver.
7 Quality and safety were critical. The team that made this
8 decision back then felt that going forward we wouldn't be
9 able to provide quality medicine, quality care without an
10 electronic health record.
11 Process efficiency is something that wasn't
12 mentioned at the beginning, but we're getting clear on as
13 time goes on and focusing more on. And delighting the
14 customers was always part of the intention, although
15 delighting internal customers like nurses and doctors is
16 something we also are getting better at as we go.
17 Just very quickly, we're in 31 counties. We have
18 42 clinical sites, two hospitals, 600 physicians. The
19 outpatient EHR is in use by all physicians and nurses and
20 office staffs. All orders are entered in it. About 80
21 percent of notes produced in visits are produced
22 electronically originally. The others are transcribed into
23 the system and signed in the system. Radiology images are
24 available throughout the system. And by the way, throughout
25 in all of this means at home and other hospitals. We do
26 about 80 percent of our radiology images electronically now.
27 Mammography is the real exception.

1 We're going to be doing inpatient order entry and
2 documentation in 2005. The patient electronic health
3 record. which I'll talk a little bit more about, has 15,000
4 users currently and is available in all of our practice
5 sites, all of our specialties; any patient that has a
6 Geisinger physician.

7 Outreach EHR. we currently provide different kinds
8 of information to external physicians so that a physician
9 that is involved in the care of a patient receives
10 hospitalization information automatically. That's pushed to
11 a HIPAA compliant we site that any physician in the region
12 can have an IDM password to access that information. If the
13 patient signs a HIPAA compliant authorization then any
14 physician in our region can have complete access to that
15 patient's electronic health record.

16 We just have received and AHRQ grant to support
17 planning for a regional health information network, which
18 again will be open to any health care professional in the
19 region; originally hospitals and practices.

20 I wanted to talk some about barriers. As you may
21 have gathered for Dr. Omura's presentation, I think the
22 critical barrier is lack of organizational ability and will
23 to transform itself. I think an organization like Dr.
24 Omura's practice that sees the EHR as one of the important
25 tools that can be used to transform the way an organization
26 improves from 55 percent performance on validated health
27 interventions to 100 percent, that does that in a way that

1 makes maximal use and maximally empowers patients, and
2 minimal requirements for human resource use, will succeed.
3 If that is absent, it doesn't really matter what else is
4 present, an organization is not likely to succeed. The
5 problem with that is that's a deep problem if an
6 organization doesn't have those two things. There is no
7 quick fix for that at all.
8 Elusive benefits. Your white paper talks about
9 that some. Obviously there is suggestive evidence, and I'll
10 present a little bit, that EHR really does have the
11 potential to improve quality and safety and efficiency
12 simultaneously. But that has not been demonstrated in
13 anything like a credible ROI study. It hasn't been
14 demonstrated in real production systems involving lots of
15 physicians whose job is just taking care of patients. So
16 that is a problem that some effective research would help
17 with.
18 Cognitive load is something that I think is talked
19 about too little. This is really difficult and goes back to
20 the first issue. Physicians, like other professionals, are
21 able to work fast and with remarkably low error rates,
22 despite all of the errors we do make, because they have
23 semi-conscious intellectual routines that they run through
24 over and over again that work extremely well most of the
25 time. Nurses the same way. When you use an EHR you have to
26 retool your brain. It's like working in a second language
27 for several months. We've worked on some ways to diminish

1 that cognitive load, but it is real, whatever you do, and is
2 one of the fundamental reasons physicians are reluctant
3 about all of this.
4 Immature software. We use what is, without any
5 serious question, the best commercial software there is. We
6 have one of the deepest and most successful implementations
7 of it, and we still bang up against the limitation of the
8 software constantly. So that while there are lots of things
9 that are more important than the software, it is still true
10 that while the software will support a very effective
11 implementation, it still needs a lot of work and it's one of
12 the things that makes implementation a real trick.
13 I want to add one other thing in there. Because
14 of the cognitive load, because of the immature software,
15 there is the risk for adverse effects. There is some
16 research on that but not nearly enough. With any
17 intervention in health care what we want to know is what the
18 benefits are and what the adverse effects are that we should
19 be watching for, and know how we're going to do deal with
20 them when we find them. We don't know enough about that.
21 One of the really important ones for us is
22 mistaking go-live for the finish line. People, we included,
23 are prone to think of EHRs as sort of like plumbing. You
24 put the pipes in and if they don't leak you're finished.
25 It's the opposite of that. What happens when you put in an
26 EHR is everybody changes the way they work. It's
27 inevitable. People who never thought about process before

1 start to see the power of good processes to improve care, to
2 make things more efficient, and start raising questions,
3 start coming up with ideas for changing processes further.
4 EHR is very hard to learn and what you hope users
5 learn by go-live is enough to get through their day and take
6 care of patients effectively. But to become effective
7 users, to really achieve the benefits that are possible in
8 terms of quality and efficiency requires ongoing, intensive
9 training, ongoing adaptation of the system. That's going to
10 go for years, for 10 years at least we'll be hard at that.
11 One last limitation that I didn't put in your
12 slides, because our project manager met the need so
13 effectively that I forget to think of it as a limitation,
14 there are not enough skilled implementers. If you could
15 give everyone in the United States enough money to implement
16 an EHR, there would not be enough people who can go into a
17 clinic, help them assess their work flows, assess their
18 needs, design the configurable parts of the EHR to fit those
19 work flows so that they can be genuinely effective. So one
20 of the things we're going to have to address really is
21 efficient ways to maximize the benefits of the people that
22 do know how to do that. Workforce approaches are going to
23 be slow enough that they won't get us where we want to go
24 nearly quickly enough.
25 I'll just talk briefly about the independent
26 physicians. We provide them hospitalization information,
27 EHR access, as I mentioned. One of the other very powerful

1 things about the EHR that actually our team designed and
2 then the vendor has built into the product is that when I
3 create a note electronically I can pull up a form and
4 automatically have the primary care physician and the
5 referring physician who sent that patient to me, but then I
6 can pattern match it by typing the first three or four
7 letters of a name. I can pattern match any physician in the
8 region and send my note automatically. Hit submit, and
9 tonight at midnight the system goes through and knows which
10 of those physicians want e-mail, which ones want fax, which
11 ones want U.S. mail, and automatically distribute my note to
12 all of those people in whatever format they prefer. We're
13 doing about 20,000 a month now, that external automatic note
14 distribution.
15 E-curbside consults we're just starting to do.
16 There's good data in the literature that you can do this in
17 a way that is effective for the referring physician and the
18 receiving physician. We're just starting to provide that
19 kind of service to external physicians.
20 The patient EHR, this is one of the places the
21 software really is critical. The way the software we use is
22 designed, the patient EHR is just another few into the EHR.
23 It's like the nursing view, or the physician view, or the
24 outpatient view, or the inpatient view. So it's designed
25 into the system. It requires very little resource and very
26 little high skill resource to implement. It provides the
27 patient the view of the same problem list that I see, the

1 same allergy and medicine list that I see, the health care
2 histories, lab results, about 95 percent now of lab results
3 are available in the system.
4 They can renew their drugs. All you do this click
5 beside the medicines that you're running out of, hit the
6 submit button. That's submitted electronically to your
7 office. Then you get a message back when that's been
8 transmitted to the pharmacy. So no more calling the office
9 and being on hold 10 minutes, and then going to the pharmacy
10 and finding out it didn't get there, and then calling the
11 office again the next day and being on hold 10 minutes and
12 finally getting it done.
13 You can request appointments and referrals, and
14 you can ask your doctor a question. Or from my standpoint I
15 can say to a patient, why don't you check your blood
16 pressure a couple times next week and we'll see if we got
17 the lisinopril right? So the patient can send me that
18 electronically and I can reply to them very easily. Of
19 course, part of the beauty is that is all captured in the
20 record then, so there's no question about what was said and
21 what was asked.
22 The patient EHR - this is the killer app, if it
23 matters. This is the thing that for patients will make a
24 visible difference in their care. Patients love it.
25 Children of patients love it. Sixty-year-old children of
26 85-year-old patients are delirious because for the first
27 time they can help their parents keep track of their

1 medicines, their appointments. They can also communicate --
2 we had one child of a patient that came for four hours to a
3 feedback group. She said, this is great. When my father
4 started to have some symptoms, I was able to send a message
5 to the doctor and they got him into the emergency room and
6 got a pneumonia early before it made him really sick.
7 Parents love it because they can print their
8 children's immunization records without schlepping into the
9 office.
10 Physicians, being good skeptics, are suspicious of
11 it at first. The more physicians use it, the more they like
12 it. The big question is, what about my problem patients
13 that need to talk to me three times the day? What we're
14 finding out is that those patients are actually much easier
15 to take care using this. Maybe they feel like they have
16 easier access, but it actually works better.
17 Talk just quickly about some of the benefits we've
18 realized. Patient satisfaction. This is a poll of 17,000
19 patients in our community practice, family practice waiting
20 rooms. 94 percent said that they found having a computer in
21 the exam room either good or very good; helpful or very
22 helpful.
23 Productivity, this is a complicated slide and we
24 can come back to it if it matters. What it shows is that in
25 almost all of our specialty clinics the productivity of the
26 physicians, the quarter that went live is as good as or
27 often better than it was the quarter previously, and then

1 those trends are prone to go up afterwards.
2 Referral reports I told you about; the automatic
3 transmission of reports to external physicians. In 2000,
4 2001 we saved about $1,000 per physician per year on
5 improved formulary compliance. We've seen dramatic
6 reductions in transcription. In dermatology they're reduced
7 transcription about 90 percent within a month. I must say
8 there are other departments who have increased their
9 transcription 40 percent, so this remains a management issue
10 as well as a technology issue.
11 We have decreased chart pulls from 1 million to
12 400,000 a year. Fairly conservatively that's $1.8 million
13 savings a year. We are printing about 372,000 less print
14 jobs annually. Paper is cheap, but the cost of filing those
15 is easily $3 per filing.
16 Performance reporting. We can produce more
17 reports now than we can act on. So we can record by service
18 line, by clinic, by physician what the average hemoglobin
19 A1C is, what the average LDL is, how well we're doing on
20 mammograms and pneumovaxes.
21 Take-home lessons. We are where we are because of
22 a remarkable combination of will and ability to change.
23 Visionary and determined leadership by the CEO and the chief
24 medical officer, support all the way through the
25 organization, a whole set of issues, but particularly that
26 change of seeing the EHR as a change tool.
27 Benefits need to be clarified. It clearly would

1 help if it were easier to make the business case. We did it
2 because we thought it was the right thing to do and we
3 thought we could afford it if we were very smart and worked
4 very hard. That isn't a recipe for widespread industry
5 adoption obviously.
6 For what it's worth, we think it would make more
7 sense to pay for performance that isn't possible without an
8 EHR than it does to pay people for having an EHR. Having an
9 EHR is neither here nor there. What the issue is, can we
10 improve 55 percent to, our goal is 100 percent. We don't
11 think people are going to accept anything less than 100
12 percent. We either did it, we documented why there was a
13 reason not to do it, or we documented that the patient
14 didn't want it after good education.
15 Decrease in the cognitive load. There's a lot of
16 ways to do that and some could actually have policy
17 implications. What we have done to do that is provide users
18 the high benefit, low learning cost modalities first, so
19 that -- lab results. That just makes something that every
20 doctor does all the time a lot easier and a lot more
21 complete than it used to be. Providing radiology images
22 everywhere actually pays for itself within two years
23 fortunately, but is also a huge winner for physicians. A
24 hospital physician on a good day spends an hour looking for
25 the films that they need to do the bronchoscopy or to
26 diagnose the patient or whatever it is.
27 Electronic communications. In our health network

1 we think one of the first things practices are going to need
2 is secure e-messaging capability, which sounds silly but a
3 lot of physicians don't have easy access to that very simple
4 kind of thing. We think e-curbside consults are already a
5 way physicians work, and particularly in our setting where
6 we have rural physicians who can be very isolated, we think
7 that will be one of the things that will get people starting
8 to use electronic systems.
9 Speed software maturation. That's a hard one.
10 I'm not going to say too much about that.
11 Leverage skilled implementers. As I said, there's
12 a severe shortage and it's going to be around for at least
13 five years. One of the things that we're trying to figure
14 out and need help with is how to take -- to understand this,
15 we have about 80 people on the implementation team. The
16 first year we probably did four practices. The last year of
17 the outpatient implementation we did 43 different
18 specialties in one year. That's with full needs assessment,
19 work flow analysis, customization of all of the preference
20 lists and diagnosis lists and order sets and note templates.
21 So one of the things that happens is you get very
22 good at this over time, if you get a large enough
23 organization that you have that kind of learning
24 opportunity. Just when you get -- it's like doing your own
25 kitchen cabinets, just when you get good at it, you're done.
26 So clearly we need to figure out ways to keep that from
27 happening.

1 Just a couple of other things that really are
2 things that you can do that would be hard for anybody else
3 to do is standard performance standards. We assume that the
4 RAND 439 interventions are performance standards. We assume
5 that the CMS 138 are performance standards. We assume that
6 the NCQA 56 are performance standards. But we need those
7 prioritized. Instead of us and Kaiser and Cleveland and
8 everybody else trying to guess which ones are first -- I
9 mean, the first six are pretty obvious. But after that it
10 would be very useful to know that these are the ones we're
11 responsible for in 2005, and these are the ones in 2006, and
12 these are the ones in 2007.
13 Fitting with that, it would be very useful if we
14 had a single reporting dataset that we were responsible for,
15 so that all of the registries, and disease registries, and
16 JCAHO, and state bodies, and federal bodies all agreed
17 together that if you provide this dataset, you have met your
18 data reporting requirement and you will qualify for all of
19 the pay-for-performance opportunities there are and all of
20 the other reporting responsibilities you have.
21 We obviously, first of all, could cooperate with
22 each other and build that at the vendor level, which would
23 be enormously effective. Epic will have 42 million
24 Americans with an Epic electronic record within a year and-
25 a-half. If we could create that single dataset, then
26 providing the information that all of those bodies need to
27 do their work would become a very efficient activity. Also

1 you wouldn't have very much trouble persuading us what
2 needed to be done.
3 Clem is the data standards master so I'm not going
4 to bother with that.
5 Here's the book we're publishing next month on how
6 to do some of this a little more efficiently.
7 DR. McDONALD: Thank you. I'd just like to
8 applaud all the things I've heard so far today, and
9 especially remember that, just like drugs, we should not be
10 so naive that we shouldn't expect bad things to happen.
11 Vioxx shouldn't have been a surprise. It happens every few
12 years and it's going to happen in to have advised said that
13 the that's a prospective or to use of adaptive and health
14 care information systems too. We're going to do bad things.
15 It's going to cause harm as well as good. Nothing is
16 perfect.
17 But I guess I'm the skeptic. I've been doing this
18 for 34 years, and it's a good thing and it's a lot of fun
19 but we have to stay scientifically honest about what the
20 likely problems are.
21 There's two approaches in the administration's and
22 Washington's mind. There's one approach in Washington's
23 mind now, is how to you get electronic records into offices.
24 Plan one is to put a little EMR in every office practice.
25 But I think there's a misconception. People think about
26 electronic medical records as being things that have data in
27 them, because when you go to a show they always have data in

1 them. But they're just empty boxes and all the work is
2 putting the data into them. It requires hand entry to
3 backload at least some data to get the things started. It
4 requires hand entry of most ongoing data. In some cases
5 physicians or a clerk. I'd point out that most pharmacy
6 systems hire pharmacy techs to put in the prescription
7 because they can't afford to have pharmacists put them.
8 Just a side issue.
9 There's the rare automatic import of outside data.
10 Sometimes lab data, but it's a tough struggle for little
11 offices to get that, and lots of operational overhead for a
12 practice. They don't know how to do backups. They don't
13 know how to buy tapes. I'm talking about the one and two-
14 man practice. There's no automatic entry of outside
15 information, and there's computer warfare between payers and
16 providers. I have some practice people who love their
17 computer system because they've been able to upcode - they
18 really get the right codes they should have got.
19 [Laughter.]
20 DR. McDONALD: But then what happens is,
21 inevitably Medicare will come back and get a better offense
22 and squish it down. We're not going to have any net value
23 for all this work and this computer investment if we focus
24 on those issues.
25 Now some of the outside information physicians
26 need -- there's lot of it -- outside consultant notes. We
27 heard about EKGs, operative notes, discharge summaries,

1 radiology reports. It goes on and on, spirometries, EEGs,
2 EMGs. So the second plan is build a highway and focus on
3 the outside information at least as much as the inside
4 information. Build the infrastructure to standardize and
5 move clinical information from where it is to where it's
6 needed. Then it's possible to efficiently provide all the
7 EMR services. You actually do it as a remote service. I
8 think that eventually will be the cheap way to do it when
9 the industry finds it way. You could deliver standardized
10 messages to larger practices. The little ones could just
11 use the central thing.

12 So it's more important to build a highway then the
13 hotel or the fast food place. So the local health
14 information infrastructure is the highway. It connects the
15 health care players. It delivers clinical data in a
16 standardized form to the users. It provides the guardrails
17 and protections for the data riding on the highway.

18 The office is the hotel along the road, the office
19 EMR. It's the one that's receiving it. It accepts the
20 clinical data from the feeds, provides special local
21 services and in fact the central system could provide many
22 EMR services. The highway always comes first in real life.
23 You don't build hotels and fast food chains and hope that
24 highways will line up along them. You have to go the other
25 way around. So I want to put some strong thought in the
26 process. Just supporting EMRs in the office is only half
27 the problem or less than half the problem maybe.

1 Now we built one of these things and we call it
2 the INPC, the Indianapolis Network for Primary Care. I
3 should say I'm from the Regenstrief Institute and Sam
4 Regenstrief invented the low-priced dishwasher in the little
5 town of Indianapolis, made 40 percent of the world's
6 dishwashers at one time. Just a little promotion for Sam
7 who's since passed away.
8 But our thing began, one project providing data
9 for all hospitals in the emergency care. We extended it by
10 adding public health, other practice physician access
11 message, and research one step at a time. I think the
12 gradualism is the only way you can do this. Big bangs are
13 explosions. Everything blows up. Now focused on the
14 clinical public health and research uses has been done so
15 far. the patient use is actually very ripe. There's big
16 challenges in a big community; who gets access and how, and
17 how do you stay out of trouble.
18 So what is it? INPC, it's a central community
19 clinical repository. Be careful about the word EMR because
20 blends all over like the word love. You never really know
21 quite what they're talking about. A repository people know
22 what it is. It's the physical record of the data.
23 There's also a secure network for moving the data
24 around. There's tools and processes for standardizing the
25 data and using it for various purposes. These
26 standardizations happen centrally and there's formal
27 agreements among all the participants. This is like a 40-

1 page document and I can't get into it, but it's important
2 that everybody knows the rules of the game and you get them
3 to agree to it.
4 Why we did it was for clinical care principally.
5 That's what motivated it; fast clinician access to the
6 complete picture. Now you can drive a car a lot better when
7 you can see out of the windshield. We're trying to give a
8 clear windshield to the providers. Preventive care is
9 something for the future, and low-cost EMR in the long run
10 we think we can do too. We're not doing that.
11 Why we did it more, we have a big interest in
12 research and you get population-based data. Now you can
13 start doing things. Long term benefit and new technology,
14 toxic effects of treatments, biologic discovery, because you
15 can get the specimens. That's a side issue. Facilitate
16 clinical trials in the future. I think that's doable.
17 There's a lot of barriers political and social. Public
18 health, automatic case finding; we do that now.
19 So all these flows come into the central system,
20 the computer looks for those reports of laboratory tests to
21 say, this guy has got anthrax. We haven't found one yet,
22 but we do find Schigella and some of these important
23 diseases. Biosurveillance for bioterrorism we're doing too.
24 And who contributes? Now it's just the hospitals or
25 principally the hospitals. Five major Indianapolis
26 hospitals, that's what we've, so that's good. Fourteen
27 hospitals, they provide about 95 percent of the hospital and

1 emergency room care. There's three hospital-associated
2 large group practices, four homeless clinics and the public
3 health department both in our county and in the state. We
4 have immunization records coming from them. We take in
5 public health department lab results. We take in their
6 tumor registry for research purposes.
7 So all hospitals contribute. They commit to
8 contributing discharge summaries, operative notes, radiology
9 reports, pathology reports, cardiology reports like EKGs and
10 cardiac echoes, tumor registry data, and two-fifths of them
11 provide a lot more. They give us everything they have.
12 Public health contributes data also, and this is much but
13 it's not everything. There's more work to be done.
14 Just to give you an idea, we have HL7 message
15 streams. We have 84 messages coming in. Realize that
16 hospitals are not monolithic. You go almost invariably to
17 these various systems within the hospitals to get the
18 messages. We have 52 million HL7 messages per year. We
19 have 660 million rows of discrete observations. We have 45
20 million radiology images. That's only from two hospitals,
21 and we're getting 81 million new observations per year. We
22 think if we get the whole city we're probably at 400 to 600
23 million observations per year.
24 Now the limits. We don't have everything. Most
25 of it comes from the hospitals. We only have 20 percent of
26 the city's medication information. Much of content is text,
27 which you can't do as much automatic with. But text

1 searching tools do give you some power. And we have data
2 from only a few large practices so far.
3 There are broad capabilities from this information
4 infrastructure for clinical care. There's large
5 possibilities for research and there's these public health
6 opportunities. Our storage strategy, we keep each
7 institution's data segregated in this common database. It's
8 a replicated database. This is how it looks from the web.
9 Now we have a system that sends reports out to doctors'
10 offices. That's what a report would look like.
11 The public health goals are to link the clinical
12 activities and the public health activities to improve the
13 population health, and I already mentioned how we do that.
14 We use the repository for medical record for a lot of
15 research purposes and there's lot of opportunities. We want
16 to maximize the research that can be done on de-identified
17 data through many mechanisms.
18 We have links to archive tissues. It turns out
19 everybody who has a pathology specimen report, the specimen
20 is kept for 10 years, and those are accessible in principle
21 by finding cases and getting to the pathology report and
22 then you can get to where they are stored.
23 We have links to other data sources. We have the
24 Social Security death tapes so we can tell who died. We
25 have tumor registries. We have hopes of getting Medicare
26 data and Medicaid data, and there are many local
27 institutional long-term research databases.

1 Problems encountered. We really haven't
2 encountered tons of problem, but we had no deadline. So
3 what one guy's problem, maybe he's not getting it done yet.
4 That's not a problem to us. We just took our time.
5 Secondly, we have a small number of health systems
6 relatively in our city; five with 14 hospitals and that
7 makes it a little bit easier. Until fairly recently it was
8 a congenial group. But as competition heats up there may be
9 additional friction and difficulties. There's a cadre of
10 medical informatics researchers who live there and we are
11 far from done.
12 Now there are many advantages that can still
13 accrue. The framework is right. The HL7 message standards
14 are in place. People complain about them, but so you take a
15 week to fix them, but you get them from. And you can get
16 them from almost all these systems. The need for
17 information is great so I think it will really happen. But
18 I think I'd advise that we shouldn't rush it. You ought to
19 at least have two or three of them running before you insist
20 everybody have them. There's this great tendency, when it's
21 hard to do it on a little scale, let's do it everywhere. I
22 was at an AMA meeting one time and they said, it's just
23 about impossible to automate a hospital's information
24 system, and then the same guy says, so what we'll do is the
25 country.
26 So physician order entry, just a caution. There's
27 a paper you might have gotten and just be careful about it.

1 There's very little experience with non-full-time MDs,
2 whether it's in an office practice where they're just there
3 all the time. Most prescribing safety benefits can be
4 obtained through other mechanisms. If you're talking about
5 drug interactions, the pharmacy systems can check that.
6 Handwriting has not been a safety problem in any formal
7 study. If there's anecdotes about it. The problem of
8 handwriting, it makes pharmacists call back on 30 percent of
9 the prescriptions. So it's an economic problem.
10 Other routes exist for delivering decision
11 support. We'll be publishing a study in a couple weeks
12 using nurse standing orders; very powerful, and it's easier
13 on everybody. And computer systems cause their own errors.
14 There was a report last year, the pharmacy industry says
15 that 8 percent of the input goes in wrong in computer
16 pharmacies. We're not measuring that side. We should be
17 looking for that's so we can fix it, because we can make it
18 perfect. But it's probably not going to be perfect going
19 out.
20 I've heard a couple of bad stories where the error
21 rates are just to the sky because you go down one line and
22 you're picking the wrong -- it's a perfect looking order.
23 It's the wrong patient. You just got off by one on the
24 mouse. So we don't want to do a Vioxx on this stuff, so be
25 careful.
26 E-prescribing. You've got a lot of great
27 potential but they aren't helping the physician much with

1 this. It's going to help the pharmacies tremendously.
2 Pharmacies collectively know all the medications they get,
3 and the physicians would love to know that. So they have to
4 first type in all the prescriptions they think the patient
5 is on, and they would love to know what else the patient it
6 getting, because those are the things that really cause
7 harm. That's not being designed into this. There's no
8 mechanisms currently to make them connect across.
9 There's no standard link -- this other problem is
10 these special formularies that everybody has got. You've
11 got to go, here's the drug, you give it to the patient. Oh,
12 it's going to cost $50. They call back. It's a mess, and
13 you cannot figure it out. It's impossible. You get these
14 books and these little -- every week you get another one and
15 it's all paper. There are a couple companies now that have
16 them electronically but there's not a standard link between
17 the plan and the formulary, so you can't automate this yet.
18 It's just for want of a nail, we could almost do this.
19 What CMS can do. Two things to think about. Make
20 Medicare data available to EMRs. Use it as the feed to
21 EMRs. It's administrative data. People complain. But it
22 tells you the procedures done. There's a lot of history in
23 there. So think about that. Also for clinical and value
24 research purposes.
25 Don't balkanize the prescription data and the Part
26 D. I'm hearing rumors that's what's going to happen, that
27 it's going to stay back in these various places. It's not

1 going to come to a central place. We're done with people
2 over 65. We've got all the data we need. We've got half of
3 it if we just had the Medicare data plus the prescription
4 data. And allow combines of Medicare and Medicaid for
5 research. We have a very advanced thinking Medicaid
6 organization in Indiana and they're now terrified that
7 they're not going to get the prescription data they're now
8 using for managing cost because of the dual cover because of
9 the new plans with Medicare.
10 I think that's all. Thank you.
11 MR. HACKBARTH: Excellent. Very helpful, thought
12 provoking. Some questions or comments from commissioners?
13 If not, I have a couple.
14 The way we've been thinking about this issue to
15 this point, the framework if you will, is a few basics or
16 crude categories. One is development of standards so that
17 as systems do develop there is the capability to share
18 information across delivery organizations.
19 A second category, for lack of a better term, is
20 market development. We've heard a lot about how difficult
21 it is to navigate this marketplace if you are a provider
22 considering making the investment in clinical IT.
23 Then the third is economic incentives of various
24 types, ranging on the one end from capital assistance,
25 loans, grants, to various types of pay-for-performance, the
26 most basic form being paying for clinical outcomes, good
27 results as Dr. Walker was talking about. But also there

1 have been proposals or ideas presented about, short of that,
2 paying for capabilities, the development of the capability,
3 per se. This is where I want to ask Dr. Walker a question.
4 You were quite explicit in saying, just having a
5 system is not what we're after. What we're after is the
6 good result, and that requires not just information but
7 acting on the information to produce better results for
8 patients, which makes eminent good sense.
9 On the other hand, one the problems that we face
10 as we look at the pay-for-performance area is that our
11 ability to develop and operationalize new measures of
12 performance is at least in part dependent on the
13 availability of information, particularly information at a
14 reasonable cost. So there's a bit of circularity here, and
15 I think that's part of the appeal of not just depending on
16 paying for performance as the way to drive the development
17 of clinical IT. I'd welcome your reaction to that or the
18 other panelists as well.
19 DR. WALKER: My concern is that developing a
20 system that helps us to deliver flawless performance and
21 then report it efficiently is complex. It seems to me that
22 if we were responsible for getting DVT prophylaxis done on
23 all patients that needed it, and someone like you, someone
24 needs to help with some kind of consumer reports function so
25 that people that don't have expert knowledge, which is
26 practically all of us, would be able to look at systems and
27 see a rating, how well they do with helping you that

1 effective reminders to do pneumovaxes, and how good is their
2 reporting module? Does it come with the standard report?
3 That would be one of the points of having a single standard
4 dataset. Does this system automatically produce that
5 standard dataset for you?
6 It seems to me we'll be a lot better off if what
7 we have is health care organizations who know what the
8 requirements are and who get help buying a product that can
9 help them do that than if we try to define a product,
10 because then you get into all sorts of gaming basically.
11 You'll be in the situation of now we've got an EHR but we
12 have to prove to you that it's a good enough EHR, and it has
13 these 44 criteria. It seems to me that we will get into a
14 regulatory and definitional quagmire.
15 Whereas if you say, there's 439 RAND and so forth
16 and you're responsible to get this many of them done and
17 we'll just pay you for every one of these you accomplish,
18 then organizations will have powerful incentives. As long
19 as they have clear help making a choice I think it will work
20 better.
21 DR. McDONALD: I think the situation and the case
22 is quite different for large organizations and small
23 offices. Large organizations are going as fast as they can,
24 best I can tell. So you're going to have it whether you pay
25 for it or not. I don't want to take any money away from
26 large organizations, but they have enough critical mass that
27 they can actually do it and have enough information that

1 it's worth making this big critter.

2 I want to come back to the smaller organizations.
3 The problem is they're talking to each other a lot. It's
4 like telephones, unless everybody has one, it's not much
5 good. I think also there's this current effort to define
6 the functional EHR, which I think is goofy. There's never
7 been a technical standard ever done that way. You'll be
8 getting into all kinds of quagmire; I got it, you don't have
9 it or something like that.

10 But I think what you could do is you could count
11 data that they've gotten electronically and is available
12 electronically, which would be the infrastructure for it.
13 So if they're using an outside lab, you incent both of them.
14 Because the labs do weird things and make it hard to capture
15 that data. If they just had a little incentive, that they
16 don't get that extra increment unless they send it in a way
17 a guy could catch it. So you can't have one hand clapping.

18 We've got to keep thinking of where this comes
19 from, and keep thinking about the road between them while we
20 do it. I think if you want to get the clinical data in the
21 small offices you've got to incent the people who send it so
22 that they have to send it in a way the guy can catch it and
23 put it in his system. Then you can incent the guy that
24 catches it too. But he can't catch it if they don't send it
25 to him well, no matter how hard he tries.

26 MR. MULLER: I'd like to thank you. Those are
27 fascinating and certainly among the fastest presentations

1 we've ever heard. Just trying to take it all in, I was
2 reeling, in terms of what Dr. Omura said in terms of the
3 small group, and then what Dr. Walker talked about, a larger
4 group, and then what Dr. McDonald talked about, about a
5 regional group.
6 Give us a little sense of the public good to
7 Medicare. Obviously, as you said, a lot of the larger
8 groups may be doing this out of their own self-interest.
9 What's the good we get by having regional solutions versus
10 provider-specific investments and solutions such as this?
11 We can all infer from what you said in western Colorado with
12 your small primary care group and then obviously at
13 Geisinger, but what level of add-on or benefit do we get by
14 having solutions that go beyond the specific providers,
15 these regional cooperative efforts?
16 DR. McDONALD: We have this mythical thing where
17 we exist in our office all by ourselves. His 5/30 practice,
18 that's not so small anymore. The one and two-office
19 practice, half their information is coming from somewhere
20 else. They're getting it from the consultant, they're
21 getting it from the hospital, they're getting it from the
22 nursing home and it's a mess as it comes in; envelopes and
23 you have to unfold it. So the regional thing isn't a
24 competitor for the one in the office, but it's just a way to
25 consciously face up to the fact, this is a connectionist
26 world in small offices. A big organization still has stuff
27 come in, but they have an awful lot they make themselves.

1 DR. WALKER: One of the real challenges, one of
2 the places that patients suffer the most is the interface
3 between outpatient and inpatient. So the patient comes to
4 the hospital, you have a medicine list but it's not clear to
5 you as you're admitting the patient what all those medicines
6 are for. It may not be exactly the right medicine for heart
7 failure but it may be particularly appropriate because the
8 patient couldn't tolerate the right medicine.
9 Then when the patient is discharged you've almost
10 always stopped some of the medicines they were on when they
11 came in, started new ones, and then often you just forget to
12 stop things that you should, like the stomach protector that
13 you gave just in case. So the patient comes back to the
14 outpatient doctor on this stomach protector that actually
15 has no reason and as a doctor I say, I can't get anything
16 out of you in terms of a history or there's nothing I can
17 tell that this is four, but I'm really scared to stop it.
18 And I can't tell why you messed up my heart failure regimen
19 that I spent eight months putting together.
20 So part of the regionalization is that we would
21 make it easy for outpatient doctors to see the hospital
22 record, for hospital admitting doctors to see the outpatient
23 record, so that we decrease both the inefficiencies but also
24 the real patient suffering that goes on because of those
25 disjunctures.
26 DR. OMURA: I think we definitely have to go
27 beyond the office-based medical records system and my

1 feeling is it needs to be the community. In our location
2 we're talking about the entire community. In a huge city
3 you'd have to define the community in a different way. But
4 there's a lot of interaction that goes on between patients,
5 consultants, and hospital that you would do well to try to
6 coordinate in a system.

7 MR. MULLER: Let me follow up on that. I can
8 certainly see the advantage of getting the information about
9 patients from all possible sources, whether it's inpatient,
10 outpatient, pharmaceutical and so forth. Both Dr. Walker
11 and Dr. Omura talked about the necessity of having the right
12 culture and organizational commitment to get these things
13 done. They don't just happen randomly. You have people who
14 are really driving it.

15 Therefore getting this time, and whether it's a
16 smaller primary care group or a larger system, I can see is
17 reasonably hard to do. So when you start thinking about
18 doing it in a bigger geography where you have five systems,
19 I could see it gets more complex. So what I'm really asking
20 is, is the desire to get the whole system, say in
21 Indianapolis, working together and, obviously, you've been
22 working at this for 34 years and you're legend around the
23 country, but does it become so much harder to do if we start
24 asking people beyond an organizational grouping such as
25 Geisinger and your primary care group?

26 DR. McDONALD: We're talking about different
27 tasks. The real hard one almost invariably involves data

1 input by people who haven't been data inputters. That is
2 where you're really retreading the whole process of an
3 organization. a get interested in right-of-way you're
4 physician order entry, putting notes in a chart. The
5 regional is not talking that. We're just saying, if you get
6 a note -- dictation is the common way -- you send it.
7 That's not hard. There's political and there's glitchy
8 things in it, but it really isn't hard.
9 So the repository is way easier than the order
10 entry side of it and the note entry side of it. When we're
11 talking about the regional we're talking principally about
12 repository functions. Delivering the information that's
13 sitting in somebody's computer in a form that can be
14 organized in somebody else's computer or on the screen.
15 MR. BERTKO: I'd just like to change the topic
16 slightly and connect maybe two dots here in the context of
17 whether MedPAC makes comments on EMRs. Part D data is
18 coming up 1/1/06. CMS has asked in the draft regs what
19 people think about having either a single repository for
20 Part D data -- that is, one entity or some jointly-owned or
21 contracted entity or individuals -- and perhaps the panel
22 would like to comment. I've had my own impressions of what
23 would work best, but there needs in this case to be some
24 real or near realtime exchange of data for people who change
25 health plans and perhaps it would be also helpful for these
26 purposes.
27 MR. HACKBARTH: I think we know where Dr. McDonald

1 stands on that.

2 DR. McDONALD: If you don't have it as central

3 we're screwed. You may just start out having it centralized

4 and using it for outcomes research or for the kinds of

5 things CMS now uses its big database for. But there's

6 opportunity to very inexpensively deliver and be a fulcrum

7 for the repository functions in communities or whatever

8 else. Because the hard part is getting it in. You've got

9 the stuff. It's just sitting there, so take advantage of

10 it. The cost of data, the more ways you use it, the cheaper

11 the entry -- you distribute the costs across that entry.

12 Then also be careful about how you store it so you have some

13 way to hierarchicize the drugs. But that's easier.

14 DR. WALKER: I certainly agree.

15 DR. MILSTEIN: It's taken a long time to get part

16 way in Indianapolis to connectivity among all elements of

17 the delivery system. Beyond Medicare through its databases,

18 being a fulcrum for exchange, is there anything else that

19 CMS might do to speed this up? Because if we take -- how

20 many years did you say it's been since you started in

21 Indianapolis?

22 DR. McDONALD: We didn't start the citywide thing

23 back then. We wasted a lot of time writing our own database

24 system and other things.

25 DR. MILSTEIN: How long have you been exchanging

26 data in Indianapolis?

27 DR. McDONALD: For all three hospitals, since

1 1997.

2 DR. MILSTEIN: So in Indianapolis we're seven
3 years into it and we have X percent of the data being
4 exchanged. On a national basis, given the enormous value of
5 having the highway built, what might CMS do over and above
6 making its data available, such that the highway system is
7 built out rapidly rather than wait for every single
8 community to go through the same learning curve and delays
9 that the pioneers inevitably ran into?

10 DR. WALKER: One of the critical ones, one of the
11 things that we anticipate in our regional network that will
12 take the most work and be the hardest is just getting
13 laboratory results rationalized and communicable. If
14 laboratories did have incentives, requirements, whatever, to
15 transmit those signals in standard ways then the work that
16 we will put into doing our system would be probably 60
17 percent less than it will be. So that's a very important
18 way.

19 What Clem says is right, what doctors really need
20 is lab, rad, and pharm. If you give doctors laboratory
21 information, drug information and radiology information,
22 they can pretty much make up the rest. You've got 80
23 percent of the benefit. That's the way we're going to build
24 our network, is put in the things that are the easiest.
25 We're already providing remote radiology all across our
26 region. Put in those things that are easy for doctors
27 because they have obvious value. They're used to using the

1 information. This just makes it available and available
2 easily. That's certainly the way we're going and the
3 biggest thing that would help us.
4 DR. McDONALD: This is like manna from heaven, the
5 opportunity to say this. Laboratory integration is probably
6 10 times harder than radiology or notes or anything else
7 because there's 3,000 to 5,000 different tests, plus codes
8 underneath it. There is not built into the culture the idea
9 they have to do anything else but get a report that someone
10 can read out. Whether the units change on that test
11 tomorrow or not doesn't make a whit of difference.
12 There's about 10 things you could do which
13 wouldn't be that hard. You put the units in the units
14 field. You use units and you don't change them without
15 changing the codes, if it's a real meaningful thing. You
16 don't just takes globs of text and jam it into the field.
17 You could do five requirements and if you gave them another
18 2 percent when they shipped out electronically the practice
19 systems could pull this in, or a central repository. You
20 come out a lot of different ways. The hardest thing is
21 they're not in the game. We're talking the guys that
22 receive it, not the guys that send it.
23 DR. MILSTEIN: My next question is really specific
24 for Dr. Omura. You're just below the cutpoint where current
25 estimates suggest that it's economically feasible for
26 practices to do it. You shouldn't have succeeded. You
27 shouldn't have been able to get payback within two years

1 because you had a practice of five physicians or less.
2 You're just below the hypothetically cutpoint for this
3 making any sense for physicians.
4 Do you think that those estimates are overly
5 conservative? If given proper help -- I don't know what
6 that source of technical assistance would be, but given
7 proper help, based on your successful implementation what do
8 you think is the cutpoint for this to have positive payback
9 even in the current bankrupt payment environment for
10 physicians to put in place an EMR of the level of robustness
11 that you successfully implemented?
12 DR. OMURA: If there's no increased reimbursement
13 for performance and no other inducements, I would have to
14 agree that you'd in general need to be bigger than the size
15 that we were to start this project. I think we had the
16 mindset to do this. We picked a good program. We had the
17 initiative to make this work, and we had an environment that
18 was supportive. All those things put together make this
19 work out well.
20 But I've run into lots of offices that have had
21 problems at the four-doctor level, six-doctor or 10-doctor
22 level, so I think we're just a little unusual. I don't know
23 what that number is. I would say probably bigger than the
24 size we are now. I mentioned that are 30-doctor practice
25 now is having problems financially related to the EMR. So I
26 would say that you'd probably need to be bigger than that.
27 DR. WALKER: Just as a comment, we have

1 implemented practices with one doctor and one PA. So
2 clearly one model is to have an organization that has the
3 capability to do it and the incentives that provides it to
4 small practices on some other basis than direct cost.
5 MS. RAPHAEL: I just wanted to ask if you could
6 amplify the issue around immature software, because I'm not
7 sure I entirely understand what you're getting at?
8 DR. WALKER: The software, most of it was designed
9 and built 10 years ago or so and has structural,
10 architectural characteristics that make it hard -- for
11 instance, you could imagine a system in which when you
12 entered pneumonia on a patient you were admitting it offered
13 you a set of questions, because there's a validated set of
14 questions that you can very reliably predict whether a
15 patient should go home on oral antibiotics or go to the ICU.
16 So the system would ideally provide you those questions.
17 You'd answer them. It would calculate the risk and say,
18 this patient is safe to go home, and then give you the order
19 set, and here's the appropriate set of medicines for this
20 patient, pick one.
21 That whole process could be done in about one-
22 tenth the time and with 10 times the fidelity that it is
23 currently done. But the architecture of the systems doesn't
24 allow you to put together and end-to-end tool like that that
25 does a couple things. First it means you always capture the
26 right --
27 A better example perhaps is atrial fibrillation.

1 25 percent of Americans over 65 have atrial fibrillation.
2 You can calculate a patient's risk of having a stroke
3 percent per year. But in chart reviews that we've done of
4 100 patients, not a single patient had enough data in the
5 record that you could have calculated that risk. So you
6 have a situation where if you had this tool you could say to
7 a patient, your risk is 10 percent per year, your risk of
8 bleeding in your head if we put you on the blood thinner is
9 2 percent per year, what do you want to do?
10 Instead what we have is a set of rules. Talk
11 about cookbook medicine -- that says a-fib equals warfarin,
12 equals blood thinner and you get tested every four weeks for
13 the rest of your life whether you need it or not. So the
14 software doesn't let us build that kind of tool that makes
15 it so that physicians are reminded of that calculation aid
16 and then enabled to make it into a workflow that really
17 runs. There's a whole lot of examples like that.
18 DR. McDONALD: There's this optimism of the world
19 of new technology is always good or right. There's a great
20 book called Wicked Problems, Righteous Solutions and it's
21 about software design and technology. How it defines a
22 wicked problem is one that's never been solved before, and
23 two, one that might have been solved before but has a human
24 somewhere in the loop. Because you can never predict the
25 behavior of the humans.
26 We're introducing radical new changes for humans
27 in these system. So we don't know anything yet about how to

1 do this right. We are in an immature era. In medicine, in
2 '65 I was an intern and we knew everything. We knew
3 everything there was and I got skewered for accidentally --
4 I thought it made sense -- giving a patient who was having
5 chest pain and an early ischemia a nitroglycerin. That was
6 known to be completely wrong because they knew -- now we do
7 it routinely.
8 But in each era we still think we're perfect. We
9 don't remember we're just as stupid as we ever were, we just
10 haven't learned it yet. So we had that problems in the
11 software development area too. It's going to be 10, 15
12 years before we -- it's partly the architecture, it's partly
13 the technology can solve these things, partly understanding
14 what we're really trying to do with this stuff.
15 DR. WOLTER: I wish I could ask this as quickly as
16 you'll answer it, Dr. McDonald. I just wanted to see if I
17 understood what you did in Indianapolis. What I believe I
18 interpreted is that you created a data warehouse into which
19 a group of agreeable institutions put their data. So in
20 essence it's remotely hosted data at that point.
21 DR. McDONALD: Yes.
22 DR. WOLTER: Related to that I'm wondering how
23 issues around privacy and security have been dealt with in
24 terms of who accesses it, and how much of the information
25 they can access. I'm wondering if the vendors -- because
26 I'm assuming this meant interfacing legacy systems that were
27 somewhat disparate -- were the vendors cooperative, and how

1 difficult was that for you? Then lastly, were providers
2 able to agree on the format of looking at lab, and were labs
3 integrated by time, or were they all still in separate
4 places depending on when and where they'd been done?
5 DR. McDONALD: You described it well. The only
6 extra step is we standardized, so we did mapping for the
7 codes and the lab. The same thing that everyone is trying
8 to do. We are very nervous about how much we open this up,
9 and we've been very slow. So the access that's available to
10 physicians across the thing -- only ER physicians, only
11 after the patient is checked in to that ER, and then we
12 leave it open for only 24 hours. Our next step is for
13 hospitalists and full-time hospital physicians, an analogous
14 rule. We get these messages. We get all the ADT messages
15 so we can tell that.
16 Then for practices, the way we think we'll go is
17 that we need to get a hold of their scheduling system.
18 HIPAA would allow us to say, you're an authorized physician,
19 we'll give you a password, a strong password. We've got a
20 secure line to your place. Let anyone in town look it up.
21 But I don't think we're ready for that. It's
22 okay, but I think people will go, what are you doing? So
23 we're going to go very slowly and test the waters and make
24 sure we have acceptance in doing it, where we have a further
25 narrowing of who can look at it and what circumstances.
26 In terms of the vendors and the legacy system, any
27 system that really works is a legacy system, you have to

1 remember, because they never work out of the box. I'm
2 actually surprised that people do believe software is good
3 because everyone uses something on their desktop and it
4 crashes on an average about 10 times the day. I won't name
5 names.

6 So the vendors didn't have to do anything.
7 Everybody has HL7 messages, and they all have interchange
8 engines and they just turn them on. They're sending them
9 from here to here and they just send a stream to us over a
10 secure line. So that's the beauty of the HL7 version two.

11 We have a little pre-processor because there are
12 things that are goofy. We re-translate them into something
13 that is more standardized. Then there is the big problem of
14 the codes. So we have to sit and look, what you mean by
15 glucose? Is it urine glucose or it is serum glucose, or is
16 it a dipstick? We have a table. That's the hardest thing.

17 Then the other hard part is they send us stuff
18 that isn't really where it belongs. It's not a problem of
19 sophisticated stuff. It says milligrams percent. That's a
20 unit to almost everybody's eyes. And there's a field called
21 units. But it's over somewhere else. It's usually in the
22 value field when they do it wrong.

23 I think Medicare could make the right. They just
24 love a couple mls per -- you give them another 10 mls on
25 each of their lab tests for sending it out right, I think
26 you'd end up with very fast compliance.

27 I don't think I answered -- oh, the

1 standardization. We really have two threads. The data that
2 we do the code standards, that see it as a flow sheet. It's
3 merged together. Each result is flagged and there's a
4 footnote about the source if it's not from their hospital
5 where they are.

6 There's another mode where we are just sending
7 reports out to be filed in physicians' offices, and that we
8 did get formal agreement, so far, that they'll look like
9 this. The name will be up here, and the only difference
10 between each of the sites is they can have a logo. This is
11 St. X and this is St. Y. Actually they think that's
12 positive because their eyes will get habituated to where to
13 find things on the reports.

14 DR. CROSSON: This is a bit more of an observation
15 than a question but I would invite the presenters to comment
16 on it. First of all, congratulations on very fine
17 presentations. This has been very helpful, you can probably
18 tell from the conversation.

19 But getting back to the issue around incentives
20 and how incentives might be used to catalyze this kind of
21 change, I think it's clear to us that there is a change
22 curve here and that we've probably moved off -- you have
23 helped move the whole situation off of the flat part of the
24 curve where a lot of work goes on but not much change
25 happens, to a point where there are starting to be
26 inflections. The sense is that the change is going to
27 happen, and yet continued community-based, particularly

1 catalyzing of change is necessary.

2 So what I took away from the discussion was that
3 those kinds of initiatives that you each have engineered
4 need to still take place, but they can in fact take place at
5 different levels. The level of individual providers, the
6 level of institutional providers, and the level of the
7 community led by champions like Dr. McDonald and others.

8 So what that means to me is that in thinking about
9 incentives or creating incentives we have to do a couple of
10 things. We have to be very clear where we want it to go. I
11 think we've had instructions here that one place it needs to
12 go is something that allows the community to be connected.
13 Another place it needs to go is to make sure that the
14 systems are in face used to drive towards the availability
15 of information that actually improves patient care, for
16 example, improves resource utilization and the like. And
17 the clarification of those endpoints is important.

18 Secondly, that whatever is done, particularly in
19 the short term, stimulates others at every level to become
20 agents of change, and at least does not inhibit that at any
21 level. So I'd just invite --

22 DR. WALKER: I just want to comment very briefly.
23 Clem is right at one level, that large organizations like
24 ours are going to do EHRs. But it is a constant battle in
25 an organization like ours, and I assume all other
26 organizations like ours, to continue to make the case to
27 invest resource in really making EHR effective. It really

1 does continue to take very large resource. The model in
2 most organizations is you have an implementation team, and
3 when the implementation is done the team is disbanded.
4 What we are moving toward but could use some help
5 making the case for, even internally, is seeing that
6 implementation team as largely transferring over to a post-
7 implementation enhancement team. Using those trainers to
8 continue training, and using those analysts to go back and
9 revisit those workflows and make sure we really have made
10 them maximally efficient, maximally error proof. That is an
11 ongoing battle, and one of the reasons I would like to see
12 pay-for-performance is because that helps us make the case
13 to ourselves that what we have got to do is drive this EHR
14 home, not just say, okay, we've got it, now what's the next
15 thing on our corporate agenda.
16 DR. McDONALD: He's right. Actually one other
17 things in terms of big organizations. We started with the
18 hospitals because, they have the data. They've got a lot of
19 it, so there's a mother lode there. Secondly, they have
20 money. Office practices have no capital typically, because
21 they're sub-S's. They basically don't have any money to
22 make the investment, so there's a real challenge.
23 But I think the idea of the big -- certainly when
24 there's one big organization, facilitate them, let them be
25 the hub that provides the medical record. It gets tricky
26 because ideally the practice would like to put other stuff
27 in there, so there's technical trickiness to it, and there

1 might be political trickiness to it. But they really have
2 the power and the infrastructure to be able to deliver that.
3 It gets tricky, but do not inhibit that, because there is
4 this inurement thing that does inhibit it.
5 DR. OMURA: I feel that just having an EMR, I've
6 seen lots of offices that have an EMR and it makes their
7 day-to-day life a little bit easier but they're not
8 utilizing it to the fullest extent because it requires
9 staff, it requires meetings, it requires a lot of effort to
10 optimize outcomes, and there's not a lot of incentive in
11 that direction. So I would encourage movement toward pay-
12 for-performance.
13 We are part of a research network with our program
14 and we're one of about 100 offices across the country where
15 they're pulling data on a regular basis, once a month, to
16 look at laboratory results, blood pressure control rates and
17 things like that. So we actually have a system in place
18 that can look at, by doctor, what percentage of patients
19 have blood pressure in control, and what cholesterol levels
20 are, things of that nature.
21 The physician who is number one across the
22 country, no one knows who that person is and there's no
23 increased reimbursements or incentives for that person to be
24 number one. But I think movement in that direction to help
25 to reward those that are spending the most time and effort
26 to provide better patient care is worth considering.
27 DR. REISCHAUER: Let the thank you for three

1 really wonderful and interesting presentations. I certainly
2 agree with what the common conclusion here is, which is pay
3 for performance, don't pay for hardware, software, IT.
4 But what I'd like to probe a little more is the
5 notion that both Dr. Omura and Dr. Walker raised which is,
6 there is little economic incentive for groups or small
7 practices to go into this. Both of you said that and then
8 you provided, it struck me, a rather convincing case that
9 that wasn't true. Here we have the five-person office where
10 the choice was invest $200,000 in a new building and then
11 variable costs for the rest of time of a couple more
12 clerical employees. Both of these expenses you would not
13 get any increase in reimbursement for. Versus $120,000
14 which you're going to pay back in two years, which I don't
15 know what kind of other investments you make but I'll give
16 you my retirement funds to invest if that's your idea of not
17 a very good ROI.
18 Geisinger, you're basically capitated in a way.
19 DR. WALKER: We're not.
20 DR. REISCHAUER: You're paid per service?
21 DR. WALKER: About 30 percent of our patient
22 population is capitation, the other 70 percent is fee-for-
23 service.
24 DR. REISCHAUER: That's too bad, you're ruining my
25 argument. The argument being that you're talking about
26 reduced hospitalization, reduced drug use, reduced this, and
27 if your revenue stream stays the same you're actually

1 getting quite a bit out of this. And Dr. Omura is getting
2 the quality bonuses, presumably, that are associated with
3 these payments.
4 So it strikes me that what we aren't doing is the
5 right comparison, which is what were your alternatives to
6 this? The alternatives in Dr. Omura's case was a bigger
7 building, and a lot more employees, and a lot of hassle, and
8 maybe no quality payment versus this. It might turn out
9 that this is really quite a sensible investment.
10 And in your situation it is conceivable that
11 Geisinger might have gone the way of some other institutions
12 in similar kinds of situations over the last decade, but the
13 quality that you showed your purchasers, which in no small
14 part was attributable to this, kept this group alive and
15 growing and really a model for the rest of the nation. So
16 it's really that versus the counterfactual that you should
17 be examining when you decide, does this make sense? It
18 strikes me that there's lots of other hurdles that small
19 groups have which keep them from doing this, but it isn't
20 necessarily the financial incentive one.
21 DR. WALKER: Our direct costs are about $50- to
22 $70 million at this point. We provide IT services at 70
23 percent of national benchmark costs. That's for 500,000
24 patients and 600 physicians. That's probably as close to as
25 good as you can do. That's direct costs. That isn't all of
26 the indirect costs.
27 We would do it again. We think it's the right

1 thing to do. We believe that within the next five years we
2 will actually see efficiencies that do start to measure up
3 against that cost. We don't think that you can provide
4 anything like high-quality health care without electronic
5 information systems, including an EHR.
6 But from a policy standpoint the issue is, how
7 sophisticated does an organization have to be? How smart
8 and passionate about business transformation does the CEO
9 and the CMO and others have to be? How optimized does your
10 governance structure have to be? And a lot of other
11 factors. How optimized does the situation have to be before
12 the organization can make the decision and then execute it?
13 You have got to remember, 30 to 60 percent of these projects
14 still fail. Cedars-Sinai spent $31 million and had to pull
15 it and has no plans for restarting it.
16 So I think the issue is, at the margins, how do
17 you make it easier for an organization that is not as
18 blessed as others with a number of those factors to make
19 this decision and then execute it? Which is equally
20 important.
21 But I grant what you're saying. The issue is
22 though is that nobody has done a credible ROI study on this
23 at all. Not even halfway credible. When I show benefits, I
24 call it benefits realization. I do not call it ROI, because
25 if you were a stockholder and I called it ROI, you would
26 laugh at me.
27 MR. HACKBARTH: Pete, last comment.

1 MR. DeBUSK: I certainly enjoyed your
2 presentations. Dr. Omura, I realize you're probably not a
3 part of an integrated health care system, but the other two,
4 are you part of an integrated health care system?
5 DR. WALKER: Yes.
6 DR. McDONALD: I don't know. I'm a university guy
7 so I don't know.
8 MR. DeBUSK: Does the hospital own you, the
9 university?
10 DR. McDONALD: No.
11 MR. DeBUSK: Does the university have a hospital?
12 DR. McDONALD: No, not anymore.
13 MR. DeBUSK: I was looking at it as being a part
14 of an integrated health care system, if we went back and
15 incentivized all the providers within the system to report
16 the data, through the payment system, then you'd have all
17 players, you'd have the complete system integrated. The
18 data would be reported from all providers. Dr. Walker, I
19 guess that would be the ideal world, right?
20 DR. WALKER: It would certainly have clear
21 advantages. For one thing, even in a well-governed
22 organization like ours where our 600 physicians are
23 employed, our physician leaders have EHR implementation
24 goals in their compensation plans and so do the physicians,
25 even in that setting it would change the discussion from, do
26 we have to do this to, why are you taking so much time
27 getting this in and getting me order sets and note templates

1 and things so I can start reporting these things and getting
2 paid?
3 MR. DeBUSK: On a national basis, with the
4 evolvement of the IHNs over the last 10 years, here is a
5 matrix that's probably a starting place where you could make
6 this thing work, where you could actually incentivize the
7 players. You've got to find someplace to start. You can't
8 start in that one-man office. There's no two ways about it.
9 But here you have got mass.
10 Anyhow, thank you.
11 MR. HACKBARTH: Thank you again. It was very well
12 done, very informative. Wish we had more time, but we
13 don't, alas. Thank you.
14 Because we are running a bit behind we're going to
15 need to keep moving here. We have a series of mandated
16 reports that we need to go through, beginning with the
17 report on physician volume.
18 DR. HAYES: Good afternoon. Dana and I are here
19 to review preliminary results for a report on growth in the
20 volume of physician services. The Congress asked for this
21 report in the Medicare Modernization Act, and based on our
22 discussion today we will proceed with drafting the complete
23 report which will be ready for the November meeting. The
24 report itself is due on December 8.
25 The specific requirements for this study are shown
26 on this next slide. The MMA begins with a request that we
27 address the extent to which growth in the volume of

1 physician services results in care that improves the health
2 and well-being of Medicare beneficiaries. It then goes on
3 to ask us to address certain factors affecting volume
4 growth.
5 First would be growth in three components that
6 make up CMS's definition of physician services. They are
7 the physician fee schedule, laboratory services, and Part B
8 drugs. That's outpatient laboratory services. The next
9 factor is changes in the demographics of the beneficiary
10 population. Next is Medicare beneficiaries, their volume
11 growth compared to other populations. Next we have coverage
12 decisions and the effects of new technology. And finally,
13 shifts in the site of care.
14 The law also asks us to evaluate whether CMS
15 adequately accounts for the impact of changes in law and
16 regulation on the sustainable growth rate. Recall that this
17 SGR is part of the formula that's used to update payment for
18 physician services and to control spending for those
19 services.
20 Today Dana will present results on the first two
21 factors affecting volume growth, the first two factors
22 listed here, the spending in those three components and
23 demographics characteristics of the beneficiary population.
24 We will present results on the other three factors at the
25 November meeting, and we will also explain what we have
26 learned about CMS's estimates of spending due to law and
27 regulations.

1 Before turning things over to Dana let me just
2 make a few points that we made in the paper for the meeting
3 about this matter of growth in volume and the health and
4 well-being of beneficiaries. For reasons that you are all
5 familiar with, we cannot definitively answer the question
6 about whether volume growth results in care that improves
7 health and well-being. Nonetheless, we are mindful of
8 research which suggests that greater volume is often not
9 associate with the improved outcomes.
10 The research that we are referring to here is that
11 done by John Wennberg, Elliott Fisher and others at
12 Dartmouth. For years they have studied volume growth,
13 volume of physician services and other services furnished to
14 Medicare beneficiaries, how that volume varies
15 geographically and how it correlates with measures of access
16 to care and quality of care. Much of the variation that
17 they have found centers around what they have termed as
18 supply-sensitive services, discretionary services such as
19 imaging, minor procedures, and tests.
20 One of the most important findings in their
21 research is that volume is often not associated with
22 improved outcomes. Indeed, in some cases outcomes are worse
23 when volume is greater. The other thing that they found in
24 working with the data, that it is possible, however, to
25 reveal more efficient providers by using the Medicare data.
26 So what we want to do going forward here is to
27 acknowledge this work in the report and to also address

1 other research that's related to care for Medicare
2 beneficiaries with chronic conditions. This is another
3 stream of research which has identified, in a lot of cases,
4 gaps between care delivered for these beneficiaries and the
5 care that's recommended. Just to illustrate, this would
6 include gaps in care for beneficiaries with diabetes and the
7 extent to which they are receiving things like eye exams and
8 monitoring of hemoglobin levels.
9 Other gaps in care that have been identified in
10 the literature have to do with monitoring care and providing
11 basic services for elderly beneficiaries. This would be
12 things like immunizations, screening and mammography. So if
13 we try to put these two streams of research together, in a
14 lot of cases it seems as if beneficiaries are not getting
15 quite the right mix of services, perhaps too much of some
16 services and not enough of others.
17 This then brings us to the question of whether
18 Medicare could become a more prudent purchaser to help try
19 to achieve a better balance in the services a beneficiary is
20 receiving. This is just a quick slide here which summarizes
21 topics that the Commission is working on in this area,
22 topics that you are very familiar with. You will be hearing
23 about paying for performance in the hospital sector
24 tomorrow. You know that in our workplan we have work on
25 physician pay-for-performance as well. This morning you
26 heard about provider profiling as another opportunity,
27 perhaps, for more prudent purchasing on the part of the

1 Medicare program.

2 So with that let me just turn things over to Dana.
3 She will discuss those first two topics starting with
4 changes in demographic characteristics of the beneficiary
5 population and then moving onto the three components of
6 spending.

7 MS. KELLEY: Demographic changes can affect growth
8 in service volume and resulting expenditure growth. Such
9 changes include growth in the number of beneficiaries, the
10 aging of the population, and shifts in the geographic
11 distribution of fee-for-service beneficiaries.

12 We looked first at growth in the number of
13 beneficiaries. Between 1999 and 2003, the total Medicare
14 population grew at a rate of about 1.2 percent per year.
15 Changes in beneficiary enrollment in Medicare+Choice
16 obviously affects the growth and composition of the fee-for-
17 service population. Between 1999 and 2003 managed care
18 enrollment among Medicare beneficiaries fell from 17 percent
19 of all beneficiaries to 13 percent. As a result, fee-for-
20 service enrollment grew about twice as fast as overall
21 enrollment, increasing about 2.4 percent per year.

22 Next we looked at aging. The aging of the
23 Medicare population is important, as you know, because older
24 beneficiaries are more costly to the program. This chart
25 shows that during the four-year period we looked at the
26 proportion of beneficiaries age 75 to 84 and those 85 and
27 older increased just slightly. You can barely see the

1 change in the green and the bottom gold bars. Beneficiaries
2 in the 65 to 74 age group, shown here in red, decreased as a
3 percentage of total fee-for-service enrollment. Again, a
4 very small change, from 43.3 percent to 42 percent.
5 Beginning in 2011 we'll this trend change as the baby-
6 boomers start to become eligible for Medicare.
7 Our analysis also found an increase in the
8 proportion of disabled beneficiaries. In addition, we
9 looked at changes in the proportion of male and female
10 beneficiaries and changes in the proportion of beneficiaries
11 who died in the given years. We found a very slight
12 increase in the proportion of male beneficiaries, which
13 would tend to increase expenditures, and a small decrease in
14 the proportion of fee-for-service beneficiaries who died,
15 which would tend to decrease total expenditures in a given
16 year.
17 Taken together, our analysis found that the net
18 effect of changes in beneficiary age, sex, and rate of death
19 is a decrease in spending on physician services, but the
20 decrease is very small. The effect on spending per
21 beneficiary during the time period was minus 0.1 percent per
22 year. So these changes explain very little of volume and
23 expenditure growth over the period that we looked at.
24 In addition to demographics, we also considered
25 the geographic distribution of fee-for-service
26 beneficiaries. This is important for two reasons. First,
27 some areas of the country have been shown to have higher

1 patterns of use than others. Secondly, Medicare's payment
2 rates for physician services are adjusted to account for
3 differences in input prices among geographic areas. So
4 expenditure growth could be affected by changes in the
5 distribution of fee-for-service beneficiaries across states,
6 whether due to change in beneficiary address or changes in
7 Medicare+Choice enrollment.
8 This chart shows the change in each state's
9 percentage of total fee-for-service enrollment. The purple
10 states saw an increase in their share of total fee-for-
11 service enrollment. For example, in 1999 6.4 percent of all
12 fee-for-service beneficiaries lived in Florida. In 2002, 7
13 percent of all fee-for-service beneficiaries resided there.
14 The four states experiencing the largest gains in
15 fee-for-service share, Florida, California, Texas, and
16 Arizona collectively represented about 20 percent of all
17 fee-for-service beneficiaries in 1990 and about 22 percent
18 of all fee-for-service beneficiaries in 2002. While no
19 state experienced a drop in the absolute number of fee-for-
20 service beneficiaries, many states experienced a decline in
21 their share of total enrollment. Those states are shown in
22 shades of yellow. The biggest declines were seen in New
23 York and Pennsylvania. New York had 6.7 percent of all fee-
24 for-service beneficiaries in 1999 and only 6.4 percent in
25 2002.
26 Overall, states with gains in fee-for-service
27 enrollment shares had higher average expenditures per

1 beneficiary than states with losses in enrollment share.
2 But spending per beneficiary was higher than average in the
3 two states with the largest losses in enrollment shares,
4 Pennsylvania and New York so the net effect of the
5 geographic shifts was very small. Our analysis shows that
6 because of these shifts, spending per beneficiary went up by
7 about 0.2 percent per year from 1999 to 2002.
8 So our analysis suggests that the only recent
9 demographic change that would be expected to have much
10 influence on fee-for-service volume and expenditure growth
11 is the rise in the number of fee-for-service beneficiaries.
12 We controlled for that rise and looked more closely, as
13 Congress asked us to, at trends in spending for services
14 factored into the SGR formula.
15 This chart shows Medicare spending per fee-for-
16 service beneficiary for physician services, outpatient lab
17 services and Part B drugs. Keep in mind that the SGR
18 formula excludes vaccines, immunosuppressive drugs, and
19 drugs used with DME, so those drugs are not included in this
20 analysis.
21 We found that Medicare expenditures for physician
22 and lab services and Part B drugs combined have increased
23 8.4 percent per year since 1999, climbing from $1,265 per
24 fee-for-service beneficiary to $1,749 in 2003. As you can
25 see in red here, per fee-for-service beneficiary spending
26 for Part B drugs has grown disproportionately over the
27 period, averaging almost 23 percent per year. As a result,

1 Part B drugs now account for almost 12 percent of the total
2 expenditures considered by the SGR, up from about 7 percent
3 in 1999.
4 Spending for Part B drugs has grown in part
5 because of expansions in Medicare coverage policies.
6 Congress has gradually increased the quantity, type, and
7 duration of drugs covered. Growth in expenditures is also
8 due to an overall increase in the volume of drugs being
9 used, and an important factor is the substitution of newer
10 and more expensive drugs for older therapies. Of the top 20
11 drugs covered by Medicare in 2001, seven received FDA
12 approval in 1996 or later.
13 Medicare's payment methodology for Part B drugs
14 has also played a critical role. Until recently, Medicare
15 set its payment rate for covered drugs at 95 percent of the
16 average wholesale price, which as you know, was not an
17 average nor the price usually paid by providers, but instead
18 was a manufacturer's suggested price. Actual prices paid by
19 providers often reflected substantial discounts. As a
20 result, Medicare's payments far exceeded provider
21 acquisition costs.
22 Further, the payment method created incentives for
23 a manufacturer to pursue market share by raising its AWP,
24 thereby increasing the spread between Medicare's payment and
25 providers' acquisition costs, resulting in greater profits
26 for providers who chose that product over competitors.
27 Recent payment policy changes are designed to rein in

1 spending for Part B drugs and change the perverse incentives
2 and projections for 2004 spending reflect that.
3 Finally, an increasing number of drugs are
4 produced through the use biotechnology, and use of these
5 drugs has also driven up costs. These products are
6 expensive when initially marketed and face limited
7 competition over time because the FDA has no approval
8 process for the generic versions of biologicals.
9 Despite the growing importance of Part B drug
10 spending, you can see here that increased spending for
11 physician services is really what's driving expenditure
12 growth. This chart shows the components of spending growth
13 between 1999 and 2004. The bars represent the annual
14 increase in per fee-for-service spending for physician and
15 lab services and Part B drugs combined. The first bar
16 represents an increase of 10.7 percent between 1999 and
17 2000. Growth in spending for physician services, which is
18 shown in green in the middle there, accounted for 82 percent
19 of the total increase.
20 Since 1999, the only point at which growth in
21 physician expenditures did not account for the lion's share
22 of spending growth for these SGR components was between 2001
23 and 2002. During that time period we had a negative update
24 for physician services, combined with a jump in drug
25 spending due in some part to reimbursement for the new drug
26 Aranesp.
27 What accounts for growth in physician

1 expenditures? Growth in service volume and intensity. We
2 controlled for changes in the number of fee-for-service
3 beneficiaries and found that volume and intensity increases
4 accounted for more than 80 percent of the growth in
5 physician spending between 1999 and 2002. A previous MedPAC
6 analysis examining growth in the use of physician services
7 over that same time period found a particularly high rate of
8 increase in use of imaging services such as MRIs and CT
9 scans, and use of tests such as cardiovascular stress tests
10 also grew rapidly during this period.

11 MedPAC also has found, as have other researchers,
12 the use of imaging services and diagnostic tests varies
13 widely across geographic areas. So some portion of the
14 change in service use over time probably represents overuse.
15 This is of concern not only because of its effect on
16 Medicare spending but also because, as Kevin pointed out,
17 greater use of services often is not associated with
18 improved outcomes. As you heard earlier, there's concern
19 among private plans about the proliferation and overuse of
20 imaging machines and other technologies and that's prompted
21 some plans to pursue purchasing strategies aimed at reducing
22 this growth in use.

23 So we'll have more for you on the mandated report
24 in November and we're happy to take any questions or
25 comments that you have in the meantime.

26 DR. MILSTEIN: The question as to whether or not
27 this reflects overuse as defined in health services research

1 or IOM parlance is a little bit problematic in that overuse
2 is defined as services for which there is evidence that if
3 the incremental service is provided it generates more
4 patient risk than likely benefit. And our list of such
5 rules for determining overuse is de minimis.
6 Most of the increased volume that we are
7 describing here would not, I don't think, fall into
8 evidence-based overuse. It would fall into the category of
9 services for which we don't have any kind of outcomes
10 information. Ergo, we don't really have much in the way of
11 evidence-based clinical guidelines. So they are essentially
12 non-value-added in terms of measurable impact on health
13 state incremental services, but they don't really violate
14 any so-called overuse guidelines, of which we don't have
15 many in this country.
16 So I just want to make the point that there is a
17 lot of evidence -- actually folks at Dartmouth keep telling
18 us that in geographies where more and more of these services
19 are being provided we're not getting much in the way of
20 population health gain, patient-perceived functional status
21 improvement, or patient satisfaction. But it wouldn't
22 technically fall into the overuse area. We just don't have
23 good rules.
24 Last comment is, one of the things I think you may
25 want to comment on if you had a chance to review it is,
26 there was an important article in Health Affairs in the
27 spring that actually by geography mapped the relationship

1 between Medicare areas with high service volume and the
2 degree of compliance with evidence-based quality rules
3 actually showing an inverse relationship. That is,
4 suggesting a so-called crowd-out phenomenon in which these
5 supply-sensitive services, which have not been shown to be
6 associated with any patient health gain, actually appear to
7 be crowding out evidence-based adherence to quality
8 guidelines.
9 DR. SCANLON: I would agree with Arnie in terms
10 that technically we can't demonstrate overuse, but I think
11 putting this into the context of the Dartmouth, if you could
12 talk about the fact that -- and this is a hypothesis -- that
13 areas where there has been demonstrated higher use and where
14 there's suspicion of overuse had similar growth rates as
15 areas that have low use to begin with. It's not that we're
16 having high use over this period of time, because the low
17 use areas are catching up. It's much more pervasive in
18 terms of growth everywhere, including the areas that we were
19 suspicious about to begin with and we would even be more
20 suspicious now that we see that they are continuing to grow.
21 MS. DePARLE: I was looking at the paper to see if
22 I could find this. Sheila and I were both a little puzzled
23 by the state chart that you showed. I just wanted to be
24 sure I understand this. Is the change in enrollment in fee-
25 for-service, do we think that's out-migration or do we think
26 those people went to Medicare+Choice or Medicare Advantage
27 plans in those states?

1 MS. KELLEY: It could be either.
2 MS. BURKE: So the New Yorkers could have moved to
3 Florida?
4 MS. KELLEY: They could have, yes.
5 MS. DePARLE: While I was sitting here trying to
6 figure that out, you made a point that I didn't follow but
7 sounded important. You said, as a result of all this we
8 think there was a 2 percent increase in fee-for-service?
9 Could you just restate it, because I missed it?
10 MS. KELLEY: The effect on spending, it was very
11 small, about two-tenths of a percent.
12 MS. DePARLE: Of the change in enrollment?
13 MS. KELLEY: No, of spending changes was due to
14 these geographic shifts.
15 MS. DePARLE: So it wasn't a very big --
16 MS. KELLEY: No, not at all.
17 DR. REISCHAUER: These are the percentages of
18 total Medicare enrollment, so for North Dakota to be
19 anything but white would be very difficult. The whole
20 Medicare population would have to move.
21 MS. BURKE: The question is, we're trying to
22 figure out what the calculation is. Are the percentage
23 shifts shown against the totality of Medicare fee-for-
24 service enrollment or against the base? For example, if it's
25 an indication of New York, is it against New York or is it
26 against the nation?
27 DR. HAYES: It's against the nation.

1 MS. BURKE: So what does that mean about New York?
2 DR. REISCHAUER: It doesn't tell you anything
3 about New York, but it answers the question they asked.
4 DR. MILLER: I think what we're trying to do here
5 is, first of all, there's a lot of geographic variation in
6 the levels of expenditure around the country. This has no
7 comment on that. You're looking at growth in volume per
8 beneficiary and you're trying to say to yourself, what kinds
9 of factors might be affecting that. So does the aging of
10 the population affect it?
11 Here what you're asking is, if beneficiaries re-
12 sorted themselves around the country and moved from a low
13 utilization state like Minnesota to a high utilization state
14 like Miami in Florida, did that have any effect on the
15 expenditures per beneficiary, and hence might explain this
16 growth in volume per beneficiary that we've seen over time?
17 What the map is saying is that -- we can quibble
18 over the metric but what it's saying is that as certain
19 states, say Florida, took more of the proportion of fee-for-
20 service enrollment over, did that have an effect on volume?
21 And the point they were trying to make is, because other
22 states went down, the net effect from this reshuffling of
23 beneficiaries around the states was very small, very small
24 positive, two-tenths of a percent.
25 MS. DePARLE: But if more people had moved from a
26 state with low practice patterns and volume and intensity
27 trends to one with higher, it doesn't answer that question,

1 does it, about what might have happened then?
2 DR. MILLER: I think it does.
3 MS. DePARLE: You think it says it wouldn't be
4 big?
5 DR. MILLER: If everybody moves --
6 MS. DePARLE: That's hard to believe.
7 DR. REISCHAUER: There aren't many people in North
8 Dakota, so with all due respect to those of you from there,
9 so even if they all moved to Miami it wouldn't shift much
10 Medicare spending in the aggregate. So that's what we're
11 asking.
12 MS. DePARLE: In the aggregate. But that doesn't
13 answer the question of what would have happened to those
14 individual people, whether their spending in a different
15 environment might have increased. One way or the other, you
16 don't know. But in the aggregate, I understand what you're
17 saying.
18 MS. BURKE: But we also don't really know from
19 this whether it is a question of out-migration or shifts in
20 delivery, payment systems. They could have all moved to
21 managed care or they could have all moved to Miami.
22 MR. HACKBARTH: I think Wennberg and colleagues,
23 their research would cause you to believe that if a
24 Minnesota beneficiary moves to Miami, that the supply-
25 sensitive portion of the care that they will start to
26 receive care like everybody else in Miami. Now if they
27 developed on the preference-sensitive part of the care

1 Minnesota attitudes about what they like in health care,
2 maybe that would move less.
3 MS. BURKE: But you don't know from this if they
4 moved to Miami. They could have just moved to Blue Cross as
5 compared to something else.
6 DR. WOLTER: I was just wondering if it would be
7 of any utility to look a the specific effects of, for
8 example, drugs and imaging one the SGR, and actually see
9 that even though you're showing that 80 percent-plus of the
10 overall effect comes out of physician services. Because it
11 may be that the ultimate policy solutions are to tackle
12 different issues here somewhat differently. In fact that
13 does seem to be happening already.
14 So in other words, how much is the drug
15 utilization part of the negative SGR predictions that we
16 have? It's possible there would be some utility to that.
17 DR. HAYES: As you know there are a number of
18 factors that are driving the SGR situation. Some of it has
19 to do with growth in the economy. There's just a lot that
20 goes into that calculation. It's possible to separate out
21 the effect of just drugs, but it's a complex task.
22 DR. WOLTER: Similarly, I don't know if this is
23 possible either, but if there is true geographic variation
24 and there's a concentration of that -- Dave is always
25 bringing up regional approaches, maybe for different reasons
26 -- but would we tackle approaches to this differently by
27 region if we had good evidence as to where this crowding out

1 is occurring? I don't know if that would be a tactic or
2 not. Then we also might look at winter versus summer
3 because I'm sure Montana and North Dakota are populating
4 many these areas in the winter.
5 DR. MILSTEIN: Has anyone examined the question of
6 whether or not as the rate of service growth has increased
7 in the Medicare fee-for-service population it appears to be
8 having detectable favorable effects on any measures of
9 quality of care? In other words, holding geographic
10 variation -- we know that the areas vary in what their basal
11 levels of service per Medicare beneficiary adjusted for
12 diagnosis, age and gender, we know what that starts.
13 So we have 50 runners. Each of those runners has
14 increased their service per Medicare beneficiary over a
15 period of time. Do we have any information about whether or
16 not that increased growth of services is favorably affecting
17 health, either overall or in the geographies that started
18 out lean, or in the geographies that have grown more quickly
19 or more slowly? In other words, what's the benefit to the
20 Medicare program, the Medicare beneficiaries, if any,
21 associated with these high rates of service growth?
22 DR. HAYES: I'm not aware of any work that has
23 looked specifically at that. The only pieces or research
24 that come to mind are the work that the Commission has done
25 just looking cross-sectionally at the relationship between
26 variation in spending and quality measures that were
27 published by Steve Jenks and others from CMS a few years

1 ago.

2 The other thing that comes to mind is the work,

3 also from Steve Jenks, which looked at the changes in these

4 measures over time and did see some improvement. But I'm

5 not aware of anyone going the next step that you are talking

6 about and trying to correlate the improvements with the

7 changes in spending and geographically. It would be an

8 interesting question, but I'm not aware of anything like

9 that.

10 MR. HACKBARTH: Anyone else?

11 Okay, thank you.

12 Next we have, actually the next two items are both

13 related to the issue of practice expense, both mandated

14 reports. The first one is the overall report on practice

15 expense that we took a first look at at our last meeting.

16 Then from there we will turn to the specific issue of

17 cardiothoracic surgeon practice expense.

18 MS. RAY: Good afternoon. Recall last month

19 Cristina and I presented results from our MMA mandated

20 study. The Congress in the MMA asked us to examine the

21 effect of implementing resource-based practice expense

22 payments on several factors that are listed on the slide,

23 RVUs and payment rates, access to care, and physicians'

24 willingness to care for beneficiaries. This study is due to

25 the Congress on December 8 of this year.

26 The draft report was included in your mailing

27 materials and the results in this report, the tables and the

1 figures are nearly identical to what was included in the
2 draft report that you reviewed for the September meeting.
3 So Cristina and I are here to get any final comments that
4 you may have about the report.
5 To briefly review our findings, our analysis shows
6 that the transition did, as expected, result in some
7 redistribution of practice expense RVUs and payments across
8 specialty types and types of services. This is what the
9 1998 CMS impact analysis predicted. Our analysis of data
10 also suggests that changes in volume do not seem to be
11 related to changes in the payment rate. Cristina presented
12 evidence last month from two national surveys and our review
13 of access to care from these surveys suggest that during the
14 transition period beneficiaries were not facing systematic
15 problems in obtaining, even for specialties experiencing the
16 largest decline in practice expense RVUs and payments due to
17 the transition.
18 Finally, we looked at assignment rates and they
19 remained high and relatively unchanged during the
20 transition, even for specialties experiencing the largest
21 decline in practice expense RVUs due to the transition.
22 The draft report concludes with a MedPAC workplan
23 outlining topics that we might consider taking on in the
24 future. We focused on two issues, updating the data and
25 updating the methods used to calculate practice expenses.
26 Here I just want to spend a moment talking about
27 the data sources used to derive the practice expense RVUs

1 and issues concerning updating them. With respect to the
2 SMS survey, those survey data were collected from 1995 to
3 1999. We did consult with the AMA and they have no plans at
4 this time to update the SMS data. So we laid out some
5 issues in the draft report concerning trying to update this
6 data source as well as trying to update the allocation data,
7 the CPEP data.
8 That concludes our presentation and we would be
9 happy to take any final comments you have on this study.
10 MR. HACKBARTH: Any questions, comments? We
11 discussed this at some length last time. So going once,
12 twice.
13 Thank you.
14 The next item on the agenda is the thoracic
15 surgeon practice expense mandated report. For those of you
16 in the audience, you'll see also listed for this agenda item
17 is the certified registered nurse first assistant study. In
18 the interest of time, we're not going to take that up again
19 today. We discussed it at great length last time. It will
20 be on the agenda at our November meeting for the final
21 discussion, but we're a little pressed for time today to go
22 into it.
23 So thoracic surgeons' practice expense.
24 MR. GLASS: This is a related, but smaller, topic
25 from the last one, so I don't think I'll be quite as short.
26 Here we're talking about cardiothoracic surgeons'
27 practice expense for the clinical staff they bring to the

1 hospitals. This was mandated in the MMA. We were asked to
2 determine if the practice expense RVUs for thoracic and
3 cardiac surgeons adequately take into account the cost of
4 surgeons providing clinical staff in the hospital. It's due
5 January 1st.
6 The background here is the RVUs for practice
7 expense, and Nancy talked about this last month, in 1994 CMS
8 was required to develop these resource-based expenses, as
9 opposed to the cost-based. The BBA of '97 required a four-
10 year phase-in, from '99 to '02. During that time, in 1999,
11 CMS decided to exclude the expenses associated with the
12 clinical staff physicians bring to the hospital. We're
13 going to talk a little bit about that decision.
14 First of all, who are the clinical staff at the
15 hospital, what are we talking about? These are people who
16 may assist in the operating room. They can provide pre- and
17 postoperative care. They could be physician's assistants,
18 surgical technologists, nurse practitioners, CRNFAs and
19 others. Some of those people are going to be eligible for
20 separate payments and some are not, as we discussed last
21 month.
22 Of course, some of these services can be done,
23 such as surgical first assistant, could be done by
24 physicians, including residents. And we're talking about
25 here the non-physician practitioners or what's called the
26 clinical staff.
27 CMS made this decision to exclude in 1999 the cost

1 of these people for purposes of computing practice expenses.
2 The CMS position at that time was that Medicare should not
3 pay twice for the same service. Some of these people are
4 paid separately, the physician assistants, nurse
5 practitioners and clinical nurse specialists. They're paid
6 separately for surgical first assisting but not for anything
7 else. So if Medicare pays directly for these people, then
8 why pay the surgeons to pay them also, which essentially is
9 what it means to include them in the practice expense.
10 So they said, we shouldn't pay twice for those
11 people. And if they're doing nursing, that duplicates the
12 nursing that's in the payment to the hospital, or the
13 facility. So if the hospital is responsible for it and
14 being paid for it, why should we pay for it twice?
15 And if there somebody for the physician and we're
16 talking about doing things like physician services such as
17 pulling chest tubes or other postoperative sort of things,
18 that's already been paid for in the physician work RVUs. So
19 again, no reason for Medicare to pay for it twice.
20 But it also said it wasn't typical for most
21 specialties. Said it only happened about 11 percent of the
22 time. And finally they made the argument that it's
23 inconsistent with law and regulation that all the Part B
24 payments for hospitalized beneficiaries that are allowed are
25 for services provided by physicians and specified first
26 assistants, and no other charges are allowed. And this
27 would be essentially allowing another charge. So those were

1 the reasons CMS gave to exclude these costs from the
2 practice expense.
3 HHS IG was asked to study this issue and they did
4 a study in 2002 on cardiothoracic surgeons, clinical staff
5 and hospitals. And they used a survey to come up with their
6 findings. They found that 75 percent of cardiothoracic
7 surgeons do bring clinical staff to the hospital. So
8 although this may be uncommon for specialties in general it
9 was, in fact, the norm for cardiothoracic surgeons.
10 But they did agree with CMS that this was already
11 being paid for. They are either paying directly for them to
12 the hospital or as part of physician work RVUs.
13 I have one other finding of interest is that 19
14 percent of the time the hospitals decided to reimburse the
15 surgeons for the clinical staff they brought with them.
16 They can do that only to the extent of the market price for
17 the time of the staff, so it isn't a kickback or anything
18 like that.
19 So they're limited in what they can reimburse but
20 they're only, in fact, doing it 19 percent of the time and
21 that's kind of an interesting existence proof that it can be
22 done.
23 Also, our analysis then was that if separately
24 billable staff or hospital reimburses, then Medicare
25 wouldn't want to include it in the practice expense because
26 the surgeons' cost is being offset. And it may not be
27 offset 100 percent, it could be less, it could even be more.

1 But the basic gross cost, so to speak, shouldn't be in the
2 practice expense.
3 There are other possibilities that exist if they
4 are not being reimbursed directly. For instance, bringing
5 these clinical staff could increase the surgeons
6 productivity. But in that case, the surgeon could offset
7 the cost because his work RVUs, if you will, are being set
8 to the average and if he can increase productively below
9 that by use of clinical staff, presumably he's doing that in
10 a way that essentially makes him some money and that he can
11 therefore offset the cost that way.
12 If bringing clinical staff improves the quality,
13 Medicare may want to recognize that. We went on a site
14 visit to see who these clinical staff were, what they do,
15 and that sort of thing. One of the things that the surgeons
16 were bringing clinical staff to do was endoscopic vein
17 harvesting for bypasses. They said that, in their view,
18 this increased the quality of the operation and cut down on
19 the infections and complications, allowed the patient to
20 ambulate quicker. So they thought it improved quality.
21 That maybe something that Medicare would want to recognize,
22 the costs of bringing some clinical staff in the practice
23 expense.
24 And finally, it could be that the physician just
25 prefers to have these staff with them. That happened about
26 30 percent of the time, according to the IG survey, and it's
27 not clear that Medicare would want to offset the cost.

1 So in sum, simply including all the cost of all
2 clinical staff and the practice expense cost doesn't seem to
3 be warranted.
4 However, of course, there are some complications.
5 We've identified these two issues. One was an issue of
6 equity really. Should the cost of separately billable staff
7 in physicians' offices also be excluded from practice
8 expense just as the ones who are brought to the hospital
9 area? Some of the clinical staff in the office, such as
10 physician assistants, nurse practitioners and clinical
11 nurse specialists, can bill separately for services they
12 provide in the physician's office. They get paid 85 percent
13 of the fee schedule for some things and 100 percent for
14 others if it's incident to.
15 And conceptually, you'd want to offset the cost of
16 employing them by the revenue that they derive from separate
17 payments. But that was not done when they completed the
18 practice expense RVUs.
19 Another issue is kind of technical, and I'm sure
20 you all memorized Nancy's explanations of how these PE RVUs
21 were derived, but to review just briefly they used an AMA
22 survey to come up with a clinical staff pool for each
23 specialty. But there was no data on how much of the
24 clinical staff pool were people in the office and how much
25 were people that they brought to the hospital with them.
26 So this raises the question did the way that CMS
27 removed the clinical staff result in appropriate RVUs for

1 all the procedures. What happened was they had this big
2 pool of expenses. And then they had the panels, which
3 included physicians, come up with kind of clinical level
4 staff for procedures, by procedure, estimates for each
5 specialty. And then they allocated the dollars that were in
6 this pool to each of those procedures. That's the point
7 where CMS took out the clinical staff that were brought to
8 the hospital, their expenses.
9 The problem is that left the pool that you
10 originally started with still too big. And that too big
11 pool was then reallocated among procedures.
12 The result of that is it drove up payment for
13 office-based procedures and some of those procedures that
14 were common with other specialties. So then they got
15 averaged down in the RVU process.
16 So the question is it's not obvious and certainly
17 not direct that this was an ideal way to do it. It's not
18 clear that the results in good or bad RVUs or payments but
19 it's so indirect that we think it may be something to be
20 looked into.
21 The redistribution expected though was, as Nancy
22 said, from some of these major procedures to office-based.
23 The conclusion for all of this is that the
24 practice expense RVUs do not include the cost of clinical
25 staff brought to the hospital. Congress asked us do they
26 account for those costs. The answer is yes because because
27 the cost that should be accounted for are generally zero, so

1 it's appropriate that they don't. But we do think that
2 there may be better ways to remove those costs. To do that
3 you need data to offset the separately payable staff in both
4 the office and the hospital and to reestimate the pools and
5 that sort of thing.

6 This could be made part of the next review of the
7 practice expense RVUs that Nancy was talking about in some
8 of the next steps we'd like to see. But probably you
9 wouldn't want to re-examine all of that for just this
10 reason.

11 The other question is could you address quality
12 somehow, because we did say that the one time you might be
13 interested in this is if the clinical staff were leading to
14 increased quality. Again, we think quality could be
15 addressed through a combined payment approach. We discussed
16 some of that last time. It's conceptually attractive. It
17 gets you to quality outcomes and improved care coordination.
18

19 We think it may be particularly appropriate for
20 this cardiothoracic surgery question. We say that because
21 it was used for the heart bypass demonstration. And then
22 that demonstration, the global rate for all physician
23 payments and hospital payments for two heart bypass DRGs,
24 they put a global payment for each of those DRGs together.
25 It turned out it saved money, led to lower costs in the
26 hospitals, and the perception at least was of improved
27 quality.

1 As noted in the paper, some hospitals actually
2 shared the savings with the physicians from that
3 demonstration. One of the ways they did it was one of them
4 converted physician employees to hospital employees, which
5 is very close to what we're talking about here. This may be
6 a good test case for that.
7 So that's about it. We'd appreciate comments on
8 the issue paper that you saw and anything else you would
9 like to us to include in our letter report to Congress
10 MR. HACKBARTH: David, I know the review of the
11 practice expense is a five-year cycle. When is the next
12 one? Where are we in that cycle?
13 MR. GLASS: I have to ask Nancy. Nancy left.
14 Kevin, do you know?
15 DR. HAYES: 2007.
16 DR. SCANLON: I think we have two different
17 considerations that we need to focus on here. First of all,
18 there's the issue of being consistent in how practice
19 expense or relative values are being set. On that one,
20 actually the first time that HCFA did that, back in the mid-
21 90s, there was some controversy because in some ways the
22 excluded certain expenses that they didn't think were
23 necessarily appropriate. The message that appeared to come
24 from the Congress was we want you to allocate what the
25 expenses actually are and pay on the basis of what the
26 expenses actually are, rather than some concept of what
27 expenses should be.

1 And so HCFA then went back and redid this process,
2 eliminated some of these what you might call edits that were
3 throwing off expenses. But this edit, so to speak, was left
4 in.
5 The big issue, in terms of whether it should have
6 been left in under this system of we're going to allocate
7 actual expenses, I think, is the question of is this typical
8 for a cardiothoracic surgeon to bring a nurse to a hospital?
9 And if it is, then the relative values are supposed to
10 reflect typical services. Then this is something we should
11 pay for through the practice expense. And if we want to
12 avoid double payment, we need to adjust the hospital payment
13 potentially, as well as the work component. If the work
14 component was set up originally based upon the assumption
15 that the thoracic surgeon is not assisted by a nurse, then
16 it's inappropriate.
17 That's the kind of discussion we should be having,
18 which is that we do this consistent with the rules and we
19 look at these other things and we see whether or not we need
20 to adjust them.
21 That's one path. The other path is to reopen this
22 issue of Medicare should be concerned about efficient
23 delivery of services and we should be thinking about, not
24 just for thoracic surgeons, but potentially more probably
25 the question of if we only validate what is out there in
26 terms of the fees, is that the appropriate thing to do?
27 But that's a very much bigger question that this

1 one. This one I think we've got to considered it in terms
2 of the context. And having been back there and having to do
3 the work on the report that you've got the diagram and
4 practice expense in there, there was a clear message from
5 Congress about what they wanted with respect to price
6 expense relative values. I think that under that set of
7 rules, in some ways, these should be recognized but we need
8 to avoid double payment.

9 We also need to be conscious of this idea that
10 there can be billing by other professions and we have to ask
11 what do we want to do about that so we don't end up paying
12 twice.

13 MR. HACKBARTH: Let me ask a question about that.
14 You're saying Congress spoke clearly that they wanted the
15 practice expense allocation to reflect what is, not
16 somebody's notion of what should be. Then why are they
17 asking us now what we think about this method? I assume
18 that they're asking us because they want our opinion about
19 whether this is the right way to do it, not whether CMS is
20 adhering to their legislative mandate to do it the other
21 way.

22 DR. SCANLON: I interpret the question that they
23 are asking us whether or not they are adhering to the
24 mandate. Because what has happened is that the thoracic
25 surgeon --

26 MR. HACKBARTH: Is that anywhere in the mandate?
27 What's the language? They asked us do we think this is an

1 appropriate way to do it? Or do they ask us whether it
2 adheres to Section -- could you read it to us, David?
3 The reason I ask that, though, is I think the
4 answer to the question did they do it the way practice
5 exists, it's a pretty obvious question. They don't need us
6 to analyze that. Clearly, they did not do it in accordance
7 with the way practice is currently organized.
8 And then CMS said we didn't do it that way for
9 these four reasons. I thought the issue that is in front of
10 us is were CMS's reasons good ones.
11 David, what's the language?
12 DR. BERNSTEIN: Medicare Payment Advisory
13 Commission, in this section referred to as the Commission,
14 shall conduct a study on the practice expense relative
15 values established by the Secretary of Health and Human
16 Services under the Medicare Physician Fee Schedule under
17 Section 1848 of the Social Security Act for physicians in
18 the specialities of thoracic and cardiac surgery to
19 determine whether such values adequately take into account
20 the attendant costs that such physicians incur in providing
21 clinical staff for patient care in hospitals.
22 DR. SCANLON: I interpret the idea of adequacy as
23 opposed to appropriateness as saying are they doing what we
24 asked them to do? Because basically over the years the
25 thoracic surgeons have said this deserves to be included.
26 This is our typical experience, which is the criterion for
27 the fee schedule.

1 And CMS has come back, even after the HHS IG
2 study, and said we're not going to include this. And so the
3 Congress, in some respects, I think is asking us to be an
4 arbitrator.
5 MR. HACKBARTH: On the face of the CMS reg, they
6 are basically saying no, we are not adjusting the practice
7 expense to reflect the actual costs. We are doing offsets
8 to reflect the way we think it ought to be so it's
9 compatible with the hospital payment system. So there's
10 really no dispute there. The issue is is this
11 inappropriate.
12 MR. GLASS: And they took out the cost of clinical
13 staff brought to the hospital for everyone, for all
14 surgeons, not just cardiothoracic surgeons but for everyone,
15 just to clarify that. But yes, I guess we interpreted
16 adequacy as should they be in there.
17 DR. REISCHAUER: What is adequacy? If the
18 situation is going along the way it is and 75 percent of
19 them are using them; right? Isn't that, by definition,
20 adequate?
21 DR. SCANLON: I guess my sense here was the
22 consistent application of the rules. And that this was an
23 inconsistency. We got into these on a number of different
24 occasions while we had to do work on the Part B drugs and
25 the overpayments in the Part B drugs. And we linked that
26 work to what was happening with respect to oncology payment
27 and talked about the underpayment there, again because of an

1 inconsistency in how practice expenses were being
2 calculated.
3 From the perspective that we had at GAO, at least,
4 was here's the set of instructions that came from the
5 Congress and were they being faithfully implemented and
6 pointing out when we felt that they weren't.
7 This was one of those cases where I think that
8 they may not being faithfully implemented. It's an
9 immediate easy reaction to say we don't want to pay twice
10 for the service. But then the question is if we're going to
11 try to avoid that, what adjusts should we make?
12 That's why I'm saying that to just deal with what
13 the Congress said, it would be think about the work
14 component, think about the hospital payment. I have a whole
15 other avenue to go down, which to me is an appropriateness
16 sort of avenue, how should we pay for these services?
17 I think the idea that they took the clinical staff
18 out for all other surgeons, there's a question of can other
19 surgeons come in and make a case, saying this is the way we
20 typically do this service. Because that's the distinction.
21 If the IG study had shown that only 30 percent of thoracic
22 surgeons used an assistant that they brought in, there would
23 not be an issue here. Because then we would be consistent
24 with what the rules had been for setting up the practice
25 expense values.
26 MS. BURKE: I think Bill is exactly right and it's
27 certainly my recollection of where we were. I want to talk

1 for a moment in that vein, specifically about the text
2 because I think there is this bigger question and I want to
3 address specifically cardiothoracic and not the broader
4 context, but specifically in this instance where there is
5 historically a pattern of using services in this sense.
6 There is, on page three, this logic table. And
7 one of the things that struck me was, as Bill suggests, I
8 think we would all state affirmatively we have no interest
9 in paying twice for the same thing in any instance. I think
10 there are an interesting set of questions as to what is the
11 pattern of practice? To what extent do we want to encourage
12 separate billing for individuals? And to what extent are
13 there individuals who do this who are not able to
14 separately? There is an equity issue there.
15 But in this logic box, I was particularly stuck
16 and somewhat uncomfortable with the third bullet, which
17 suggests that essentially if it increases their productivity
18 so they can go out and make more money, then that's enough
19 answer, we don't have to pay for it. I'm not sure that's a
20 solution or an answer that I would want to propose as being
21 a reasonable one.
22 I think we ought to deal directly with the
23 question of is it a legitimate expense? How do we sort out
24 between the hospital side? Because what we have is a
25 strange scenario where, in some cases, the hospital bears
26 the cost, will pay the surgeon. In some cases, the
27 individual can separately bill. There are also individuals

1 who are not capable of billing. Does it make them any less
2 useful? I think there's a quality issue over time that
3 ought to be studied carefully about whether this is practice
4 that is appropriate and, in fact, results in better quality.
5 I vaguely recall, Nancy and I both do, that there
6 was a discussion around this. In fact, I believe the result
7 was that, in fact, it was effective and it was a useful
8 method of practice.
9 But I particularly am struck and am quite
10 uncomfortable with saying that it ought to be just a
11 question of well, they ought to be able to pay for it
12 because it lets them bill for more of them because they have
13 more time. I would sooner not have that as an answer to the
14 question.
15 But I do think, to Bill's point, there is this
16 complicated question of how do we separate out where it
17 ought to be paid for? If it ought to be paid for in both
18 scenarios, in the sense that either the hospital or the
19 physician, but it's a legitimate cost and we've got to
20 figure out how to parse those out. I don't think we can
21 simply say okay, if the hospital wants to pay for it fine,
22 we'll pay for it there. If the doc wants to pay for it
23 because they can bill separately, that's fine. But if they
24 fall in this netherland of neither the hospital nor billing
25 separately, does that make them illegitimate in terms of the
26 cost of the care? And I don't think it does. But I think
27 that's what this leads us do.

1 So I'm concerned about going down that track. But
2 I particularly am struck by that particular point. I don't
3 think it's something I would want to say.
4 MR. HACKBARTH: Would you address that?
5 MR. GLASS: The productivity one is kind of
6 interesting because the question is if the work RVUs are set
7 up at some point and they start using clinical staff to
8 increase their productivity, and the work RVUs to stay
9 constant, which in fact they did -- the work RVUs actually
10 have gone up for some of these things -- then is it paying
11 twice to pay them as part of practice expense for bringing
12 in these people that are then going to increase their
13 productivity without any change in --
14 MR. HACKBARTH: But in a basic sense, aren't all
15 of the staff there to increase physician productivity? So
16 the physician doesn't have to answer the phone, so the
17 physician doesn't have to keep the books. They're all there
18 to increase physician productivity.
19 MR. GLASS: I guess the question is the change.
20 MS. BURKE: But we pay for them. It's like a good
21 circulating room nurse will increase productivity, but it
22 doesn't mean we don't pay for her, that somehow she gets
23 paid for because they are able to do more surgeries. That
24 doesn't make sense. Either it is a legitimate cost or it's
25 not. If it is, then we find a way to pay for it. You don't
26 just say well, you figured it out because it means you can
27 do 10 more whatevers. I don't think that's the answer to

1 the --

2 DR. SCANLON: I think it points out some of the
3 problems you have with administrative prices, that you
4 almost need to be in a constant revision mode. We may talk
5 about the need to revise the practice expense relative
6 values through a peak, but you've also to keep the work side
7 working and going at the same time. You also maybe should
8 have some kind of link between the two. That if someone
9 comes in and makes the case that we've reorganized the way
10 this procedure is done and we're using more clinical staff
11 within our offices, you ask the question okay, what does
12 that imply for the work? And make both revisions at the
13 same time.

14 MR. GLASS: And that's what struck us, that the
15 work RVUs had not decreased. They, in fact, had stayed the
16 same or gone up.

17 MR. DeBUSK: I think we should hear from Nick on
18 that.

19 DR. WOLTER: I am reluctant to comment because our
20 thoracic surgeons will read this someday.

21 I'll just be very practical and really not address
22 the issue that Bill has raised. I think the traditional
23 practice was the traditional practice. It wasn't
24 necessarily any more valuable to the practice of thoracic
25 surgery than if a pulmonologist did the same thing or a
26 general surgeon did the same thing. So from a practical
27 standpoint, the result of valuing this and paying for it in

1 a different way, to me, is not consistent with how the
2 practice of medicine is done in other places.
3 But I think it does point up the fact that for
4 physicians who do their work primarily in the hospital,
5 these artificial separate payment systems are problematic
6 and they get us into these quagmire conversations. I know
7 the thoracic surgeons have felt that their payment on the
8 outpatient side hasn't been valued adequately, and I'm sure
9 that's one of the reasons this issue is on the table.
10 I don't know where that takes us down the road,
11 but that is why the Part A/Part B thing is more problematic.
12 And especially as we get into looking at how quality is
13 driven in the physician world, where they work primarily in
14 the hospital, continuing to do the silos separately in terms
15 of those quality payment adjustments, we're going to have
16 more issues like this eventually.
17 MR. HACKBARTH: Other comments? Answers?
18 DR. MILLER: Unfortunately, I have to summarize, I
19 think, what has just happened here and I'm struggling with
20 that a little bit. Do you want to?
21 MR. HACKBARTH: No. He was whispering the right
22 answer to me.
23 DR. MILLER: I'm not at all sure of that.
24 I have to admit, I'm a little unclear on the
25 difference of the mission of adhering to the law versus what
26 the right thing is. I understand the distinction, but what
27 our mission is, even given the mandate, we may speak to the

1 mandate and also speak to the right thing.
2 I think, in some ways, Nick is saying Medicare
3 shouldn't be in a position -- no payer should be in the
4 position of litigating these things item by item. The way
5 this litigation should work is on the floor, in the
6 hospital, with the clinician saying I need this person
7 because it makes me more productive, higher quality,
8 whatever the case may be. And we should be able to work
9 that out among ourselves, hospital and physician, in that
10 conversation. So I get that and I think that's one point.
11 To the more narrow point of this, I think the
12 bridge here, while you may not like the bridge or may not
13 agree with it, I think the bridge is that you could say that
14 the decision was we're pulling this out and one could reach
15 the conclusion that it's potentially appropriate because
16 it's been paid for elsewhere, either through other people
17 who bill separately or through the hospital payment.
18 And so there's a narrow question of did you get
19 the practice expense right for this thoracic surgery? And
20 the answer might be look, if that's all you're looking at,
21 the answer is no. And I think we do the knowledge that
22 those costs were pulled out in the paper.
23 The broader decision is but there was some thought
24 that this was taken, the slack if you will, was taken up,
25 probably not completely or appropriately or all the rest of
26 it, elsewhere. And so that this was a reasonable decision.
27 And I'll stop talking with just one other thing.

1 The one other thought I wanted to ask you guys is when we
2 say at the end of the paper -- and that's what I was going
3 through at the end, to try and figure out how big of a
4 difference we actually had here -- we're saying at the
5 legislative time that one could revisit work expense RVUs,
6 we have this sentence, at that time you could take into
7 account more generally the effect of clinical staff brought
8 to the hospital.
9 In that instance, is it possible that the solution
10 that is contemplated is yes, you could make an upward
11 adjustment to the payment at that point in time? And you
12 could have as a rider along with that language, but if
13 you're going to do it that way you have to take it out of
14 everything else to do it right.
15 I'm trying to figure out whether there's really a
16 big disagreement here or whether what we're saying in the
17 conclusion is when that's revisited, that could be revisited
18 either way.
19 MS. BURKE: Mark, can I just ask you question
20 following on to that suggestion with the following scenario?
21 If that, in fact, is the direction we take, then
22 the scenario today is the hospital can pay for the services,
23 essentially their staff. Or they can choose to pay for the
24 staff that the physician brings with them. Or the
25 individuals who bill separately can bill separately.
26 So we're either telling the hospital to do it or
27 people that bill separately. But if the physician employs

1 those people, who are not able to or that we don't want to
2 particularly encourage separate billing for staff that are
3 an integral part of their clinical staff when they come to
4 the hospital, we're essentially saying there is no option.
5 The only option is the hospital eats the cost; correct?
6 MR. GLASS: A simple kind of compromise view of
7 this would be is you take what the reported clinical staff
8 brought to the hospital costs are and you subtract from that
9 any separately payable. Right? Because you could figured
10 that out. CMS could figure that out.
11 MS. BURKE: Separately payable to whom?
12 MR. GLASS: Staff that physicians bring who
13 receive separate payment from Medicare.
14 MS. BURKE: And if they can't bill independently?
15 MR. GLASS: No, you can let them go ahead and do
16 that, but you could take the sum of all of that happening
17 and subtract. You can identify which procedures we're
18 talking about. You can take the sum of all that happening
19 and subtract from the amount the physicians are claiming as
20 practice expense.
21 DR. MILLER: But the other logical solution is you
22 put it all in and tell them that they can bill separately.
23 That's why CMS felt themselves in a bit of a box,
24 notwithstanding all of the data problems and the rest of
25 that, and just how complicated it was to estimate this,
26 because they were saying there were these other revenue
27 streams going on. And our view is well, I'm not sure

1 they're not be compensated.
2 MS. BURKE: I guess the problem is in individual
3 circumstances and whether or not it is considered part of
4 the base or not, whether you make the subtraction. If, in
5 fact, someone bill's independently, then clearly it ought
6 not be paid to the physician as part of their costs. No
7 question.
8 If the hospital incurs that cost, it ought not to
9 be billed separately. But in the case where the physician
10 bears those costs, they are not independently billed for by
11 the individuals that work for the physician. then
12 essentially the only scenario is that the physician, because
13 it's not in the base -- I mean, essentially if you pulled
14 it out of that practice cost, it is not in their
15 reimbursement. So in that case, they simply bear the cost;
16 correct?
17 DR. MILLER: Except that when you construct this
18 it's going to be an average payment across the specialty
19 that will reflect a lot different outcomes.
20 MS. BURKE: If it's an average payment where it
21 does not exist, where it's not part of that calculation, if
22 the average for the physician is calculated minus those
23 amounts that you assume are going to be separately billed,
24 then in no case will it be represented in their payment
25 because your presumption is it's being billed separately.
26 So it is no longer part of the average. Or am I missing
27 what you're suggesting? It's out of the calculus.

1 MR. GLASS: If the practice expense pool you start
2 with includes the expense of everyone works for the
3 physician, including the people who get paid separately,
4 then it would seem reasonable to at least subtract that out,
5 the separate payments.
6 MS. BURKE: Absolutely.
7 MR. GLASS: That would be the compromise position
8 on this is you say well, I think you may still want to look
9 at -- you don't even have to do that.
10 If you have this entire big practice expense pool
11 that included all the people who work for the physicians and
12 then subtract out all the separate payments made to those
13 people who work for the physician, both the ones he brings
14 to the hospital and the ones who work in his office, I guess
15 you could conceivably do that to get rid of some of the
16 double payment question.
17 MR. HACKBARTH: Do we know anything about the
18 proportions here? So of all of the people that thoracic
19 surgeons bring to the hospital do we know what proportion of
20 those are, in fact, people who bill separately, staff who
21 are able to bill separately for Medicare?
22 MR. GLASS: No, I think the Society of Thoracic
23 Surgeons did come up with a figure of how much they received
24 the year this was done, but I think it was like $19 million,
25 I think.
26 MR. HACKBARTH: $19 million relative to --
27 MR. GLASS: $19 million relative to 45 or

1 something.

2 MS. DePARLE: Didn't the IG report cover this?

3 MR. GLASS: They may have. I'm not sure that we
4 have that.

5 MR. HACKBARTH: Sheila is saying that that's a
6 critical question. If you say we're going to forget about
7 paying twice for people that the hospital could have
8 provided but didn't, and we're going to recognize those as
9 still legitimate physician expenses, and the only deduction
10 we're going to make is for people who bill separately, then
11 a critical variable is how much of this expense that
12 currently is not counted actually is billed for separately?
13 And it may take a big number and reduce it way down. I
14 don't have any firsthand knowledge but I would guess that a
15 lot of these people are separately billable physician
16 assistants.

17 DR. MILLER: David, wasn't that the figure that
18 they weren't able to break out?

19 MR. GLASS: In the practice pool they started
20 with, they couldn't break out between clinical staff brought
21 to the hospital and clinical staff used in the office to
22 begin with. That's the first problem.

23 DR. STOWERS: It just seems to me that this really
24 isn't something we should really be involved in at all.
25 This is really between the hospital and that physician
26 that's bringing in a worker that the hospital really should
27 have provided in the first place. So if we're only going to

1 pay for it one time, then they can work it out, whether the
2 hospital provides that person or the physician does and the
3 physician gets reimbursed for it at fair market value so
4 there's no incentive thing created.
5 MS. BURKE: But the question is is it a part of
6 what is calculated as the physician's reimbursement? It is
7 an issue for us if we are either including or excluding it
8 in the practice expense.
9 So to that extent, it is an issue for us because
10 the question we ask is are they being adequately reimbursed.
11 DR. STOWERS: But is that our job, to reimburse
12 them when the hospital is already being paid for that? Or
13 is it the hospital's job to reimburse them for that? And
14 I'm saying it's really the hospital's job to reimburse them
15 for that because we are already paying the hospital for that
16 type of --
17 MR. HACKBARTH: What I hear Bill saying is that
18 the history of this is that Congress said no, we want them
19 to have that counted in the practice expense. We don't want
20 them to have to go chase the hospital and negotiate the
21 hospital.
22 DR. SCANLON: I don't think Congress was as
23 specific as that. Congress said we want to pay for what is.
24 In this instance, Ray, I think that what the thoracic
25 surgeons argued to us at GAO was that these people were --
26 they did deal with the issue of the surgeons' productivity,
27 that they were substitutes for the surgeons' time. And the

1 only reason that they regarded them as substitutes for the
2 surgeons' time was because they were in partnership with the
3 surgeon, as opposed to be an employee of the hospital.
4 So that this nurse was with this surgeon and the
5 surgeon knew that they could rely upon this nurse and wanted
6 that nurse to be their employee. So it's very parallel to
7 what happens in an office, in terms of hiring clinical staff
8 and using clinical staff. The complicating factor is that
9 it's happening in the hospital.
10 MS. BURKE: To your point if, in fact, if we do
11 presume the hospital bears the costs, which I understand,
12 then they shouldn't be allowed to be able to bill. Then
13 it's a zero-sum game. Then it's the hospital's problem and
14 no one should they be able to bill. The only difference
15 here is there are people who can bill and people who can't.
16 So if our decision is, as you suggest, that this ought to be
17 a hospital/physician relationship, then the hospital bears
18 the costs. In those circumstances should anybody be able to
19 independently bill for that activity? That would be
20 consistent.
21 DR. STOWERS: And essentially what I'm saying is
22 that we're paying for this service. If the hospital
23 negotiates with the physician to allow that physician to use
24 theirs to increase efficiency and whatever, that there's
25 something worked out between the hospital and the physician
26 to reimburse the physician for them being the one that is
27 supplying that and we're out of it at that point. That's

1 all I'm trying to say.

2 MS. BURKE: Which is fine, but under those
3 circumstances we should prohibit people from billing because
4 right now people can bill independently.

5 DR. STOWERS: I understand.

6 MS. BURKE: So we should stop the billing as well.

7 DR. WOLTER: I don't know if what I see is
8 representative across the world but my sense is where
9 billing occurs it's usually sustained in the operating room.
10 My sense is those are not the nurses who do rounds for the
11 physician and write in the notes and sometimes do the
12 dictations. I don't think there's a billing mechanism for
13 that.

14 I think what's primarily being requested here is
15 the latter activity, since the former activity, assisting in
16 the operating room, does have the opportunity for billing.

17 MR. GLASS: Depending on who it is. Is this a
18 surgical tech?

19 DR. WOLTER: My point is the surgical tech,
20 there's some billing, that's probably not the activity for
21 which some kind of recognition is now being requested. In
22 my observation of cardiothoracic surgeons, they did have a
23 history of bringing a nurse into the hospital, helping them
24 with rounds, helping them go over medications at discharge
25 time and that sort of thing.

26 Personally, I think the only argument for going
27 ahead and recognizing that would be if there was some

1 typical practice language at a certain point in time that we
2 would want to grandfather that activity in, because I think
3 that many people could make the argument that that might be
4 valuable to their practice. But in fact, in all other
5 cases, that is an arrangement physicians work out with
6 hospital staff, in terms of how medication, discharges and
7 medications and that sort of thing are done. And that's why
8 I think this is complicated.

9 MR. HACKBARTH: Nick, let me ask you a question.
10 Isn't the surgeon getting a global fee that covers not just
11 the time in the OR cutting, but also the rounds?

12 So if you're a first assistant, say a PA, working
13 with out of the practice of cardiothoracic surgeon,
14 assisting at surgery, and then doing post-op rounds and
15 whatnot, and you're getting a first assistant's fee, billing
16 separately for that for the practice, doesn't that cover
17 also post-op rounds and whatnot?

18 DR. WOLTER: My understanding is there is a
19 mechanism to do some billing for non-physician assisting in
20 the operating room.

21 MR. HACKBARTH: For just the OR time?

22 DR. WOLTER: For just the OR time. And from what
23 I've observed, that is a different individual than the nurse
24 or assistant who accompanies the physician and works with
25 the patient out on the floors or in the ICU. That's what
26 I've observed.

27 DR. SCANLON: Glenn, on the assistants at surgery,

1 that fee has just been set at 13 percent for these personnel
2 of the global fee without an empirical basis to say that
3 this is what it should be. Also, I think the more
4 widespread perception is that it's only for operating room
5 time. Because when a surgeon is the assistant, a physician
6 is the assistant, then it's more clearly defined as only
7 operating room time.
8 DR. REISCHAUER: Just a factual question here. 75
9 percent of the time the surgeon brings somebody with them.
10 19 percent of the time the hospital reimburses a physician
11 for this activity. 81 percent of the time of the 75
12 percent, I suppose, that doesn't take place. Of that 81
13 percent, what fraction are separately billable folks and
14 what fraction are actual employees of the doc?
15 And if there are these two avenues you wonder what
16 is the economic logic ever of having your individual, as
17 opposed to the separately billable person, involved in this?
18 I mean one that you have an ongoing relationship with.
19 MR. GLASS: It seems to me that there are people
20 that they feel -- that have been working with them, they're
21 training to work with them.
22 DR. REISCHAUER: But a physician's assistant could
23 be somebody --
24 MR. GLASS: They also use surgical technologists,
25 for example. The place we visited, one of the people is a
26 surgical technologist.
27 DR. REISCHAUER: Do you know what the percentage

1 split is on that?

2 MR. GLASS: We don't know the percentage, no. But
3 the surgeon thought it was important enough to have that
4 particular individual that that's who he brought.

5 MR. HACKBARTH: I feel like we're spinning our
6 wheels a little bit. Personally, I'd like to learn more
7 about the history that Bill described so we understand
8 exactly the question that we're being asked by the Congress.
9 I had a different notion in my head and I may have been
10 wrong.

11 I'd like, if at all possible, to see if we could
12 at least get some idea of the magnitude of some of these
13 numbers that Sheila and Bob have been referring to. It
14 gives us at least some sense of proportion of what we're
15 talking about.

16 So let us do little homework on those issues and
17 come back, hopefully in a way that will allow us to get
18 efficiently to a conclusion. Jay, and then Pete, and then
19 we'll move on.

20 DR. CROSSON: I understand the mandate is about
21 cardiovascular surgeons bringing people to the hospital to
22 help. But it sounds like they're not the only ones who do
23 this. Other surgeons do. They may be the ones that do it
24 most frequently, but others do this also.

25 So it strikes me that if we end up with a
26 recommendation that is narrow, just to cardiovascular
27 surgeons, which is what the mandate is, the very next

1 question then would likely be what about the other surgeons
2 who do this?
3 As we work our way through to a recommendation, I
4 think we ought to acknowledge that and make a conscious
5 decision which of the two things we want to do and what the
6 implication is of just doing it narrowly.
7 MR. HACKBARTH: I think that's a good point.
8 There certainly are other types of surgeons, orthopedic
9 surgeons for example, where I think this is relatively
10 common. What I heard David say, though, or maybe it was
11 Bill, said that this is the one where it's very common as
12 opposed to something that happens occasionally. But we can
13 track down those. And that ought to be something we address
14 specifically in the report.
15 MR. DeBUSK: We've sort of gone in circles here
16 about how this thing happens. But if at present the
17 physician is being paid, which of course he is, and he has a
18 nurse practitioner or a PA who is billing separate, then the
19 question comes down what about the physician who is coming
20 to the hospital to do the surgery, that first assistant is
21 there but there's an additional person who is helping with
22 that, taking care of that patient to provide better patient
23 quality? Then it looks to me like we're in a scenario where
24 we're going to take and add another level of payment, maybe
25 in addition to the doctor's fee, to cover that nurse. Isn't
26 that about where we're at? That's the question?
27 MR. HACKBARTH: That's the question at hand, is

1 whether that additional expense ought to be includable in
2 the physician practice expense for cardiothoracic surgeons.
3 CMS is concern is that we're double paying for that service,
4 so they didn't want to take into account all of these. Am I
5 missing your point, Pete?
6 MR. DeBUSK: I'm just looking. It's all about
7 that third person and is that third person qualified or
8 should they be paid? Are we already paying for that? And
9 of course, we're talking about the hospital reimburses
10 partially for this.
11 It looks to me like there should be the option
12 well, if the doctor's going to bring this then the hospital
13 should be mandated to pay for that if you're going to get it
14 fair and equal and what have you here to cover the surgeons'
15 cost.
16 If what we're doing already, doing something in
17 addition, moving some money around, it doesn't look to me
18 like it should be that complicated. Just identify that
19 person and pay them.
20 MR. HACKBARTH: In Nick's world, it isn't all this
21 complicated. If they're dealing with a prepaid system,
22 they've got a pool of dollars and they can work it out
23 relatively easily, I imagine. But when we've got all of our
24 separate payment silos and rules, it's hellishly complicated
25 I'm afraid.
26 MR. DeBUSK: I don't think those silos, I don't
27 think they are necessarily wanting these silos to go away

1 under the present structure or they wouldn't be bringing
2 this up.
3 MR. HACKBARTH: We are done for now.
4 I'm really looking forward to our next discussion
5 of this. I just can't wait.
6 The last item is the mandated report asking about
7 eliminating physician referrals to physical therapy.
8 MS. CARTER: That's right. I want to first
9 acknowledge two analysts who help me with this report, Margo
10 Harrison and Sarah Kwon. Their work was invaluable to me.
11 This report mandate was included in Section 647 of
12 the MMA. It requires us to study the feasibility and
13 advisability of allowing Medicare fee-for-service
14 beneficiaries to have direct access to outpatient physical
15 therapy services.
16 Under current Medicare coverage rules, a
17 beneficiary must be referred by and under the care of a
18 physician for outpatient therapy services to be covered.
19 Medicare does not require physical therapist to be
20 supervised by a physician and physical therapists can
21 directly bill for their services.
22 What's at issue here is the physical therapists
23 would like to have the physician referral and review
24 requirements eliminated. So when the term direct access is
25 used, that's what it's referring to is the elimination of
26 the referral and review requirements. Let's quickly review
27 what those are.

1 The physical therapy services must be referred by
2 a physician. The physician must review the plan of care
3 every 30 days and must reevaluate the patient after 60 days
4 for longer-term care.
5 Let's quickly review the Medicare coverage for
6 outpatient therapy services. Outpatient physical therapy
7 services are covered as long as they are furnished by a
8 skilled professional, are appropriate and effective for a
9 patient's condition, and are reasonable in terms of service
10 frequency and duration. There are no time limit or visit
11 restrictions on coverage. Coverage is limited to
12 restorative services. Medicare does not cover physical
13 therapy when the services maintain a level of functioning,
14 when the therapy is considered a general exercise program or
15 a patient no longer can benefit from therapy.
16 Just a couple of background points, about 9
17 percent of beneficiaries use outpatient physical therapy.
18 The services are provided in a variety of settings. You can
19 see them in the overhead. But regardless of where the
20 services are furnished, payments are established in the
21 physician fee schedule under Part B. And like all Part B
22 services, the beneficiary is responsible for a 20 percent
23 copay.
24 One key reason to require physician referral is to
25 help ensure medically appropriate care. Only physicians can
26 order and evaluate the results of lab tests and radiological
27 exams used to assess if physical services will benefit a

1 patient and to modulate a plan of care. Once therapy
2 begins, physicians ensure that the plan of care continues to
3 match patient's care needs. In short, the requirements help
4 screen out unnecessary care and ensure proper medical
5 attention.
6 If referrals were no longer required, some
7 beneficiaries could receive unnecessary care and delays in
8 getting more appropriate medical attention. The delays
9 could result in worse patient outcomes.
10 Physical therapists counter that their training
11 and practice ensure that patients are adequately screened
12 for medical referrals. They note that physician referrals
13 do not always provide much clinical guidance regarding the
14 services to be furnished. For example, general instructions
15 such as evaluate and treat require the same assessment
16 skills and responsibilities that they would assume if the
17 referral requirement was eliminated.
18 Medicare has similar physician requirements for
19 other services such as home health care, skilled nursing
20 facility stays and occupational therapy. The requirement is
21 also similar to those in place for other practitioners such
22 as physician assistants and nurse practitioners.
23 We looked a little bit at what private payors do
24 for physical therapy services. What we found is that
25 private payers often use a combination of strategies to
26 control service use. Many plans, managed-care companies and
27 self-insured plans require physician referrals. Blue Cross

1 and Blue Shield plans vary in their requirements for
2 physician referrals, depending on the plan and the employer.
3 Representatives from the Blue Cross Blue Shield Association
4 told us that even when a referral is not required, many
5 physical therapists prefer to have one before they begin
6 treating patients.

7 Most private payors restrict service use by
8 limiting the days or visits allowed. Some private payers
9 also use practice guidelines to recommend a course of
10 treatment and to indicate an average number of visits for a
11 specific medical condition.

12 There's considerable variation in state laws
13 whether they explicitly allow the provision of physical
14 therapy services without a physician referral. Most often,
15 state laws limit in some way the services a physical
16 therapist can provide. The most common restriction is that
17 physical therapists can evaluate but not treat patients.
18 Several states are silent on the issue. And in these states
19 coverage policies of the insurers may still require physical
20 therapy referrals. Only two states explicitly allow
21 physical therapists to treat patients without any other
22 restrictions.

23 Another concern with eliminating the referral and
24 oversight requirements is that unnecessary care might
25 increase. Long-standing concern about the appropriate use
26 of outpatient therapy services has prompted the examination
27 of the services furnished to Medicare beneficiaries. These

1 studies, done by the Office of the Inspector General and
2 GAO, have consistently found that medically unnecessary
3 therapy services were frequently furnished to beneficiaries.
4 Most often, the services were medically unnecessary because
5 the services were not skilled, the patient did not require a
6 skilled level of care, the treatment goals were too
7 ambitious for the patient's condition, the frequency of the
8 service provision was excessive, given the patient's
9 condition or a service was continued to be provided even
10 though the patients had already met their goals. These
11 studies indicate that even with physician referral and
12 review requirements, unnecessary therapy is often provided.
13 Outpatient physical therapy service provision is
14 already highly variable, suggesting that some of the
15 services are unneeded. For example, service provision
16 appears to increase as Medicare payment policies become less
17 restrictive. After the implementation of the outpatient
18 therapy caps in 1999, Medicare spending decreased 34
19 percent. And then, when the therapy caps were lifted in
20 2000, spending increased 36 percent. Spending also varies
21 considerably, ranging from three to fivefold across states
22 and different providers. A better understanding of the
23 reasons for this variation, coupled with efforts to reduce
24 it such as practice guidelines or provider profiling, would
25 result in more appropriate service use.
26 Stepped up medical review of physical therapy
27 services could help deter and reduce medically unnecessary

1 services, but currently less than 2 percent of all
2 outpatient therapy claims are reviewed. This scale of
3 activity is unlikely to ensure that services provided meet
4 coverage rules. The lack of aggressive oversight is another
5 factor to consider in relaxing the referral and review
6 requirements.

7 Proponents claim that lifting the physician
8 referral requirement would save the program and
9 beneficiaries money. But for some patients, the physician
10 evaluations result in treatment other than physical therapy.
11 For these patients, the physician referrals would result in
12 more appropriate medical care and by eliminating unnecessary
13 physical therapy services the current requirements may
14 result in net savings to the program.

15 Supporters point to one study that compared the
16 cost of care for patients with and without a physician
17 referral in Maryland Blue Cross Blue Shield enrollees. This
18 study, which was funded by the American Physical Therapy
19 Association, found that the care provided to patients
20 without a physician referral was shorter in duration and
21 about half the cost of care that began with a physician
22 referral. However, the authors acknowledge that
23 differences in severity between the patients seen by
24 physical therapists with and without a physician referral
25 could explain the differences in the cost of care. We also
26 do not know if similar cost differences would be observed in
27 an older population.

1 Proponents of removing the physician referral
2 requirement also assert that delays in care would be reduced
3 and promote quicker recoveries. Yet most beneficiaries
4 report that they do not encounter problems in getting
5 special therapy services. In 2003, we found that 85 percent
6 of beneficiaries reported having no problems, an increase
7 from 2000. 6 percent of beneficiaries reported big problems
8 in getting special therapy services and 8 percent reported
9 having little problems. All but one subgroup of
10 beneficiaries reported fewer problems in 2003 compared with
11 2000.
12 Another measure of access is the number of
13 beneficiaries receiving outpatient therapy services.
14 Between 1998 and 2000 the number of beneficiaries receiving
15 outpatient therapy services grew at the same rate as the
16 growth in the number of beneficiaries. Although this
17 measure does not consider if the services were appropriate,
18 the number of beneficiaries receiving services is stable.
19 In conclusion, there are several compelling
20 reasons to retain Medicare's current requirements. They
21 help ensure physical therapy services are medically
22 appropriate and necessary. To the extent that requirements
23 reduce the amount of unnecessary services, they result in
24 net savings. Access to physical therapy services for most
25 beneficiaries does not appear to be impaired. The current
26 requirements are consistent with Medicare coverage rules for
27 other services. Changing the requirement for physician

1 referrals would have clear repercussions for other services.
2 And last, the requirements are consistent with
3 private payer strategies. All payers have some kind of
4 restrictions in place to try to limit the amount of
5 unnecessary service use.
6 I'd be glad to answer any of your questions or
7 gather comments from you on the draft.
8 MR. DURENBERGER: What is it about the physician
9 reimbursement system under Medicare that assures us that
10 physicians only recommend medically appropriate physical
11 therapy services?
12 MS. CARTER: There is nothing specific that would
13 ensure that the services were appropriate, but I think you
14 could assume that physicians wouldn't refer patients on for
15 services that they didn't need.
16 MR. DURENBERGER: Why can you assume that anymore
17 than you would make the assumption that physical therapists
18 will not provide services that are medically inappropriate?
19 MS. CARTER: The referral requirement is the same
20 as for many other services. I think Medicare has
21 traditionally used physicians in the role of reasonable and
22 necessary and that's been sort of the standard that's been
23 used in the program really across the board for all
24 services.
25 MR. DURENBERGER: I know that's the 1965
26 definition of Medicare and I don't think there was such a
27 thing as a physical therapist in 1965. So I'm asking you a

1 question which simply says where is the assurance to the
2 system of reimbursing physicians that would give us the
3 assurance that only appropriate referrals are made? Is
4 there anything in the nature of the payment system today
5 that gives the physician an incentive not to refer
6 inappropriately?
7 MS. CARTER: I don't think there's an incentive
8 either way.
9 DR. WAKEFIELD: A couple of comments. The
10 takeaway for me on this, from my perspective I don't see,
11 from this report, any compelling reason for Medicare to
12 change from what it's currently doing in terms of expecting
13 referrals or requiring physician referrals. But I can tell
14 you the tone of this report doesn't provide me with a slam
15 dunk that there's no compelling reason not to change either.
16 Let me just make a couple of comments about it.
17 First, I'm talking about some of the text
18 specifically. There's a lot of reference to -- and this
19 might be a little bit, I'm not sure, of what Dave was
20 getting at. There's a little bit of text that talks about
21 the IG studies that are cited on page seven and it indicates
22 that there are clearly problems with the current system writ
23 large in terms of policing the provision of unnecessary
24 services, trying to tamp that down. You cite that series of
25 studies. That seems to indicate to me that physician
26 referrals don't necessarily ensure that medical necessity or
27 appropriate utilization occurs across the board.

1 So in other words, just because we've got that
2 expectation in place. those IG studies say there are flaws
3 in that process. People are getting unnecessary care. The
4 system is paying for it.
5 But on the back end, it is a major reason why we
6 are arriving at the conclusion that we arrive at at the end.
7 That is in your last slide, that if you keep that oversight
8 it helps ensure PT services are medically appropriate and
9 necessary. And yet, there is that series of studies that
10 suggest there are big problems with it, at least in some
11 sectors and so on. So I had a little bit of a disconnect
12 between those two points.
13 I think then we're talking about keeping a key
14 solution in place that has serious flaws. As I said, I
15 don't think that that necessary carries over to the
16 concluding part of the report.
17 The other point on that is that we indicate the
18 findings of those IG studies but I think it also might be
19 worth it to take a look at what was recommended to address
20 those problems and I don't see that here.
21 I think, and I could be corrected on this, but I
22 think that what you might find in terms of recommendations
23 are things like exactly what we raise elsewhere, that is
24 more FI oversight. That the system really ought to have
25 more FI oversight. That was one of their solutions. And
26 another solution, I think, was that you ought to have more
27 provider education brought into the mix.

1 And I don't know that they recommended, for
2 example -- well, I think those are sort of two of the key
3 solutions and I think that might merit mention in this
4 report. Because again, I see such a disconnect between our
5 recommending a solution that clearly has problems on the
6 front end.
7 And also on that very point, I'd say you talk
8 about in the report the variation between orthopedic
9 surgeons and primary care providers and their utilization of
10 physical therapy services varying. And yet we're kind of
11 coming back at the end of the report to saying this is about
12 a problem with the potential for PTs, removed the referral
13 requirement to overutilize.
14 So there's a balance in the tone of that report
15 that bothers me a little bit. I think if we could thread
16 those points through a little bit more to the end, that
17 would make me feel a little bit more comfortable.
18 The last point I'll make is we raise a couple of
19 other issues, one suggesting that underlying medical
20 conditions might be missed. Maybe. We said a lot of maybes
21 throughout this report. That might be true.
22 We also know that there is -- it sounds like it's
23 terribly small, I don't have the exact numbers from your
24 report, but it sounds like there is a pretty small but real
25 set of physical therapists who are exercising their own
26 direct access and they're not seeing patients through
27 referrals.

1 So I guess what I'd say is if we're going to raise
2 some of those kind of questions, like gee there might be
3 real problems with treatment not appropriate to the health
4 care problem, if there is a small subset of patients that
5 could be looked at to try and better understand what's going
6 on there, maybe that's also worth throwing in and commenting
7 on that, too.
8 That is, there is direct access. It is being
9 operationalized. Perhaps we ought to see if, in fact, there
10 is an increase in medically inappropriate services and/or an
11 increase in compromises in quality of health care that are
12 being rendered to the patient.
13 The last point, on the very last paragraph of this
14 report, where you say Medicare may want to consider
15 expanding its controls, particularly ones that are tailored
16 to specific medical conditions. For me that question
17 prompted an okay, on whom are those controls going to be
18 expanded? For what? Under what circumstances? What
19 medical conditions are we talking about? We haven't talked
20 about, to my knowledge, any specifically to that point. So
21 it's a lot the tone here that I'm reacting to, I guess, and
22 just to give you a few of examples of that.
23 MR. HACKBARTH: Mary, are you saying that you
24 disagree with the conclusion that we ought not -- are you
25 saying we ought not have a physician referral requirement?
26 Or are you saying well, even if we keep it there is abundant
27 evidence of problems and we need to recommend some

1 additional things as well?

2 DR. WAKEFIELD: That's why I started with where I

3 end up in my comments. That is, I'm not suggesting that

4 there is a compelling reason to lift the current requirement

5 based on the data. I also don't think it's the slam dunk

6 that --

7 MR. HACKBARTH: That the current system isn't

8 great.

9 DR. WAKEFIELD: And even the text of this report

10 would lead me to.

11 DR. STOWERS: Carol, I think it's a good chapter

12 and I agree with your conclusion in the end. I wanted to

13 clean it up a little bit.

14 When you say there's 6 percent that have a problem

15 with access, I don't think there we want to be inferring

16 that that's necessarily there because of the physician

17 requirement that's involved there, because there's a

18 considerable shortness of physical therapists in rural

19 areas, and that sort of thing. That's where we tend to run

20 into the lack of access that may be coming in that survey,

21 rather than necessarily because of the physician referral

22 part.

23 Another thing is, just in practice from day to

24 day, it's very rare that we do this evaluation for physical

25 therapy in some kind of an independent state. Because you

26 usually have a patient that's had a cardiovascular incident,

27 or they're a diabetic with foot surgery, or something like

1 that.

2 So when we get to looking at offsetting the
3 physician's visit against the cost of savings for the
4 physical therapy, it's very rare that there's a separate E&M
5 there for the purpose of evaluating this physical therapy.
6 I can't even remember the last time I had a visit that was
7 just for that, that it wasn't part of the continuous care of
8 the patient. Because most of these have multiple diagnoses
9 and chronic care problems and they're being seen anyway.

10 And another thing, if we're going to make that
11 comparison against those costs, I think it might help in the
12 chapter to have what the average cost of a therapy session
13 is versus this care that's being picked up probably as part
14 of their routine E&M services anyway without a separate
15 visit. So I think I'd look at that.

16 And then I think we have to be a little bit
17 careful when we criticize the order by the physician for
18 just evaluate and treat because if there's a good
19 relationship between the physical therapist and the
20 physician, and they're used to working together on these
21 patients, it's sometimes a show of respect not to get in and
22 try and micromanage the physical therapy treatment. Because
23 I agreed with what you said a while ago, that really the
24 physician is there to evaluate for appropriateness of the
25 therapy, not to get in and micromanage the therapy
26 treatments.

27 I just wanted to make those three points that I

1 think would make the chapter a little clearer.

2 MR. SMITH: Very briefly, because Mary made the
3 point I wanted to. The chapter does read that it would be a
4 good idea to keep the physician and the gatekeeper role
5 here, as we do for other services. But it doesn't work very
6 well but let's keep it anyway.

7 I do think we've got to figure out some way to
8 address the it doesn't work very well, either with more
9 financial intermediary oversight or with some notion that
10 we're not suggesting that we ought to do this because we
11 ought to do it. There is a reason that we have physicians
12 in this gatekeeper role and we ought to address the part of
13 it that's not working. I think the report needs to reflect
14 that tone, rather than we see no reason to change.

15 DR. MILSTEIN: I'd like to say even from my
16 perspective, I think the report does a very nice job of
17 answering the question that was asked. And I think, in the
18 course of answering it, uncovered the fact that what we
19 proposed to fall back on, which is physician referral
20 doesn't work too well. But I think the report does a very
21 nice job of answering the question that was asked.

22 Do we want to expand the scope of our answer to
23 address issues that we're not being asked to answer? If so,
24 I have an opinion, but I'd defer to you, Glenn.

25 MR. HACKBARTH: It depends on how far afield you
26 want to go. If you want to talk about bundling of surgeons
27 in the hospital, the answer is no.

1 DR. MILSTEIN: I think one of the challenges here
2 and one of the things that I think the research on
3 appropriateness won't tell you, is that it isn't like we
4 have any kind of a decent evidence base for knowing when a
5 physical therapy service in a given situation is going to
6 improve patient outcome.
7 If you've ever done a utilization review of
8 physical therapy -- and I did some early in my career --
9 it's a very subjective game. If you really wanted to answer
10 the question we weren't asked, which is how would you go
11 about assuring more appropriate, a higher degree of
12 "appropriateness" of physical therapy services, step one
13 would be to make an investment in some outcomes research so
14 that was an evidence base on which either physicians or the
15 fiscal intermediary or any other third-party could attempt
16 to impose a greater discipline between when the services
17 were ordered and when there was some reasonable probability
18 of the patient experiencing a health gain.
19 MR. DURENBERGER: That's where I was going.
20 MR. HACKBARTH: That's definitely not too far
21 afield.
22 DR. REISCHAUER: I agree with most of the
23 statements that have been said.
24 It strikes me that relative to the problems faced
25 by private plans, by and large, Medicare doesn't have as
26 great a degree of problem. And maybe John, would disagree
27 with me on this, but I see it as an area every day in

1 anecdotal evidence that I see abuse in. And 40 percent
2 might look good.
3 What I was wondering is, looking at the
4 distribution of Medicare payments and Medicare patients in
5 the back chart, if we knew what the situation looked like
6 for the non-Medicare population, because it strikes me that
7 physical therapy is being provided in a very different mix
8 than it would be for an under-65 population and a mix of
9 institutions that, in many ways, might have, first of all,
10 individuals with much more need, proven need, and much more
11 supervision of what's going on.
12 And that if I looked at the private under-65
13 population, the private physical therapist would be
14 providing a big, big, big chunk of what was going on. And
15 while many of those services are fine, but that is the area
16 I think that you worry about the most.
17 MS. RAPHAEL: I just wanted to briefly reinforce
18 what Arnie said because in my experience it's very hard to
19 predict who's going to be successful with physical therapy
20 and the word appropriateness, I think, is subject to many
21 interpretations. Because a lot of times you want to try to
22 do restorative physical therapy but you really can't restore
23 function and you end up just getting into maintenance. A
24 lot of it has to do with motivation and other kind of
25 accompanying conditions.
26 I would be very reluctant to look to the FIs as
27 really the way to deal with this because I just don't think

1 we have enough of a clinical base here to really make those
2 decisions. And I don't think the FI, by looking at a piece
3 of paper, is really going to be able to make good judgments
4 in this area right now.
5 I guess I also question where we want to go with
6 this, recognizing that what other people have said, we're
7 recommending the physician stay as sort of a control point
8 but we also feel it's an inadequate control. But I just
9 don't know whether or not we have enough information to make
10 recommendations to remedy the situation.
11 MR. HACKBARTH: Sometimes that's reality, is that
12 you don't have perfect options. You don't even have all the
13 information that you would want to have. In those cases,
14 sometimes it's better not to make any change, try to develop
15 a better information base to guide future decision making.
16 And I think that's where we may be in this particular case.
17 Any other comments on this issue?
18 DR. WAKEFIELD: Only if I can come behind the
19 recommendation for more information, to say that's a little
20 bit of part of what I was talking about when I said we might
21 assert that there's a potential problem with quality of
22 care. We might assert that diagnoses, for example, will get
23 missed. But unless we take a look at good data, where we
24 get that data from, we're not going to know the answer to
25 that. And so we sort of put these hobgoblins up there but
26 not the solution to try and address them.
27 I agree with you, Arnie, about the need for data.

1 MR. HACKBARTH: I may just pick up specifically on
2 Carol's point about urging increased FI activity. One of
3 the concerns that I personally had and the Commission itself
4 has expressed concern about variability in FI decisions,
5 particularly in the absence of definitive evidence about
6 what works and what does not. So just saying well, we don't
7 know what to do but you go in there and police it is not a
8 recommendation that I personally feel all that comfortable
9 with.
10 DR. MILSTEIN: Again, I don't know whether you
11 want to expand the evidence we look at in coming up with
12 recommendations. But if we do and we have the resources,
13 one area of American health care activity where this is a
14 front and center issue in terms of volume and
15 appropriateness is worker's comp care. And if you begin to
16 look at, as states have struggled in worker's comp laws, to
17 figure out how you get the right amount of physical therapy
18 to a population but not, in the course in doing so, risk a
19 lot of extra services, I think there is some useful lessons
20 that may be applicable in terms of what control mechanisms
21 work.
22 In many states, for example, looking to some
23 external presumed neutral source of authority in the absence
24 of an evidence-base and coming up with treatment guidelines
25 that diagnosis specific is where they've gone. The American
26 College of Occupational Medicine has come up with guidelines
27 for physical therapy and similar services. A number of

1 state worker's comp systems have begun to say we're going to
2 presume that that is the right amount of volume of services
3 that somebody needs given a condition.
4 As you listen to it on the face of it, you can see
5 what might be imperfect about that one-size-fits-all
6 solution. But nonetheless, I think there is some useful
7 information as to how to better control these services that
8 can be culled out of 50 different states struggling with the
9 question of physical therapy appropriateness in worker's
10 compensation care.
11 MR. HACKBARTH: Okay. Thank you, Carol
12 Before we do the public comment period, we need to
13 return to the issue of the mandated report on benefits
14 design and cost-sharing in Medicare advantage plans. We
15 were there eight hours ago or thereabouts, as you will
16 recall. And based on the discussion this morning, Rachel
17 and Jill have put together some draft recommendations that
18 we think reflect the input that they got this morning. So
19 we're going to review those.
20 I don't think we need to go into details about the
21 wording and format. Think of these more in terms of the
22 basic substance. I think the process, and correct me if I'm
23 wrong Mark, is that we want to hear your reaction to them,
24 hear if they basically capture the substance of what you
25 want. And then we will refine them and bring them back to
26 the next meeting for the final vote. Or even tomorrow.
27 That would be even better. We can do that tomorrow.

1 DR. MILLER: Think through them, we tinker with
2 things, and then everybody's in place, we can knock this out
3 in 10 or 15 minutes tomorrow.
4 DR. SCHMIDT: Here is how we have crafted
5 recommendation number one. To provide critically important
6 about the implications of coverage and benefit options, CMS
7 should use an array of approaches for beneficiaries and
8 those who help them. In the short-term, CMS should continue
9 to provide estimates of out-of-pocket costs for 2006 on the
10 Medicare Personal Plan Finder; begin to make available more
11 advanced consumer decision tools that reflect out-of-pocket
12 costs under various scenarios for use of services and their
13 likelihood. Over the longer-term, CMS should develop tools
14 that use individuals actual experience to project future
15 out-of-pocket spending.
16 Here's recommendation number two. CMS should
17 interpret its authority granted in the MMA to negotiate with
18 MA plans broadly. Specifically, MedPAC believes the Agency
19 has authority to set minimum standards for benefits and
20 should use this authority to ensure that plans do not
21 discriminate on the basis of health status. The Congress
22 may need to provide CMS with additional staff resources and
23 administrative flexibility to carry out this function
24 effectively.
25 And the final one, to prevent discriminatory
26 benefit designs, CMS should develop guidelines for plans on
27 benefit design and cost-sharing that, if adopted, would

1 provide safe harbor from extensive negotiations with the
2 Agency. Plans could choose between an out-of-pocket cap on
3 cost-sharing for Medicare-covered services provided within
4 the plan's network or limitations on cost-sharing to prevent
5 disproportionately high cost-sharing on services that are
6 less discretionary in nature such as chemotherapy.
7 MR. HACKBARTH: Okay. Why don't we go back to the
8 first one and ask for comments one by one.
9 Any comments on number one?
10 DR. MILSTEIN: For reasons I think I previously
11 explained, I would certainly like to see the over the
12 longer-term language replaced with as soon as feasible or
13 something like that. The other industries figure this out.
14 MR. HACKBARTH: Okay.
15 DR. SCANLON: I think that in your presentation
16 this morning, you talked about the the fact that
17 distributional information would be useful to beneficiaries.
18 And that actually that's part of that first sub-bullet under
19 number two, which is it's a lot less than an advanced
20 consumer decision tool. It's really some pretty basic
21 statistics that you could get out of the same data that
22 you're using now to give them averages.
23 MR. HACKBARTH: So you're saying we make it sound
24 more difficult than it is.
25 DR. SCANLON: That first bullet is too modest,
26 continue to provide estimates of out-of-pocket costs. I
27 would say to continue what the currently provide and expand

1 information on out-of-pocket costs. It's short of this more
2 advanced consumer decision tools which, I think, are future
3 steps.
4 DR. MILLER: That's what the second dash is
5 supposed to speak to, continue doing what you're doing and
6 expand.
7 MS. RAPHAEL: I feel like Bill was saying,
8 continue doing what you're doing, they can do more. The
9 average is what they're presenting now.
10 DR. SCANLON: I think if we talk about in the body
11 the advanced consumer decision tools, we're talking about
12 things like we had this morning, the issue of being able to
13 bring in your own experience or being able to develop a
14 scenario based on other information.
15 There's a lot of things that are a whole lot more
16 basic and I think that they're in the spirit of the first
17 one, which is CMS is already calculating average out-of-
18 pocket costs. But they're not telling you what the 98th
19 percentile is going to be.
20 MR. HACKBARTH: Let me just see if I've got this
21 right. The first bullet, continue to provide estimates, is
22 there because it's our understanding that they plan to stop
23 doing even that; right? Or are considering not doing that.
24 And so we're just trying to be explicit in saying we want
25 them to keep what they're doing.
26 The second dash, begin to make available more
27 advanced tools, to me sounds like it may be a little bit too

1 grandiose. What we're talking about is stuff like Walt
2 Francis did for years and I think is still done in the
3 Consumer Checkbook for Federal Employees. Just saying under
4 different basic scenarios about your health care costs, this
5 is what you would incur under different plan options. It's
6 really not high-tech. It's pretty basic. Is that what
7 you're referring to?
8 DR. SCANLON: Yes. Maybe it's the language
9 advanced.
10 DR. REISCHAUER: Advanced consumer tools I thought
11 were in Arnie's.
12 MR. HACKBARTH: Then the last bullet over the
13 longer-term, or modified as Arnie requested, is where we
14 start to individualize it based on actual historical
15 evidence about that particular patient's experience.
16 DR. MILLER: So we'll swap the language around.
17 In the dash, we'll refer to it as tools. And then in the
18 final bullet, we'll refer to it as more advanced consumer --
19 MR. HACKBARTH: I think that would do it.
20 DR. BERTKO: Not to completely disagree with
21 Arnie, but I think CMS has got a lot to do here. I had some
22 input on the Plan Finder a couple of years ago. I think the
23 job they have to insert Part D is so important into the
24 short-term bullets that I personally like the last bullet's
25 wording, over the longer-term, as opposed to as soon as
26 possible.
27 Also, with our plan who does do this, it took

1 several years to get all of our systems, and we're a little
2 bit more than a single platform. But it's fairly complex.
3 MR. HACKBARTH: Other comments on number one?
4 MR. SMITH: Very quickly, I thought we had had
5 earlier a third short-term bullet, which was to ensure that
6 1-800-Medicare and the SHIP programs had adequate resources.
7 It seems to me we ought to add that back in.
8 DR. SCHMIDT: We weren't clear whether you wanted
9 that as a recommendation or in the text.
10 MR. SMITH: I'd be happy with it in the text, just
11 clearly there.
12 MR. HACKBARTH: On this issue of as soon as
13 possible or over the longer-term, ultimately under as soon
14 as possible, CMS is the arbiter of how soon that is. I
15 think we could address that again in the text by just saying
16 we recognize the Agency has got a lot going on and as soon
17 as possible we'd like to see this happen.
18 So I think were in agreement on number one. Okay,
19 let's go to number two. Any comments on number two?
20 DR. SCANLON: Unfortunately, let me make a legal
21 comment, as a nonlawyer. That is the issue that already in
22 the statute is a requirement that MA plans provide Medicare
23 Part A and Part B benefits. So given that there's that kind
24 of language, what does it mean to say that CMS has the
25 authority to set minimum standards for benefits?
26 I was mentioning to Rachel and Jill earlier at the
27 lunch break that when they said that CMS had interpreted

1 their negotiating authority narrowly, or more narrowly than
2 OPM maybe has, I was wondering if it was, in some respects,
3 the various things are in the law about what MA plans are
4 supposed to do that OPM doesn't have similar kinds of
5 prescriptions in the law.

6 DR. MILLER: What about this? What about we cut
7 out the reference to the authority for minimum standards and
8 just say MedPAC believes the agency has the authority to
9 ensure -- and pick up the last clause of it -- to ensure
10 that the plans do not discriminate on the basis of health
11 status, as contemplated by the -- I wouldn't put those words
12 in. Just cut it down to that last phrase and I'm saying
13 that because they have the wide authority granted to them in
14 the MMA.

15 DR. REISCHAUER: The chapter that we're talking
16 about here, or the report, deals with benefit design. They
17 can discriminate -- there are lots of tools for
18 discrimination. And I think we want to focus on the fact
19 that this uses authority to ensure that plans do not use
20 benefit design to --

21 MR. SMITH: It's really not even benefit design.
22 It's a broader question of design, in our case, focusing on
23 copays. It has nothing to do with whether or not the
24 benefit is there. The benefit has to be there, which is
25 Bill's point. It should be plan design, or some broader
26 phrase.

27 MR. HACKBARTH: I like Mark's proposed shortcut.

1 Do people understand what he said and agree with that?
2 DR. BERTKO: My only insertion, and it's probably
3 not needed, would be a for example before the word plans
4 could choose between.
5 MR. HACKBARTH: I'm sorry, I didn't follow that,
6 John.
7 DR. BERTKO: I don't want the two bullets there to
8 necessarily be prescriptive. And instead it would be for
9 example -- on the sixth line. For example, plans could
10 choose between...
11 MR. HACKBARTH: You want to add for example,
12 that's the change?
13 DR. BERTKO: I mean that not as an editor today
14 here, but just to say that these two don't necessarily have
15 to be the ultimate decision by CMS. But there are two
16 examples of safe harbors that would be useful.
17 MR. HACKBARTH: I agree with that.
18 DR. SCANLON: I've forgotten what we exactly say
19 in the conclusion, by I think just before we come to the
20 recommendations, it would be good to remind the Congress
21 that they did set a catastrophic cap for the regional plans
22 and that the catastrophic cap, in some respects, is a
23 protection against some of the problems with cost-sharing.
24 MR. HACKBARTH: And so we could have, in the text
25 for that matter, it goes across all three categories of
26 plans, traditional fee-for-service, the regional PPOs and
27 the local MA plans. And one of our consistent themes has

1 been a level playing field. Ideally, we would get to that,
2 which would include a catastrophic cap in all three, from my
3 prospective.
4 DR. SCANLON: Except that, I think, the Congress,
5 in some respects, was trying to make the MA plans more
6 attractive. The fact that one of the principal concerns
7 about traditional Medicare is that it doesn't have a cap.
8 And knowing that the cost of that is quite significant.
9 That's probably why they haven't addressed it directly. But
10 this also does make the MA plans, where you also get
11 management, more attractive.
12 DR. MILSTEIN: Again, relevant to the out-of-
13 pocket cap, we have language that reads now within the
14 plan's network. I would proposed an amendment, and
15 formulary.
16 DR. REISCHAUER: Play by the rules.
17 DR. MILSTEIN: Exactly, play by the rules.
18 MR. HACKBARTH: Did people get that? The issue is
19 whether to count out-of-pocket expenditures for nonformulary
20 drugs towards any catastrophic limit or count expenditures
21 outside of network for any catastrophic limit.
22 MS. BURKE: We've get two modifiers now. As I
23 understand it we now have two modifiers, one of which
24 assumes that these are illustrative rather than
25 determinative. So that's the first question. Have we
26 agreed that these are illustrative? So it's a for example
27 scenario.

1 In that context, I am trying to understand how
2 specific or detailed we should be on the illustrations. As
3 I understand it, this suggestion is that we modify the out-
4 of-pocket cap or modify both with the question of what is
5 counted.
6 MR. HACKBARTH: I think it's a reference to the
7 out-of-pocket cap bullet only.
8 DR. REISCHAUER: It's the reference to the fact
9 that network doesn't cover all of the types of services and
10 Arnie just wants to make sure that that is sort of explicit
11 as opposed to implicit.
12 MS. BURKE: Okay.
13 MR. HACKBARTH: So basically, Arnie is saying that
14 in requiring a catastrophic cap we shouldn't tie the plan's
15 hands in terms of active management of the costs by saying
16 once you hit the cap no holds are barred, you get to go
17 wherever you want and use whatever drugs you want. And part
18 of this option is people enroll in these plans, they buy
19 into their management, and we shouldn't tie their hands and
20 ability to manage.
21 MS. BURKE: And how is it structured in the
22 regional? How is the catastrophic cap structured under the
23 regional plans?
24 DR. BERTKO: My rough recollection is there is a
25 number somewhere around $5,000 of out-of-pocket and then
26 it's covered by -- there may be some cost-sharing.
27 MS. BURKE: But what counts towards out-of-pocket?

1 DR. BERTKO: In the regional? I don't know
2 offhand. I don't know that it's specified.
3 DR. REISCHAUER: It's not specified in the law. I
4 think these are going to be with the regs are going to lay
5 this all out.
6 MS. BURKE: What I'm trying to understand is is
7 there going to be an inconsistency? My only question is a
8 consistency issue.
9 DR. SCHMIDT: I don't think that the regs specify
10 a cap. The law does say that there needs to be a separate
11 in-network and out-of-network cap.
12 MS. BURKE: So we presumably want consistency;
13 right? Or do we?
14 MR. HACKBARTH: That's the question.
15 DR. REISCHAUER: I think we're getting too
16 detailed for what this is, really. Remember, this is a
17 solution to a problem that we are concluding doesn't really
18 exist.
19 MS. BURKE: Which is fine. My only point is if
20 we're going to put in details, then we ought to be sure that
21 we agree that the details are, in fact, consistent with what
22 we expect the details to be in the regional plans or we're
23 going to end up setting two definitions of what the cap is.
24 I agree that maybe the answer is not to put it in
25 any detail. But if we're going to put in any details, then
26 it would seem to me there's some logic to consistency so we
27 don't end up having two definitions of what counts towards

1 the cap, that we're suddenly suggesting can be used in
2 creating a safe harbor.
3 So I'm with Bob. I'm fine to have no detail. But
4 if we have it, then it seems to me we ought to have some
5 knowledge of whether we're consistently defining what counts
6 towards caps as we create them.
7 MS. RAPHAEL: I would prefer not to get into what
8 should count towards the caps. I think what we're saying is
9 the guidelines for safe harbor might include an out-of-
10 pocket cap on cost-sharing or some limitation on cost-
11 sharing having to do with discretionary services period. I
12 wouldn't even mention chemotherapy, for example. I would
13 leave it broader than that.
14 DR. REISCHAUER: And of course, to jump on
15 Sheila's bandwagon here, if we were going to be consistent
16 in these two, we would talk about cost-sharing within the
17 network, which we haven't done.
18 MR. HACKBARTH: I agree with you, Arnie, on the
19 merits of the issue. But I think we are getting too far
20 afield for this particular purpose in prescribing detail.
21 And so, what I'd ask that we do is just make it a reference
22 to a cap on cost-sharing.
23 DR. REISCHAUER: We can elaborate in the text,
24 too. That's the right place to have that kind of
25 discussion.
26 MR. HACKBARTH: Let's do that.
27 MR. SMITH: I don't want to draw our solution to

1 Bob's correctly described small problem. but I find myself
2 uncomfortable with John's opening it up recommendation.
3 Maybe we should say guidelines should include: rather than -
4 - that gives the opening that John wants but it takes away
5 the strength of this recommendation, which says there should
6 be a catastrophic cap and there should be --
7 MR. HACKBARTH: I think that's a good point and
8 consistent with his intent. It isn't limited to this list.
9 It could be others as well. Jay?
10 DR. CROSSON: I'm not sure this a countercurrent
11 suggestion, but I think what we're trying to do here is to
12 provide continued flexibility to plans because that has a
13 value. But I think also try to focus on a particular issue
14 which has to do with beneficiary protection for, again, a
15 relatively small number of vulnerable people.
16 I almost wonder whether this is too general an
17 approach, although I like the first bullet point, I think
18 that's correct. But I would almost argue that it might be
19 better to say something like in particular, there should be
20 protections for -- I don't get the wording here -- for
21 beneficiaries at risk of disproportionately high cost-
22 sharing on services that are less discretionary in nature,
23 perhaps such as chemotherapy, and that can be resolved
24 either through an appropriate out-of-pocket cap on total
25 cost-sharing or limitations on cost-sharing for those
26 services.
27 So just flipping it around and narrowing it closer

1 to the problem that is meant to be addressed. I could try
2 to write it out.
3 MR. HACKBARTH: Say that one more time for me.
4 I'm sorry, I'm getting slow.
5 DR. CROSSON: I think the issue that we were
6 grappling with --
7 MR. HACKBARTH: Just the language part, just
8 repeat.
9 DR. CROSSON: Do you want me to say exactly the
10 same thing I said before?
11 It might be easier for me to write the text and
12 write it out.
13 MS. THOMAS: We have it. Can you read it back?
14 [The reporter read the record as requested.]
15 DR. CROSSON: It seems to me it provides more
16 emphasis on the problem, yet it keeps flexibility.
17 MR. HACKBARTH: I want to caution us about trying
18 to word smith. Let's avoid trying to do that. I understand
19 your point but let's keep the substance here.
20 I think we can take some things like chemotherapy
21 out of the boldfaced recommendation and put them in the text
22 and make it both sharper for you, Jay, and also a little
23 cleaner in terms of being a recommendation in our usual
24 format. So give us the freedom to try to polish it up.
25 But substantively, I think we've got agreement on
26 this.
27 MR. DURENBERGER: A question relative to Medicare

1 Advantage plans generally, and maybe a future work product.
2 I have been thinking about what Nick said this morning and I
3 have some apprehensions about the role that Medicare
4 Advantage plans will play when they are fairly unrestricted
5 in the way they are creative, as we say in here, about
6 benefit design. I'm not sure that whatever I might have to
7 say or he said this morning is responsive to the actual
8 question for the study.
9 So I would hope that at some point in time we
10 spend a little bit more time analyzing the whole issue of
11 getting back to standard benefits or whatever it may be so
12 that we have some more analysis of the plan structure as a
13 way in which to facilitate the provider/patient
14 relationship, not to get in the way with it, which I think
15 is part of the argument that he was making.
16 When you talk about creativity of benefits, that
17 only works to the advantage of the health plan. If you talk
18 about creativity of services within a benefit structure,
19 that works to the advantage of the care providers and the
20 patients.
21 And I think about this particularly with regard to
22 people who are chronically ill, who are the ones who will be
23 probably working with their providers to determine which
24 plan would be the best for them and things like that.
25 So I don't want to belabor it in the context of
26 this, but I think that that whole context of the
27 relationship between the plan, the providers and the

1 consumers, in terms of plan benefit design, deserves some
2 discussion or some analysis at some point in time beyond
3 this.
4 I hope we can do that sometime.
5 MR. HACKBARTH: Any other comments?
6 DR. MILLER: So what the game plan is is we will
7 redraft these along the lines that you said, and hopefully,
8 say first thing in the morning, hit it for 10 minutes or so,
9 have you look at it, see the changes, take the vote, and be
10 done with it.
11 MR. HACKBARTH: Okay. Thank you for the fast
12 turnaround.
13 We will have a brief public comment period with
14 the usual ground rules.
15 MS. McILRATH: I just wanted a couple of words
16 about the SGR. We are very grateful to the Commission for
17 being against the thing and having it removed. It hasn't
18 happened yet. So long as it exists, it seems like in the
19 discussions that you have on different issues that affect
20 physicians that one should always keep in mind what will be
21 the impact so long as you have the SGR.
22 So in that respect, I would like to endorse what
23 Dr. Wolter said about looking at the impact of the growth of
24 the drugs on the SGR.
25 Just to give you a little more flavor for how fast
26 that is increasing, it was 3.7 percent of the pool in the
27 base year. It's 12 percent now. It's expected to go to 29

1 percent in 10 years.

2 So physician services may be driving the increases
3 right now. They certainly are growing at a small, minuscule
4 part of the rate at which the drugs are growing. And so you
5 get to a point where not only are they a bigger share of the
6 pool, but because they are a bigger share of the pool and
7 because the penalty is not applied to the drugs, then the
8 part of the services for which the penalty is applied is
9 smaller and smaller and therefore the penalty has to be
10 bigger and bigger. And there's more and more likelihood
11 that you will exceed the target because the drugs are
12 growing so rapidly.

13 Another point, just to look at when you're looking
14 at expenditure shift and when you're looking at what's
15 happening with imaging, there was a comment about looking to
16 see did growth in physician services have an impact on
17 quality. I would say you should probably also be looking at
18 did it have an impact on spending in other sectors.

19 We know that there are 95 codes that now have a
20 practice expense in a physician's office that in the
21 beginning of the practice expense, the resource-based
22 practice expenses, they didn't even have an office-based
23 practice expense. So that alone, there is a big shift over
24 there and there's no way that there's no adjustment
25 whatsoever for any of that.

26 And then just to conclude, on the electronic
27 records there was a discussion and one of the physicians

1 said one of the things that was good about that for the
2 practice was that it sent out reminder notices and people
3 came in more frequently. I would say that could have an
4 impact on the SGR, as well. Obviously, in some cases there
5 may be some trade-off. In the chronic care Medicare
6 demonstrations we talked about it. But it's frequently a
7 trade-off on the hospital side. You do more on the
8 physician side to get a savings on the hospital side.
9 So it would be helpful, I think, if the
10 Commission, when it's talking about doing some of the things
11 that everybody wants to do, would talk about the restraint
12 that the SGR imposes on doing those things.
13 DR. GUCCIONE: Andrew Guccione of the American
14 Physical Therapy Association. First of all, once again I
15 want to thank commissioners for considering the issue that
16 was put before you today, and we certainly appreciate the
17 conversation and the discussion.
18 We also appreciate that regardless of whether
19 individual commissioners believe the referral requirement
20 should be retained or not, there does seem to be widespread
21 agreement that the physician referral requirement does not
22 serve the purpose for which it was intended, which is as a
23 utilization control. And that recognition, we think, is
24 quite valuable.
25 We also certainly appreciate staff's very cautious
26 presentation of counterarguments and the conditional use of
27 may and could is very heartening. Obviously the association

1 presented the strongest evidence in support of the arguments
2 we put forward, and we believe the strongest evidence that
3 is out there to be used. Clearly, the counterarguments are
4 speculative.
5 I think that we would certainly look forward at
6 some time to working with commissioners and staff to answer
7 some of the questions about evidence-based practice which
8 have arisen about physical therapy in particular. We are
9 delighted that, in response to our work with the OIG and CMS
10 over the last several years, we have actually an electronic
11 patient record which will be entering the marketplace this
12 spring with an outcomes instrument which will lead to a
13 national outcomes database, as well as we also have
14 available to physical therapist members a repository of now
15 over 1,600 articles summarizing the peer reviewed literature
16 on treatment effectiveness with the calculation of effect
17 sizes where such calculations were appropriate.
18 So we're taking our commitment to avoid medically
19 unnecessary services and to eliminate the abuses that we see
20 in what is charged for as PT. We take that very, very
21 seriously.
22 However, all that said, and given the speculative
23 nature, I think we would have hoped and we still may hope
24 that the commissioners might find themselves exactly where
25 the Senate did when it actually passed its version of the
26 bill that finally got this issue to MedPAC, which was that
27 to truly answer these questions one needs to study them

1 directly.

2 The Senate version of this bill actually had
3 included a demonstration project, a limited demonstration
4 project in five states. We were very enthusiastic about
5 that possibility. Should that possibility still go forward,
6 we would be delighted to finally have the answers to these
7 questions, given the recognition that the physician referral
8 requirement does not have the effect that it has been
9 proposed to have.

10 Thank you.

11 MR. HOGAN: I'm Mike Hogan with the Society of
12 Thoracic Surgeons. I have a number of pieces of information
13 that you had asked for in your deliberations over the
14 adequacy of practice expense payments to cardiothoracic
15 surgeons. To be merciful, I will submit them to you all in
16 writing.

17 But there's one piece of information or a major
18 point that I think was absent in your deliberations and that
19 is this. Medicare is paying for the cost of these clinical
20 assistants that cardiothoracic surgeons bring to the
21 hospital to help them in surgery every day. These costs are
22 being paid by Medicare but they're just not going to
23 cardiothoracic surgeons. Because of the way they calculated
24 it, these costs are being leaked to the E&M codes in the
25 form of two cents for every E&M visit billed by every
26 physician in the Medicare program.

27 These costs are in there. So there's an easy,

1 equitable, budget neutral solution and that is just to
2 recapture these costs out of the E&M pools and back into the
3 cardiothoracic practice expense.
4 There were a couple of things that were inaccurate
5 in the slides that you saw and I just wanted to correct in
6 two places on slides five and six. It says that the work
7 RVUs for these positions take into account or pay them for
8 the costs of these clinical assistants. That's not true.
9 The RVUs are specifically physician time and physician time
10 only.
11 The rest I will submit to you in writing.
12 Thank you.
13 MS. STEIN-LLOYD: My name is Leslie Stein-Lloyd
14 and I represent the American Occupational Therapy
15 Association. We appreciate the opportunity to be able to
16 address you today. We particularly appreciate the outreach
17 that your staff has had in contacting us to get our
18 opinions, the occupational therapists opinions, on this
19 important issue of therapist access to patients and the
20 relationship with physician referrals.
21 It struck us today that, first of all, we want to
22 note that we have brought some copies of our letter that
23 have our viewpoints on this issue because we strongly feel
24 that any referral changes that may be contemplated now or in
25 the future for physical therapy should be applied to all
26 three therapist disciplines, as well.
27 It struck us when were listening to what you were

1 talking about on accessing appropriate care that the
2 Institute of Medicine has recently come out with a
3 compelling study called the Health Professions Education: A
4 Bridge to Quality. It deliberates many aspects of how to
5 attain quality care through education. One of the major
6 findings is that collaboration among clinicians is essential
7 to assuring patient safety quality of care.
8 AOTA strongly believes that individuals have the
9 right to direct their own health care and that the right of
10 patients to direct their own health care can be greatly
11 enhanced by the collaboration approach to rehabilitation.
12 That does include the collaboration between physicians and
13 therapists like occupational therapists.
14 We also hope that if you continue to consider this
15 issue in the future that you will include in your
16 discussions equal access to all three therapies.
17 Thank you.
18 MR. HACKBARTH: Thank you. We will reconvene at
19 9:00 a.m.
20 [Whereupon, at 5:35 p.m., the meeting was
21 adjourned, to reconvene at 9:00 a.m. on Friday, October 29,
22 2004.]
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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, October 29, 2004
9:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

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1 P R O C E E D I N G S

2 MR. HACKBARTH: Good morning, everybody. Would
3 you take your seats, please?
4 We have three presentations this morning and also
5 we need to return and do the vote on the Medicare Advantage
6 benefit issue that we discussed yesterday. Since we are
7 still missing a couple commissioners we will proceed and do
8 at least one of the presentations first. First up is
9 hospital pay-for-performance.
10 Karen, are you going to lead the way on that?
11 MS. MILGATE: Yes. In this session we're going to
12 discuss whether it's feasible, given the status of quality
13 measures for hospitals, for Medicare to base a small portion
14 of hospital payment on quality. First we'll summarize
15 briefly past Commission discussion on the topic and then
16 through the body of our analysis on the quality measures for
17 hospitals that are available.
18 Two years ago, in evaluating incentives to improve
19 quality the Commission found that one of the most important
20 incentives, payment to individual settings, was either
21 neutral or negative towards quality. To address this
22 problem, the Commission supported the concept of tying some
23 portion of payment to quality and develop criteria for
24 determining whether settings were ready for this type of
25 initiative.
26 In March of 2004, the Commission determined that
27 quality measurement for health plans and facilities and

1 physicians who treat dialysis patients in fact was ready and
2 recommended that Congress should establish a pay-for-
3 performance program for those settings of care.
4 This is the first discussion to consider whether
5 measures and measurement activities for hospitals meet that
6 criteria. We are not suggesting the Commission identify a
7 specific set of measures, but rather to determine whether a
8 sufficient number and type of measures are appropriate for
9 this use.
10 To assist MedPAC staff in this evaluation we
11 convened a hospital measurement expert panel. The type of
12 organizations that came to that panel were in your mailing.
13 This presentation is based on staff research on measures as
14 well as the discussion of the panel.
15 So again, the purpose of this analysis to try to
16 answer the question of whether it's feasible to base a small
17 portion of hospital payment on quality. There's really two
18 broad considerations. First, the criteria that I've
19 described and that Sharon will go in some detail next. And
20 second, to think of that in the context of the cost of not
21 moving forward balanced with the potential cost of moving
22 forward with pay-for-performance. The cost of not moving
23 forward can be measured in dollars as well as patient lives
24 through complications, longer lengths of stay, readmissions
25 and unnecessary pain and suffering for some Medicare
26 beneficiaries.
27 This needs to be balanced with the cost of moving

1 forward which primarily there are two that we've identified.
2 First, the administrative cost to hospitals and CMS to
3 collect and analyze the data as well as to develop a ranking
4 system, as well as the potential unintended consequences if
5 in fact the criteria the Commission has laid out are not met
6 in the hospital world.

7 MS. CHENG: After looking at a couple dozen
8 private attempts to link payment and performance, MedPAC
9 developed four criteria that help us to gauge whether or not
10 a sector is ready to move to pay-for-performance. The first
11 criterion is whether there is a set of well-accepted
12 evidence-based measures. By this we mean, is there a set of
13 measures that are familiar to providers that are going to be
14 measured? Are they evidence based? Are processed measures
15 based on clinically proven standards of practice? Are
16 outcome measures based on an aspect of performance that has
17 been linked to the outcome that we are measuring? And are
18 they reliably measured?

19 The second criterion is whether there's a
20 standardized mechanism for data collection. We look at this
21 one to determine whether or not this measurement would pose
22 an undue burden on either the providers or on CMS. We are
23 also looking for standardized data collection to make sure
24 that when we get this data we have something that we can
25 compare from hospital to hospital.

26 Our third criterion is risk adjustment. If it's
27 necessary, it should be adequate to maintain equity for

1 providers and access for beneficiaries.
2 And our fourth criterion is whether or not
3 providers can improve on these measures. This has a couple
4 of aspects. First of all, are we getting a measurement that
5 we can use on as many providers as possible? Are we
6 measuring something that the providers believe is under
7 their control? And is it an area that's been identified
8 that needs improvement?
9 All of these criteria add up, hopefully, to
10 whether or not a sector is ready for pay-for-performance and
11 whether or not moving to pay-for-performance is going to
12 lead to a substantial improvement for a substantial number
13 of beneficiaries.
14 MS. MILGATE: To assess the measures that are
15 available and in use for hospitals we divided them into four
16 types of measures. Those would be process measures,
17 outcomes measures, structural measures, and then patient
18 experience of care as a separate measure. We're going to
19 discuss each type in turn.
20 First, process measures are probably the most well
21 used in the hospital sector, and they try to answer the
22 question of whether patients in the hospital are receiving
23 clinically appropriate care. That is, does the hospital
24 have in place processes known, and are they used, that are
25 known to produce better outcomes?
26 The strength of these measures, at least as
27 discussed in our expert panel, was that at the same time it

1 measures the quality of hospital care, it also helps
2 identify what needs to be done to improve that care. In
3 addition, because generally they are evidence based, they're
4 well accepted by providers.
5 Examples of process measures include aspirin on
6 arrival and discharge from a hospital for those with a heart
7 attack, assessment for left ventricular function for
8 patients with heart failure. For patients with pneumonia,
9 whether they received an antibiotic within four hours of
10 coming to the hospital. And for surgery patients, whether
11 they received an antibiotic as a prophylactic one hour
12 before surgery, and then was that antibiotic discontinued
13 within 24 hours after surgery. Hopefully that gives you
14 some sense of what the measures are like.
15 So who uses process measures and how are they
16 used? As I said, they're widely used. The Joint Commission
17 on Accreditation of Healthcare Organization uses them in
18 their accreditation process where hospitals have to report
19 on some process measures to be accredited. The Leapfrog
20 Group uses some process measures in their public reporting
21 and pay-for-performance initiatives. The National Quality
22 Forum is not an organization that uses measures but is a
23 consensus building organization and they have endorsed a
24 fairly broad set of process measures in their consensus
25 process.
26 CMS uses process measures for a variety of
27 reasons. They use them and have used them for quite a long

1 period of time in the QIO program. They actually developed
2 some of the measures and use them for feedback to hospitals
3 to improve care. They also use process measures in the
4 Premier demo, which is a demonstration they're conducting to
5 look at the possibility of doing pay-for-performance in
6 hospitals in Medicare. They also use process measures in
7 the new initiative where they tied reporting on some process
8 measures to getting the full update to hospitals last year.
9 One initiative that they work with the private
10 sector on is the next one listed on the slide and that's the
11 Hospital Quality Alliance. A few years ago CMS, the
12 American Hospital Association, the AAMC, the Federation of
13 American Hospitals, JCAHO, AARP and AFL-CIO -- I believe
14 there's actual organizations that were also involved in the
15 beginning of this initiative -- developed and identified a
16 set of 10 that hospitals could report on voluntarily. So
17 that's another way that CMS uses them and that's a whole
18 other initiative that is also going on at this time. This
19 initiative has also identified another set of measures
20 beyond the 10 initial that they also are going to ask
21 whether hospitals would voluntarily report on sometime in
22 the next six months to a year.
23 The most visible and widely used of any set of
24 process measures are the 10 I spoke of. These are the 10
25 that the voluntarily reporting initiative had as their
26 initial set and the 10 that Congress said they wanted to tie
27 to the update last year. Hospitals, in that particular

1 initiative, it's expected that almost all hospitals that
2 were eligible to be a part of the program will report and
3 have reported on that. There's around 3,800 hospitals that
4 CMS expects to put their individual scores on the process
5 measures up on their web site in November. So that's next
6 month.

7 So just to summarize, as I said it's used for a
8 wide variety of processes; accreditation, internal feedback,
9 public reporting, as well as pay-for-performance.

10 So are there process measures that meet our
11 criteria? Just to lay out the criteria here. Many are well
12 accepted and evidence based, in particular the 10 I spoke of
13 as well as the seven or so that the voluntary initiative
14 intends to use in the next few months. In particular, our
15 expert panel thought that the surgical infection prevention
16 measures that were included in that were particularly
17 promising. There are seven different surgeries that they
18 cover and they thought that would be a good effort to really
19 work on patient safety across the organization, so it wasn't
20 so condition specific, which most process measures are very
21 condition specific.

22 While a burden to collect, most hospitals are
23 currently reporting on some for multiple purposes. They are
24 reporting for the update purpose, for QIOs, as well as for
25 the Joint Commission. Providers emphasize to us that if
26 they were to be measured on process measures that it would
27 be very important that all of those that ask for information

1 from them define the measures the same. That they not be
2 similar, they not be in the same area, but they be the same
3 so that they're collecting it once for multiple purposes.
4 Risk adjustment on these measures is not
5 necessary, so that's not an issue that we deal with here.
6 Can hospitals improve on these measures? Clearly,
7 more improvement is possible on many of the measures.
8 However, we did see that on the reporting on the initial
9 hospitals in a voluntary initiative there were several that
10 are at a fairly high level, which point out the need to
11 continue to evolve to new measures as hospitals do improve
12 to certain high levels across the country.
13 Most hospitals do see patients with one or more of
14 these conditions. For example, if a hospital doesn't see
15 heart patients, they may see pneumonia patients. It also
16 might be useful though to look at some crosscutting measures
17 such as surgical infection so that you aren't limiting their
18 incentives program to a certain set of hospitals.
19 And there has been some discussion that a broader
20 set of measures might be necessary for small and rural
21 hospitals, and if critical access hospitals were included in
22 the program, to recognize some of their core functions such
23 as stabilization and transfer.
24 MS. CHENG: The next type of measures that we're
25 going to discuss are outcome measures. The panel that we
26 spoke with agreed that outcomes are really the bottom line.
27 Payers would to know how the care that they purchased

1 affected their patients. Outcomes can capture clinical
2 effectiveness and patient safety. However, as strong as a
3 consensus was on the importance of outcomes, it was less
4 strong for this type than for the other types on the subject
5 of the readiness of the available measures.

6 Broadly, there are two types of outcomes,
7 mortality and adverse events. An example of mortality might
8 be the rate of mortality following coronary artery bypass
9 graft procedure or other procedure-specific mortality rates.
10 Perhaps the rate of mortality of patients hospitalized for
11 pneumonia or other condition-specific mortality rates.
12 These could be in-hospital, 30-day after admission, or a
13 number of various windows.

14 A third example of an outcome measure would be the
15 percent of patients who developed decubitus ulcers during
16 their hospital stay. This is an adverse event and we
17 measure it because we believe it's reflective of patient
18 safety conditions at the hospital.

19 Some outcome measures are currently very widely
20 used. AHRQ uses mortality in adverse events in their
21 national report on the quality of health care. The NQF
22 launched its efforts to develop a consensus on measuring
23 hospital quality with a set that included some mortality
24 measures and patient safety measures. JCAHO uses a measure
25 of mortality in their core set and also in the information
26 on hospitals that they make available to the public on their
27 web site. The Premier pay-for-performance demo also

1 includes mortality measures.

2 Some mortality rates are also reported widely

3 publicly. For example, the hospital-specific CABG mortality

4 rate on every hospital in California is currently available

5 to patients in that state. And Health Grades, which is a

6 public database of information hospitals includes mortality,

7 and also on the very first page they have patient safety

8 indicators that are available to patients on every hospital

9 in that database.

10 The criterion that we mentioned earlier about risk

11 adjustment is especially important for outcomes measures.

12 The reason is because some types of patients are much more

13 likely than others to experience mortality or adverse

14 events. To maintain equity among the providers that we're

15 measuring and access for risky beneficiaries, risk

16 adjustment for outcomes should be sufficient to identify the

17 relative complexity or severity of the hospital's patients.

18 The adequacy of risk adjustment was an important

19 criterion for the groups that considered whether or not to

20 include mortality and patient safety in their measure sets.

21 As your paper discussed in some detail, AHRQ, NQF, and CMS

22 all considered the adequacy of risk adjustment before

23 putting together their measure sets, and they included some

24 mortality and some patient safety, but not all.

25 Risk adjustment can be achieved currently with the

26 administrative data that we already have. Alternatively,

27 the Commission might wish to consider a recommendation about

1 adding some information to the claims or the administrative
2 flow of data that would give us a somewhat better level of
3 risk adjustment.
4 Information such as a secondary diagnosis on
5 admission would allow patient safety measures to better
6 distinguish between something that happened before a
7 hospital stay and something that happened during a hospital
8 stay.
9 As another alternative, a risk adjustment method
10 similar to the private benchmarking organizations that do
11 similar quality measures could be considered. However, this
12 level of risk adjustment requires record abstraction or
13 other intensive data collection efforts. The Commission
14 would need to consider the trade-off between the burden and
15 the improvement in risk adjustment before you would consider
16 that to be a feasible measure for our measure set.
17 So are there outcomes measures that meet all four
18 criteria? There are generally familiar evidence-based
19 outcome measures. Depending on the risk adjustment they can
20 pose very little burden. Some outcome measures can be
21 measured on most hospitals. Hospitals do have room for
22 improvement. And a sufficient level of risk adjustment
23 remains a question for many measures.
24 MS. MILGATE: Structural measures are measures
25 that are used to ensure that the hospital is capable of
26 delivering quality care. They often address systemwide
27 problems rather than specific condition problems.

1 Examples of structural measures, there's really a
2 wide variety as you can see from this slide. Accreditation
3 was discussed in our hospital panel as a structural measure.
4 Implementation of computerized provider order entry, also
5 another example of putting a system in place to avoid
6 medication errors.
7 If a hospital puts in place systems such as just
8 having more sinks in the hospital that are available to the
9 health care providers. that is one structural way that they
10 could encourage handwashing. Or if a hospital puts in place
11 a program to try to avoid similar medication abbreviations
12 to alleviate some medication errors, that's also considered
13 a structural measure. Those two are both a part of a
14 broader set that we'll talk about in a little bit more
15 detail that the National Quality Forum developed their safe
16 practices list.
17 Another example of a structural measure which was
18 discussed in our hospital panel was volume as a structural
19 measure. That would be, for example, the number of CABG
20 procedures that are performed at the hospital. There's some
21 literature that shows a relationship for some procedures
22 between the volume of procedures and hospital quality.
23 So who uses structural measures and how do they
24 use them? Probably the organization that supports
25 structural measures the most is the Leapfrog Group, and
26 they're also well known for this. When they began their
27 program a few years ago, two of their first leaps, as they

1 called them, were whether a hospital had implemented a
2 computerized provider order entry. This was as a structural
3 measure to look at whether a hospital was trying to reduce
4 medication errors. The other was whether ICU units used
5 intensivists. There had been some literature that showed
6 that length of stay in ICUs was shortened when they used
7 intensivists.

8 They also look at volume and have in the last year
9 endorsed the use of the NQF-endorsed safe practices list,
10 which includes the three that they had put in place at first
11 and then 27 others.

12 The National Quality Forum, as I said, developed
13 this consensus list and endorsed 30 safe practices. CMS
14 uses structural measures primarily through its deemed status
15 relationship with accreditation, but also has in place in
16 their QIO program some safe practices measures that -- they
17 overlap with their surgical infection measures, but I would
18 think those would be considered structural as well. Then
19 JCAHO, their accreditation product is a structural component
20 itself, and within that there are quite a few different
21 structural standards that they look at. In particular, the
22 safe practices, they have their own questions about whether
23 a hospital does safe practices or not.

24 So these have been used for pay-for-performance,
25 in particular by Leapfrog, public reporting, and for
26 certification processes.

27 So are there structural measures that meet our

1 criteria? Some, such as the safe practices list and
2 accreditation, are well accepted; others less so. There is
3 a debate over whether implementation of the CPOE in the
4 hospital is something that is perhaps too expensive for
5 enough hospitals that it should not be used as a measure.
6 There are discussions back and forth on that and I won't go
7 into the detail of that now, but suffice to say there's some
8 controversy about that.
9 In terms of intensivists, again the debate is one
10 about whether there are enough intensivists available for
11 hospitals to actually use them all over the country. The
12 proponents of using intensivists suggest that if in fact
13 this were used as a quality measure the supply might
14 increase. So the debate goes both ways.
15 The burden of collecting the data varies, but many
16 hospitals are already doing it. For example, for
17 accreditation many hospitals are also assessing some of the
18 safe practices. The Leapfrog Group told us that they expect
19 within this reporting cycle to have 1,200 hospitals who have
20 filled out or are filling out the survey on whether they are
21 using, and the degree to which they are using safe practices
22 identified on that list.
23 Risk adjustment is not necessary and our panel was
24 pretty much in agreement that improvement is possible for
25 all hospitals on many of these measures. They were
26 particularly supportive of measures that moved into the area
27 of trying to improve safety by looking at what the practice

1 should be to improve safety rather than counting the adverse
2 events that were the result of unsafe practices.
3 MS. CHENG: The final measure type that we'll
4 discuss this morning are patient experience measures. This
5 type of indicator measures whether or not the goals of the
6 patient were met during their hospital care. They may
7 reflect whether or not the patient was truly at the center
8 of care, did doctors and nurses and other professionals
9 listen to the patient and try to understand what he or she
10 was trying to achieve during their hospital care? Did the
11 patient receive adequate information to be an active
12 participant in his or her care while they were in the
13 hospital?
14 These measures are cross-cutting in a couple of
15 ways. First, they can apply to almost all types of
16 patients. They're not restricted just to surgical patients
17 or patients with a particular kind of condition. You can
18 measure pretty much anybody who walks in the door of the
19 hospital for care.
20 Second, they can transcend hospital care a little
21 bit and break out of the silo by asking patients how well
22 prepared did you feel for going back home or going to your
23 next setting of care? So in that way they can be somewhat
24 cross-cutting.
25 Some examples of patient experience measures are,
26 how often did a doctor listen to you carefully? How often
27 did nurses explain things in a way that you could

1 understand? And did you get information about symptoms or
2 health problems that you should look for after you were
3 discharged from the hospital?
4 Many different hospitals use many different tools
5 to measure some aspect of patient experience. CMS and AHRQ
6 looked at all this measurement activity going on and
7 realized that it would be good to develop a standardized set
8 so that hospitals would have comparable information so they
9 could compare patient experience. They worked to develop
10 HCAHPS, which would be a standardized tool that hospitals
11 could use. They also looked at the tools that are already
12 in use and they looked at the CAHPS survey that's used by
13 health plans to measure patients' experience within health
14 plans.
15 They used a broad stakeholder process to design a
16 tool that would be relevant to as many information users as
17 possible. They included hospitals, the American Medical
18 Association, and AARP, among others, as they designed their
19 tool. They streamlined the tool working with this group and
20 with researchers, and they only retained items that passed
21 tests for reliability and validity of measurement. Their
22 inclusive approach to designing the HCAHPS tool will
23 continue as they submit it to NQF also for their input on
24 the tool. This tool has already been field-tested at over
25 100 hospitals in three states. It will go through
26 additional dry runs in the field and is expected to be in
27 final form for voluntary use by hospitals in the summer of

1 2005.

2 So are there patient experience measures that meet
3 our criteria? Generally measuring patient criteria is well
4 accepted. It may pose a small burden on hospital's
5 depending on the tool. Risk adjustment for patient
6 experience may not be necessary, but in fact with HCAHPS
7 will be available. And improvement is possible on these
8 aspects of patient experience.

9 MS. MILGATE: So we've covered a lot of ground
10 here and in the background materials and we'd like to ask
11 two things from you. First, we'd ask you to identify
12 concepts or measures you think that would enhance the
13 discussion that we may not have covered here, and to react
14 to the analysis we've laid out. What we've found through
15 interviews, evaluation of measures and their use, and the
16 opinion of our expert panel is that the most promising type
17 of measures for pay-for-performance are probably process
18 measures. There's one set, the 10 we spoke of, which is
19 already being reported to CMS on a widespread basis. And
20 the same initiative that encouraged reporting on these
21 specific 10 also intends to roll out a variety of others in
22 the next six months to a year, including promising cross-
23 cutting measures such as surgical infection.

24 In terms of outcomes measures, both mortality and
25 complications are widely used. However, the level of risk
26 adjustment is at issue. Some have felt comfortable simply
27 using claims for risk adjustment. Other initiatives require

1 a deeper level of information. The Commission may wish to
2 recommend additional data collection to improve risk
3 adjustment methods. That said, two indicators are widely
4 used that are outcomes and those are mortality for AMI and
5 mortality for CABG, and others are used for public reporting
6 by one or more organizations as well.
7 In terms of structures, we find some disagreement
8 on some of the measures, but also agreement on a few. For
9 example, accreditation could be used as a good basic
10 framework and as one measure for a set of measures used in
11 pay-for-performance. Our panel felt that volume was
12 something that would be useful information that should be
13 included, for example, the number of cases in a measure, but
14 not as a measure itself. The National Quality Forum safe
15 practices were discussed as a good set of safe practices
16 that could be measured. And while CPOE and use of
17 intensivists may have positive benefits as measures, our
18 analysis would find that they are less well accepted than
19 some of the other structural ones.
20 In terms of patient experience, they appear to be
21 very promising and our hospital panel felt they were a
22 critical condition to the set of measures that would be used
23 for hospitals, and that possibly they could be included when
24 HCAHPS is final and in use by hospitals.
25 MR. MULLER: I know it's traditional to compliment
26 you on the work, but this is exceptional. I think both this
27 and the next topic on the agenda the staff really did

1 extraordinary work. Mark and Glenn, this is just wonderful
2 work.
3 I think we all have some comments where we might
4 quibble a bit, but I think that the field has advanced so
5 much in the last year or two. I think the fact that, as
6 you've pointed out, a lot of the people who are working in
7 this field have come together to try to get more
8 standardized. I think even compared to our discussion two
9 years ago when there were a lot of complaints about
10 everybody's coming at in a different way, I think there's
11 been exceptional progress made in terms of these initiatives
12 at AHRQ and Leapfrog and all the people that you mentioned
13 in your oral presentation. So I think for once we should
14 say this is something that is moving quite well and
15 aggressively, because oftentimes we say things aren't
16 working as well as they should. So I think your chapter and
17 your presentation lays that out.
18 Obviously, the more we standardize on this, the
19 better we'll be able to get people to improve the
20 performance, which is the ultimate goal here. So I think
21 since the fact that enormous progress has been made we
22 should note that and encourage all of the participants in
23 this to keep trying to work in a common way so that in fact
24 doctors, hospitals, payers, patients can all see what
25 they're getting.
26 To paraphrase what our IT panel said yesterday,
27 getting the tool out there, in some ways it's the start of

1 the journey. And then obviously how we all in the field
2 respond to this is of critical importance. In the state
3 that I'm in, Pennsylvania, this reporting has been going on
4 for close to 15 years, largely on what you call outcome and
5 safety measures. I think it's fair to say that the response
6 to that public reporting has not been as dispositive of
7 changes as one would perhaps like it to be. It's largely
8 used there for evaluation. I think tying payment to make it
9 is a critical step and in these recommendations we're moving
10 more and more in that direction.

11 I know in the New York State CABG report over the
12 same 15 years there have been reports that behaviors have
13 changed in a very positive way. But I would say probably
14 Pennsylvania has the most advanced system that I know about
15 in the country. So just having the tool out there and
16 having it public is not sufficient. Tying payment to it is
17 of critical importance. I think moving to it in the kind of
18 aggressive way that you're suggesting may not seem too
19 aggressive, just 1 percent to 2 percent in the beginning,
20 but I think moving in that direction is a very positive
21 step.

22 I would also note that it's important to keep
23 evaluating as we go, the responses as we start implementing.
24 I think having both MedPAC and CMS and others get the
25 learnings out there very quickly is of great importance, so
26 that the best practices get both agreed upon as to what they
27 are. Also the learnings as to what works in terms of making

1 things better I think it's very important to get out there.
2 So in all I think this summarizes very well where
3 the field has moved very aggressively, at least
4 intellectually in the last few years. So I feel very good
5 about the direction that we're going in.
6 DR. MILSTEIN: One's perspective on performance
7 measurement and use of performance measurement for purposes
8 of payment looks very different from the perspective of
9 different stakeholders in the American health care system.
10 It's not difficult for anybody to project, based on their
11 place in the health care system as to how they feel about
12 issues of how ambitious we should be about performance
13 measurement and reporting now. I want to cite Ralph as an
14 exemplar of providers that embrace performance measurement.
15 From a purchaser perspective, the world tends to
16 look a little different and I'd just make a couple of
17 comments along those lines. First, at the end of the day,
18 once you immerse yourself in performance measurement in
19 health care you realize you really have two broad choices.
20 You can either measure a small number of narrow facets of
21 care very perfectly and very cheaply, or you can measure
22 care performance broadly, less perfectly and more
23 expensively. Those are the two ends of the spectrum.
24 I think the staff suggestion about CMS requiring,
25 in a judicious way, supplemental data on hospital bills in
26 order to support better performance measurement is
27 absolutely essential to helping us resolve the dilemma I

1 just cited. The quality work group of the National
2 Committee on Vital and Health Statistics has actually done a
3 very thoughtful piece recommending what is essentially the
4 smallest increment to data that is currently submitted on
5 hospital bills that if routinely submitted would allow the
6 biggest increase in our ability to move forward more
7 confidently on a broader set of more valid performance
8 measures.
9 The structural measures discussion maybe would
10 benefit from the additional following comment. If you look
11 at structural measures, some structural measures are what I
12 will call low bar structural measures. That is, these are
13 things that you shouldn't be allowed to have your doors open
14 if you're not doing, and that's what the JCAHO is focused
15 on.
16 If one looks at the other end of structural
17 measures, which I'll call more aspirational performance
18 measures inspired by Quality Chasm visions as to what
19 American health care should be, that's where you get into
20 what the staff diplomatically described as areas of
21 controversy and disagreement. I think the ICU staffing is a
22 perfect example of that. In the NQF review of this they
23 cited 12 published articles and the folks at Hopkins who
24 have most recently published a review on this say that if we
25 had the kind of staffing that are built into the NQF
26 measures of ICU physician staffing, essentially something on
27 the order of magnitude of 60,000 American hospital patients

1 would not die every year. The majority of those would be
2 Medicare beneficiaries. So it's controversial, but that
3 doesn't mean we should shy away. It's not only length of
4 stay and cost reduction issues but it saves a lot of lives.
5 Last, in terms of your question, what might we
6 want to see on this list in the way of measures that we
7 don't currently have, I would put near the top, measures of
8 hospital longitudinal efficiency. Elliott Fisher and Jack
9 Wennberg keep telling us that Medicare patients by and large
10 tend to be well longitudinally to particular hospitals and
11 their medical staffs. And those hospitals and medical
12 staffs vary dramatically in the amount of Medicare benefits
13 fuel burn associated with their managing a population of
14 patients over time. So I would love to see a measure of
15 longitudinal efficiency, which is one of the six IOM domains
16 of quality, added to the list.
17 The last comment is that I think performance
18 measurement in health care is off by several orders of
19 magnitude. If you think about the 10 measures that were
20 agreed upon by that alliance -- I think it's called the
21 alliance -- and you say, if you were to build denominator in
22 the average American hospital of the number of important
23 processes that take place in that hospital that have to
24 happen right if you're going to get a good outcome and say
25 what percent of those important processes do those 10
26 measures represent, I would say it probably is less than
27 one-hundredth of a percent.

1 For example, it's estimated for an average ICU
2 patient each day something like 162 processes have to happen
3 right. So 10 process measures is not even close to what we
4 might need. Steve Jenks at CMS who does this research has
5 basically said, if CMS continues -- CMS has used the QIOs to
6 perfect these same 10 measures over the last several QIO
7 scopes of work. He's basically said that if we keep working
8 at and keep going are our current rate of performance
9 improvement, by the year 2025 the Medicare program will have
10 achieved near-perfect care for 10 process measures for three
11 conditions. That is what we refer to as off by orders of
12 magnitude.
13 So I guess I'll close by saying that people have
14 said that one of the problems with the health care industry
15 with respect to performance management has been what Don
16 Berwick has called poverty of ambition. There's an
17 equivalent danger on the buy side of poverty of ambition
18 with respect to our purchasing and what we measure and what
19 we reward. So I would hope that we would consider the
20 broader end, the wider end of a measurement approach and not
21 buy into what is in orders of magnitude accession to the
22 difficulty of measurement. It's difficult but we have a lot
23 of measures that are plenty good enough and it's a good time
24 to move forward.
25 DR. NELSON: Terrific work. Great chapter. I
26 really enjoyed it. I'd like to highlight a couple of the
27 areas that I was struck by particularly. I think it's great

1 to point out that there are some areas where we have
2 improved. We are getting flagellated a lot and it's really
3 nice to have some numbers that show improvement in areas
4 where we've shined the light. I enjoyed that.
5 I like the emphasis on feasibility in terms of
6 considering the burden and the cost of collection. One area
7 that you might supplement that with would be to give some
8 numbers on the current costs of record abstracts, maybe
9 based on New York or Pennsylvania, just to get an idea of
10 what it costs now. Perhaps you can do some extrapolation on
11 what the additional cost might be for collecting data from
12 chart abstracting.
13 You pointed out the need for coordination among
14 the entities that are requiring data, to encourage
15 standardization, and agree on a single set that can be
16 reported to all of the various users. I'd really like to
17 have that emphasized. There isn't any reason for successive
18 hordes of folks coming into hospitals asking for the data to
19 be arranged in a little different fashion for their purpose.
20 If they can all agree on what they want and how they'd like
21 to have it delivered, it would be very helpful from the
22 standpoint of cost and burden.
23 One area that you didn't mention with respect to
24 data and it might be worth a sentence or two would be the
25 importance of looking at the data with respect to racial and
26 ethnic disparities. Data on race and ethnicity are being
27 collected. The problem is that in quality measurements,

1 performance measurement, oftentimes they aren't being looked
2 at with consideration of whether we are making progress as a
3 nation or individual facilities are making progress in
4 reducing those disparities.
5 The final point has to do with the panel. It may
6 be that you mentioned the composition of your expert panel
7 before I came in. I didn't see it in writing. Unless they
8 wish to remain anonymous, I think it would be helpful to
9 have them identified because the validity of their comments
10 depend on what they brought to the table.
11 DR. MILLER: I thought we named the groups that
12 were represented in the mailing materials.
13 MS. MILGATE: Did you want to go through the
14 groups? We didn't provide individual names, but I can you
15 who the groups were.
16 DR. NELSON: I'm sorry, I must have missed it.
17 DR. MILLER: Generally our strategy in these
18 things is we tell people when they come that we'll represent
19 the views and not identify individual comments to
20 individuals. So generally we put the organization, but we
21 can tell you who was at the panel as well. We have no
22 problem with that. We just want to attribute specific
23 comments to specific people.
24 DR. NELSON: I understand that perfectly. I'd
25 like to know who they are.
26 DR. MILLER: The list of the organizations that
27 were represented were --

1 MS. THOMAS: It's at the top of page six.
2 MS. MILGATE: I'd be glad to go through it.
3 DR. NELSON: We can do it off-line. That's fine.
4 Thank you.
5 MS. RAPHAEL: There was one recommendation that
6 your panel made that I thought was particularly important,
7 and I don't know where it belongs in the way we're
8 organizing process, structure, outcomes or patient
9 experience. That was the hospitals capturing secondary
10 diagnoses upon admission and also upon discharge. I thought
11 that was something that really could have a lot of impact in
12 terms of how care was delivered both within the hospital and
13 after discharge. I think that is a problem, when someone
14 comes in for one procedure and all you get is that one
15 procedure, and they have hypertension and other things,
16 cognitive impairment going on and you don't know it at all.
17 Both the people in the hospital don't necessarily know it
18 and then you don't certainly don't know it upon discharge.
19 I think that really creates a lot of gaps that contribute to
20 unsafe practices.
21 Then my other thought is, as Ralph was saying, in
22 New York State we have captured mortality data. Then the
23 question becomes, how is it used? Because every year
24 there's a flurry of activity when it comes out in the
25 newspaper and then hospitals spends a lot of time on PR and
26 how are they going to respond to this, either both to put
27 out an ad saying, we are among the best or defend themselves

1 if they're among the worst. And then lo and behold, it's
2 over and nothing really happens after that.
3 So for me one of the questions is, let's say we
4 get this right and we get the right order of magnitude.
5 What then?
6 MR. HACKBARTH: Carol, to me, my response to that
7 is that providing the information in and of itself is a good
8 thing. But that's why we need to start moving towards
9 paying for quality as well. We need to start acting on it.
10 So the action can occur at many different levels but that,
11 in a nutshell, is why I think it's important for Medicare
12 and private payers to begin using the data and making a
13 difference with it.
14 DR. MILLER: To go one step further, cautiously.
15 I think we've pitched our whole approach to P-for-P and this
16 is the next installment in that discussion that we've been
17 having for a year now, as this is integrating these measures
18 for the purposes of payment. We acknowledged at the outset
19 of this discussion a year ago that other people were doing
20 things like public reporting and CMS. I wouldn't say that
21 we're excluding that from a possibility, but for our
22 purposes and what we were headed towards ultimately
23 recommending, I think we're talking about making it as part
24 of the payment system. Is that fair?
25 DR. REISCHAUER: With respect to the patient
26 experience measures, they make me very queasy when we get to
27 pay-for-performance. I was wondering if in any of the

1 literature they have examined whether there are systematic
2 socioeconomic differences in responses? Because I have this
3 feeling that the expectations of different groups are really
4 quite different. If a doctor passes through the room of
5 some group they're perfectly satisfied, and another group
6 wants to intensively question the physician. That's their
7 view of satisfactory interaction. That would be question
8 number one.

9 The second thing is an observation that comes from
10 Arnie's comments. I take it at face value and look at
11 where, notwithstanding the fact that we are going at warp
12 speed compared to how we used to go, Arnie is saying we
13 aren't going to get off the runway in 25 years. I'm
14 starting a different metaphor today. Everybody get their
15 instructions on that? No farm stuff today.

16 [Laughter.]

17 DR. REISCHAUER: In a sense we might feel good and
18 we might have some good PR, but we really aren't going to be
19 changing the system unless there's a correlation between
20 good behavior in the one-tenth of 1 percent we are measuring
21 and everything else. I mean, do institutions which d the
22 right thing on this little microcosm that we're measuring
23 have different management styles, different operating styles
24 that cause good behavior elsewhere? Somebody should be
25 looking at that, the extent to which there are externalities
26 and correlations here because maybe you don't have to
27 measure everything and reward everything if you find that

1 there's a very high correlation between some key things and
2 almost everything else that goes on.
3 MR. MULLER: That in fact is the intent.
4 Obviously, there are so many things that go on in these
5 settings, you couldn't have 20,000 measures are hundreds of
6 measures. So the question is, can you empirically show what
7 the cross-cutting measures are? For example, one that has
8 gotten more and more attention is infection control, for
9 obvious reasons. If one is good at infection control that
10 can therefore be correlated to a lot of other outcomes as
11 well.
12 So I agree with Arnie. If you thought that you
13 were just doing one-tenth of 1 percent, you're obviously
14 missing the quality improvement opportunities. So the
15 question is, are there cross-cutting measures that are
16 correlated with good performance in general? I think,
17 again, there's been a lot of progress made in understanding
18 what those might be.
19 I would argue that you don't want to try to
20 measure 200 things because that's exactly where confusion
21 sets in. I do think you have to keep it to a simpler
22 number. Whether that's 30 or 40 or 50, the way Leapfrog is
23 moving, that's probably the right magnitude, even though as
24 the analysis indicates quite well, here and there you will
25 miss certain populations. Some things are just for kids,
26 some are for adults, and so forth. But I think keeping
27 those kind of cross-cutting measures is an empirical

1 question and I think we should definitely look in that
2 direction.
3 DR. REISCHAUER: You also have less hesitation
4 putting a greater weight on the pay-for-performance if
5 you're comfortable in that. You don't have to restrict it
6 to the weight of the activities that you are measuring.
7 MS. CHENG: Just to quickly respond to your
8 question on the patient experience. The folks that have put
9 HCAHPS together also included in their research some of the
10 effects of patient characteristics. So there is actually a
11 risk adjustment module that goes along with HCAHPS. It
12 includes age, education, self-reported health status,
13 whether English is spoken in the patient's home, what type
14 of service area they received in the hospital, the
15 interaction of age and service, and the mode of survey
16 administration. So there is that module.
17 MR. HACKBARTH: Can I just leap in here and pursue
18 this for a second? When Arnie was talking I found my heart
19 beating faster, and I'm with you. I believe that we ought
20 to be able to go faster.
21 But I want to really focus on this issue because
22 in a sense what you're saying is a direct challenge, or
23 arguably a direct challenge to one of our stated criteria
24 about well accepted. It really raises the question of what
25 is Medicare's role, what can Medicare do, being a public
26 program run through a political process? We originally
27 chose well accepted because we thought that that allowed us

1 to build confidence and move forward in an orderly way with
2 maximum political support and less friction that would slow
3 down the process. It was sort of a step-by-step, cautious,
4 very Washingtonian sort of process.
5 You're saying from your vantage point that that is
6 mistaken. I think that is something that we need to hear
7 from other commissioners about, because it is a challenge to
8 one of our basic criteria.
9 DR. MILSTEIN: Maybe a 30-second response to say
10 that the pivot is the question, is the term well accepted.
11 Well accepted by whom? The narrow, inexpensive to measure
12 process measures are very well accepted by providers. If
13 you were to say to informed consumer leaders or purchasers,
14 how do you feel about judging this segment of your supply-
15 chain, if you're a purchaser -- to use the CMS 10 -- 10
16 measures of three conditions for everything you're paying
17 for under Medicare? Any experience procurement person for a
18 Fortune 500 company would say, you've got to be joking.
19 So well accepted has to be something that is
20 arbitrated by not just the suppliers, the hospitals, but
21 also the purchasers. I think the NQF, what's nice about the
22 NQF is it's a place where multiple stakeholder views as to
23 what needs to happen and what's reasonable to do gets
24 arbitrated. In the NQF, for example, they said that there
25 were 39 measures, not 10 measures, that would be a
26 reasonable starting point, and also endorsed 30 safety
27 practices. And I think they're about to endorse HCAHPS. So

1 there we have a measure set of 70 that multiple stakeholders
2 have come together, laid out on the table their own
3 definition as to what's acceptable to them and come to some
4 agreement. So I think that's an example of a richer set.
5 MR. HACKBARTH: Then maybe the gap is narrower
6 then it sounded initially, because de facto that is what
7 we're doing. We're looking to organizations like NQF to
8 validate, if you will, through their disciplined process
9 that these are reasonable measures. We never explicitly
10 said, we're just going to use the NQF, we're going to limit
11 ourselves to that, but in fact that's what we've been doing.
12 MS. MILGATE: A couple of thoughts I'd add though
13 is that the NQF hasn't done an analysis -- and it doesn't
14 mean that these measures couldn't be used for this purpose.
15 But they haven't done an analysis of whether they think
16 these measures would be appropriate for pay-for-performance.
17 So they said, we think these are good measures of hospital
18 quality. Now that's a really gray area and who's really to
19 decide? But that wasn't the purpose that they put them in
20 the set.
21 Having said that, the 39 that they endorsed
22 include the 10, include the seven that the voluntary
23 initiative is going to go forward with, includes some of the
24 others that CMS and JCAHO have also said are good measures.
25 Just that they haven't evaluated them specifically for that
26 purpose, so to say, let's just take theirs and those are
27 fine is a little bit of a jump.

1 MR. HACKBARTH: But implicit is that there might
2 be a higher standard yet for NQF to say that they're
3 appropriate for pay-for-performance, if they say they're
4 good valid measures but there's --
5 MS. CHENG: It could be that, yes. When you're
6 putting money on the table -- and that's the other point I
7 would add. I've heard Steve Jenks' comment and I think
8 that's a really good comment that he makes. But he also was
9 talking, I think, in the context of the QIO program where
10 you didn't have public reporting, where you didn't have an
11 actual dollar attached to the measure. Those were the only
12 two other thoughts I'd add into the mix.
13 DR. MILLER: Could I just say one thing about
14 this? This will be a little stylized and won't have the
15 detail quite right, but what we did is when we pulled people
16 together on the panel it represented these groups that we're
17 talking about. It also had hospitals there in one form or
18 the other. You obviously can't get everybody in that way.
19 Again this is highly stylized.
20 The take on it was, if you're thinking of pay-for-
21 performance, there's probably a lot of process stuff that's
22 ready to go, and lots of already agreement on sets of 10,
23 13, 39, depending on what level of outcomes. Probably a
24 couple of them or some of them ready to go, but risk
25 adjustment remains an issue. The structural stuff I'm a
26 little less clear on. then finally, the patient experience,
27 everybody's doing it but not a lot of gelling across the

1 industry and maybe not so much. But it was specifically to
2 bring those different points of view together.
3 If you think I'm off-base here you need to say. I
4 think in your walk-through and trying to explain each of the
5 pieces and where they thought the places were ready, in your
6 summary, that's in a sense what you were trying to represent
7 across those groups.
8 MS. MILGATE: Yes, I would say we wouldn't have
9 suggested from what we saw that those 10 are the only ones.
10 Maybe that's what you're trying to get it. There certainly
11 are some others, and I guess that's what we were hoping you
12 would help with. This is the direction we saw in our
13 research on the measures, the use of the measures and the
14 hospital panel. But we didn't mean to suggest that only
15 those 10, for example, would be the only ones. If the
16 Commission feels like there's some other areas it's
17 important to push in, there do appear to be measures that
18 are used for public reporting, for example.
19 MS. DePARLE: Just on the narrow point of the
20 National Quality Forum. I sit on the board of that and
21 others here have been involved in it. It may be true that
22 the development of those hospital criteria did not
23 explicitly talk about pay-for-performance. But I just want
24 to emphasize something that they've said, which is that was
25 a very lengthy process with a lot of stakeholders, and it
26 was a difficult process. I don't think anyone who was
27 involved in that was unmindful that eventually that's where

1 this was going.

2 That's why, frankly, everyone was at the table,
3 duking it out, making sure that we could move in one
4 direction. There was a lot of concern about having multiple
5 different groups coming up with all these requirements. But
6 I don't think anyone would say, oh, I'm shocked that someone
7 might think these could be used for that.

8 MR. HACKBARTH: Thanks. That's helpful.

9 MS. BURKE: Following in Bob's analogy of the day,
10 the airport analogy, if I think of the hospital as the
11 airplane, I'd like to talk for just a minute about the
12 pilot.

13 In the course of this discussion, which was
14 spectacular and I understand that the purpose here was to
15 inform us about what was occurring specifically with respect
16 to hospitals and measures, I wondered at what point we ought
17 to also again opine on the importance of the relationship
18 between the physician and the hospital in terms of the
19 achievement of these activities. There is a reference in
20 the text, in some cases the hospitals are concerned that
21 they have little control in some respects because of the
22 role of the physician.

23 I was questioning Nancy-Ann because I had this in
24 the back of my mind and couldn't recall specifically. There
25 was the activity in New Jersey, which has subsequently been
26 halted as a result of lawsuits, relating to the hospital's
27 capacity to share in the benefits as a result, with the

1 physicians. I wondered if in the course of this there isn't
2 reason to talk about, more directly, the things that would
3 have to occur, or whether it makes sense to begin to look at
4 to what extent physicians play a role in any of these
5 outcome measures, whether they are the process measures or
6 whatever they happen to be, and how one might begin to think
7 about the relationship and how we would provide the
8 opportunity for that to occur.
9 I don't mean to get into the middle of a lawsuit
10 in this case where the demonstration has been halted, but I
11 think we ought to, in the course of talking about this,
12 continue to reference the importance of that linkage and how
13 over time it ought to be a system, just as we talked about
14 yesterday, the need to particularly tie the A and B side so
15 in fact the rewards are linked, and that there is a benefit
16 to both hospital, but as well there is opportunity to
17 influence the physician or engage them in these outcomes.
18 In the course of this it seems to me, talking about what we
19 know or the importance of that linkage more directly, may
20 make a lot of sense.
21 MS. MILGATE: I am anticipating in the discussion
22 we're supposed to have next month on physician pay-for-
23 performance that we'll have a discussion of that, but it
24 certainly could be included in this one as while.
25 MS. BURKE: I think we need to create the linkage.
26 They are, at the moment, distinct in a sense, but in fact we
27 do reference it briefly in the text about the concern that

1 without that linkage hospitals are somewhat impeded in terms
2 of what they can achieve. Similarly, physicians' success
3 will be tied in part to the hospital also putting in place
4 the systems that allow the physicians to succeed. So they
5 have to be supportive systems. And the measures are clearly
6 linked. But I think we ought to look at it in both cases so
7 they don't continue to appear to be distinct activities
8 because they're really not.
9 MR. HACKBARTH: I have three more on the list and
10 then we're going to have to move on.
11 DR. WOLTER: Just a few thoughts. Karen, your
12 verbal summary of the presentation I thought was quite nice
13 and I assume we'll see some version of that in writing when
14 the final chapter comes out. But in your comments on the
15 process measures I'm glad to see how our thinking about that
16 is evolving, because those are, right now at least, a very
17 important way to tackle quality if they are evidence based.
18 They have one other virtue, there a little bit less
19 dependent on volume than some other things. So I think even
20 organizations with lower volumes who are working on those
21 process measures contribute to quality. Also in and of
22 themselves, to measure them you have to put system
23 approaches to care in place. So in a way it incents the
24 behaviors and the changes organizationally that need to
25 happen.
26 I'm going to pick up on a couple other things,
27 just say them a different way. One of the things I believe

1 we need to do is be somewhat bold in our tone about this
2 issue, and to push pretty hard, that this work needs to move
3 very quickly. I think we need to be very specific that we
4 will be moving very quickly beyond 10 measures. I think
5 also if we link this, at least conceptually, to the episode
6 profiling that we discussed yesterday, if those two
7 initiatives were pushed, at least in parallel, aggressively
8 I think it would create huge beneficial changes in how
9 health care is delivered in this country, and perhaps push
10 changes in how we are organized and how we deliver health
11 care. So I see a linkage there that we might want to
12 explore. So some sense of urgency -- and I know we talked
13 about that last year as a commission -- on this particular
14 topic.
15 The issue of trying to create coalescence of the
16 different groups creating these measures is important, not
17 only so that it's easier to be doing one set of things and
18 not different sets for different groups. But there's
19 another issue. If these measures will continue to evolve,
20 which I believe they will, we need a place where experts can
21 help that evolution and make decisions fairly quickly. When
22 is ACE inhibitor no longer a measure? When is ventilator
23 bundle measurement a new measure? If those things are very
24 fragmented it's going to be hard for this whole effort to
25 move along as efficiently as it might.
26 So I don't know what that means, but should we as
27 a commission be looking at recommendations about the process

1 of oversight that ultimately should come into place so that
2 we can really push these initiatives very hard, but also
3 have an organized way to get those changes adjudicated as we
4 move forward, and as Arnie said, to make sure that the right
5 stakeholders are a part of that conversation. I think that
6 could be an important contribution as well.
7 DR. WAKEFIELD: Just a request. You give it a nod
8 in a few places, and to just ask you as you keep doing your
9 work that you try to call out, when it makes sense, some
10 special attention to small rural facilities because of some
11 of the unique circumstances that they face. Most of the
12 folks I speak with have no interest in standing outside of
13 the work that's underway in quality. That is, critical
14 access hospitals, small nursing homes, et cetera. As a
15 matter of fact I think a lot of them would feel that that
16 would do them ultimately a disservice. That is if they're
17 not part of this, and reporting and providing information to
18 the public that sends very much the wrong message.
19 So how we reconcile that when you're talking about
20 payment and given the way some of our payment structures
21 currently exist is a challenge. It's also a challenge
22 because of low volume. So where there are measures that are
23 tied to volume, if we get a lot of empty cells on the
24 reporting, that's problematic too. If there are a lot of
25 asterisks there, there's plenty of concern in the field
26 about the message that inadvertently sends. If you can't
27 report, then what's going on in this facility? So those are

1 some of the challenges.
2 I guess some of us who work in this field are
3 really looking for breakthroughs, hoping that it comes from
4 the person sitting next to us because we don't have the
5 immediate answers. But if there are ways of reporting,
6 rolling up data, aggregating information that would allow
7 more data to be put into those cells that otherwise would
8 remain blank -- there's got to be some additional thinking
9 and hopefully some breakthrough that occurs on that front.
10 So that's one issue, engaging everyone in this, trying to
11 find ways to engage everyone and making sure that we're
12 collecting data on areas that make sense for those small
13 facilities.
14 Some of us have been working on patient safety
15 issues and patient safety practices in rural hospitals now,
16 I've been part of an initiative for over a year, and clearly
17 there's a lot of good overlap on areas of focus between
18 what's coming out of -- associated with urban hospitals and
19 what seems to be quite relevant for rural hospitals. But
20 there is also some variation around the edges in what I
21 think are fairly important ways. You mentioned them; i.e.,
22 issues of transfers and referrals and patience
23 stabilization. So to really try to track on those areas
24 that might make the most sense, especially to the smallest
25 facility, we need to be every bit as concerned about quality
26 there as we are, obviously, in those large facilities.
27 The last point I want to make, just to stay with

1 Bob's, and hopefully I'll be the last one that makes this
2 comment, but to stay with this aviation analogy and extend
3 Sheila's remarks. You can fly someplace in a 757. You can
4 fly someplace in a Supercub. Some of us prefer to be in
5 Supercubs over being herded into 757s. But the point of it
6 is that the structures and the processes are a little bit
7 the same. Both of those planes are trying to accomplish the
8 very same outcome, but the way they're configured is a
9 little bit different, how you move the controls is a little
10 bit different, who's flying them and on and on and on.
11 So the point of it is to say, even if you're
12 applying something like an intensivist standard to intensive
13 care units -- UNC is doing some really good work right now
14 and they'll be able to report it pretty quickly about what
15 intensive care units look like in rural hospitals. And I
16 can tell you, being an old intensive care unit nurse, when I
17 worked urban hospitals there wasn't a huge difference
18 between one critical care unit to another; same equipment,
19 et cetera. You look at intensive care units as defined in
20 rural hospitals, it can be anything from one monitored bed
21 at the end of a med-surg wing to a free-standing, patients
22 on ventilators, full bore wraparound sets of services.
23 So we've got to be thinking about what we're
24 applying those measures to. Standardization is absolutely
25 critical, but there's going to be a little variation on the
26 theme that we'll want to be sensitive to as well. That's
27 going to be hard but hopefully we can pay a little bit of

1 attention to that.

2 MR. DURENBERGER: Mr. Chairman, I'm back with your
3 comments about your heart rate. I think it's probably an
4 appropriate analogy, but I'm going to start testing my pulse
5 from now on when I read this material, because I agree with
6 everybody else that just in the two years plus that I've
7 been on MedPAC, the strides that we've been making are
8 really tremendous.

9 One comment about a reference that was made here,
10 just by way of an observation from our part of the world,
11 and then I have a question.

12 The reference is made at the end of the material
13 to Health Partners and their decision to deny patient for
14 hospital care resulting in serious avoidable events. That
15 came about quality only because Mary Brainerd, the CEO, was
16 also chair of several patient safety commissions and
17 committees and things like that. And in some setting she
18 made a comment about why should we be paying for seriously
19 avoidable events. All of a sudden that got into the
20 newspaper. Of course, all hell broke loose because of all
21 of her colleagues in the hospital business, who work quietly
22 behind-the-scenes reporting all of their serious events for
23 the first time in history, got very upset with her.

24 So that's sort of like a comment to clarify, this
25 was not a really deliberate strategy on the part of some
26 payer to take us to the next level. It was just the logic -
27 - I remember my wife and I sitting at 5:30 in the morning,

1 reading our St. Paul paper, and we said gee whiz, why do we
2 pay for errors?
3 And then the next question is why do bill for
4 errors? Which is a question I asked of the head of the
5 Minnesota Hospital Association, how many of your hospitals
6 are actually billing for errors, how many doctors bill, et
7 cetera.
8 That's our little background from Lake Wobegon.
9 My question is sort of like Bill's on something I
10 think Sheila and Nick were talking about. And that is
11 developing measures of labor productivity. I know it isn't
12 quite right on point of the outcomes approach and things
13 like that. I guess the hospital people here can speak
14 better to this than I. But changes in clinical care
15 processes are so critical to achieving the quality goals and
16 the performance goals but they are also a great value to the
17 organization in enhancing the productivity, the efficiency
18 and so forth of the process of delivering care.
19 It would just strike me that it would be
20 worthwhile, as we develop our work on this, and I'll leave
21 it to others to comment, to encourage labor productivity and
22 to recognize the various ways in which people are taking on
23 the connection between quality, clinical care, operations,
24 satisfaction within the organization, as well as
25 satisfaction from those who are the beneficiaries of the
26 organization.
27 DR. MILSTEIN: I wanted to follow up on the

1 question that Alan asked. Alan said has anyone priced out
2 what supplying the information from the medical record would
3 cost if we wanted a better set of performance measures.
4 If you look at the recommendation from the Quality
5 Work Group of the National Committee on Vital Health
6 Statistics and let's say order of magnitude, what are they
7 suggesting CMS and other payers require as a condition of
8 payment going forward? You sort of say about how much would
9 it cost a hospital if it got into production mode to
10 routinely collect those data elements and report them on a
11 hospital bill?
12 That's not been priced out specifically, but a
13 very, very similar market basket of about the same magnitude
14 and estimated workload has been up and collected in
15 Pennsylvania routinely as a condition of payment for about
16 the last five to 10 years. And that has been estimated at
17 about $18 per hospital discharge for a very substantial
18 improvement in our ability to measure not just processes but
19 risk-adjusted outcomes.
20 DR. NELSON: And that's down from $34. They got
21 that started in late '80s or something like that. And the
22 first couple of years it was $34 an abstract. So it's come
23 down substantially then, if you take into account inflation.
24 MR. HACKBARTH: Okay, thank you. Well done.
25 We are going to now turn to the recommendations on
26 Medicare Advantage and complete that before we move on to
27 specialty hospitals.

1 Since we've been through the entire set, I think
2 we can dispense with any reading. We'll just pause for a
3 second, let people read what's on the screen, have brief
4 discussion, as brief as possible please, and then proceed to
5 a vote.
6 DR. REISCHAUER: I'm sort of wondering why we have
7 the year 2006 in there. I mean, I know that's when they
8 were planning or maybe would drop it. But until we have
9 better measures we should continue it. So we just drop the
10 2006.
11 MR. HACKBARTH: Fine. Right.
12 Okay, all opposed to recommendation one?
13 Abstentions? All in favor?
14 Let's put up two.
15 All opposed to number two? Abstentions? In
16 favor?
17 DR. SCHMIDT: I think there's a word missing in
18 the very last tick. I think it was limitations on
19 disproportionately high cost-sharing.
20 MR. HACKBARTH: Yes.
21 Okay, all opposed? Abstentions? In favor?
22 Okay. Thank you.
23 Okay, next on the agenda is specialty hospitals.
24 MR. PETTENGILL: Good morning.
25 The Medicare Modernization Act requires MedPAC to
26 study physician-owned specialty hospitals and report to the
27 Congress in March of next year. Under this mandate, we have

1 been asked to compare the costs of care in physician-owned
2 specialty hospitals and in community full service hospitals,
3 the extent to which each hospital treats patients in
4 specific DRGs, and the mix of payers in each type of
5 hospital.
6 We've also been asked to analyze the financial
7 impact that specialty hospitals have on community hospitals
8 and how the current DRG payment system should be updated to
9 better reflect the costs of care.
10 At the last meeting in September, Ariel, Carol and
11 Jeff presented information on federal laws governing
12 physician investment in hospitals and other facilities,
13 characteristics of specialty hospitals and the markets in
14 which they are located, preliminary findings from our
15 analysis of payer mix and findings from our site visits to
16 three markets that have specialty hospitals.
17 Today I'm going to present preliminary findings on
18 three issues related to physician-owned specialty hospitals.
19 The first one is whether Medicare's hospital inpatient
20 payment system may be creating financial incentives for
21 specialization by setting payment rates that are more
22 profitable for some diagnosis related groups than for
23 others.
24 To answer this question, we estimated costs,
25 payments and relative profitability for DRGs that are
26 important to physician-owned specialty hospitals. To
27 measure relative profitability, we calculated a payment-to-

1 cost ratio for each DRG. That is, we took all the payments
2 for all the cases in the category and we divided them by all
3 the costs for the cases in the category. Then we divided
4 all those payment-to-cost ratios by the overall average
5 payment-to-cost ratio. This results in a set of numbers for
6 all DRGs that are centered around one. The numbers show
7 whether patients in each DRG, on average, are more or less
8 profitable than the overall average.
9 For example, suppose that payments in DRG 105 were
10 10 percent greater than costs. We would have a payment-to-
11 cost ratio of 1.1. If the overall average payment-to-cost
12 ratio were 1.04, then we would have a relative profitability
13 ratio of 1.06, 1.1 divided by 1.04.
14 The second question is whether relative
15 profitability may differ across patients with different
16 severity of illness within DRGs, thus creating financial
17 incentives to select less severely ill patients. To answer
18 this question, we estimated a similar measure of relative
19 profitability for patients grouped in the all-patient
20 refined DRGs. Now all-patient refined DRGs, called APR-
21 DRGs, are similar to DRGs but they make better use of
22 secondary diagnoses to distinguish patients in four severity
23 levels.
24 There are roughly 350 APR-DRGs, four severity
25 classes per APR-DRG, and those classes are characterized as
26 minor, moderate, major and extreme severity.
27 Again, we calculated a payment-to-cost ratio for

1 each severity class within an APR-DRG and we divided them
2 all by the overall payment-to-cost ratio, which gives us a
3 measure that tells us about the national average relative
4 profitability of patients in each such category. It really
5 tells us whether there are differences in profitability
6 within DRGs.
7 The first two questions are about the payment
8 system. The third question is about what physician-owned
9 specialty hospitals actually do. Do they treat a relatively
10 favorable selection of patients? That is, those who are
11 expected to be relatively more profitable than the average?
12 To answer this question, we constructed two
13 measures of expected relative profitabilty for each
14 hospital. These measures are designed to isolate the effect
15 of each hospital's mix of Medicare cases given the national
16 average relative profitability values for each DRG and APR-
17 DRG severity class.
18 Thus, if each hospital had the national average
19 relative profitability in each DRG and each APR-DRG, would
20 its mix of cases be relatively more or less profitable than
21 the overall Medicare average? That's the question. These
22 measures don't tell us anything about a hospital's actual
23 performance, only whether its Medicare case-mix is drawn
24 primarily from relatively more or less profitable
25 categories.
26 These questions are all motivated by the potential
27 for some kind of a misalignment between payments and costs,

1 either across or within DRGs. How might this happen?
2 Differences in relative profitability across DRGs
3 must arise from the case-level features of the payment
4 system, primarily the DRG relative weights and the outlier
5 payment policy. The DRG weights are intended to measure the
6 relative costliness of typical patients in each DRG. At the
7 beginning of the prospective payment system in 1983, the DRG
8 weights were based on costs estimated at the claim level,
9 using charges and other information from the claims, and
10 data from the hospitals' annual cost reports.
11 In 1986, CMS changed to using charges alone. This
12 decision was based on research which showed that cost
13 weights, cost-based weights and charge-based weights were
14 very similar.
15 Although the claims are needed in either method,
16 they are somewhat more timely than the cost reports and the
17 process of estimating the weights is much simplified if you
18 use just the claims and the charges. But over time weights
19 that are based on charges are vulnerable to the effects of
20 hospitals charging practices.
21 We know from the cost-to-charge ratios on the cost
22 reports that hospitals typically set higher markups for
23 ancillary services such as tests and supplies and so forth,
24 operating room time, than they do for routine and intensive
25 care, which would be room, board and routine care, and they
26 maybe also raise these sets of charges at different rates
27 over time.

1 Distortions in the weights also may occur if costs
2 grow at different rates but hospitals fail to reset their
3 charges accordingly.
4 The next slide shows the results of a simulation
5 exercise we ran just to show what happens if you have
6 different charge inflation rates with DRGs that have
7 different mixes of services. Here we have two DRGs, each
8 with a different service composition. In DRG A, 70 percent
9 of the charges are typically for ancillary services such as
10 imaging, operating room time or supplies. 30 percent are
11 for routine services, room, board and routine nursing care.
12 In DRG B the shares are reversed. So it's 30/70
13 instead. For this illustration, we assume that costs
14 increase at the same rate over time. In these
15 circumstances, if hospitals were to raise their charges for
16 ancillary services just 1 percent more faster per year than
17 those for routine services, the DRG weights would diverge as
18 shown on the slide even though these DRGs would continue to
19 have equal costs. The difference in the weights is 4
20 percentage points after 10 years and 8 percentage points
21 after 20 years. Because the costs remain equal, the
22 diversion of the weights translates directly into
23 differences in relative profitability between the two DRGs.
24 The same kind of discrepancy in relative
25 profitability can occur if costs change at different rates.
26 Cost growth may vary between DRGs because of changes in
27 productivity growth or input price inflation that affect one

1 DRG differently than another. In this instance, DRG weights
2 would not diverge because nothing's happened to the charges.
3 But because the costs diverge, the weights become less
4 accurate in measuring the true relative costliness of each
5 type of patient. As a result, the relative profitability
6 would rise for DRGs that exhibited slower cost growth and it
7 would fall for those that exhibited faster cost growth.
8 We have two more sources here in our list.
9 Distortions in measured relative costs for typical cases
10 among DRGs can also arise because of the way we treat
11 outlier cases in calculating the relative weights. Most
12 outlier cases are included in the weight calculation.
13 Because outlier cases and related charges are very uneven
14 across DRGs, including them can create an upward bias in the
15 weights for high cost categories where most of them occur.
16 Finally, we can have profitability differences
17 within DRGs because of the definitions of the categories.
18 The DRGs are broadly defined and they include subgroups with
19 very different severity of illness and cost of care.
20 The next slide gives an illustration for one DRG.
21 This table shows an example of differences in estimated
22 relative costliness for cases included in the four severity
23 classes of APR-DRG 165. As I mentioned earlier, they are
24 similar to DRGs but we have four levels of severity.
25 The cases in this APR-DRG come almost exclusively
26 from DRG 107, which is bypass with cardiac catheterization.
27 Here we see the cost per discharge can vary from 70 percent

1 of the average for the overall category to 170 percent of
2 that average. Our preliminary cost estimates for other DRGs
3 suggest that this pattern of escalating costs is consistent
4 among the severity classes within DRGs. Because the current
5 DRG payment rates don't change nearly as much as the costs
6 do, however, that makes substantial differences in relative
7 profitability very likely within most DRGs.
8 To examine whether Medicare's payment rates are
9 more profitable for some DRGs than for others, we estimated
10 relative profitability across DRGs in APR-DRG severity
11 classes. We focus on relative profitability here because we
12 want to know whether payments are being allocated
13 appropriately across patients. That is, consistent with the
14 expected differences in relative costliness. We used more
15 than 10 million Medicare claims and matching cost reports to
16 estimate costs and payments for each claim. We estimated
17 costs by multiplying charges on the claim by the cost-to-
18 charge ratio for the corresponding department in the
19 hospital. We estimated payments for each claim using our
20 hospital inpatient prospective payment system payment model.
21 Then we used the estimated costs and payments to
22 calculate payment-to-cost ratio for each DRG and APR-DRG
23 severity class and then divide them by the overall average.
24 This yields a relative profitability ratio for each DRG and
25 APR-DRG severity class. The next two slides show
26 supplementary results for these measures for DRGs and APR-
27 DRGs that are important to physician-owned specialty

1 hospitals.

2 This one shows estimates for DRGs and APR-DRGs
3 that are important to physician-owned heart hospitals. The
4 top six above the heavy line are surgical DRGs, and I'll
5 name them for you. Valve without cath is 105. Bypass with
6 cath is 107. Bypass without cath or angioplasty is 109.
7 Percutaneous procedure with stent is 517. Percutaneous
8 procedure without stent is 518. And 116 is pacemaker
9 implant.

10 The last two below the line are medical DRGs that
11 are less likely to be treated in a physician-owned heart
12 hospital. These are heart failure and shock, 127; and
13 arrhythmia with comorbidity or complication, 138. Let's
14 walk through one of them, taking 107 as an example, bypass
15 with cath.

16 The relative profitability ratio for this category
17 is 1.093 or 9.3 percent above the average. If the national
18 average payment-to-cost ratio were 1.04, then we would
19 expect payments to be 13.7 percent above costs in this DRG.

20 Except for DRG 116, pacemaker implant, all of the
21 surgical DRGs are relatively more profitable than the
22 national average. Medical DRGs are relatively less
23 profitable. The last four columns show the estimates for
24 severity classes in the corresponding APR-DRGs. For these
25 APR-DRGs, the minor and moderate severity patients, those in
26 classes one and two, are relatively more profitable than the
27 average. This is true even in the medical APR-DRGs, that

1 overall are less relatively profitable than the national
2 average.
3 Patients in the major and extreme categories, on
4 the other hand, are generally relatively less profitable
5 than the average. It's important to remember these are
6 national estimates for the DRGs overall. They don't tell us
7 anything about actual performance of physician-owned
8 hospitals or any other hospital group. They do indicate
9 that under current policies some DRGs and subgroups within
10 them are financially more attractive than others.
11 Consequently, hospitals have a potential opportunity and a
12 strong financial incentive to influence the mix of patients
13 they treat.
14 The next one shows comparable preliminary
15 estimates of relative profitability for categories that are
16 important to physician-owned orthopedic hospitals. the
17 first three above the line, again, are surgical DRGs: major
18 joint and limb reattachment, 209. Most of those are hip
19 replacements. Other hip and femur except major joint with
20 comorbidity or complication, which is 210. And back and
21 neck procedures excluding spinal fusion with comorbidity or
22 complication, that's 499.
23 The last two DRGs below the line are medical DRGs,
24 again less likely to be treated in a physician-owned
25 orthopedic hospital, hip fracture and medical back problems
26 are these two. Only one of the DRGs, back and neck
27 procedures, is relatively more profitable than the average

1 here, 499 with a value of 1.04.
2 All but two of these DRGs, however, have low
3 severity categories within them, patients within them, that
4 are relatively more profitable than the national average.
5 Again, our preliminary findings suggest that under current
6 policies relative profitability differs across and within
7 the DRGs. As a result, hospitals have an opportunity and an
8 incentive to influence the mix of patients.
9 Next we turn from relatively profitability of the
10 DRGs in the APR-DRGs at the national level to what
11 physician-owned specialty hospitals do. We have two
12 questions on patient selection. Do physician-owned
13 specialty hospitals focus on DRGs with above average
14 relative profitability under Medicare? Within DRGs, do they
15 treat groups of patients that are expected to be relatively
16 more profitable than the average? That is, do they treat a
17 favorable selection of Medicare patients across and within
18 DRGs?
19 To answer these questions, we wanted measures that
20 would isolate the effects on relative profitability of a
21 hospital's mix of Medicare cases across and within DRGs. We
22 calculated two measures, one for DRGs and one for APR-DRGs.
23 Assuming that each hospital had the national average
24 relative profitability in each DRG, the first measure tells
25 us whether a hospital treats a relatively more or last
26 profitable mix of Medicare cases compared with the national
27 average.

1 Similarly, assuming that each hospital had the
2 national average relative profitability for each APR-DRG
3 severity class, the second measure tells us whether a
4 hospital treats a relatively more or less profitable mix of
5 cases across and within DRGs. By comparing the two measures
6 we can separate the impact of selection across the DRGs from
7 that within.
8 Again, it's important to note that these measures
9 don't tell us about hospitals actual profitability. They
10 only tell us whether the cases that a hospital treats are
11 relatively favorable in the sense of coming from DRGs that
12 are expected to be more profitable.
13 This table shows the preliminary results from
14 these measures for physician-owned specialty hospitals and
15 peer comparison hospitals. You may remember from the last
16 meeting that peer hospitals have a high concentration in the
17 same clinical category but they're not physician-owned.
18 The first column is the measure based on the DRGs.
19 The last column is the measure based on the APR-DRGs, and
20 the middle column is the difference between the two. The
21 first thing to note is the national average relative
22 profitability is 1.0. the common sense of that is that if
23 you have the national average relative profitability in each
24 DRG and APR-DRG category, then the national average mix of
25 cases is neither favorable nor unfavorable.
26 For heart hospitals, however, the 1.06 in the
27 first column means that, on average, physician-owned

1 hospitals treat Medicare patients in DRGs that are
2 relatively more profitable than the national average. They
3 also treat a favorable selection of patients within DRGs.
4 This is the 1.03 in the middle column. So that overall
5 their expected relative profitability is 1.09 or 9 percent
6 above the relative profitability of the average Medicare
7 patient.
8 Peer heart hospitals also have a favorable
9 selection of DRGs, but not as favorable as the physician-
10 owned hospitals. But peer hospitals also have a slightly
11 unfavorable selection within DRGs, at 0.99, so they end up
12 with an expected relative profitability value of 1.03. It's
13 still above average, but it's not as high as for the
14 physician-owned hospitals.
15 The physician-owned orthopedic hospitals, in
16 contrast, have a definitely unfavorable selection of DRGs
17 but that's more than counterbalanced by their favorable
18 selection within them. So that overall they end up above
19 average.
20 Peer orthopedic hospitals have an equally
21 unfavorable selection of DRGs but their selection within
22 DRGs is only slightly favorable, so they end up still below
23 average.
24 Physician-owned surgical hospitals start with an
25 average selection of DRGs but they have a very favorable
26 selection within DRGs and therefore end up well above
27 average. The peer surgical hospitals start with the same

1 roughly average selection across DRGs and they have a
2 slightly favorable selection, a somewhat favorable selection
3 within the DRGs as well, so they end up overall above
4 average.

5 Now I'd like to briefly recap the findings, first
6 on relative profitability and then on selection. Among the
7 DRGs we looked at, those important to physician-owned heart,
8 orthopedic and surgical hospitals, the evidence suggests
9 that current payment policies create differences in relative
10 profitability both across and within DRGs. Surgical DRGs
11 are generally relatively more profitable while medical DRGs
12 tend to be relatively less profitable than the overall
13 average. Within DRGs, patients in low severity groups tend
14 to be relatively more profitable. Conversely, those in high
15 severity groups tend to be relatively less profitable.
16 Consequently, hospitals appear to have financial incentives
17 to specialize and to treat low severity rather than high
18 severity patients.

19 On selection, the preliminary evidence suggests
20 that physician-owned heart, orthopedic and surgical
21 hospitals treat a significantly more favorable selection of
22 patients than the average community hospital or than peer
23 hospitals that have a high concentration of patients in the
24 same specialty but are not physician-owned.

25 I'd be happy to take any questions or comments.

26 DR. SCANLON: I think these are an incredibly
27 powerful analysis that you provided and raises real

1 questions about our calculation of the relative DRG weights.
2 I guess I can think of us is moving toward the
3 direction of both reinstituting the use of costs in this
4 process; and secondly, the idea of using something like the
5 APR-DRGs.
6 I want to ask you in terms of either of those
7 things what the concerns would be about those two steps?
8 There is always questions raised about how quickly DRGs are
9 adjusted to reflect new technologies. So the idea that we
10 would have a lag in cost report information that could be
11 used is going to be a bone of contention. And I would think
12 about getting around that by thinking about using the most
13 current cost report data that were available, even knowing
14 it's lagged, combined with current charges as a way of
15 creating a hybrid that could be somewhat more up-to-date,
16 certainly better in terms of accuracy with respect to
17 relative profitability than the current situation which has
18 ignored costs for so long.
19 With respect to the APR-DRGs, I guess there is the
20 issue of burden and reliability, and I'd like to hear about
21 what might be the field's perspective on the readiness to
22 adopt them today.
23 DR. MILLER: Can I say one thing before you go
24 into the specifics? The other thing that's changed recently
25 in the inpatient PPS is the technology add-on. So there is
26 that, which is a little bit different feature than has been
27 the case.

1 MR. PETTENGILL: On using the cost data there are
2 two concerns basically. One is the issue of timeliness that
3 you talked about. That's important in a way, because the
4 charging practices that hospitals engage in, raising their
5 charges over time, tend to lower the cost-to-charge ratios.
6 So if you try to mix cost-to-charge ratios from the cost
7 reports with more recent claims, you end up applying ratios
8 that are too high, thus overestimating costs. Now if that's
9 consistent across all services, no problem. It doesn't
10 affect the relatives. But it may not be.
11 The other issue there is that when you do this you
12 are limited by the data you have. You have cost-to-charge
13 ratios for departments that are fairly broad, for the most
14 part, within hospitals. You are applying those cost-to-
15 charge ratios to charges for services that are more narrowly
16 defined. In some cases, there is not a match. The cost-to-
17 charge ratio will really not be appropriate for the
18 particular service. It will be either too high or too low,
19 so you end up either overestimating costs or underestimating
20 them.
21 What this does, among other things, is it tends to
22 cause some compression in the weights. That is, the weights
23 will not have as much variability across patient categories
24 as the real costs vary. And that's an issue. How strong
25 that effect is is hard to tell because obviously we don't
26 have the true data.
27 On the APR-DRGs or something like them, the

1 principal difference between the APR-DRGs and the DRGs is
2 how you handle secondary diagnoses. The concern at CMS has
3 always been the gameability of the APR-DRGs, that you can
4 manipulate what you report. You can change reporting
5 practices. That may or may not be largely a onetime effect.
6 It might actually play out over a few years if history is
7 any guide. But that's the concern that most people have.
8 And there's also the problem of having some
9 categories that have relatively few cases, where you always
10 have difficulty setting the weight. Currently CMS sets the
11 weights differently for categories that have less than 10
12 cases. If you use something like APR-DRGs, you would have
13 more such categories.
14 I think there were also issues raised over time
15 about whether all of the APR-DRGs are equally fruitful. If
16 you look at the differences in costs between the first and
17 second severity category, sometimes they're not very large.
18 So it's possible that instead of using like 1,250 or
19 thereabouts categories, you can use a smaller number and get
20 pretty much the same bang for the buck.
21 All of these problems, I think, are addressable to
22 some degree but they would still remain. I guess in the end
23 you have to think about how do the limitations of these
24 methods compare with the limitations of the current method
25 or some other alternative that somebody might dream up.
26 DR. SCANLON: I agree with you completely on that.
27 I think it's an issue of the trade-off, recognizing that

1 there's not going to be a perfect measure but that we can
2 potentially improve upon what we're doing today. I also
3 think there are probably additional analyses that can be
4 done to guide us in terms of understanding what the
5 improvement might be and what the trade-offs of particularly
6 the hybrid that I suggested might be, in terms of its
7 accuracy and trying to make the updates more current.
8 Thanks.
9 DR. WOLTER: I saw a reasonably credible analysis
10 in the last month that said that about 80 percent of the
11 profits in the not-for-profit world come from four or five
12 service lines, which I believe is related to this analysis
13 that we've just seen. I do think that although specialty
14 hospital is the issue before us right now, there are huge
15 capital investment strategies currently being enacted in the
16 not-for-profit world around these four or five service
17 lines. I would say our imaging conversation yesterday is in
18 this picture.
19 It would be a good thing, from my standpoint, to
20 look at some way of redistributing payment so that there is
21 an equal desire to deal with geriatrics and mental health
22 and pneumonia in the elderly. I worry about that, although
23 I don't know a fix-it. Bill, we'll need your thoughts on
24 how to fix this.
25 MR. MULLER: I second Nick's comments, but I would
26 say again, in this very excessive analysis there are some
27 hints as to how to do it, which is to perhaps do some

1 onetime reweighting of the ancillary-driven DRGs, vis-à-vis
2 the more nursing driven DRGs. The more technical people can
3 think about how to perhaps do onetime reweighting of this as
4 the analysis indicates 20 years of cumulative effect of
5 reweighting ancillaries gets you the result that Nick and
6 Bill have just spoken to.
7 I think the analysis also indicates that in
8 hospitals that have a wider range of activity, some of what
9 you just indicated Nick is mitigated by having patients
10 across the range. So one of my concerns that this analysis
11 points out is that the system here really rewards patient
12 selection rather than our goal of efficiency and
13 effectiveness inside the system. And that way it is really
14 destructive of the whole payment system.
15 So I want to say we often couch our words, but
16 this really destroys our payment system to have this go on.
17 I think something has to be done about it rather than just
18 evaluate it for a long period of time. So I think just our
19 discussion on quality indicated that we should move with
20 some urgency. I really think we have to move with some
21 urgency here to not reward this kind of behavior which
22 undermines the overarching program.
23 So again I think I would recommend this primer on
24 DRGs should contain this. Not that everybody goes around
25 reading the MedPAC website, but for all of you in the
26 audience I'd read this one. This is one of the best
27 excavations I've ever seen on how the DRG system works.

1 I think it gives us all some good reasons to move
2 towards changing some parts of it that encourage the wrong
3 kind of behaviors. Because in fact, as we know, the
4 financial incentives inside the Medicare system, are
5 powerful when they, in this case, divert so much from what
6 we really want to do. It just has to be stopped and I think
7 we have to look at what we can do, whether it's Nick's goal
8 of having equal money for geriatrics or mental health
9 compared to CABGs.
10 But I think we saw this in Medicare Advantage, in
11 terms of patient selection, and we're seeing it here. I
12 think I really undermines the whole Medicare system when we
13 reward section of patients rather than rewarding effective
14 care. So I think just like we've come out in terms of
15 effective care, we really have to come out against the
16 gaming of the system by selecting the less ill and
17 concentrating resources on the less ill when, in fact,
18 resources should be there for the entire population.
19 DR. REISCHAUER: There is a tendency in these
20 kinds of discussions to look at the evidence and draw
21 motivational conclusions. And within DRG selection it is
22 perfectly possible that more complex cases are, in a sense,
23 "better served" in a full-service facility and the
24 "selection" is occurring for that reason. And so I think we
25 want to be careful that we don't overinterpret the evidence
26 that we have in front of us. The system clearly is flawed
27 in the sense of the payment incentives and that is causing

1 behavior which should be expected if we think we have an
2 efficient economy here. And there are other explanations
3 for some of this behavior, as well.
4 MR. HACKBARTH: What's striking to me is that both
5 Nick and Ralph, if I understand them correctly, are saying
6 this is an issue not just in specialty hospitals but really
7 across the hospital sector, not-for-profit, for-profit,
8 specialty, general hospital. This is a more fundamental
9 issue.
10 I agree with you. You create the incentives. The
11 whole principal of the system is that people are going to
12 respond to incentives.
13 So I think Ralph and Nick --
14 MR. MULLER: My point is that the issue is
15 somewhat mitigated when you take care of a broad range of
16 patients. And therefore the ones where you're at 0.9 on
17 payment-to-cost balance out the ones where you're 1.5. Not
18 perfectly and maybe not -- obviously, as Mary has often
19 pointed out -- in every last hospital in the country. But
20 by and large, if you have a fuller range, some of that is
21 mitigated.
22 DR. STENSLAND: Just to echo what Bob said, on our
23 site visits we found pretty much what you said. Many of the
24 surgical hospitals and the orthopedic hospitals specifically
25 told us we don't think it's appropriate for us to treat
26 these higher severity patients and they had explicit
27 criteria not to. The heart hospitals give a different

1 statement, that they were more wide-open in terms of who
2 they would treat. I guess you can see some of that
3 reflected in the data we have up there. It just really
4 matches up with what we saw in our site visits.
5 DR. SCANLON: I was going to respond in the sense
6 that the important part of this analysis to me was not
7 necessarily the chart that's up there now, which showed
8 what's happening within the specialty hospitals but the
9 earlier chart which showed what was happening with respect
10 to across DRGs and also within the APR-DRGs because that's
11 more the issue of our overall system and how we're paying
12 all hospitals.
13 I agree with Ralph that the hospital that serves
14 enough patients, that there's going to be an averaging out
15 and this has been the premise behind the DRGs.
16 The data here, though, cause you to pause and ask
17 how many hospitals are going to have a sufficient caseload
18 to be able to average out. We really need to be concerned
19 about being able to deliver all of the services. And so
20 it's that earlier chart, which is independent of any
21 motivation. It comes back to our setting the payment rates
22 that we really need to focus on, too. I know you agree.
23 DR. REISCHAUER: There's a problem. There's no
24 question about it.
25 DR. MILLER: Can I make one small point on this?
26 And I agree that there shouldn't be attribution. But the
27 last table that was up there did compare the physician-owned

1 to peer hospitals and the effects are larger, although we
2 haven't statistically gone through and determined whether
3 those effects are different in any kind of statistical way,
4 I believe.

5 MR. MULLER: This is going to certainly dampen the
6 investments in orthopedic hospitals.

7 DR. MILLER: We put the peers up there because we
8 were trying to see whether the effect was more peculiar to
9 the concentration.

10 DR. REISCHAUER: But aren't some of the peers
11 associated with full-service hospitals?

12 DR. MILLER: Yes and I was just about to hit some
13 of the caveats. That, as well as the level of concentration
14 in the peer hospitals is not as concentrated as the
15 specialty hospitals. On a continuum between community and
16 the specialty, the peer falls between that. So it's not a
17 perfect comparison by any means.

18 DR. STOWERS: Just so I understand it, is the one
19 taking all hospitals? Would that be the average
20 profitability?

21 MR. PETTENGILL: Yes.

22 DR. STOWERS: So that would really be the
23 community hospital because they're the huge majority?

24 MR. PETTENGILL: It's the national average with
25 all of hospitals in.

26 DR. WOLTER: This is just a question and it may
27 not be an easy thing to get at, but is there any way to look

1 at utilization rates in physician-owned, peer and full-
2 service hospitals, just to see if there's any difference
3 there? It may be very difficult to do.
4 DR. STENSLAND: That's coming up on the agenda
5 where we'll look at the utilization rates to see if the
6 moving in, say of a heart hospital, effects the total
7 utilization in the market. And also, what types of things
8 get done to patients. Is there a shift in the physician
9 practice patterns once the physicians become owners of the
10 hospital?
11 DR. BERTKO: Just to do the obvious follow up to
12 Nick's question here, if in fact we get a bunch more
13 surgical suites in any kind of hospital and cardiac things,
14 is there supply-induced demand here that increases cost in
15 the whole system, let alone just for Medicare?
16 MR. MULLER: I thought this analysis, as I
17 indicated and other commissioners have too, is so powerful.
18 One of the things that we've been concerned about in
19 general, not just inside this topic, is how much the cost of
20 the overall program is being driven by the very appropriate
21 revolution in technology. I think there's at least evidence
22 here that we're exacerbating that by rewarding technology
23 more then we reward nurses. I think one of the things we
24 have to look at that I think your data gives you a great
25 lead into is if, in fact, that is one of the great drivers,
26 whether it's around the imaging conversation we've had over
27 the last six months, around drug costs, around the argument

1 I've been making around the proliferation of all kinds of
2 devices driving costs, if we then not just have that great
3 technology, which I think we should feel great about that
4 that's going on, but also reward it disproportionately to
5 rewarding hiring nurses and social workers and nutritionists
6 and so forth then, in fact, our system causes even more
7 explosion to go on.

8 So I think the data we have here should also be
9 used in our overall analysis of how the payment system is
10 driving the overall growth in costs, especially in the
11 technology-related areas rather than in the more people-
12 related areas and the costs of those which I think there's
13 at least, if not surface, at least some preliminary evidence
14 here that we kind of underreward the hiring of nurses and we
15 over reward the inclusion of MRIs.

16 DR. CROSSON: I would just like to compliment the
17 staff on the study, too. This is very helpful, very clear
18 and very concise. I just have a question to think about the
19 complexity or difficulty of resolving this, trying to find a
20 solution. Because it seems like in order to find a
21 solution, you have to have one that rebalances between DRGs
22 but also one that rebalances within DRGs.

23 And so would the consideration be with respect to
24 rebalancing between DRGs, how broad would that need to be?
25 And would we be looking at rebalancing within all DRGs? Or
26 would this be something that's targeted at what appears to
27 be areas of concern now or might be areas of concern?

1 Because it seems like you could design something that was
2 relatively narrow or something that was relatively broad.
3 And if it was relatively broad, it would come with a lot of
4 costs and difficulties. So have you thought about that yet,
5 or is that the next meeting?
6 DR. MILLER: The way this is going to play out is
7 we have some additional analysis coming up on the mandate,
8 like the cost associated with specialty hospitals relative,
9 the impacts on the community hospitals. We have tried to
10 get at this notion of is there a whole community impact?
11 It's going to be hard but we're trying to get at that
12 question.
13 And then we're going to start cranking through
14 policy options and they will be organized into payment and
15 other kinds of options. I think your notion of broad versus
16 narrow, I'll be honest, for myself I've been thinking about
17 it mostly broadly. How would you recalibrate DRGs if you
18 were going to go in and do it? I think we could take some
19 time to see whether there are more narrow fixes. But maybe
20 we could come to you with kind of a thought process of
21 narrow to broad.
22 I will say I think technically it's a little bit
23 more difficult to do it narrowly because you're always
24 balancing across a set of cases. We can at least give it
25 some thought.
26 MS. DePARLE: Just to clarify, Mark, I was just
27 looking back at the text of the paper that you wrote. I,

1 and I'm sure other commissioners, have received a lot of
2 mail about this issue, and some of it from specialty
3 hospitals who are presenting information about higher
4 quality that they believe occurs in their settings, better
5 outcomes. There are some studies, I think, that have been
6 done that they're offering up on that.
7 That is not one of the things we were asked to
8 look at; is that right?
9 DR. MILLER: It's not specific in our mandate; is
10 that correct?
11 DR. STENSLAND: Right.
12 DR. MILLER: It's not, but we are taking a shot at
13 it. That word is chosen very carefully because this is very
14 hard to do.
15 Arnie, you made a suggestion at the last meeting
16 or the meeting before to talk to some of the specialty
17 societies and see whether they have information available on
18 the specific set of hospitals that we're looking at. And we
19 have been exploring that. A lot of it hasn't worked out but
20 we're not quite finished yet and we have some things that we
21 have in play.
22 The other thing that I think we're trying to do,
23 and I say this very carefully and looking at Carol, we're
24 doing some transfer work. We're going to be looking at
25 trying to look at transfers between hospitals to see whether
26 there's any pattern there. We don't have okay, here's the
27 quality measure, I have enough cases, I'm going to compare

1 them. That kind stuff, that's not going to happen.
2 DR. REISCHAUER: Can I just make a comment on the
3 quick fix versus the more comprehensive approach and remind
4 us all that this is an issue where rapid change is
5 occurring. There's a moratorium. There is a lot of capital
6 that might want to be invested in a particular area. And
7 sort of asking for a comprehensive reform, which takes five
8 years to implement, not to slip back into yesterday's
9 analogy, but the cows will be long gone from the barn at
10 that point. And then, in a sense, the game is over because
11 the politics of the situation changes.
12 MR. HACKBARTH: Okay, we're going to have to move
13 on. Thank you very much, excellent work.
14 Our last item is to review some preliminary work
15 on the update recommendations for hospital, physicians,
16 skilled nursing facilities and outpatient dialysis.
17 I would ask that the people who are leaving the
18 room do so quickly and quietly so we can proceed.
19 Jack, are you going to lead the way?
20 MR. ASHBY: Every year MedPAC develops update
21 recommendations for the payments in several fee-for-service
22 sectors for the next fiscal year. And that, as a reminder
23 right off, is fiscal year 2006 in this case.
24 We start by looking at several factors to assess
25 the adequacy of factors in 2005. A reminder here, too,
26 we're only three weeks into 2005, but we will be looking at
27 that as the current year.

1 We typically look at six factors in this
2 assessment. They are beneficiaries' access to care, supply
3 of providers, volume of services, quality of care,
4 providers' access to capital and the current year margin.
5 The margins data will not be available until December, but
6 we do have preliminary information on some of the other
7 sectors. And given the workload that we have for December,
8 we wanted to go ahead and get started.
9 Obviously, we have less than an ideal amount of
10 time this morning for this work, so we thought we would
11 first try to economize on our presentations, and we will do
12 that. But secondly, we would like to suggest that perhaps
13 we hold discussion after each one of these four
14 presentations to questions of clarification.
15 Then, if there's any time that at the end, we can
16 have a more general discussion but we'll keep things moving
17 in that way
18 MR. HACKBARTH: I think that's a good idea.
19 MR. ASHBY: So with those ground rules in mind, I
20 will go ahead and turn to the hospital sector.
21 First. just a reminder that we developed separate
22 updates for inpatient and outpatient services. That's what
23 we're going to be about in the hospital sector. But we make
24 a single determination of payment adequacy for the hospital
25 as a whole. We won't go into that detail, just something to
26 keep in mind.
27 This morning we're going to have information on

1 the factors that you see listed in this first slide and
2 moving right ahead to access to care. We use changes in the
3 number of hospitals over time as well as the breadth of
4 services that those hospitals offer as our indicators of
5 access to care.
6 In this first chart, we're looking at the percent
7 of hospitals that offer various hospital outpatient
8 services. You can see that the proportions grew slightly in
9 the late '90s and have generally held constant since.
10 These next two charts show the proportion of
11 hospitals offering a set of specialty services that cut
12 across inpatient, outpatient and ancillary services. The
13 proportions on this first page have grown in every case and
14 I would point out that that includes burn care and trauma,
15 services that have traditionally been viewed as among the
16 least likely to be profitable. The increase in the share
17 for trauma centers is particularly healthy, from 26 to 34
18 percent.
19 Then continuing, the services in this slide also
20 increased in proportion except in psych services, where it
21 dipped slightly from 50 to 40 percent. So in sum, we found
22 in 13 of the 14 services we looked at that the proportion of
23 hospitals offering the service has grown or stayed the same.
24 Next we look at hospital participation rates and
25 that's Tim.
26 MR. GREENE: We examined changes in the number of
27 hospitals participating in the Medicare program and

1 providing care to Medicare beneficiaries. We found that in
2 2003, for the second year in a row, more hospitals began
3 providing care than closed. 41 facilities ceased
4 participating as acute care hospitals and closed. There
5 were 58 new participants of which 28 identified themselves
6 by name as specialty hospitals. They described themselves
7 as surgical, specialty, orthopedics, heart or women's
8 facilities.
9 Concern that closures in rural areas might impair
10 access to care for Medicare beneficiaries led the Congress
11 to enact the Critical Access Hospital Program and the BBA.
12 Since then approximately 1,000 hospitals converted to CAH
13 status. The program now plays an important part in
14 maintaining access in rural areas. We looked at conversions
15 to CAH status in 2003 and found that more hospitals
16 converted to critical access hospital status than closed.
17 Of 157 hospitals that ceased participating as acute
18 hospitals, 116 became CAHs and 41, as I indicated a moment
19 ago, closed and stopped providing care.
20 I will now turn to indicators of volume, changes
21 in volume in hospitals.
22 The rate of increase in discharges for both
23 Medicare and all payers increased after 1998, peaking at 4.6
24 percent for Medicare in 2001 and 3.3 percent for all payers
25 in 2000. The change in Medicare discharges in part reflects
26 changes in enrollment. Fee-for-service enrollment grew in
27 2001 and 2002 as many beneficiaries left Medicare+Choice

1 plans and returned to fee-for-service. This is reflected in
2 2001 and 2002 in a sharp increase in fee-for-service
3 discharges at PPS hospitals that you see here.
4 Discharge growth continued afterward with Medicare
5 discharges increasing 2.4 percent in 2003 and all payer
6 discharges 1.4 percent. In the case of Medicare, that keeps
7 discharge growth still in excess of fee-for-service
8 enrollment growth, which was 2.3 percent in 2003 when
9 discharges increased 2.4 percent.
10 The average length of stay of Medicare patients
11 fell more than 30 percent during the 1990s. Peak declines
12 occurred in the mid-'90s with drops in excess of 5 percent
13 per year from 1993 to 1996. Length of stay decline
14 moderated after that but has increased again after 2002 and
15 we see a decline in Medicare length of stay of 1.3 percent
16 in 2003.
17 Pattern of length of stay decline for all payers
18 generally moves the same way as Medicare length of stay
19 change but is historically more moderate. Here we see
20 modest all payer length of stay decline, an actual increase
21 of 0.2 percent in 2002 and no change at all in all payer
22 length of stay in 2003. You see no number there because all
23 payer length of stay change is zero in 2003 compared to the
24 1.3 percent decline in Medicare length of stay.
25 MS. BURKE: What is the number now? How many
26 days?
27 MR. GREENE: About six, a little below six. I

1 don't remember exactly.

2 DR. REISCHAUER: Because all payer includes
3 Medicare and Medicare is a big chunk of the all payer, the
4 difference between Medicare and non-Medicare is really much,
5 much larger. In fact, in some of these years would be of a
6 different sign, particularly in 2001. I would think, in a
7 way, it might be more useful to try and do that, although
8 the non-Medicare would have the Medicare+Choice people in it
9 is the problem; right?

10 MR. ASHBY: Part of the reason we don't do that is
11 because the non-Medicare number is a real mixture that
12 actually includes some Medicare, as you say. So it's a
13 funny number.

14 MS. BURKE: Jack, remind me again, what percent of
15 hospital admissions are Medicare? The full boat.

16 MR. ASHBY: Approximately 40 percent of all types
17 of Medicare, which is broader than the Medicare measure that
18 you're looking at.

19 DR. ZABINSKI: Moving away from inpatient volume,
20 I'm going to discuss volume in the outpatient PPS.

21 In the March 2004 report we measured volume in the
22 outpatient PPS as the number of services provided rather
23 than number of visits because the outpatient PPS pays on the
24 basis of services. This means we count number of biopsies
25 performed, number of MRIs done, number of radiation
26 therapies and so forth.

27 We'll continue to use this measure of volume in the March

1 2005 report.

2 Using claims data, we have found that volume has
3 grown strongly since the outpatient PPS began in August of
4 2000. For example, overall volume of services grew by 8.4
5 percent from 2002 to 2003 and by just 13 percent from 2001
6 to 2002.

7 A couple of notes on these findings are first of
8 all that they exclude pass-through devices, pass-through
9 drugs and other separately paid drugs. We made this
10 exclusion because nearly all devices and drugs on the pass-
11 through list in 2002 had their pass-through status sunset at
12 the end of 2002. Therefore, the volume for pass-through
13 drugs and devices dropped substantially in 2003 because most
14 were packaged with services rather than being paid
15 separately as they were in 2002.

16 A second point is that about two-thirds of the
17 increasing in volume from 2002 to 2003 is due to increased
18 volume of care per beneficiary who receives outpatient PPS
19 services. And then most of the remaining growth from 2002
20 to 2003 was due to an increase in the fee-for-service
21 beneficiary population.

22 And now David is going to discuss hospitals'
23 access to capital.

24 MR. GLASS: One of our indicators of payment
25 adequacy from the payment adequacy point of view is the
26 aggregate amount about right. Industry plans on their use
27 of capital, this is from a 2004 Bank of America Security

1 survey for nonprofit hospitals. They forecast a 10 percent
2 increase in capital spending. 41 percent of the hospitals
3 actually expected to increase the capital spending more than
4 15 percent. So they're planning on having access to
5 capital.
6 The HFMA also found a 14 percent annual increase
7 over the next five years versus only 1 percent from '97 to
8 2001, so they too are forecasting access to capital
9 Nearly 82 percent of hospitals actually plan to
10 increase capacity, that is expand capacity, get bigger
11 bricks and mortar sort of thing. And 54 percent plan to
12 increase inpatient capacity. And other sources concur in
13 that, that there is a move towards increasing capacity.
14 Nearly 87 percent report access to capital is the
15 same or better than five years ago. Interestingly, 94
16 percent of rural hospitals report that to be true. So they
17 expect to have capital available.
18 This shows hospital construction spending from
19 Census Bureau data. As you can see, it's gone from about
20 $13 billion in 2000 up to $20.5 billion in 2004. The change
21 in 2003 to 2004 is about 12 percent. So we look at what
22 they expect to do, this is what has happened up until now,
23 and the construction spending clearly has been strong,
24 capital has been used.
25 Looking at tax-exempt hospital municipal bond
26 issuances, these are for nonprofit hospitals, 2004 is the
27 second highest in total over this period, starting in 1994.

1 Interesting, new money, which is the darker part of the bar,
2 is at its highest level for the entire period, over $20
3 billion. So they're not just refinancing to get lower
4 interest rates, they're actually getting new capital.
5 The interesting point is that all of this
6 borrowing has not lowered the median credit ratings, that
7 operations and other income can support the additional
8 borrowing without lowering key ratios such as debt service
9 coverage and days cash on hand. Downgrades still outnumber
10 upgrades but the dollar value of upgrades in the last
11 quarter, according to one of these sources, exceeded the
12 value of the downgrades by 70 percent. So more money was
13 getting upgraded than downgraded, even though the number of
14 hospitals was the other way around. And it could still be
15 that smaller hospitals are downgraded more but the vast
16 majority are unchanged, they're neither upgraded nor
17 downgraded.
18 There are also hospitals that do not issue
19 publicly traded bonds, so they could have other capital
20 access problems. But interesting, other forms of financing
21 are available as well. Banks are moving more into this area
22 and their private placement tax-exempt bonds are increasing
23 and there are also groups that are now securitizing small
24 tax-exempt bonds and selling them as packages to investors.
25 So there are other sources of capital that are showing up
26 that we wouldn't be able to track from this kind of data.
27 Also of course, the hospitals can lease equipment which

1 doesn't show up as debt and doesn't show up as borrowing.
2 For-profits, of course, can issue equity directly.
3 Recently one announced that they're borrowing as much as
4 $2.5 billion to repurchase shares, so they seem to have
5 sufficient access to capital there. We'll revisit the
6 findings if new numbers come up that change any of these.
7 MR. HACKBARTH: Under your proposed approach,
8 we're going to turn to physician next?
9 MR. ASHBY: Questions or clarifications? If none,
10 then we will skedaddle.
11 DR. MILSTEIN: Relevant to some of our prior
12 discussions, do we know anything about the relative rate of
13 investment in new hospital capacity in what Elliott Fisher
14 would suggest are the high volume, high cost regions of the
15 country versus low volume? That's question one.
16 Question two, and maybe relevant to our IT
17 discussion yesterday, do we know very much about the degree
18 to which this capital that is being raised is being
19 deployed? What's its relative use in terms of deployment
20 for bricks and mortar versus IT and other things that might
21 be used to improve hospital performance?
22 MR. GLASS: I think we have some information on
23 the latter, at least what the plans were, whether they were
24 going to use it to invest in technology. We can get that to
25 you.
26 DR. CROSSON: Relative to the upgrading or
27 downgraded, and I know the data shows that most hospitals

1 don't change in a given year, but there was a significant
2 number moving in each direction. I wondered, do we know by
3 hospital type who was being moved up, who was being moved
4 down, hospital size, ownership, public hospitals, academic
5 hospitals, for-profit chain hospitals?
6 MR. GLASS: We can probably put something together
7 on that.
8 MR. ASHBY: We don't have it right now.
9 MR. GLASS: The larger systems, I think, tend to
10 be more stable than individual hospitals.
11 DR. MILLER: But the sources of this analysis that
12 we have often don't break it up into the usual categories
13 that you are use to looking at, teaching, nonteaching, that
14 type of thing. We can infer it often from pieces of what we
15 read but I suspect it won't be a nice table, quantifying it
16 by category of hospital.
17 MR. GLASS: Unless we want to go into it hospital-
18 by-hospital and count them. We could do something like
19 that, I think.
20 DR. MILLER: Do you actually have the capability
21 of doing that, including time?
22 MR. GLASS: We can try. Time, maybe not.
23 DR. MILLER: I think that's the point I'm driving
24 at.
25 MR. HACKBARTH: We have to move ahead to the
26 physician.
27 MS. BOCCUTI: I have a very brief presentation on

1 results from some recent surveys on beneficiary access to
2 physician care and, of course, a more comprehensive analysis
3 on access to physician care will be in December.

4 The first study I'd like to discuss was sponsored
5 by CMS and conducted in 2003. It's called the targeted
6 beneficiary survey because it surveyed beneficiaries in
7 market areas where rates of reported physician access
8 problems were highest in the 2001 CAHPS fee-for-service
9 survey.

10 The study found that even in these areas suspected
11 of higher than average access problems, only a small
12 percentage of beneficiaries had access problems attributed
13 to physicians not taking new Medicare patients.

14 Specifically, the study found that within these 11
15 markets, only 90 percent of beneficiaries reported that they
16 were able to get a personal doctor they were happy with
17 since joining Medicare. Similarly, over 90 percent of those
18 needing a specialist reported no problems seeing one in the
19 past six months.

20 Ability to get timely appointments was a little
21 more problematic in these areas but still not bad. 73
22 percent reported always getting an appointment as soon as
23 they needed and 20 percent said they usually did. So that
24 leaves about 7 percent who reported that they sometimes or
25 never were able to get timely appointments.

26 Less than 4 percent of beneficiaries reported that
27 problems accessing physicians were due to physicians not

1 taking Medicare patients or not taking assignment. Other
2 reasons beneficiaries gave for access problems included that
3 the doctor was not taking any new patients or didn't like
4 the doctor or they had transportation issues.
5 And finally, access problems were a little more
6 problem for transitioning beneficiaries in these areas.
7 Transitioning beneficiaries are those that are new to
8 Medicare or recently disenrolled from a Medicare+Choice
9 program, or new to the market area in general. These
10 beneficiaries had higher rates of access problems, finding a
11 personal doctor and a specialist. In some respects, that
12 can be expected. I think the survey was careful to
13 oversampled that group to get a really good sense of what
14 their experience was.
15 Next, I'm going to turn to a MedPAC-sponsored
16 survey which was piloted last fall which you may recall that
17 I talked about. We conducted it again this year, just this
18 past August and September. Although we did not target
19 specific areas, we expanded on our pilot survey by including
20 privately insured people aged 50 to 64 to allow some
21 comparisons between these populations, that is the Medicare
22 population and the people aged 50 to 64. We hope to
23 continue tracking these trends with both these groups.
24 Results from this telephone survey showed that the
25 majority of Medicare beneficiaries and people aged 50 to 64
26 reported either small or no problems with access to
27 physicians in 2004. Access to physicians for Medicare

1 beneficiaries is the same as or better than that for
2 privately insured people aged 50 to 64. Differences in
3 Medicare access between 2003 and 2004 were not significant.
4 So I'll talk about a bit about these specifics.
5 Looking at the last two columns, both the Medicare and
6 privately insured groups reported more difficulty finding a
7 new primary care physician than a specialist but the
8 majority, that's 88 percent which is the sum of the no
9 problem and the small problem group, reported that they
10 experienced small or no problems finding a primary care
11 physician. Regarding specialists, 94 percent of Medicare
12 beneficiaries and 91 percent of privately insured
13 individuals reported the little or no problems accessing
14 specialists.
15 Looking at the first two columns, which track
16 access from Medicare beneficiaries from 2003 to 2004, the
17 difference between the two columns is not statistically
18 significant, though keeping track of possible increases in
19 the share reporting the big problems will continue to be
20 important. And also looking at the 2003 Medicare column, I
21 want to mention that the results from our survey were very
22 consistent with relevant indicators from the CAHPS fee-for-
23 service, which came out recently, and that was for 2003. So
24 we have 2004 results but the recent 2003 results for the
25 CAHPS study are similar to what we found last year.
26 When asked about difficulty getting an appointment
27 as soon as that they wanted, respondents indicated that for

1 routine care Medicare beneficiaries fared slightly better
2 than the privately insured group. And 73 percent of
3 Medicare beneficiaries and 66 percent of privately insured
4 individuals reported that they never had to delay their
5 appointment. But 2 percent of Medicare beneficiaries and 3
6 percent of privately insured individuals reported always
7 experiencing a delay.
8 As expected for illness or injury, delays are more
9 common for both groups but I didn't put that up on the
10 slide.
11 Another measure of access also not on the slide
12 that many surveys use examines whether people saw a
13 physician when they thought they should have but that they
14 didn't. In our 2004 survey, 6 percent of Medicare
15 beneficiaries and 11 percent of privately insured
16 individuals said that they think they should have seen a
17 doctor for a medical problem in the last year but that they
18 didn't.
19 Within this group, physician availability issues
20 such as finding a doctor or getting an appointment time were
21 listed as the problem for really only a small share of those
22 people that said that they didn't see the doctor. More
23 common responses for these people were that they didn't
24 really think the problem was serious enough or that they had
25 cost concerns or that they were really just putting the
26 problem off or reporting off making an appointment.
27 So that concludes what I'm showing you today. In

1 December, I will complete the access analysis with a little
2 bit more looking at physician willingness to serve Medicare
3 beneficiaries. And that will be part of the whole of
4 payment adequacy analysis.
5 MR. HACKBARTH: Before we move on to SNF, any
6 clarifying questions on the physician?
7 MS. DePARLE: I had one but this is going to make
8 you go back to your slide. Page four of your slides.
9 I think you comment a little on this, but do we
10 need to be concerned about the primary care physician, the
11 change between the 2003 and 2004 of those number of
12 beneficiaries who said it was a big problem?
13 DR. MILLER: That's exactly why -- we went through
14 a lot of this in talking about how to display, because
15 you've got tons of information here. We wanted to bring
16 this up specifically because there's a couple of ways to
17 look at it.
18 When you compare it to the 50 to 60, Medicare
19 still seems to be doing better. And also, even the split
20 over time is a little bit funny. The no problem got better,
21 people saying they had no problem got better. And then the
22 people with a problem got worse.
23 And so we wanted to flag this for you. There's no
24 statistical difference but there is a jump in that number.
25 And that's what Cristina said, that this is probably an area
26 that we need to keep an eye on. But it is a little bit
27 anomalous because you've got the people with no problem,

1 more of them saying that there's no problem too, at the same
2 time.
3 MS. BOCCUTI: I'll mention also that the 18 and 11
4 is small but it's just on the cusp of being statistically
5 significant. It's probably in the 90 percent confidence.
6 But the issue with the primary care physicians is
7 we're really looking at people who are trying to get a new
8 primary care physician and this reduces your N a lot because
9 they have more experience trying to get a new specialist
10 because they have a new condition. But the statistical
11 significance -- but when we look at the other surveys, it's
12 relatively consistent.
13 But I didn't want to blow over what you raised by
14 saying that we're going to keep tracking this and if there's
15 fluctuations over time, then these are within the range of
16 similar. But if there's a trend that keeps continuing then,
17 if we always track it back to 2003, if say in 2007 it
18 becomes a trend that's wildly different from 2003, we'll
19 know that.
20 MS. DePARLE: I guess I'm trying to remember from
21 the earlier work the number of physicians who say -- there's
22 one number of physicians who are participating, then there's
23 a number of physicians who will take new patients and a
24 number who will take new Medicare patients. What I remember
25 is that hadn't changed much. But I'm just wondering to what
26 extent is this a proxy for a change there, because that's
27 obviously something we would be concerned about.

1 MS. BOCCUTI: Right, and that's why we try -- we
2 couldn't do it today because we're trying to collapse
3 everything, but to always balance this with the physician
4 willingness to take new patients. And we try and look at
5 that, too. And that's sort of what you're going at, but
6 this is a beneficiary access survey.
7 MS. DePARLE: I'm just wondering if that change --
8 and I hear you saying it's not statistically significant,
9 although it looks like a sort of large number -- does that,
10 in some way, indicate something about physicians willingness
11 to accept new Medicare patients?
12 MS. BOCCUTI: We'll keep that in mind as we
13 continue the analysis and we'll be able to track it over
14 years.
15 DR. MILLER: Cristina, do we plan in December to
16 talk about the other data sources, which would include that?
17 MS. BOCCUTI: Like caseload issues?
18 MR. HACKBARTH: No, physician willingness to
19 accept new Medicare patients.
20 MR. MILLER: Isn't that one of the other surveys?
21 MS. BOCCUTI: The sources that we look at,
22 typically we have the NAMCS, which is the National
23 Ambulatory Medical Care Survey. And that won't give us
24 2004. And hopefully we'll have it in time to look at 2003.
25 So the tricky part is that we're happy that we
26 have such recent data but it's never going to be in any of
27 the other surveys that we provide. We try and track that

1 every time, physician willingness, with whatever sources we
2 can obtain.
3 DR. NELSON: Cristina, if it's possible to break
4 out your numbers for Medicare patients over the age of 70
5 and under the age of 70, pick a number, but I'd be reassured
6 if we didn't see a difference in access problems from the
7 66-year-old relatively healthy semi-retired businessperson
8 from the frail elderly person with multiple chronic
9 illnesses.
10 MS. BOCCUTI: Actually, some of the data is cut
11 that way for our analysis, so I'll see what I can do about
12 doing that. I understand your point and the discrepancy in
13 the full Medicare population ages compared to the 50 to 64.
14 I'll look at that.
15 DR. REISCHAUER: Just a question of clarification.
16 Is this a question asked of all Medicare beneficiaries or
17 those who are looking for a new primary care physician?
18 MS. BOCCUTI: The first question about primary
19 care physicians? That is only asked if you were looking for
20 a new primary care physician.
21 DR. REISCHAUER: And what fraction of total
22 Medicare participants is that? Is it 10 percent?
23 MS. BOCCUTI: A little under 20, I think. I need
24 to look at that number to be sure.
25 DR. MILLER: This is 11 percent of 20 percent is
26 what it is, so we're talking about small numbers.
27 MS. BOCCUTI: But I have to check that number.

1 MR. HACKBARTH: Thanks, Cristina.
2 MS. LINEHAN: First, we're going to look at entry
3 and exit of SNF providers. Data from 2004 indicate that the
4 trend in the supply of SNFs we've seen for the past few year
5 continues. From 2003 to 2004, the total number of SNFs
6 participating in Medicare remained almost unchanged, with
7 the number of hospital-based SNFs declining 6 percent and
8 the number of freestanding SNFs increasing by 1 percent.
9 These changes in the past year tracked very closely with the
10 average annual change in the supply of SNFs over the past
11 five years. In 2004 the number of SNFs is about the same as
12 it was in 1999, the first full year of the PPS.
13 The next factor we'll consider is the volume of
14 SNF services provided in 2002, which is most recent year for
15 which we have data, and it's an update from what you saw
16 last year, which is 2001 data.
17 Between 2001 and 2002 the overall volume of SNF
18 services increased, discharges covered and average length of
19 stay all increased. Total payments to SNFs increased while
20 the average payment per day actually declined. This follows
21 a 13 percent increase in average payment per day between
22 2000 and 2001. The expiration of some temporary payment
23 add-ons affected payments in the last quarter of 2002.
24 Other payment add-ons will remain in place until the
25 implementation of case-mix refinements to the SNF PPS.
26 Looking ahead to 2004, SNF spending will also be
27 affected by the full market basket update plus the

1 administrative increase to correct for past market basket
2 forecast errors.
3 The CMS Office of the Actuary projects that
4 Medicare spending on SNFs will be $13.5 billion in 2003 and
5 $14.3 billion in 2004.
6 Next, we're going to look at access to care. Our
7 primary source of information has been OIG studies on
8 discharge planners ability to place Medicare patients in a
9 SNF after an inpatient stay. Consistent with the MedPAC
10 recommendation, the OIG is currently conducting of a follow-
11 up to this study but they won't have results until spring of
12 2005 so we can't consider them for this year's update. So
13 ideally, we'd have this information, but instead I'm going
14 to present information on case-mix that shows that the same
15 types of patients are accessing SNF care between 1999 and
16 2002 and some data on utilization to show that utilization
17 has increased.
18 Past OIG studies from 1999, 2000 and 2001 of
19 discharge planners ability to place Medicare beneficiaries
20 found that those needing rehab therapies have ready access
21 to SNFs but those needing other types of services might
22 experience delays in accessing SNF care.
23 Another OIG study on the change in case-mix
24 between 1999 and 2002 -- and case-mix is measured by the
25 assignment of one of 44 RUGs - indicates that SNFs continue
26 to treat the same mix of patients with slight shifts towards
27 rehab and extensive care and a small decrease in the

1 proportion of patients in special care and clinically
2 complex RUGs. More than three-quarters of SNF patients
3 continue to be assigned to rehab RUGs.
4 Assuming that the need for different types of SNF
5 care hasn't changed markedly, this suggests that those types
6 of patients that had no difficulty accessing care in 1999
7 may have had similar access in 2002 and that those
8 expressing delays in 1999 may have also experienced delays
9 in 2002.
10 Next, we're going to look at some of the results
11 from Chris Hogan's work that he presented last month on
12 benes' use of post-acute care. He found that the number of
13 SNFs episodes increased between 1996 and 2002 and that the
14 proportion of discharges to a SNF increased between 1996 and
15 2002.
16 Ideally, we'd have information on whether those
17 who need SNF care can get it as our measure of access. But
18 these data suggest that since the implementation of the PPS,
19 more beneficiaries are using SNF care. In addition, the
20 minimal change in the assignment to RUGs suggest that SNFs
21 are providing a similar mix of care in 2002, similar to the
22 mix that they provided in 1999.
23 Last, I'm going to turn to quality. In our
24 previous meeting last month, we talked about our long-term
25 quality agenda for SNFs. Today I'll present available
26 evidence to examine quality trends specific to SNF patients
27 from three sources for purpose assessing payment adequacy.

1 The first quality measure we'll look at is
2 information about SNF patients adjusted readmission rates
3 for five potentially avoidable conditions between 1999 and
4 2001. We're going to update this for 2002 with data that we
5 just received. These five categories of readmissions to the
6 acute care hospital from a SNF setting were developing by
7 researchers at the University of Colorado Health Sciences
8 Center and judged to be the types of readmissions that are
9 avoidable if patients are receiving good quality care in the
10 SNF.
11 After controlling for diagnosis and functional
12 severity of patients, we found mixed results. Rates of
13 readmission for congestive heart failure, electrolyte
14 imbalance and UTI increased. We saw a decline in rates of
15 rehospitalization for respiratory infection and the rate for
16 sepsis remained the same.
17 Next, we'll look at again some work from Chris
18 Hogan on quality for short-stay patients. He compared rates
19 of mortality, readmission to the hospital and discharge to
20 community after 30 days in 2002 to those rates in 1996. As
21 he explains, this is not the most refined measure of the
22 performance of the system. It's a short-term outcome. it
23 doesn't address the long-run. It doesn't address people who
24 don't use post-acute care. It doesn't address functional
25 status.
26 With that said, the 2002 expected numbers were
27 based on what he predicted to happen based on the diagnosis

1 of cases in 2002 and based on the outcomes in that post-
2 acute setting that occurred on average for those cases in
3 1996. Again, here we see mixed results. Medicare benes in
4 a SNF in 2002 had lower than expected mortality but greater
5 than expected number of readmissions. And here, readmission
6 is just a readmission after 30 days, any readmission, and
7 lower than expected number of successful discharges to the
8 community.
9 The last quality indicator we'll look at comes
10 from CMS's Nursing Home Compared database. What you see on
11 this slide are the median values for skilled nursing
12 facilities on three quality measures for short-stay
13 patients. It's important to note that these data are not
14 weighted for the number of short-stay patients in the
15 facility so these are facility rates.
16 There was no change in the percent of short-stay
17 patients with delirium between 2002 and 2004, and a decrease
18 in the proportion of SNF patients with moderate to severe
19 pain. We can't present trend information on pressure sores
20 because we only have 2004 data.
21 It's important to note that for each of these
22 measures in each year about 30 percent of facilities didn't
23 report data either because they just didn't report it or
24 they had too few patients to report.
25 In sum, all of these quality measures show some
26 improvements and some declines in quality but the changes,
27 where they exist, are small.

1 This is all I have for this month. I can take
2 clarifications or questions.
3 MR. SMITH: Just a quick question. I'm always a
4 little confused by the number of SNFs rather than the number
5 of beds as a indicator of what's out there. Do we know how
6 many SNF beds there are relative to the previous year?
7 MS. LINEHAN: I don't have those data now. The
8 complicating factor, in my understanding, is that facilities
9 will certify all of their beds as Medicare beds. And so
10 we'll know a total number of beds in the facility but not
11 necessarily the number of beds that are being used by
12 Medicare patients.
13 But I can look into getting information about
14 that.
15 DR. REISCHAUER: But you have a very different
16 picture of you look at covered days. It's going up like a
17 bandit and the number is sort of holding still. That could
18 be filling excess capacity or what, you really don't know.
19 DR. SCANLON: Some information, essentially
20 Medicare's only covering about 10 percent of facilities
21 beds. So there is the flexibility to change over time, even
22 though you're not certifying anymore. It was with the
23 introduction of the PPS that facilities started to certify
24 virtually all of their beds as opposed to maintaining a
25 distinct part for Medicare purposes. And so we lost track
26 in terms of what they want to do, in terms of service to
27 Medicare patients.

1 MS. RAPHAEL: I had two questions. One is trying
2 to understand what has led to the increase in the percentage
3 of hospital discharges going to SNFs. I don't remember the
4 exact number but I do recall that looking from 1984 to the
5 present the percentage of those over 65 who are in nursing
6 homes has declined. So I'd like to try to understand what
7 is happening there, whether there's a redistribution in
8 terms of rehab facilities in home health care or is it
9 correlated in some way with the fact that you said more than
10 three-fourths of the cases are for rehab services?
11 That leads me to the second question. I know you
12 have little bit on that but one of the concerns we have had
13 has been whether or not what we call clinically complex
14 patients have access to the SNF. I can't entirely tell from
15 this what's happening in that area but that seemed to be the
16 patient group that we were most concerned about.
17 DR. MILLER: I think you're right. At least at
18 this point we aren't able to parse that very well. Some of
19 the recommendations that we made in previous years, for the
20 IG to go ahead and look at this, is to hopefully get drilled
21 down on some of that. I'm not aware that we have, and
22 Sally, you should -- I'm not aware that we have a really
23 good way to get the quality measure specific to the
24 diagnosis in question. So we're reporting them at the
25 aggregate level. We're a little bit stuck is the point.
26 DR. MILSTEIN: Triggered by this presentation but
27 a little bit broader, this presentation and others for me

1 stimulate the question what kind of a freshly populated
2 measurement dashboard does MedPAC need to make good
3 recommendations? Because some of this information -- and
4 it's not obviously a staff problem. This has to do with
5 information flow. But if we're expected to offer useful
6 opinions but not, for example, have information on severity
7 of illness and who's going in and out of SNFs -- to borrow
8 Clem's metaphor, we've got a very cloudy windshield we're
9 trying to steer through.
10 Both with respect to offering good recommendations
11 on adequacy of SNF payments and probably across the board,
12 if we thought about it, as we're discussing these
13 individually we can be accumulating a list of what we might
14 than recommend in the future ought to be a regular fresh
15 measurement flow into this organization so that we can offer
16 more informed opinions.
17 DR. MILLER: And that's some of what we talked
18 about last meeting when we were talking about the work plan
19 for going through SNF quality analysis. We openly
20 acknowledge that, particularly to distinguish facility-
21 specific types of outcomes, that we have a problem. We've
22 stepped back and articulated the direction we're going to
23 go. And at an aggregate level, this is sort of what we
24 have. We're hoping the IG comes online following
25 recommendations that we made. But this is not to say no to
26 you at all. We do get that.
27 MR. HACKBARTH: Anything else?

1 DR. WOLTER: This is sort of related. Is it
2 possible to look any of these quality indicators, hospital-
3 based SNF, and break it out that way, versus freestanding?
4 It's a little bit related to this clinically complex patient
5 issue in my mind.
6 MS. LINEHAN: Yes, it is. For this one it is, for
7 adjusted readmission rates. For what it's worth, this one
8 is, too. We can come back next time with that.
9 MR. HACKBARTH: Just one other thought about
10 Arnie's question. I remember a couple of reports ago we did
11 an appendix on data needs and at the time I thought we were
12 thinking about that being if not an every issue feature but
13 a regular feature with this intent in mind, sort of trying
14 to look ahead in an organized way, saying if we could start
15 to fill these holes it would not only help MedPAC, of
16 course, but everybody involved in the program
17 So that's a thought that we may want to pursue.
18 Let's move on. Thank you, Kathryn. Let's move on
19 to outpatient analysis
20 DR. RAY: Okay, we will close today's proceedings
21 with a first look at indicators assessing outpatient
22 dialysis payment adequacy. You will have opportunities at
23 the December meeting and the January meeting to again
24 reflect upon these data as well as additional data we'll be
25 bringing to you.
26 Your mailing materials included four indicators of
27 payment adequacy: looking at changes in the supply of

1 providers, beneficiaries access to care, changes in the
2 quality of care and changes in the volume of services
3 furnished to benes.
4 In terms of the supply of providers, we've updated
5 our data to include the number of facilities for 2003 and
6 2004. Between 1993 and 2004 the number of facilities has
7 increased 6 percent per year. For-profit and freestanding
8 facilities are a higher share of all facilities over time.
9 And the share that are located in rural areas has remained
10 steady at about 25 percent.
11 Moving onto beneficiaries access to care, one way
12 we look at access to care is to look at the pattern of
13 facility closures to see if beneficiaries are facing
14 systematic problems in getting care. To do this we compared
15 facilities that stayed open and 2003 and 2004 to those that
16 closed in 2004. Consistent with our results from previous
17 analyses, a disproportionate number of facilities that
18 closed were small, nonprofit and hospital-based.
19 Again, consistent with what we found, is that
20 closures did not disproportionately occur in rural areas or
21 in HPSAs. We used Bureau of Census data that measured
22 racial, ethnic and economic characteristics of an area on
23 the ZIP code level. And here we found that closures were
24 not disproportionately occurring in lower income areas,
25 again what we have found before.
26 Our new finding here, though, is that some
27 closures may be occurring in areas where a higher proportion

1 of the population is African-American. Here we found that
2 18 percent of the population were African-American in areas
3 where facilities remained open versus 24 percent where
4 facilities closed.
5 I want to caveat this measure. This is not a
6 perfect measure because it's measuring in areas ratio and
7 income characteristics, not the facilities. Nonetheless, we
8 think it's important to continue to monitor trends here. In
9 the future what we may want to do to more accurately look at
10 this is to link patient claims, so we can get race, to where
11 beneficiaries are being treated so we can do this analysis
12 on the facility level.
13 In terms of quality of dialysis care, we used
14 CMS's quality measures which show between 1999 and 2002
15 improving dialysis adequacy. This is hemodialysis adequacy
16 and peritoneal dialysis adequacy and improving anemia status
17 for dialysis patients. There is little change in
18 nutritional status among both hemodialysis and peritoneal
19 dialysis patients and a very small change in vascular access
20 care.
21 Another aspect of quality that MedPAC has analyzed
22 in the dialysis area is the relationship between providers'
23 costs and quality. Just to remind you, back in June 2003 we
24 used 2000 cost report data and we showed that no difference
25 in the quality of care, in terms of dialysis adequacy and
26 anemia status, between lower-cost providers and higher cost
27 providers. We've updated this information, which was a

1 included in your mailing materials for 2001, and we found
2 similar results.
3 Finally, in terms of the volume of services,
4 volume is increasing. We look at volume in terms of
5 spending to put it on a common metric here. MedPAC analysis
6 between 1996 and 2002 shows that the growth in spending of
7 injectable drugs went up faster than dialysis spending.
8 Injectable drug spending went up about 17 percent per year.
9 Dialysis spending, that's composite rate service spending,
10 went up at about 6 percent per year. The multiple factors
11 affecting injectable drug growth spending include increasing
12 use of the drugs, higher cost for new drugs, and the
13 increasing patient population.
14 By contrast, the utilization growth for dialysis
15 services is limited because Medicare covers a maximum of
16 three treatments per week. And so any increase here is
17 limited to the growth in enrollment.
18 That concludes the presentation.
19 MR. HACKBARTH: Any questions or comments?
20 MS. DePARLE: I agree with your comment about data
21 following the last presentation. This one reminds me that
22 this is an area where we could have more timely access to
23 data. and if there's something we could do about that it
24 would be helpful.
25 Nancy hears this all the time, but the dialysis
26 providers, many of them, say that they provide cost report
27 data and they don't understand why it takes so long for us

1 to get access to the more recent data. I don't know if
2 there's anything we can say about that but I think it's
3 something that we can agree with the industry on.
4 DR. RAY: Right, and I think my first cut of the
5 analysis of the cost report data suggests that I'll have
6 data for about 2002 and 2003, that we will have a sufficient
7 sample this year. So that, I think, is the good news.
8 DR. MILLER: And Nancy, to that point, in our
9 comment letter --
10 DR. RAY: Yes, and that's true, also. In our
11 comment letter on the Part B reg, we actually did mention
12 the need for up-to-date and timely cost report data.
13 DR. MILSTEIN: I may have missed this, but do we
14 have access to information that would tell us about either
15 differences between dialysis facilities or trends overall
16 for all dialysis facilities with respect to the total costs
17 of care associated with patients who are in renal dialysis?
18 Things that would be giving us a clue as to the rate at
19 which readmissions or admissions to hospitals are occurring
20 for infections, et cetera?
21 DR. RAY: When you say total cost of care, do you
22 mean both for dialysis and non-dialysis? Or dialysis and
23 injectable drugs?
24 DR. MILSTEIN: The former, the works. In other
25 words, things that would begin to give us an index of
26 propensity of patients to get into trouble and require a lot
27 of medicare payments and services that are not included or

1 not even delivered by dialysis facilities or included within
2 the dialysis facility rate?
3 DR. RAY: Yes, that's doable. We looked a little
4 bit at that in our June 2004 report where we looked at
5 spending in the pre-ESRD period and one year into ESRD. But
6 we can give some additional thought to that and get you back
7 to on it.
8 DR. MILSTEIN: Thank you.
9 MR. HACKBARTH: Ralph's comment was that Jack
10 Rowe, when he was on the Commission, often -- in fact, at
11 every discussion of dialysis -- would urge us to think more
12 broadly about the treatment being delivered and the overall
13 cost, the overall quality.
14 Anything else?
15 Okay, we will have a brief public comment period.
16 MR. HACKBARTH: Seeing no one rushing to the
17 microphone, we are finished. Thank you very much.
18 [Whereupon, at 12:02 p.m., the meeting was
19 adjourned.]
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