MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

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P R O C E E D I N G S

MR. HACKBARTH: Let's begin. This morning we have two sessions related to physician payment, in fact both related to our report on alternatives to the SGR.

So Scott or Dana, who's going first here? Dana.

MS. KELLEY: Good morning. The Deficit Reduction Act requires that the Commission report to the Congress on mechanisms that could be used to replace the sustainable growth rate that's used to update the physician fee schedule. The report must discuss disaggregating the current national target into multiple pools using five alternatives: group practice, hospital medical staff, type of service, geographic area, and physician outliers.

The mandated report also provides an opportunity for the Commission to comment on other reforms that would improve the value of the physician services Medicare buys for its beneficiaries.

So today we're going to step away from the five alternatives that we're mandated to consider. First, I'm going to present a summary drawn from Commission discussions and recommendations that forms a vision for the future of Medicare's physician payment system. Then Scott will

discuss potential modifications to the current SGR.

As you know, Medicare expenditures for physician services are growing rapidly. In 2005 spending on physician services increased 8.5 percent. It's not clear what's behind this growth in spending. Some argue that volume growth is spurred by consumer demand, which may be fed by direct-to-consumer advertising, the Internet, and lifestyle changes that have resulted in rising obesity, diabetes, and other chronic illnesses. The need to practice defensive medicine is also blamed.

But research has not found these factors to be driving forces. Some researchers have found no underlying explanation for the growth in the volume of physician services, pointing out that volume varies significantly across geographic areas and that variation is primarily due to greater use of discretionary services that are sensitive to the supply of physician and hospital resources. And care is often no better in areas with high volume.

What does seem clear is that the system itself fails to provide the right kind of incentives. Ideally, payment systems are designed so as to encourage providers to furnish better quality of care and to coordinate care, as

well as to use resources judiciously. At the same time, beneficiaries would have the information they need to maintain a healthy lifestyle and to choose the highest quality care at lowest cost. Providers would have the information they need to provide better care and reduce or limit growth in resource use. Medicare administrators and policymakers would have sufficient information to give to beneficiaries and providers in usable form and to formulate better policies.

Medicare's physician payment system is far from these ideals. Improving the value of the services Medicare pays for will require a shift in the incentives inherent in the physician payment system. It will also require the collection and dissemination of information to help physicians improve their performance and greater attention to program integrity and provider standards.

MedPAC has recognized the desire for some control over rapid increases in the volume of physician services, but wise stewardship of the program goes beyond controlling its cost. The Commission's overarching goals is to recommend policies that will improve the efficiency of health care delivery without lowering access or quality.

I'm going to take us through 11 different ideas drawn from your discussions and from previous MedPAC recommendations that together will create more rational incentives for providers and beneficiaries and will improve the structure of care delivery.

First, we'll talk about changing the payment incentives. Medicare has a responsibility to ensure access to high quality care for its beneficiaries, but beneficiaries receive care in a system that's known to have quality problems. While care is improving in many settings, significant gaps remain between is known to be good care and the care that is delivered.

Medicare pays all of its health care providers without differentiation based on quality. Providers who improve quality are not rewarded for their efforts. In fact, Medicare often pays more when poor care results in unnecessary complications.

In a series of reports, MedPAC has recommended has recommended that Medicare change the incentives of the system by basing a portion of provider payment on performance. The Commission has found that two types of measures for physicians are ready to be collected and used

in a P4P design. The starter set of measures for physicians reflects the needs to balance two priorities: building capacity and minimizing burden.

First, MedPAC recommended using structural measures associated with information technology, such as whether a physician office tracks its patients use of follow up care. These types of structural measures apply to all types of physicians.

Further, as physicians adopt IT in response, the capacity to move toward more sophisticated and complete measure sets will grow. The idea is to transition to process measures by a specified date. This will create incentives for the physician community to collaborate on the development of measures.

The Commission recommended that P4P be budget neutral. It would be funded by setting aside initially a small portion of payments. All payments set aside would be distributed to providers achieving the quality criteria.

MedPAC recommended that the Secretary establish a formal process composed of private and public sector participants to streamline, update and improve measure sets. Some of these functions could be performed by CMS or under

contract with CMS. Others could be separate from CMS but coordinated with the program. This process should help decrease the burden on physicians of quality reporting by coordinating Medicare's efforts with other payers seeking similar information.

Another systemic problem is that many beneficiaries with chronic conditions do not receive recommended care and may have hospitalizations that could have been avoided with better primary care. Researchers attribute this problem to poor monitoring of treatment, especially between visits, and the lack of good communication among providers. Medicare fee-for-service provides little incentive for care planning, management and monitoring over time and across settings.

Physicians have limited time and training for care coordination. Few practices have invested in the necessary tools, namely IT systems and care manager staff. And beneficiaries may not know what they should be doing to monitor and improve their own conditions.

Care coordindation services are described as the glue that holds beneficiaries' care together. Providing this glue may improve quality and reduce costs.

In the June 2006 Report to the Congress, MedPAC outlined two illustrative care coordination models for complex patients in the fee for service program. Medicare could contract with providers in large or small groups that are capable of integrating the IT and care manager infrastructure into patient clinical care. CMS could also contract with stand-alone care management organizations that would work with individual physicians. In the second instance, the care management organization would have the IT and the care manager capacity.

In either model, patients would volunteer to see a specific physician for their care related to the complex condition that qualifies them to receive care coordination. The physician, or in the case of a provider-based program the group on behalf of the practitioner, would receive the monthly fee when the beneficiary enrolls in the care management program. This designated physician would serve as the central resource, a sort of a medical home.

Yet another payment concern is the unit of payment. Compared to most other Medicare payment systems, the unit of payment in the physician fee schedule is very disaggregated, generally representing the discrete services

that physician furnish. Such a small unit of payment gives physicians a financial incentive to increase the volume of services they provide, since providing more services usually results in more payment.

A larger unit of payment puts physicians at greater financial risk for the services provided and thus gives them an incentive to provide and order services judiciously. Medicare already bundles pre-operative and follow up physician visits into global payments for surgical services. Candidates for further bundling might include services typically provided during the same episode of care.

Questions remain, however, about the extent to which an expanded bundling policy is appropriate. Although bundled payments could lead to fewer unnecessary services, they can also lead to stinting and to unbundling. Medicare should explore options for increasing the size of the unit of payment to include bundles of services that physicians often furnish together or during the same episode of care.

The volume inducing effects of the physician fee for service payment system may be exacerbated by mispricing. Misvalued services can distort the price signals for physician services as well as for other health care services

that physicians order. Some overvalued services may be over-provided because they're more profitable than other services. At the same time, undervalued services may prompt providers to increase volume in order to maintain their overall level of payment. And conversely, some providers may opt not to furnish undervalued services, which can threaten access to care.

In addition, if certain types of services become undervalued relative to other types of services, the specialities that perform those services may become less financially attractive. Over time, that can affect the supply of physicians by influencing physician decisions about whether and how to specialize.

Although CMS, with the assistance of the RUC, reviews the relative values assigned to physician services every five years, the Commission has found evidence that some physician services continue to be misvalued. Given the importance of accurate payment, the Commission recommended changes to CMS's process for reviewing the relative values for physician services. MedPAC recognized the valuable contribution made by the RUC, but concluded that CMS relies too heavily on physician specialty societies that tend to

identify undervalued services without identifying overvalued ones. MedPAC also found that CMS relies too heavily on the specialties to provide supporting evidence.

To maintain the integrity of the physician fee schedule, we recommended that CMS play a lead role in identifying overvalued services so that they are not ignored in the process of revising the fee schedules' relative weights and that CMS establish its own group of experts, separate from the RUC to help the Agency conduct these and other activities. This recommendation was not intended to supplant the RUC, but rather to augment it.

Research has shown that areas with higher volume and more specialists, as I mentioned before, do not have better access, higher quality, or greater patient satisfaction and in fact, may be worse on these measures. Increasing the use of primary care services and reducing reliance on specialty care can improve the efficiency of health care delivery without compromising quality.

But Medicare's payment system provides few incentives for physicians to furnish preventive and primary care services. In addition, Medicare's cost sharing requirements provide little encouragement for beneficiaries

to seek services where appropriate from primary care practitioners instead of specialists. Even if Medicare's payment policies and cost sharing structure were aligned to encourage the use of primary care, questions about the number of U.S. medical students choosing careers in primary care raise concerns about the availability of these physicians in the future.

MedPAC's pay for performance and care coordination recommendations should help encourage the use of primary care. Changing Medicare's cost sharing requirements to provide incentives for beneficiaries to seek primary care may also help.

Going further, some commissioners have argued that the relative value units of the physician fee schedule could be set, at least in part, on the value of a service and not solely on the time, effort, and skill needed to perform it.

As I mentioned, physicians lack the time to provide all evidence-based preventive and chronic care services. Multi-specialty group practices offer the potential for better care coordination and efficient resource use. For example, physicians can team up with non-physician colleagues to perform routine preventive care

functions and manage less chronic care. In addition, because of economies of scale and greater access to capital, group practices may have greater potential to invest in the IT that can improve physicians' ability to provide quality care and coordinate care appropriately.

However, research comparing the quality and efficiency of group practices to other physician practices is very limited. We'll hear more about this issue tomorrow during the panel discussion we have scheduled.

Improving Medicare's payment incentives also calls for rethinking the program's cost sharing structure. Ideally, cost sharing would encourage beneficiaries to evaluate the need for discretionary care but not discourage necessary care. Cost sharing should be higher for services that may be discretionary and could potentially be overused and lower for services that are necessary or desirable, such as emergency and preventive services. Cost sharing can even be designed to steer patients to lower cost or more effective treatment options.

Medicare's fee-for-service cost sharing structure deviates substantially from this idea. For example, Medicare imposes a relatively high deductible for hospital

admissions, which are rarely optional. In contrast, Medicare requires no cost-sharing for home health care services, even though wide geographic disparities in the use of the services have raised concerns about their potential discretionary nature.

Unlike in many plans, Medicare's cost sharing requirements for visits to specialists are the same as for visits to primary care practitioners. And further, Medicare's fee-for-service benefit does not provide protection against catastrophic levels of out-of-pocket spending.

About 90 percent of Medicare beneficiaries have supplemental coverage that provides some protection against out-of-pocket spending, but that coverage also reduces beneficiaries' sensitivities to the cost of care, thereby undermining the role of cost sharing in health insurance. The Medicare benefit could be significantly improved by combining increases in Medicare's cost sharing requirements with implementation of a catastrophic cap on out-of-pocket spending, which would limit the financial burden on beneficiaries who need the most care.

Cost sharing should not be raised

indiscriminately, however, since doing so can impose financial barriers to essential care and can cause hardship. Rather, cost sharing requirements should be designed so as to encourage the use of cost-effective and necessary care while prompting beneficiaries to carefully consider the use of discretionary services. Since supplemental coverage would temper any savings from a policy that raised cost sharing, policymakers might want to simultaneously introduce measures that would restrict first dollar coverage. Restricting such coverage would lead to sizeable savings for the Medicare program, large enough to finance some catastrophic protection.

Now let’s turn to the need for more information. As we all know, across the U.S. there’s a wide variation in practice patterns and use of services. But beneficiaries living in regions of the country where practitioners deliver many more health care services do not experience better care or outcomes, nor do they report better satisfaction with care. This suggests that the nation could spend less on health care without sacrificing quality of physicians whose practice styles are more resource intensive reduced the intensity of their practice, if they provided fewer

diagnostic services, used fewer subspecialists, use hospitals and ICUs less frequently as a site of care, and did fewer minor procedures.

The Commission has recommended that Medicare measure physicians' resource use over time and feed back the results to physicians. Physicians would then be able to assess their practice styles, evaluate whether they tend to use more resources than either their peers or what available evidence-based research recommends and revise their practice styles as appropriate.

This process is critical to precipitating reductions in inappropriate resource use. Moreover, when physicians are able to use this information in tandem with information on their quality of care, it will provide a foundation for improving the value of care received by beneficiaries.

Confidential feedback alone may be sufficient to induce some change. Eventually, we envision Medicare using the results in payment, for example, as a component of a P4P program that rewards both quality and efficiency or to enable beneficiaries to identify physicians with high quality care and more conservative practice styles. Later

this morning, Niall will be presenting information from our analysis of how episode groupers measure physician resource use.

We also need more information about the costs and health outcomes of services. Until more is known about the clinical and cost effectiveness of new and existing health care treatments and technologies, patients, providers and the program will have difficulty determining what constitutes good quality care and effective use of resources.

Clinical and cost effectiveness information could help Medicare use its resources more efficiently and improve the quality of care delivered to beneficiaries. Medicare could use clinical and cost effectiveness information to inform providers and patients about the value of services, since there's some evidence that both might consider cost effectiveness information when weighing treatment options.

Medicare might also use the information to prioritize pay for performance measures, target screening programs, or prioritize disease management initiatives. In addition, Medicare could use cost effectiveness information in its rate setting process.

Given the potential utility of cost effectiveness information to the Medicare program, and increased role for the federal government in sponsoring the research may be warranted. There have been concerns raised about the variability and lack of transparency in methods and the potential bias of researchers conducting clinical and cost effectiveness research. It's been shown, for example, that industry-sponsored studies are significantly more likely than non-industry sponsored studies to reach conclusions that are favorable to the sponsor.

The federal government could help set priorities for clinical and cost effectiveness review and research. Services could be selected based on disease prevalence, high per unit cost, high total expenditures, or other factors.

Forming a public-private partnership could address concerns raised by stakeholders about the use of cost effectiveness analysis. Private payers alone have little incentive to undertake these analyses and may fear that using such information may lead to criticism that they're more concerned about profits than they are about patients' health. A public-private partnership would also send a clear and effective signal to researchers to improve their

methods and develop valid and transparent cost effectiveness analyses.

It's worth nothing, of course, that cost effectiveness analysis might not save Medicare money. Wider use of cost effective, under utilized services might result in increased Medicare spending, which might not be offset with savings elsewhere. On the other hand, over the long run, cost effectiveness could save the Medicare program money if it encourages manufacturers to develop services that are more cost effective than current ones or helps inform providers and influences their patterns of care.

Now we turn to provider standards and overall program integrity. Increasing the value of the Medicare program to beneficiaries and taxpayers requires concerted efforts to identify and prevent Medicare misuse, fraud and abuse. This includes supporting quality through the use of standards as well as ensuring that services are provided by qualified providers to eligible recipients and verifying that services are appropriate and rendered as billed, and that payments for those services are correct.

CMS has set standards to ensure minimum qualifications for various types of providers, such as

hospitals and skilled nursing facilities, but there are very few examples of federal standards that apply to physician officers. Traditionally, Medicare has paid for all medically services provided by physicians operating within the scope of practice for the state in which they are licensed. But the lack of standards may undermine efforts to improve quality of care and, in some instances, may encourage volume growth.

Such is the case with imaging studies provided in physicians' offices, where we've seen that the lack of comprehensive standards for this setting has resulted in evidence of quality problems and significant growth in volume.

Where appropriate then, CMS should consider imposing quality standards as a condition of payment. The Commission recommended, in the March 2005 Report to the Congress, that such standards be implemented for physicians who perform and interpret imaging studies. CMS would require statutory authority to implement this change, but there is a precedent. In 1992, the Congress gave the FDA the authority to set standards for physicians who read mammograms. In the future, other types of services may be

candidates for such standards, as well.

An important element of program integrity is contractor reform. The MMA requires CMS to use competitive procedures to select Medicare administrative contractors and to follow the Federal Acquisitions Regulations. These are substantial departures from previous rules. By July 2009, CMS plans to substantially reduce the number of contractors responsible for paying Medicare claims and to make contractors responsible for both A and B claims. CMS also plans to institute performance incentives in the new contracts, which will be based on a number of different factors, including Medicare error rates.

At the same time, Medicare is consolidating its 14 data centers that conduct claims processing functions into two data centers. The changes will improve Medicare's ability to implement many of the ideas we've outlined today. CMS should capitalize on its new flexibility to assemble the needed datasets and disseminate information to providers and beneficiaries. For example, CMS will not be able to more effective track beneficiaries' use of services across providers during episodes of care, which could help the program determine whether beneficiaries receive appropriate

care and ultimately could help to improve quality of care and longitudinal efficiency.

The changes will also improve program integrity by making it easier to determine if beneficiaries are eligible for services and to connect the dots, so to speak, between health care providers and questionable claims or to spot spikes in particular types of services across localities. Since research has shown that there is significant fraud and abuse in the Medicare program, this is an important step in reducing improper payments.

In summary, Medicare's physician payment system encourages volume growth, it discourages quality of care and judicious services and coordination of care.

Increasing the value of physician services Medicare pays for will require a shift in the incentives inherent in the payment system, the collection and dissemination of information to help physicians improve their performance, and greater attention to program integrity.

The ideas I've outlined will not, in and of themselves, address the volume growth program and on their own some might actually contribute to cost growth, and

certainly not every problem can be solved by these ideas. But the expectation is that the collective impact of these ideas will have the effect of improving the structure of care delivery and the incentives providers and beneficiaries face, thereby improving value to Medicare.

These improvements will increase demands on an already overburdened CMS. The Commission has called repeatedly for Congress to increase the Agency's funding. Implementation of our ideas will require Medicare to measure the care delivered by a very large number of physicians, collect and analyze a significant amount of new data, and continue research and assessment. As the improvements are intended to achieve better value for Medicare spending, the Congress will need to provide CMS with the financial resources and the administrative flexibility necessary to undertake them.

Now I'll turn it over to Scott.

DR. HARRISON: Last month you saw a discussion of geographic and type of service options for subnational SGR targets. And next month you will see some other options based on subnational groups of providers. To be complete, this month we wanted to briefly show you how some options

that work off the current national SGR target system might affect updates in spending.

We will give these options a rather mechanical treatment today as we discussed target setting methods last month and we expect to look at them in more depth when we discuss cross-cutting issues that pertain to national and subnational targets in a future meeting.

Before I walk you through some options, let me remind you how the current system works. The current system uses the SGR as a target which allows volume to grow at the same rate as the country's gross domestic product, or GDP. The SGR also incorporates growth in Medicare fee-for-service enrollment and the underlying price of services.

The physician fee schedule is updated each year by the MEI, adjusted by a comparison of spending against the target. The system is cumulative, meaning that the expenditure growth in the previous year as compared with a target and the total cumulative spending since the beginning of the system is compared with growth in the SGR target over that time period.

In any year the reward or penalty resulting from target comparisons is limited plus 3 percent on the upside

and minus 7 percent on the downside. So the update will be between MEI plus 3 and MEI minus 7.

We have created an illustrative base case with which to compare other options. Simply put, the base case is how the current system would have worked under current law if there had been no misestimates of GDP enrollment or expenditure growth and if Congress had not intervened by providing higher updates. We used the actual SGR volume and MEI data from 2001 through 2005 and assumed that there had been non misestimates of that data when the targets were set. And we assumed that Congress allowed the resulting fee reductions to take place.

The updates in spending produced by this base case will look different from what really happened during our simulation period because there had been significant misestimations during the early part of the period that helped cause the system to widely miss the target, resulting in negative updates in each year starting in 2002.

However, in every year after 2002, congressional and administrative actions resulted in positive updates.

I want to note that even though the base case no longer results in missed targets due to estimation errors,

targets are still missed because the volume growth is significantly above GDP growth in every year during this time period.

There has been some dissatisfaction with the current SGR system because it has resulted in negative updates for the past few years and projected negative updates for the foreseeable future. Therefore, we have modeled three alternative options that are softer or less aggressive than the base case so that you might see the tradeoffs of higher updates for higher Medicare costs.

We have constructed three options to the base case. Each case uses the GDP-based current SGR as the annual target for expenditure growth. We model each option using the same GDP, enrollment and volume growth data from the 2001 to 2005 period that we used to model the base case.

All three options are non-cumulative, meaning that only the previous year’s spending performance is compared to the target, only that is used to adjust the update. The old VPS system that preceded the SGR operated like these non-cumulative options.

The first option has no limits on how much the update can differ from MEI. Remember that the base case

keeps the update between MEI plus 3 and MEI minus 7. Compared with the cumulative base case, this option will result in higher in spending if volume remains above the target.

The second option is a corridor allowance. Under a corridor allowance the update is MEI unless expenditures fall outside the corridor. We chose to model a corridor of plus or minus 2 percent. Thus, if spending was above or below the target by more than 2 percent, then a penalty or reward would be applied to bring the expected spending back to the corridor, however not all the way back to the target. If volume remained above the target, this option would forgive excess volume growth of up to 2 percent a year.

The third option keeps the update within a limited range between zero and the MEI. If expenditures are at or below the target, then the update would be the MEI. Spending above the target would reduce the update, but never below zero.

Here we get a quick comparison of how the three non-cumulative options compare to the illustrative base case. The base case produces negative updates across the entire time period and would continue to do so after the

period. The three illustrative options are displayed in order of increasing cost. The non-cumulative option with no limits generally has higher updates than the cumulative base case because the volume was way above GDP in 2001 and that year's performance only affects the update in 2002 in the non-cumulative options but continues to depress updates for the cumulative base case.

The corridor allowance compresses the updates for that option. The 2 percent corridor raised the largest negative by two percent and there was a year when the option resulted in a full MEI update of 3 percent.

The limited range compressed the updates further and indeed the updates ranged from zero up to the MEI. You can see in the last column that as the update adjustments are more tightly constrained, the cost relative to the illustrative base case increases. We are trading off higher updates for higher spending. The figures in the last column represent the average spending over the illustrative four year period. Those percentages represent large extra expenditures as the actual physician spending in 2005 was around $80 billion and it is likely that budget scores would be calculated over a 10-year period.

Now Dana and I are happy to listen to your discussion and answer any questions on anything you've seen.

DR. REISCHAUER: Scott, just a clarifying question.

When you vary the updates in your simulation, do you have a feedback on volume effect?

DR. HARRISON: We use what the actuaries use for volume, which is it offsets 30 percent of the decrease below MEI.

MR. HACKBARTH: Good job.

Let me just say a word about this summary slide here. It should have draft stamped prominently on it. This is very much a discussion. We, at the end of the process, may add to the list or delete items from this list.

As Dana said at the outset, what we've tried to do is capture ideas that the Commission has discussed in the past, some at great length like pay for performance, and we've made quite specific recommendations. But there are other items on this list that have been discussed very little. Individual commissioners or small groups of commissioners have said this is something that I think ought to be considered. So all of it is fair game.

Now in particular, I want to emphasize that for our public audience. People should not infer that this is a MedPAC endorsed list at this point.

To me the significance of this list is that I think there is agreement, although I could be corrected on this as well. But I think that there is agreement within the Commission that improving the efficiency and quality of the services provided to Medicare beneficiaries is not as simple as coming up with a new SGR mechanism. There's work to be done on many different fronts if we want to improve efficiency and quality. That's why we're talking about this list. It puts in context whatever we decide to recommend specifically about changes in the SGR. So that's the purpose of this.

DR. WOLTER: I thought this was a very well done chapter, I will say, on a complicated topic. As I look at it, I guess the way I'm framing this in my mind, I'd like to start by saying that MedPAC is on record as saying that the SGR has not served its original purpose, and that we should move away from it. I think that's worth reiterating.

I think that, when I look at this list, the way I think we should say this is that volume control or

appropriate resource utilization is a program goal. It's not limited to Part B and to physician services. We might want to be very explicit about that. I think it might make physicians feel better about this conversation because we do need physician involvement in tackling the issue. And I think this list then becomes a list not just of services physicians are involved in but a list that tackles resource utilization in a way that crosses silos.

I think, in that regard, if we're going to take this patient-centered philosophy to heart, one of the problems we have right now is we're trying to solve a lot of problems by putting new mechanisms of payment or whatever into current silos. And we are not looking at ways to integrate and coordinate approaches that might be more successful.

This is a great list. One of the things I would really like us to start emphasizing more is that in the early years of tackling more appropriate resource utilization in pay for performance, there would be tremendous merit to creating some focus. If you were to say what are the six or seven areas of incredibly high volume and high cost in the program, what would that list be? And

what would the tactics be to go after it?

I don't hear anybody saying that. What I hear is we need a measure for every specialty or we need a payment tactic for every silo. I think we're at great risk of being tremendously unsuccessful with resource management and with pay for performance if we don't create tactics that really go after where the cost is.

Some of the things on this list will do that and they will start creating things that bring the silos together. But I think it would be a great contribution on the part of MedPAC to be more explicit about some of these things and really make it clear that we're looking at resource utilization. I keep thinking about some of the Dartmouth work on how the growth of capacity drives increased volume and increased utilization. I think that would be an add to the list.

In that regard, I think that the issues related to self-referral, physician ownership, MRIs in every doctor office. But the issues are not limited to physicians. We have hospitals that have tremendous strategies built around expansion and growth and they hire physicians explicitly with the goal that volumes will increase. DRGs maybe help

you with the episode of admission, but there are many strategies around hospital resource use that we really could add to this list that I think would really help us.

Lastly, this is more of a very specific comment, I also think we would do a great service by making clear that the structural measures related to IT, as Ralph said earlier, really are about systems and processes of care that are supported by IT but aren't really going to be solved by IT unless those systems and processes of care are really tackled. And that really is very hard work. I think that would be a contribution.

DR. CROSSON: I like the approach also. It's a bit more expansive than I think we have been framing this issue around solving the SGR or fixing the SGR. And I think it's appropriate because it's going to end up with a better project. So I understand we have a mandated report that we have to do on alternatives to the SGR but I would assume that there's range there that we could decide around how to answer that. I think this begins to suggest something.

I wanted to suggest that maybe this is actually -- it is a list of things we've talked about. But we may be able to think about it in a way that maybe frames the issue

differently. So if you start with what question do we think we're trying to answer here, we could simply say we want to discuss alternatives to the SGR because we need to have an effective mechanism to control volume or to manage volume, appropriate volume, reward appropriate volume or whatever you want to call it.

Or maybe we need to propose alternatives to the SGR because we need to do the volume thing, but we also want to avoid or find a way to avoid unreasonable and inequitable cost payments to physicians. I think both of those are goals we've talked about and both of those things have been part of previous MedPAC documents.

But this takes it a little further, I think, because it essentially, to me, is saying we would like to find an alternative to the SGR or, putting it another way, we would like to take advantage of the opportunity created by the problem that we have with the SGR in order to do something perhaps grander or more important. And that would be something like to restructure physician payment, including the update portion of physician payment to try to improve the Medicare program more broadly.

And as you look at this list, it really says what

we're after here is to use the physician payment mechanism to improve quality, there's some doubts about quality; to try to approach the coming problem in physician manpower, particularly the lack of primary care physician supply; to perhaps make some changes in benefit design, which would have perhaps a long-term result in improving quality and cost; to perhaps incent the development of more effective delivery system structure; or to alter payment to the delivery systems to get the kind of aggregation that Nick was talking about. And in the end, to create sustainability by, in effect, dealing with the volume concern.

So I guess as I looked at this, rather than a list we might, in fact, be more explicit that what we're after here is to restructure physician payment to deal with the volume problem, to make sure we do not have inappropriate and inequitable cuts in physician payment, but also to do it in a way that improves the Medicare program along those lines that I described.

DR. CASTELLANOS: I have a lot of comments.

Nick, I couldn't agree with you more. We need to get the physician involved. The physician is the core to the Medicare system. And a lot of these issues that we

discussed today was not physician involvement. And we need to do that.

You know, it's interesting, the physicians are the only payers in Medicare that are held to the standards that you're making us. Nancy, you made that point a number of times. Everybody else gets paid a certain percentage of increased cost of living, et cetera, but the physician community doesn't. If you look at the five-year reviews that just came out, 45 percent of the doctors are going to take more cuts.

I don't understand the equity there. I understand that's the law and that's what we need to really follow.

But to use my payments, and I'm a practicing physician, contingent upon a lot of the problems that we've been dealing with for 20 years, it doesn't make sense.

The SGR, we need to move away from it. The volume control isn't there. There's no incentive for the physician to do volume.

I'd like to go back on that for a few minutes. There are a lot of good points. The RUC report about where you want to have an expert panel is absolutely correct. There's no doctor that's going to raise his hand and say I

make too much money. There's no businessman that's going to do that. And I think the expert panel is excellent. I think that's good to pick up the overpriced things, and I think that's good.

I have a technical problem. You continue to talk about volume control and the variations in the different areas. You quote the Wennberg report or the Dartmouth report.

On your page 10, or what we have, you implied that there's no difference between access to care or quality or patient satisfaction, which is true. But you also implied that it may be worse. I have the Wennberg report right in front of me. I've heard that four or five times. I've gone back to the report. I have the editor's notes, and I'll be glad to show you that. There's nothing in that report that says it may be worse. I'd really like to talk to you individually about that because that bothers me, it kind of irritates me.

One of the things that, and I look back at my practice and I say what can we do? How can I, as a physician, and what am I doing in my practice that tries to control volume? There is one thing that we do do. One is

cost sharing or putting the patient at risk or tiering. We see that in the Medicare Prescription Drug Program. A lot of times my patients will say to me doctor, I can't afford that medicine. And I'm on the patient's side so I'll say to him, you're right, let's see what we can work out.

But when I try that on diagnostic studies or x-ray studies, their first comment is listen, I have insurance, it pays anything. I don't want any cut cost. I want you to do the right thing. I have a cancer and I want to be taken care of and I have a right because I have insurance.

But I think if we put the patient more at risk in a cost-sharing basis, I think that's something that may be of benefit. I've really thought that out from a practical viewpoint.

Coordination of care I think is excellent. There are a number of CPT codes for it, very few of them are funded. So here again, you want the physician to participate in coordination of care and you have CPT codes available, but CMS hasn't funded them. Again, you're putting the burden on the physician and I have a real serious problem about that.

Volume, let's just talk a little bit about volume.

Mark and myself have had a lot of discussions on that. There's some good volume changes and there's some bad volume changes. What we really need to do is get down to the core values of what is good volume and what's bad volume. Just to say that we can't go above GDP, which is no relationship between GDP and quality of care or volume, doesn't make sense.

There are a lot of other comments I could make, but I think other people want to talk, too.

DR. MILLER: If I could address one factual point, particularly since you were irritated by it. I'm just trying to navigate this carefully.

We did actually pay attention to that slide and actually talk through what words to put on that slide very precisely, on the quality could potentially -- is worse in some instances. The studies that we're referring to are the series of the Annals of Internal Medicine that Eliot Fisher did. I thought that Dana phrased it pretty carefully. She said on some of the measures quality was worse. And that was the point that we were making there.

DR. CASTELLANOS: I'd like to show you the report

and the editor's note. There's no comment on that on the editor's note, and I'll be glad to show this to you.

MR. HACKBARTH: We'll actually have Eliot Fisher here next month, so we can discuss it personally with Eliot.

DR. REISCHAUER: We'll swear him in.

MS. BEHROOZI: I'm going to venture into an area I know very little about and I'm sitting next to Ron so I'll be careful. But I do want to endorse the notion of adding value of a service to how rates are set in terms of physician payment. What little I understand of RVUs is that it's really from the physician perspective, I guess, what the physician thinks they're putting into it.

And if we're talking about a more patient-centered model that we want physicians to move to and we're talking about the interests of Medicare, I think we absolutely should become value-based purchasers like everybody who's minding their pennies is supposed to do.

So now I'm going to talk about something I do know a little bit more about, and I'm going to be swimming against the tide of the common wisdom, I'm sure, but I want to express some caution about the recommendation or the potential recommendation on the draft list to revisit

Medicare's benefit design and impose additional cost-sharing on Medicare beneficiaries. Ron touched on it a little bit.

It is the common wisdom that when you charge people something for a commodity that they will be more careful in purchasing it. But health care is different than consumer goods. It's not that kind of a commodity. So when people make decisions based on what they can afford, it really shouldn't be the same exercise that they're going through with respect to health care as if they're buying a car or whatever. You have options of different kinds of cars and different kinds of optional features you can load onto the car. But when you need health care, you need health care.

But there are ways, of course, that we think -- or people would have different opinions of that. But in terms, going back to the value notion, there are things that we think are better ways for people to access care or certain types of care that are more valuable, right?

So if we want to talk about imposing cost sharing, we need to do it in a way that talks about changing people's behavior, as opposed to setting it up as a barrier to access. To charge everyone the same copayment, particularly

Medicare beneficiaries, many of whom are on fixed incomes -- and when we talk later about the profile of the future Medicare beneficiary, we're going to talk about people who are losing employer coverage, who have already lost employer coverage before they become retired, pensions plans that are being decimated. When we talk about that, we'll talk about looking at the growing gap in wealth and income among Medicare beneficiaries.

It's not the same to charge people a flat copayment. They're not going to make the same decision. The person who can afford the $20 copayment is going to say give me every test, give me every drug, send me to every specialist. The person who can't afford the $20 copayment because they're making a choice between that and picking up their prescription drugs or purchasing transportation, buying their Metro card or whatever, and they have to do that, they're going to say okay, I'll live with this cough a little longer. I'm not going to go to the doctor.

So I think we have to be very careful about imposing copayments or other kinds of cost-sharing in a way that incents the behavior that we want from the beneficiaries like going to a primary care provider first

and receiving a referral. There should be no penalty. There should be no burden on doing it right.

And actually, at some other point I'll talk more -- not now -- I'll talk more about how we do it in our benefit fund that I run, where we cover a lot of low-wage workers and we don't want to impose barriers to access. And we have first dollar coverage. But there are other ways to incent appropriate behaviors.

MS. BURKE: Glenn, could I just follow up just a brief note on the point Mitra has raised, which I absolutely agree with? And that is we have another discussion that is scheduled that relates to this sort of changing demographics of the program and issues that we might confront.

I have the same concerns about the nature of the Medicare beneficiary and what, in fact, we're facing. But I think in the course of that conversation the question of who the patient is going to be, who the client is going to be going forward, the changing racial makeup of the population, the changing age of the population, the absence of employer-sponsored insurance. I think this might well be a conversation that could also play into that and might help us think broadly about -- in the broader context, not

specific to this -- what, in fact, should we be thinking about? Who, in fact, will the Medicare beneficiary be 10 years from now? And I think it does have a direct relationship to this question of can we assume they are what they are? How does that play into how we look at the benefit design, as well as encouraging certain kinds of behavior?

So I'd like, just as a side note, to say we should come back to that point when we have that further conversation.

DR. HOLTZ-EAKIN: I also want to just share my congratulations on the chapter. It was a great read.

I'm a new person, so I'm catching up on the vision. So there are a couple of points I didn't understand on the details.

One is really a question for the group. Is there an interest in promoting physician groups, per se? Or are they a means to an end in which there is better coordination of care, the infrastructure for IT platforms, best practices, things like that? It just struck me it sort of stood out that they're just picking this way to do business. That was one question on details.

A second was on this notion that you could set these resource value units in a way that was not a measurement of cost but somehow God's correct price for different activities. I'd like to know how you're going to do that?

And then some of the broader issues that it raises, I think, is really the point that was made earlier about needing to focus. This is a tremendous list, very impressive. But what are you going to do? And back to the point made earlier today, in what order are you going to do them? The sort of focus and sequencing.

Measuring resource use, for example, is at the heart of trying to get all of these efficiency measures right, doing that up front, making sure the doctors explain how they do business I think would be absolutely an imperative and ought to be up front and we ought to think about that.

And it also, I think, would help in some of the discussions. If you're taking care of efficiency and quality through other means, the cost sharing is less scary. It's a sensible thing to do. A lot of this is about costs. It gets scary if you think somehow you're stinting on

something or you don't know what you're cutting out. And so making that point would, I think, make a more sensible discussion of things like cost-sharing.

Finally, I want to close with at least my view that I would be very disappointed if this group somehow said well, we're going to go do this list and let's just pitch the SGR. The SGR is a highly inelegant offense to anyone who looks at health care. It is, however, a very clear recognition of the fact that we're scared about how much it costs and how much we're spending in the federal budget and in the economy as a whole. And I think to discard that casually would be a big mistake, especially if this is going to be done sequentially. There will be pieces that are or aren't covered by these new incentives. And especially if we're not really sure if these incentives are implemented the way they're envisioned at this table and effective in the way that the research suggests.

And so I, at least, would like to keep some overall pressure on the spending that we're doing before we discard it entirely in favor of what we hope would be a much better system.

I want to make clear, that's not a criticism of

this list. It's just a recognition that it is still a consideration.

MR. HACKBARTH: I'd like to take a crack, Doug, at your first question about how groups fits into this.

To me, the goal is not to promote groups but rather to promote better care, higher quality care, as efficient care as we can possibly get for beneficiaries. So it would not be my view that we ought to just say groups, per se. Indeed, groups come in all sorts of different sizes and shapes and flavors and some may have more potential than others to provide high quality, integrated, well coordinated care.

And so I'm a believer in multispecialty group practice. I think everybody knows that. But I wouldn't say that Medicare ought to simply pursue a policy of rewarding groups, promoting groups. I think that's a very different proposition.

What I would say is that the current Medicare payment systems are not well designed to support the efforts of people who are in some types of groups, who are eager to provide that high quality, efficient, well coordinated care. The fragmented fee-for-service model is not conducive to

supporting groups that may want to do things differently.

So I think of it not so much as promoting groups but creating more avenues in the Medicare payment system that can support group practice for the people who want to do that. But if there are other physicians who don’ want to do that, I don’t think they should be herded into groups. I think we should evaluate their performance and pay them well if they perform well and pay them poorly if they don’t.

DR. WOLTER: I think that’s exactly right. The issue is can we create an accountable network of care providers that can respond to the needs to provide higher quality with appropriate resource utilization? Many do believe groups probably have some advantage that way, in terms of infrastructure they can build. But there would be other virtual groups that could possibly play in that arena.

I think the add, though, is that we also need to provide some incentive for physician groups, whatever that means, and hospitals to cooperate and coordinate. Because again, back to what should our focus be in these early years, where is all the cost? And it tends to be at that intersection where physicians are caring for patients in hospital. There’s so much cost there, there’s so much

opportunity there. And yet we really aren't creating an approach in P4P or with incentives unless we can move along with bundling or gainsharing or some of these other opportunities, to really incent that cooperation.

DR. MILLER: Just to give you a quick response on the price, and I think it's much more complicated than I'm going to say. And I think invoking God is probably an appropriate point.

I can think of it in three ways, and obviously I'd be looking at my guys to see if I'm off point.

There's some technical things that I think we can look at. When we did the work on the RUC and the valuing of the work, which Ron referred to, there were points in the process where we could point to and say look, there's a bias here that could be corrected.

And there's some technical stuff on the practice expense side that you're going to see shortly. There's that kind of work, getting really down in the weeds and fixing some stuff.

Another way to think about price, and again this is not technical and I don't think there's a clear empirical standard. If people -- and this has been expressed by some

commissioners -- think we're not doing enough for primary care. Maybe we should be amping up what we have in the fee schedule related to primary care. Accuracy is a funny word there. That's more going for some outcome that you want in that particular instance.

Exactly, it's not a technical and empirical.

And then there is one last thought, and it's a big thought and it's way down the road. And I think this is in part how the cost effectiveness and clinical effectiveness work comes into play. If you had clinical effectiveness information and you knew for certain services that one was superior to the other, that might go in -- to Mitra's point -- into setting a price for one thing versus another.

I think that's another thought on the pricing front.

MR. BERTKO: I also have a list. I'll try to be brief.

First of all, I'll agree with many of the earlier comments. But in focusing on the one that Nick made first, the SGR doesn't seem to be doing what maybe it was hoped to be done. And recognizing Scott's numbers there that they are just a couple of illustrations. But the point to be

made, if you multiplied those by the baseline, they come out to be very big numbers.

If we're going to agree that that's necessary, we ought to be getting better value across the board from this.

The next comment is I'll compliment you guys on doing a great job of discussing all these draft elements. But to be more explicit and follow up Doug's comment here, in my mind, at least, it might be useful to have a broad timeline or chart. Many of these things are connected to each other. And yet they are sequential.

So P4P, there may need things that need to be done immediately, the feedback perhaps followed by the payment mechanism. And having some illustration that we could all see together and hopefully gain some consensus would be important.

In particular, on that side, as we've just talked about the primary care manpower thing, strikes me, from what limited I know about it, it's a very long term change. So to get doctors incented to become primary care physicians is perhaps a five, seven, 10-year mechanism, in order to have enough. And I believe the manpower is such that a large number of them will be retiring over the next 10 years. And

that has implications on access first, of course. From at least our data it has cost implications.

Primary care doctors generally do a very good and very cost effective job, compared to having send the same person with the same condition to specialists and the use of appropriate care there.

I forgot to say, I'm going to agree with Doug that some version of a target or otherwise constraint needs to be recognized in whatever we do.

DR. KANE: I think John was looking at my notes, but I agree that there is a need to -- maybe we should think about bundling our proposals because I noticed, for instance, with the severity adjustment that we thought should go with a cost-based update for the DRG system, that we were fearful that that could get unbundled and pretty much undo what we were hoping to accomplish with those adjustments to the DRG system.

So I think we need to be very explicit about what needs to go together. And not only do I think the pay for performance needs to go with payment, but I agree with Nick's point that the physician piece and the hospital piece need to go together. In fact, if you would incentivize

physicians to reduce volume, the hospitals will start complaining and doing odd things that will offset that.

So I think we really do need to think about how these things work in concert and not try these one by one unless it's very misleading to think that these things aren't totally related to each other.

My last point, the only thing I would add -- I hate to do this to a list that long. But I would add that we should start thinking about what incentives or encouragements can we give to the medical education system? Because I still see, I train a lot of physicians and young physicians who come out -- really, they're still sometimes third year medical school. And I say what are you thinking of for a specialty? And they say dermatology or anesthesiology or pathology. And I say what about primary care? They say we get told day one to stay away from that.

So obviously the training system is not helping us with our problem. And I don't know whether it would be good to pay higher for primary care residencies or reward medical schools that actually produce people who choose primary care specialties. It's a deeply ingrained culture, anti-primary care culture in many medical schools. But we need to think

about how can we start to offset that. Otherwise, I think it's going to be longer than 10 years to get people to be coming into the primary care side. And it really starts right there at the medical school.

MR. HACKBARTH: I saw a lot of heads nodding in response to John's and Nancy's comments about how to organize that, to try to think of this in terms of links among proposals and steps that might be pursued in sequence over a longer period of time. That's attractive to people, I sense?

Now I think it's easier to say in the abstract than it is to do in practice. But we can devote some effort to trying to accomplish that if people want to go that direction.

DR. WOLTER: This is on Nancy's comments really, and other comments on primary care, which I'm a very big supporter on the primary care issue. I'm very worried about the supply over the next 10 or 15 years.

It's a complicated issue, though, and I think that there are other specialities where we're going to see significant shortages. I'm very worried about general surgery. There are also lots of opportunities on quality

and cost management that will involve the appropriate numbers and involvement of other specialists.

So it's sort of a complex issue. And it seemed to me in the '90s, when managed care was all the rage, everybody thought primary care was the solution to everything and their predictions were we would move to two-thirds of all physicians being primary care and one-third specialty, which is kind of the reverse of what we had today. That hasn't happened and I don't think it's a likely scenario either in the next 10 or 15 years.

So the question I've had is where is the planning around physician manpower and woman power mix going on? I don't know if it's going on anywhere. But it's a fairly complex issue.

DR. CROSSON: It just strikes me that perhaps a timetable or a schedule with dates and years, as was mentioned earlier, may be hard. But I do think it would be valuable to frame, as I said earlier, why we are talking about physician payment and what we're trying to achieve by changing the physician structure, and then to identify the critical interdependencies, some of which are temporal and essentially draw the reader to understand that some things

have to happen first, and some things have to happen in concert. Otherwise, you don't get the goal that you're looking at.

MR. HACKBARTH: On the issue of primary care and the point that Nick raised about the same concerns being relevant for other specialities, I know from past conversations that both Karen and Ron share that concern that in other specialties there may be developing problems, as well. Not just primary care.

It's a tough issue in the sense that we can't be the place that starts with a fresh piece of paper and says here's what the manpower or person power ought to look like for the long-term. That's just way beyond our expertise and our capabilities.

I'm sort of getting tangled here. What I'd like to do is go back to the people who have been waiting patiently and then if there are some other comments on these issues, we can try to get them at the end, as well.

DR. MILSTEIN: One of the levers that we've discussed previously is this notion of, within the limits of what the current statutes permit, better synchronizing Medicare efforts to improve clinical efficiency with what's

happening in the private sector. So with that as an introduction, I thought I might share at least my view as to where I see a fair amount of private sector convergence with respect to these issues. We might think about how we might align.

First, I think there's an increasing view among private payers, whether they are self-insured employers or insurance companies or union managed Taft-Hartley trusts, that we have, in this country, given uniquely high levels of authority to our physicians in the country to determine resource use and to shape the speed with which quality improves. There are others in the private sector who would add to that comment, as we've also accorded our physicians, on average, a much more favorable income level relative to cost of living as compared to other industrialized countries with which we compete economically.

With that greater authority and more favored lifestyle ought to come a greater accountability for driving performance improvement overall in the health care system.

So I think a simply stated vision of private sector convergence is that we need to make changes in how we manage our health benefits programs that, in particular,

incentivize physicians to lead in efficiency gaining innovations because of this great power and authority we've given them. There's almost no component of the health benefit supply chain that isn't very sensitive and affected by what doctors do.

So a simple way of putting it is how do we -- given that we're operating in a very complex system, what is the smallest number of changes you can make such that within the not-too-distant future we have physicians in America who wake up in the morning and foremost in their minds are how they might innovate in delivering care that day to improve efficiency, both quality and resource use, by the days end or the weeks end or the years end.

As I look at our list, first of all I think it's a terrific list, and the only things that occur to me in terms of refinements would go something like this: number one, I think we remain far too conservative with respect to our recommendation to let resource use only be something in the near term we use for provider feedback.

I think almost all of the big national commercial health plans are using measures of physician resource use in ways that have substantial consequences for physicians, such

as tiering, tiered networks or narrowed networks. Aetna, Cigna, United, Humana, they're already there.

So whatever imperfections there may be in that measurement system, clearly they are not enough to outweigh what are perceived to be the advantages of moving forward. So recommendation one is can we consider notching up that particular recommendation? Maybe we should hold our discussion of that until our next presentation, which is on this issue of feasibility.

Second, I just reinforce earlier comments about content of medical education right now. Our medical education dollars are really without strings. I think that, per some of the examples cited, that's not working out very well for us right now. And so I think moving the federal government or, for that fact, private sector payers into the content of medical education or mix of residencies selected is obviously maybe not the first place you would want to go but we're clearly failing, I would say, with respect to this idea, this policy of no strings attached which has been the policy in place since the beginning of Medicare's medical education payments.

Third, another thing that would maybe be a

possibility for adding to the list is can we think about -- what about the idea of doing more to incentivize physicians and everybody else in the delivery system to use their creative powers to come up with innovations that improve both quality and efficiency?

One way that could be done that we don't do today would be to essentially say we're going to treat innovations that have a favorable profile with respect to efficiency gain, both resource use and quality, with a faster track for Medicare coverage for that subset of innovations that would require a coverage role. I'm thinking about some of the agony that innovators, for example in remote patient monitoring devices, a subset of which might carry a favorable profile with respect to substantial improvements in efficiency and quality.

People who come up with such innovations face very long roads to Medicare coverage decisions, and there's nothing for them more favorable when they've got an innovation that, for example, not only improves quality but also reduces cost, as compared to somebody that has an innovation that improves quality equally but worsens Medicare sustainability because it's cost additive. Could

we consider a faster track for that subset of innovations that require coverage decisions and which have an extremely favorable profile with respect to both quality and more conservative resource use or lower cost per unit?

Those are my three suggestions.

DR. REISCHAUER: I'd like to congratulate the staff on what I think is a very comprehensive and good treatment. But I was thinking, were I staff on the Hill or a member of Congress and we have the SGR, a sledgehammer, it isn't working, and we sent a letter to MedPAC and say give me an alternative and here I have a whole lot of good ideas that are hard to implement and I really don't know what to do with them. They undoubtedly, if they were all implemented, would improve quality. And they may have some modest impact on cost growth. But I would feel that I didn't have something to sink my teeth into.

I think Doug raised a very important issue, which is the impetus behind the SGR, of course, was to moderate the growth of expenditures so that it fit within some notion of affordability. We need this because Medicare is an entitlement, which means we have no budget constraint on it at all. We spend what millions of individuals and their

providers decide they want to have in the way of medical care during the year. And maybe we should try and structure this in really simplistic ways to help Congress understand why, in a sense, the mission that we've been asked to do is almost impossible, meaning come up with a silver bullet that will substitute for the SGR without causing an outcry from Ron or patients.

We could look at this and say you can affect quantity, volume. You can affect price, or you can affect the way resources are put together to produce the health outcome.

We, as a society, have decided that we're very reluctant to directly affect quantity or volume. That's called rationing. And while we -- directly, I said. While we put some limits like how mental visits can you have during a year, we aren't willing to go the next step, which would be to go through lots of different diagnoses and say for this you can have two x-rays and one MRI, for that you can have none.

Jay, I'll give you equal time afterwards. I see you shaking your head at everything I say -- shaking it the wrong way, right to left.

But in that group, as far as we seem to be willing to go is to entertain mechanisms that would eliminate volume of services that seem to have no benefit or very low benefits, and do it through cost effectiveness studies or evaluating the worthiness of various medical interventions about which we do based on faith rather than an evidence base that this works.

We can directly affect price, and that's what we've done. That's what the SGR is, and it can have significant impact. It's focused right now on physicians, Ron, you're right. But we have and do change the updates of all of the other providers as well, when we think budgets are running amok.

But what we have here is a bunch of rather softer proposals to move forward in that area, like let's set the prices right so they really reflect the cost of producing the service accurately. But the way we do that now, through the RUC and all that, is to dampen down the price here but then throw the money back into the pool. So in effect, we've done nothing to the overall pool. We've made prices better reflective of underlying cost, but we haven't "saved" any money.

Mitra wants to set prices based on value, and I'm all for that, too. But I'll be damned if I know how to do it. In the rest of the competitive world we have markets and they determine what the value of a plasma TV set is versus a new tire. But in this area, we really wouldn't have anything except professional judgment. And I'm not sure that's going to get us very far.

Third, we can try to improve efficiency, or the way in which we put together resources. That's what a lot of this is. But it's a long haul and it will occur very gradually and have to involve a whole lot of behavioral and structural changes.

I think if we go through it like that then you can understand better why it isn't so simple to throw out the SGR and replace it with something else.

Just a footnote on cost sharing and where one might go with that. I'm very skeptical that we could ever institute limitations on supplemental policies that said you can't, in a sense, prepay for the cost sharing that Medicare requires. What this really is is who's going to pay for it? Is Medicare going to pay for it? Is the individual going to pay for it through premiums to Medicare? Or is the

individual going to pay for it through their Medigap premiums and their former employers? That's really what we're talking about.

Think of how hard it would be to say to those with employer sponsored retiree benefits, you have to redefine this, which is set in a contract, so that the first $500 is a deductible. In theory, it's a great idea to go that direction, but I think we'd be tilting at windmills that it would never occur politically.

DR. HOLTZ-EAKIN: I didn't mean to suggest that.

DR. REISCHAUER: No, I wasn't looking at you. No. I was looking at you because everybody else has disagreed with everything I've said so far and you were the sole friendly face in this side of the table and I was trying to boost my confidence here.

[Laughter.]

DR. REISCHAUER: In a desperate attempt to get agreement further around the table, the right way to do this is to have an appropriate catastrophic benefit in Medicare that's defined on the income of the beneficiary so that a person with a $20,000 income would have a $500 catastrophic limit and somebody with $80,000 would have a $5,000 limit or

something like that.

MS. BURKE: Of course, you'd have to get agreement on what income was.

DR. CROSSON: I just wanted to appropriately respond to my body language indication.

I just wanted to make two points. The point I reacted to was I don't really think that volume management is the same as rationing. Because I think the issue of appropriateness or necessity has to come in there. I've never heard the term rationing and Mercedes Benz used in the same sentence.

So the issue of, I think, rationing as a term generally comes in when someone is talking about having to limit things that are necessary or appropriate. But everything that we're dealing with in some of the volume issues doesn't fall into that category. That was the only point that I argued.

But I would heartily agree, and I don't think I believe that if we do these things or many of these things on the list and walk away from the volume piece, that we've done the job. We have not.

I think what I was saying earlier was that I think

we ought to just recognize that we have an opportunity here created by the conundrum of the failure of the SGR to more broadly address physician payment and call out explicitly those things that we think need to be improved in the Medicare program that can be impacted by a better physician payment system, among which is appropriateness or excessive volume.

And I don't have a Mercedes Benz.

MS. BEHROOZI: Just on value, but when you buy something in the market, when you buy tires, don't you look at Consumer Reports or some kind of expert advice? There is evidence about which things provide higher value. And the market isn't always right. The market doesn't always price things according to their value. That's kind of what value is. Can you get more by paying less?

So I think that we talk enough in this group, and certainly there's plenty of evidence out there and private payers are using all of that evidence. It seems to me to be really not progress for us to sort of put up a wall and say we'll never be able to figure it out because it's too complex and there's too many political implications and whatever. And I think Dana's point about it's going to take

a lot more administrative dollars to be able to make good judgments about value. But some of them just jump out at you. And to say it's going to be too complex and too fraught to come up with a whole value-based system isn't a good reason not to at least start moving on the things that we spend a lot of time looking at and there's plenty of evidence for.

And on the cost sharing, I think we have different notions of cost sharing. In terms of a chunk of $500, yes, that's something that you get insurance for, whether it's a deductible or a back end catastrophic. But in terms of things that incent behavior, like copayments, a few bucks here or there, I don't know that that's the kind of thing that people buy insurance to cover.

And not only does that incent beneficiary behavior, but also provider behavior. Whatever is easier for the beneficiary obviously becomes easier for the provider.

MR. HACKBARTH: We're running short of time.

MR. MULLER: Being this late in the process, a lot of the things have been covered before. But I want to go back and build on a point that Nick made, which is there's a

lot of incentives inside the system for everybody to do more. It's not just doctors that are -- the issue at hand is the SGR but providers do, pharma does, device manufacturers do.

And as Bob and others and Doug have pointed out, in a system where prices and markets don't work that well, given the way we insure and cover, going back and looking at the professional judgment of the physician as a central player in the system, a point that Ron made earlier, I think is a critical thing that we should be looking at.

It's not just that they have more physician services. But they admit people to hospitals, they order imaging, they write medication scrips for their patients, et cetera, and so forth.

So I think in terms of some of the issues that we have around the costs of the program, the access for beneficiaries and so forth, looking at ways in which, based on the evidence that we have, one has incentives for the physician to be more a central player in cost control and access I think is a critical part of this. Because we do ultimately have to rely on their professional judgment. There's many ways of abetting their professional judgment

through appropriateness criteria, through evidence-based medicine, through investments in IT, et cetera that we ve discussed over the course of the last few years.

So I'm not a believer in just saying every physician should just come to this professional revelation on their own. There's an awful lot of what we've learned in the understanding of quality and the appropriateness of care over the last 10 years we should bring to bear.

But I would like, as we think about these 10 or 11 things on these summary slides, to focus on the role of the physician as the central player in the whole system and not just in the more narrow sense of how we define the SGR and how they affect the whole thing. I think Arnie and others have said that, as well. And that's why I said, some of these may be repeats.

But we might say to the Congress or whoever is looking to on this, the central thing we've learned is these players are the ones that can have some shaping of the fact that most of the health system is very asymmetric in its incentives. The incentives are there to do more. There's very few incentives to do less.

As Nick and others have said, you don't want to

merely start getting into thinking that doing less is stinting. You want to have appropriateness. But I would really focus on therefore how the appropriate behavior and appropriate incentives to physicians can help the whole system. And whether we do that through doing even much more than we have ever done on gainsharing, where I think our efforts are basically a tweak like this compared to what could be done, I think is of critical importance. Because if they don't have those right incentives, then all the things we're worried about is going to keep happening and happening.

MS. HANSEN: Many of the comments have been made, but I just would add one more different one relative to the primary care component. I believe there's actually a nascent plan for the IOM to take on whole aspect of the geriatric workforce, which will include primary care and other disciplines, as well. As you said, this is not really the work of our focus, but we probably would benefit from working with that in tandem, including given the fact of chronic care management being a large part of it.

I just want to put forth here, even though the funding is not quite there, but the whole aspect of really

looking at alternative or complementary providers like nurse practitioners in this. So the physician is still the core of this, but the complementariness of really making sure standardized kinds of issues that will grow in both number and need to be able to look at alternative practitioners.

DR. BORMAN: Just a couple of things that will relate to future topics. One, with regard to the encouraging or using clinical and cost effectiveness information, I think that's where we've put IT under that umbrella. We've all said IT can be for good or for bad.

I sometimes find myself waiting for the perfect system before I make a decision. I think we regularly fall into that trap.

I would say, under this one that, for example, some regularly recurring things like prescription renewals or cross-checking prescriptions relative to side effects, follow-up appointments, annual preventive services, and so forth. I don't think we have to debate the value that IT can help a practitioner with those. And maybe we do need to endorse those things as a good things of IT and kind of move forward and leave the things that we have to figure out the data for, okay, we'll get to those. But let's not just not

move with regards to the areas where we know those can be of benefit.

Another, with regard to encourage care coordination. I think I'm coming to learn that the word encourage means potentially pay more or potentially pay others less. So in that mode, I would wonder if perhaps staff could -- and you can just get it to me or whatever, but the definition of certain services that are provided and billed now includes care coordination. And it's things like post-service work of evaluation and management visits. It's things like some of the education and preventive visits, some of which the Medicare program chooses not to cover currently, and that's a separate issue. But there have been some values assigned to those.

But any rate, I would like to see us take that big column that we show in the comparative graph that's evaluation and management services, and let's find out what percentage of that, at least in theory, already is supposedly representing coordination of care. Before we put more money into coordination of care, let's find out the percentage of that that's already marked to that.

MR. HACKBARTH: I think that would be useful to

do.

Let me go back to your initial comment about encourage means pay more money. In some ways that's true but in some ways it isn't. I think this is actually an example.

If you want to "encourage" care coordination, you might move on several fronts. One is, as you pointed out, do we have codes for that? Is it a payable activity?

So that's the most basic level. And maybe we do have lots of codes. You know 100 times more about that than I do, and we can document that.

The next step though is do we pay sufficiently for that activity to get as much as we might want? And that could be an issue of the unit price that we pay for whatever codes we've got for care coordination.

But then the third aspect is one that actually we focused on in our report of last June, which was look, there are spillover benefits to the broader system of this activity of care coordination that we may want to allow the providers who do it to share in those savings. And that's a third way to encourage care coordination.

So we need to decide which of the levels we want

to work on, where we've done enough, and where we haven't done enough.

DR. BORMAN: You gave me a lead-in to my next comment, which was that I would encourage everybody to remember that the scale that we use is purposefully termed relative. And I'm going to suggest to you that as you consider these things here that, before you move things around here a fair amount, you want to know -- on the physician side, we may all say to you we're all underpaid. The issue here is are we appropriately relatively underpaid or whatever adverb or adjective you want to put in there?

And let's keep in mind here that we are talking relative. The ephemeral notion of value, I await seeing the criteria in the definition. And maybe it's a sniff test, Supreme Court kind of pornography kind of thing. But I think we have to be a little careful about that because the same value word goes into a lot of nuts and bolts of the physician fee schedule. I think we have to be a little bit careful about translating that how we currently do RVUs corresponds to the notion of value that Mitra brings forth, as best I understand it. And I think we get a little bit confused in that terminology.

MR. HACKBARTH: I'm sure that we do. I think it was at the last pubic meeting, Karen, or maybe this was in our conversation, I thought I heard you second an idea that Bill Scanlon had made, which is that our basic framework now is a resource-based relative value scale. So we tried to assess the resources that go into 7,000 different codes and make sure that on a resource basis the payments are equitable.

I thought I heard you say well, that might be a good starting point but it isn't necessarily the ending point. And it may be appropriate to break out of that framework and say for policy reasons that we want to start with the resource-based relative value and then adjust it to achieve other goals.

DR. BORMAN: You're absolutely correct, and what I'm supporting, however, is that we maybe move past the sniff test piece to maybe some criteria or better definition or whatever of what it is we're doing here. I mean, as opposed to is this a farm subsidy? Is this a signing bonus? Give me a little better sense of how we build something around that.

Just a brief comment about education issue, since

I am an academic physician. I guess I have a little bit different view perhaps than Nancy has seen. In state-supported medical schools there has been a huge press to encourage primary care and encourage those students. Frankly, to the detriment of some specialty recruiting at those institutions. So I think it's a bit geographic variable.

I would agree with her that the pipeline is long for primary care. It's even longer for certain other things. I think you need to know something about the patterns of what students select and at least why they say they select them.

I would tell you that in every survey of students about selection, the first thing is it's something that I can be passionate about or interested, and the other things flow. And in fact, the group that is deserting primary care at the greatest speed are male U.S. medical graduates and they are going to some of the specialities that you mentioned in terms of radiology, dermatology, and so forth.

So I think you have to look at the data and see what they tell you. And I'm not sure that exactly what they tell us is that, as it's been presented to you, that people

are discouraging them from primary care.

I would just close with that comment. Thanks.

MR. HACKBARTH: Thank you Dana and Scott. Interesting discussion.

We have one more session before we break for lunch, and that's on measuring physician resource use.

Whenever you're ready, Niall.

MR. BRENNAN: Thank you, Glenn.

Good morning, everybody. Today we'll be presenting our latest findings related to our assessment of two commercially episode groupers and how they perform on Medicare claims and their suitability for measuring physician resource use.

I'd like to start off by thanking Megan and Jennifer, both of whose work is represented in this presentation.

To briefly review the two groupers we're using are Episode Treatment Groups created by Symmetry Data Systems and the MedStat Episode Grouper, created by Thomson Medstat. These groupers are designed to comb through administrative claims to create clinically distinct episodes of care. These episodes can vary in length and a beneficiary can have

more than one episode open at any given time. For example, a beneficiary can have concurrent episodes of diabetes and sinusitis.

Today we're going to revisit some regional variation issues that arose when we last presented to you on this topic in April. And we'll also present some initial results from our analysis using the groupers on 100 percent of Medicare claims in six selected MSAs, Boston, Greenville, Miami, Minneapolis, Orange County, and Phoenix.

Some of you may remember that when we compared episode costs across MSAs back in April, for certain conditions areas that have traditionally been thought of as high resource use, such as Miami, turned out to be low resource use and vice versa. This was most pronounced for coronary artery disease. This table presents additional information on CAD episodes from the ETG grouper. I mentioned the ETG grouper because the data you've seen to date on this issue has been from the MEG grouper. However, these regional differences to occur in both groupers.

As you can see, average costs for CAD episodes are roughly $3,500 in Minneapolis versus $2,700 in Miami. One of our initial hypothesis was that Miami CAD episodes might

be shorter in duration or be comprised of fewer claims than those in Minneapolis. However, the average number of claims per CAD episode is the same in each MSA.

However, we did find that a greater proportion of beneficiaries in Miami had a CAD episode, 23 percent versus 9 percent, perhaps suggesting that beneficiaries in Miami are more likely to visit a physician in the first place and more likely to be coded as having CAD when they do.

Beneficiaries in Miami have more total episodes than those in Minneapolis, six versus four, and this difference rises to 15 versus 10 episodes when we restrict the comparison solely to those beneficiaries with an episode of CAD.

Finally, because CAD beneficiaries in Miami have a greater number of episodes, they also see a greater number of doctors over the course of those episodes, 7 versus 4.

We then decided to split CAD episodes in each MSA into diagnostic and treatment or intervention categories. We defined treatment CAD episodes as any episode that involved either a major CAD procedure such as CABG or insertion of a pacemaker or a hospitalization. As the second and third rows of the table indicate, there are

different rates of diagnostic versus treatment episodes in each MSA, 29 percent of CAD episodes in Minneapolis involve treatment versus 21 percent in Miami.

The fourth and fifth rows of the table indicate that, not surprisingly, per episode costs are much higher for treatment episodes than they are for diagnostic episodes. So if Minneapolis has more treatment episodes, it stands to reason that it's overall average costs would be higher.

Interestingly, however, for diagnostic episodes, average costs in Miami are almost twice as high as those in Minneapolis, $822 versus $448.

If average costs for diagnostic episodes in Miami were the same as in Minneapolis, if they were $448, the difference between the two MSAs will be even greater. Miami's average would be $2,400 instead of the $2,700 you see at the top of the table there.

Put another way, if Miami had the same rates of diagnostic versus treatment episodes as Minneapolis; i.e., a higher rate of more expensive treatment episodes, its per episode costs will be largely similar to those in Minneapolis, $3,400 versus $3,500.

This is only part of the story because even when we broke our CAD episodes into diagnosis and treatment episodes, average cost for treatment episodes were still somewhat lower in Miami versus Minneapolis. We were initially concerned that there might have been an error in the way we had standardized hospital payments that was systematically leading to lower costs in Miami. But what we instead found was that there was a different mix of DRGs reported on hospital claims in the two MSA with a higher proportion of hospital admissions for CAD in Minneapolis tending to be for more expensive DRGs, which also has the effect of pushing up their overall average slightly.

Finally, the last two rows of this table show the number of claims per diagnostic and treatment episode. As you can see, the higher cost for diagnostic episodes in Miami is reflected in a higher number of claims, 14 versus 11, and these additional claims and the dollars associated with them are mainly E&M, evaluation and management, and imaging claims.

Another hypothesis we had regarding these regional differences was that perhaps due to a greater concentration of physicians and specialists in Miami, beneficiaries in

Miami were being assigned to other heart-related episodes, as opposed to remaining in a single CAD episode, as in Minneapolis. We examined all other types of episodes for beneficiaries with at least one CAD episode in both MSAs, categorizing all ETGs or episodes into one of 22 major practice categories. For example, cardiology, dermatology, gastroenterology, et cetera.

This permitted us to see if CAD beneficiaries in Miami had additional cardiology episodes compared with those in Minneapolis. We found that beneficiaries with a CAD episode in Miami had more cardiology episodes than those in Minneapolis, an average of almost three per benficiary compared to two in Minneapolis.

In addition to having higher rates of cardiology episodes, CAD beneficiaries in Miami also had higher rates of episodes in every other type of major practice category with the exception of preventive care. Overall, CAD beneficiaries in Miami had 15 total episodes of care compared to 10 for similar beneficiaries in Minneapolis.

So just to summarize, at first blush, Miami does have lower per episode costs for CAD than Minneapolis. However, this is driven by the fact that Miami has a

disproportionate number of lower cost diagnostic CAD episodes, even though those diagnostic episodes may, in fact, be provided inefficiently, as evidenced by the $800 to $400 comparison on the previous slide.

Additionally, Miami CAD beneficiaries are more likely to have other types of episodes and care for Miami CAD beneficiaries is more expensive than Minneapolis when calculated on a per capita basis.

All this suggests that more research is needed into the issue of regional variations and how they effect episode-based analyses. It's also possible that perhaps some limited chart-based review might be necessary to especially drill down to the hospital level where we're finding some differences in the types of DRGs even.

The next few slides will present some descriptive statistics from our analysis of 100 percent of claims in six MSAs. At the last meeting there was some concern raised about the ability of the groupers to deal with claims from settings where Medicare was the dominant payer, as they were initially developed for use in the commercially insured non-elderly population.

We calculated the proportion of claims that were

successfully grouped to episodes across all six MSAs and across eight different types of claims: hospital inpatient, physician, hospital outpatient, skilled nursing facility, home health, long-term care hospital, rehabilitation hospital and psychiatric hospital. We found that the ETG grouper does successfully group claims to episodes. The lowest proportion of claims that are grouped in any MSA are 94 percent of hospital outpatient department claims in Orange County while PPS hospital claims generally have the highest grouping rates of between 99 and 100 percent in every MSA.

Even the 94 percent for Orange County can be viewed as something of a low outlier in a way. Across our six MSAs and our eight different types of claim combinations, more than 70 percent grouped at a rate of 97 percent or higher.

Looking specifically at settings where Medicare is the dominant payer, such as rehab and long-term care hospitals, grouping rates were all in the high 90s.

Of course, there’s a difference between grouping to an episode and grouping to a clinically appropriate episode. We looked at episodes to which claims from

settings such as rehabilitation and psychiatric hospitals were grouped. Over 90 percent of claims from psychiatric hospitals were grouped to episodes such as schizoaffective disorders, bipoloar disorders, alcohol or drug dependence and dementia. Similarly, the majority of rehabilitation hospital claims were grouped to episodes such as hip fracture or replacement, stroke and spinal trauma.

The data in this table just confirms that at a highly aggregated level, our findings from the 100 percent analysis are similar to those from our 5 percent analysis. Across our six selected MSAs the average beneficiary had five episodes at an average episode cost of $942. Per capita costs for those beneficiaries were slightly less than $5,000.

However, at the individual MSA level there was variation in all these statistics. The number of episodes per person ranged from a low of 4 in Minneapolis to a high of 7 in Miami. And the high number of episodes per person in Miami enabled their per episode average cost to be in line with other MSAs but their per capita costs in Miami were significantly higher than other MSAs, $6,400 compared to as low as $4,000 in Minneapolis.

This last table shows for each MSA in our 100 percent analysis a highly aggregated look at the components of cost across all episodes in an MSA. We split those costs into six categories: evaluation and management dollars, procedure dollars, imaging dollars, test or other dollars, hospital dollars, and post-acute care dollars. That's what the PAC stands for.

Again, as you can see, there is some variation in the proportion of episode costs accounted for by different service types across MSAs. Boston episodes have a higher than average share of costs attributable to post-acute care while Miami has higher than average shares of E&M and imaging.

Echoing some of the CAD results presented at the beginning of the presentation, Minneapolis has the highest share of episode costs attributable to inpatient hospital care, 40 percent of all their episode costs. While Orange County, in contrast, has the lowest proportion of hospital care, 29 percent, but higher than average E&M care on procedures, 24 percent and 24 percent respectively.

So in conclusion, we feel that we have some interesting and illuminating results on the regional

variation issue, but we're also continuing to examine it and the implications that it has for episode-based analysis.

We've looked closely at the ability of the groupers to assign claims to episodes and found that a high proportion of claims are successfully assigned to episodes, even from Medicare dominated settings.

Finally, we're working hard on taking this data and looking at it at the provider level and we'll return in November with details on this analysis and how it might inform the outlier portion of the SGR report.

I'd be happy to take any questions that you have.

MR. HACKBARTH: If you look at the Miami versus Minneapolis analysis, I'm trying to think how this tool can be used to reward and encourage efficiency.

We looked at this comparison and we found some surprising results last time, namely that the episode costs were lower in Miami. So what you did was subdivide the CAD episodes by diagnosis versus treatment, and then you looked at the number of episodes per beneficiary with CAD. And you found, at least to my eye, some potential explanations that help us reconcile that initially surprising finding with our other beliefs about the relative efficiency of Minneapolis

and Miami. So that's good. I feel better now than I felt before.

But this all raises the question in my mind, how would you then apply this tool in a payment policy so that you truly reward efficiency? Are you saying that you'd have to subdivide episodes into treatment versus diagnosis for all the categories and take into account the number of episodes? I know we've got people here who have used these tools so this is a question for everybody. That's where I am in this sequence.

Niall can go first, and then --

DR. HOLTZ-EAKIN: My question is about these groupers themselves, the software. In their development, what do we know about the testing, for example putting together artificial databases where you know the actual episodes that should be grouped and you look at the success rate in the software in actually putting together the right claims?

To the eye, it looks like they've successfully assigned these things to the right places. But did they really group the episodes the way the doctors actually did them?

MR. BRENNAN: There are a couple of questions here. I think I'll start with Doug's, because it's slightly easier, I hope.

There is an extensive clinical background, going back 10 or 15 years, behind these products. They are private sector products and it's my understanding that they're quite expensive to use and employ. So they have panels of physicians and clinical expert panels that look at the algorithms. And I'm sure they take specific cases and make sure that yes, this beneficiary ended up in this episode and this episode was appropriate.

I'm probably not the person to say whether or not they're absolutely perfect or even if absolute perfection is the goal here. Certainly I think, based on our analyses, which have not been very rigorous in terms of a clinical evaluation, things like the types of episodes to which psychiatric -- that is encouraging to a non-clinician like me.

Last year, in April, we presented some information on the components, before you got on the commission, on the components of costs for different types of episodes. And again, without it being a rigorous clinical evaluation, you

could sort of see that certain episodes were very heavy on inpatient costs and it was kind of well, that make sense, and certain episodes were very heavy on E&M care, and that makes sense, too.

We could do a number of things. We could get some of the vendors in here or we could reach out to them to get a more systematic explanation of their clinical logic and any internal testing or validation that they've done.

DR. HOLTZ-EAKIN: That was helpful.

MR. BERTKO: First, I'll address the easier of the questions, Doug. We've used some of these and we've held them up to physician audiences where we've applied them, and in a relatively friendly fashion explained them using one of the developers to stand there. And they have passed that kind of face test of validity.

So not the detail that you perhaps were suggesting here, but were they acceptable? That answer was yes.

DR. HOLTZ-EAKIN: Do you pay based on them?

MR. BERTKO: We tier based on them, so indirectly, yes.

First of all, I want to recognize Niall. When he said he worked hard, he worked really hard with his staff to

do this, because these datasets are just gigantic. But what's next?

There's lots of ways. This data is very, very dense. Lots of interesting things to find. So the per beneficiary or per beneficiary with disease view of these is more of how does it work?

Now how would you apply it? I think, and Niall, I'm going to suggest -- interpreting what you said here is the next step here for next month is to build on the physician case loads, is the way that it's actually applied. Arnie, you can jump in after me.

But instead of looking at it on a per beneficiary, you look at it either implicitly or explicitly on what does a physician do across a practice pattern? We used two of them. One of the ones we use actually builds up a specific market basket much like the CPI has done for those kinds of things. The implicit ones like ETGs and the MEGs do it and just say if you've got all of this and you severity adjust it, you've essentially got the basics of a physician practice. And that's where you begin to see efficiency and inefficiency in terms of it.

And to that I would say you impute or infer that

folks that are way out here at the end of the tail in terms of efficiency probably have inappropriate care. And as we've been forced a couple of times to provide feedback, you find things like imaging is 200 percent of the peer group within the speciality within the market, let alone -- I'm sorry, market-to-market.

So Niall, have I correctly imputed, inferred that the next go around we'll be closer to telling how we would use it?

MR. BRENNAN: We're certainly going to aggregate episodes to the physician level. We're looking at several different ways of then computing a composite type score, be it a market basket type approach or a more indirect standardization type approach.

In partial answer to Glenn's question, I think it does raise a number of interesting issues. I think both makers of the software are interested in this issue and they're amenable to change if they feel that this is something that isn't working.

It's also most pronounced at a cross-national regional variation level. And one thing you could possibly envision -- and Mark can cut me off at any time -- is that

there are regional variations. But within Miami there's still a distribution of efficient and inefficient providers. So one way would be to possibly combine some kind of a per capita evaluation with then a per episode evaluation in a defined geographic area.

This is way, way, way down the road, but do you really want to use these tools to literally compare a physician in Key West to a physician in Anchorage? These are all implementation issues that need to be thought through and discussed.

I think what we've discovered is very interesting analytically and, like I say, the makers of the software are interested in working with us or other people to try and either come up with a solution or a work around.

DR. REISCHAUER: Niall, I thought this was absolutely fascinating and incredibly discouraging. Having come out of the IOM experience and thinking that if we got good episode measures of resource use this might be used in a P4P system for measuring efficiency, and I come out of this and I'm just mind-boggled by the variation between Miami and Minneapolis on the fraction of the beneficiary population that has CAD episode, 9 versus 23 percent.

Now it's conceivable that unhealthy people leave cold climates and all you have left is Norwegian bachelor farmers who are very healthy except when they have horrendous heart problem, and huge numbers of sick people go from New York and New Jersey down to Miami to be treated.

But it just strikes me that the variation across regions is not so much -- and I'd like to see this actually, just try to do a calculation -- it's not so much how much resources does the average CAD person get in Miami versus the other, but how many of them are there? And 9 percent versus 23 percent, and then you extended that to other types of conditions and the incidence was high in Miami for everything.

It just strikes me as a hugely complicating factor because you have to then, if you're worried about regional differences in per beneficiary aggregate spending, you have to ask yourself, are people being woefully underserved in Minneapolis or horrendously overserved in Miami or are there real variations in the underlying population?

And until you answer that question, you can't go to the next step in using this kind of information.

MR. BERTKO: Bob, some of that actually is known

through the CMS-HCC risk adjuster. And in Miami, for example, because I pay close attention to it, about a third of the variation is explained by I'll call it disease-specific risk adjustment. And the rest of is -- I won't use the word horrendous --

DR. REISCHAUER: But the risk adjuster, unless I'm wrong, comes out of your utilization of resources in the previous year. So it's sort of like a self-fulfilling prophecy.

MR. BERTKO: No. That's partly true, but mostly you only get one flag per unit of service. And if you have 10 units of service, you don't get 10 flags, that is 10 points. You get one point.

DR. MILLER: One other point on this. I think you could begin to look at some of the disaggregation that Niall was doing here, and start to ask the question of -- you began to see where the differences were accruing. And a lot of this, in this instance, was the diagnostic work which begins to raise questions about okay -- I mean, I think that begins to start to segue into some of the other work that Wennberg has done is these services tend to be more discretionary.

I'm not saying that it answers your questions, but it really gives you much more directed focus of what you're looking at. I think you could begin to disaggregate some of this and point more precisely to why is it that there's so much more diagnosis that's going on here, as opposed to treatment in this particular example?

DR. REISCHAUER: But if I were interested in the explanation for the differences between aggregate beneficiary spending in Miami versus Minneapolis, how much of it is going to be due to that sort of thing versus the fraction of individuals who are diagnosed with a certain condition? I don't know.

From just looking at the numbers, my guess is it's going to be 60 percent from the difference in the percentage of individuals who have CAD and --

MR. BERTKO: It's the other way around.

DR. REISCHAUER: Well, 40 percent is still a big number.

MR. BRENNAN: Can I just clarify a little the 23 versus 9 percent? I may have been a little imprecise in my language. It's not a true prevalence from a pool of all Medicare eligibles. The pool was anybody who had a claim.

There's still obviously a difference there, and Miami was higher.

DR. REISCHAUER: I'll bet you lunch that the fraction of people in Miami who have one claim is higher than it is in Minneapolis.

MR. BRENNAN: It is. We don't have to bet that. I just wanted to clarify.

DR. MILLER: Don't bet him, because we're paying for his lunch.

[Laughter.]

MS. BURKE: I really want to continue in the vein that Bob was going in. If Bob had looked on this side of the table, he would have seen affirmation of his comments in this context.

DR. REISCHAUER: I did.

MS. BURKE: Thank you.

But I, too, am confused and am not certain that I fully understand what it is we now know.

DR. REISCHAUER: Less than we thought before.

MS. BURKE: And how this informs us, to Bob's point, is what do we now know? And how might we apply this as a routine matter, in terms of a method going forward?

But I, for example, was particularly struck with the number of physicians, for example, that were seen by the patients in Miami as compared to the number of physicians that were seen in Minneapolis, where there was a far greater rate of referral in Miami. So the presumption is they're less efficient. So I'm trying to understand what we know and why we know that from that referral pattern, that the presumption is they are less efficient because they see more people.

And also by the rates of hospitalization in Minneapolis, which were far greater, and whether we assume that is because the patient is more acutely ill and therefore they would use more hospital services as a routine matter because they are seen later because they are these stalwart Norwegians who only wait until they are in acute distress.

I'm trying to understand, what are the message? I know we've got wonderful information now and I'm trying to understand how to understand the data and what the data tells us. What do we presume to be inefficient in this case? We're looking at both a per episode, but we're also looking at per capita. And we get different messages,

depending on what that combination is.

In the course of this, Niall, what you've said is perhaps we look at some combination of those two things. But I'm trying to understand how going forward we get to the point of understanding what is efficient and what isn't? How one determines that? There's a presumption here, for example, about the number of referrals that we might or might not use.

And I'm trying to understand, how do we know what is, in fact, the appropriate -- is four better than seven? Or is seven better than four?

So I'm trying to understand how using this it really informs us going forward in terms of its application in a broad range of cases? How much information do we need to gather to be able to apply this and adjust appropriately? At what point is it a risk adjuster? At what point do we have some certainty that the tools are, in fact -- I mean, I felt better knowing that, in fact, the episode, the gathering of information around an episode, seems to be relatively good. Beyond that, I'm not sure what I know with any certainty and how I interpret it without presuming to have interpreted something that may not be right.

DR. MILLER: Just to take a crack at this, and other people can offer their opinions.

I think what we're doing here in this exercise is really two things. And I think you've summarized this well in the sense that you're getting different signals, depending on which measures you look at. And in some ways that just drives you to saying we've got to think of these things together. And I think, to Niall's point earlier, there's a question of within what universe do you want to start looking at this?

But I think in the end, at a very conceptual level, we're only doing two things here. One is the standard will always be a standard that's relative to some metric. You will always be within -- I don't know whether Miami, or whether it's the country in this particular instance. You would say why four, why seven? And look at the people who are out at the tails and say I'm going to focus my efforts there to find out why so much more imaging or so many more visits or so many more physicians.

So there will never be a standard that says seven is correct and four is incorrect. It will be why is somebody way outside of the range?

MS. BURKE: To your point, which I think is exactly, right, is that the measure we even look at? Do we care what the referral pattern is? If we're looking at the per cost episode, or are we looking at the per capita? Because in the case of the episode, irrespective of the number of referrals, they were less expensive. But in the case of the per capita, they were more.

So the question is do I care how many referrals there are?

MR. BERTKO: Yes.

MS. BURKE: Yes, if you're looking at per capita. If you're looking at per episode, it didn't matter.

MR. BERTKO: No, it does.

MS. BURKE: But it didn't, in terms of the cost.

My only point is how do I know which of these indicators it the right one to care about, to your point? It is a question of what you mix and match, and it is a question of where the outliers are. And the question is which outliers do I care about? Do I care about the outliers that relate to referrals? Do I care about the outliers that relate to per episode costs? Do I care about the outliers that relate to per capita? At what point do I

decide for a payment purpose how many of these outliers I care about and which of these I track? Or do I care about all of them? And then you sort of combine them all together and figure out where it matters?

That's really what I'm trying to understand. I'm presuming I do care about the referral pattern, but to what end? Because it costs more? Because I think it's inefficient? Because I don't like who they're referring? Because I don't think cardiologists ought to be dealing with -- I mean, which of those do I care about? And why do I care about them?

MR. BERTKO: I've got to jump in here. Niall and his crew are about halfway through the book. Sheila, you asked a good question. But until you get to the part which is next month's, you don't know what the answer is.

The beauty of episodes, in general, is that they collect everything together. And when you do it then you have a couple of different things.

Think of the way a physician practices as a bell-shaped curve that looks a little odd. And so you've got several things that go on. The first thing to do, and this is kind of Niall's comparison, is you're looking where the

means are. And the means do move around but that's not necessarily the important part. It's the distribution of the tail, particularly the right side of the tail.

Our evidence shows that in some places, and South Florida is one of them, the potential for improved efficiency, that is reducing inappropriate outcomes, is really high, well above 10 percent and maybe as much as 20 percent.

I don't have Minnesota, we don't have a market there. But in Wisconsin, the potential is really low. And the grouping, the density around the mean, is quite tight. So the Garrison Keillor kind of things about the doctors behave well in Wisconsin and probably Minneapolis is right. They all behave about the same way and so there's not much tail to be fixed there.

But the episodes in general, when you look at it using that kind of a viewpoint, tell you something immediately. And then it's up to people like Jay and Ron and Arnie, who are docs, to say okay, what's the cutoff there? What is inappropriate care.

MS. BURKE: But let me, if I could, just follow that up. And I'm more than happy to wait for chapter two to

be told the answer. But if I understand your logic, if I could follow it for a moment, if the episode matters -- which I would agree it does matter -- then arguably they're doing better in Miami, based on this information.

MR. BERTKO: Yes, and I didn't mean to say that. It's actually the practice of the specialty, which includes numerous kinds of episodes, all severity adjusted, for the people who take care -- the ones who take care of very, very sick patients get a divisor that reduces their score. The ones who take care of only the easiest patients have a divisor which increases their score. And then it's compared across a market basket.

You can ask Ron. A given specialist, you probably do 10 or 15 procedures which are the bulk of your practice. Once you grab those for a urologist, I think you could say that you know what the urologist is doing. And each of the specialties has that kind of a package, whether it's a market basket or otherwise.

MS. BURKE: Again, just to take it one step further, and I don't want to prolong this, if we're going to have this further conversation, we'll come back to it. But I just want to understand the logic.

In that case, it is the episode by physician within the episode, not the episode.

MR. BERTKO: No, it's the physician practice in a grouping of episodes.

MS. BURKE: But again, to that point, in Miami this information suggests to me that Miami is doing a more efficient job than Minneapolis.

MR. BERTKO: No.

MR. HACKBARTH: We've got a number of people in the queue. I'd like to get to them because we're behind.

MR. BRENNAN: Could I just respond to both Sheila and John? You're both correct.

MS. BURKE: That's a perfectly perfect answer in every way.

MR. BRENNAN: But it's a fairly complicated undertaking we're doing here and we never said that this would be the magic bullet to figure out things. I've always likened this to like kicking the wheels on a car.

But we had a potentially confounding result for CAD, which is an individual episode in two MSAs. Our initial instinct was let's find out why that's happened. We've tried to find out why it's happened.

John is right. Now we're going to move away from looking at individual episodes and we're going to count all of the episodes a physician has, not just CAD.

But I would also caution that when we come back in November, it will probably raise just as many questions as it has raised today. This is an ongoing process and certainly, at least in the Medicare world, I know in the private sector world, people are significantly more comfortable with these tools. But we're still taking baby steps, so to speak.

DR. HOLTZ-EAKIN: I'm trying to interpret this dialogue, and I think there are really two very different ways even Medicare could go using these. And you're talking about different exercises.

One exercise would be to use these kinds of tools to find the appropriate payment for an episode, all the things that went on in that episode and bundled together, and really hit the gold standard that we aim for.

And when that gets raised using this grouper, Bob worries about the kind of people coming in. You worry about whether it's appropriate care and all those issues. That's not ready for prime time.

There's a different suggestion this group has made even today that says suppose we inform doctors about the way they look compared to everyone else? There the focus is not episodes but doctors. And if you organized by doctors and just sent this to them and said look, you are the imaging king of Coshocton, Ohio. Did you know that? It might affect behavior in a beneficial way.

And so those are two different exercises and they shouldn't be confused.

MR. HACKBARTH: And incidentally that was the initial recommendation for how this should be used.

DR. MILSTEIN: First, we have to remember that our frame of reference is what we have today when we do nothing to draw attention or incentivize efficient resource use. And so in some ways our competition is even worse than what we're seeing here.

Second is if you reflect back on last month's presentation, what we saw was when we used total longitudinal spending for various illnesses, that we had no counterintuitive findings for most categories of illness. There were two categories of illness for which we had counterintuitive findings, and that's what we're drilling

into now.

So in terms of rending a judgment about whether episodes might be a useful basis for a variety of potential policy changes, I think what this tells us not that we throw this out. For example, this works great and there were no counterintuitive findings for hip fracture. But we have two chronic illnesses in which there's a lot of coding and diagnostic discretion where we realize we have a problem.

And hopefully, in the next session, we will explore a variety of solutions, one of which is what John outlined but I think with more preparation time will be more comprehensible maybe to everybody.

Another approach, and I'll defer to Eliot Fisher in his next presentation, might be for these small number of chronic diseases where we're getting counterintuitive results is to think about fashioning an index that not only took into account cost per episode but number of episodes per year within a chronic illness. That's where I'm going to predict someone like Eliot might land.

And so I think that we have to have the right frame of reference. Where we're drilling into the two diagnoses among all that we looked at were the only ones

that had some counterintuitive findings. And I think we ought to reserve judgment until our next meeting as to whether or not we have some solutions that at least represent progress in judging and rewarding physicians relative to what we have today, which I thin is indefensible and not working.

DR. CASTELLANOS: Unlike Bob, I find this very, very fascinating and very, very encouraging. You're discouraged but I'm encouraged.

Niall, your group did a great job. This is a tremendous amount of work. This is the first time I saw data on a longitudinal viewpoint.

It goes to show two things. You need to look at the data more carefully, not just breeze through it. You've got to look at the data more carefully.

But more importantly, as I see it, you need to get the physician involved right away. You need to let the doctor know about these things. And don't be afraid to tell physicians. We've all been very competitive. We compete to get into medical school. We compete to get into residency programs. And when the data is available to utilization review and practice patterns, it's going to make a

difference.

So I'm excited about this, and I think it may be something that we can identify the outliers and maybe identify why we're having a lot of excess volume.

DR. CROSSON: On this one, I'm joining the Bob Reischauer fan club -- you're nervous now -- because when I finished it I had the same degree of skepticism, I think. So I asked myself what was the lesson of this? Is it simply that looking at the cost per episode is a limited but useful tool? Or is it that it's so limited that without the information about how many episodes and what kind of episodes you really can't draw any firm conclusions? And that in order to get to better conclusions you have to have all that information?

But then I matched that up with what we initially said was the original idea here, which was we're not going to chop the tail off, which is I think where it has been used successfully commercially. But what we're going to try to do is provide information to physicians to help them understand how they're doing compared with their peers.

My concern is if it's this arcane, and I realize we just biopsied the most obviously odd one. But I would

imagine that that issue is buried in other diagnosis groupers, and that is that there isn't necessarily a one-to-one relationship between the cost of an individual episode and/or the number of episodes and/or the kind of episodes.

And so my concern, and we'll see more later, is that when we end up with this are we going to have something that is understandable and actionable enough to meet the need that we said we were after in the first place?

DR. WOLTER: It seems to me at least one of the questions this raises, I think Bob that's what you were trying to say. But in my simple way of thinking about it, utilization is the driver of cost. And is that a big factor in what's going on in these two comparisons? And when John says two-thirds of these things tend to not be related to underlying disease incidence, if I heard you right, then that tells me we have a big issue there that is going to need attention if we're going to tackle these things well.

And of course, this isn't a surprise really because all the Wennberg work over the years has shown that the number of back surgeries in Montana per 1,000 beneficiaries way exceeds that number in Maine. And there are many other examples in other disease states. The

question is why is that?

I was worried that this data was the reason that Dave Durenberger didn't make it today, but I would say that again, when I hear John talking about Wisconsin, there's been a lot of work done in Minneapolis amongst the different medical groups around clinical protocols, the ICSI group, et cetera, et cetera. And one of the things I think that's in our future is how do we create some kind of protocols around decisions as to when things are needed? We can't do that for everything in medicine, but we can do it for some things. That's one of the lessons here.

Sheila, I don't think the number of hospitalizations is necessarily more in Minneapolis because the number of episodes is so many fewer, that if we looked at hospitalizations per 1,000 beneficiaries we might find that's still equivalent or maybe even lower in Minneapolis.

I don't know if you know offhand?

MR. BRENNAN: The absolute rate of hospitalizations among people with a CAD episode is higher. If you abstract back to a population-based Medicare eligible, it probably is lower because they're less likely to have a CAD episode.

DR. WOLTER: The rate within the episode analysis is obviously higher in Minneapolis, but there are so many fewer episodes.

MR. BRENNAN: Right.

DR. WOLTER: I think that skews your thinking about this.

The other thing that this really strikes me is that, relative to our earlier conversation, although the physician is so much the driver of the decision about whether or not some of these things are done, when you look at the total cost involved, much of that is dependent on other factors that the physician has no control over. And that would be hospital costs or post-acute care costs or imaging costs.

That's why ultimately we need to be thinking about bigger units than the physician alone, in terms of accountability. I'm much less optimistic than Arnie that by focusing on the physician alone as the unit of accountability we can make as much progress as if we create some other set of accountable providers.

Arnie said an interesting thing, and that is cutting off the tail. That is a strategy. Find the

outliers and deal with them. But to really deal with the issues in the Medicare program, we're going to have to find a way to move the middle of the pack of the bell curve forward to best practices. So we sort of have to move beyond that way of thinking about the utility of this information.

DR. MILSTEIN: For the record, that was not my description or suggestion.

DR. WOLTER: I'm glad to hear that.

MR. HACKBARTH: Thank you Niall. We look forward to the next chapter.

We'll have a brief public comment period. Just a reminder on the ground rules. Brief means no more than two minutes per person.

MS. McILRATH: I liked it better when you talked about hospitals and I didn't have to get up here every month.

I'll be brief. I just want to focus on two things. One is to sort of expand on the scenario on what physicians are facing right now. Dr. Castellanos mentioned the 45 percent. That's 45 percent of physicians that, if Congress does not act, are going to be facing on January 1

cuts that are greater than 5 percent because there are a number of other things going on. That would be partly budgetary neutrality factor on the five year review. It's partly the imaging adjustments. It's partly that the floor on the work GPCI is going away. There are 5 percent of physicians that are facing cuts in the neighborhood of 16 percent, 13 that are facing cuts of greater than 10 percent.

So when you think about how you are going to do some of these things, and if you continue to have an SGR, that they are really working against each other. So when you think of is this -- the things you have talked about today, are they in addition to or are they instead of an SGR?

Think about all the ways that the SGR is incompatible with all the other things that you want to do. How can you have pay for performance and ask people to investing in IT when they are today being paid at the same rate that they were in 2001? You're not asking that of any other provider group. And then to expect them to come in and make the investments that they need to make if you want them to do this. And then, when they are still facing cuts of nearly 40 percent over the next nine years. And what

they might get back if you had a 2 percent bonus. And if they were in the specialty that has the highest Medicare mix is about $5,000 a year. Then it just doesn't seem feasible to a lot of physicians.

Add to that that about a third of them are over 55, and that's on average. In some specialties, it's much higher than that. And you can start to think about that there might be a lot of these guys that will simply say I'm out of here.

So the other thing about the incompatibility is if what you're trying to do is focus on the chronic conditions and actually hit on just the things where it's going to have more impact with Medicare, when you tie it to the payment and you tie it to an SGR-type system where the only way people can avoid being penalized is to have a measure, that's what drives -- we've developed, in the physician consortium, 170 measures. That's still not going to cover every single physician.

So you end up having the way you've tied these two things together driving what measures you develop more than what would actually make a difference.

Also, you're going to have an increase on the

physician side of the equation because what you're trying to do is get those people in to see the physician more often so that you can keep them out of the hospital. Under the SGR, they will be penalized for doing that.

So I just think those are things to think about when you're thinking about the big picture here.

MR. HACKBARTH: Okay, we will reconvene at about 1:35.

[Whereupon, at 12:52 p.m., the meeting was recessed, to reconvene at 1:35 p.m., this same day.]

AFTERNOON SESSION [1:40 p.m.]

MR. HACKBARTH: A couple of people have asked about the temperature, it's a bit chilly. Those are the ones who can still speak. We're trying to get it warmed up a bit.

DR. REISCHAUER: Do you want me to speak more?

[Laughter.]

MR. HACKBARTH: First up this afternoon is a session on the 21st century beneficiary. Dan, you can proceed when ready.

DR. ZABINSKI: Over the coming decades the population of Medicare beneficiaries is likely to change in some important ways. One of these changes is a well-known increase in the number of beneficiaries as the baby boom generation becomes eligible for Medicare.

A second change that has not been widely studied is a change is a change in characteristic profile of beneficiaries. Today I will discuss a work plan for analyzing the effects of this changing profile of beneficiaries say over the next 20 to 30 years.

Some of the changing characteristics that could be important to the Medicare program in the future include

first, a decline in the proportion of beneficiaries who have employer-sponsored insurance to supplement their Medicare coverage. This ESI coverage is relatively generous so its decline in prevalence could increase beneficiaries' exposure to financial liability and could affect beneficiaries' retirement decisions.

There also could be a change in the prevalence of some chronic diseases and conditions. For example, obesity is becoming much more common among Medicare beneficiaries. Obesity is a rather unusual chronic condition because, first of all, like most chronic conditions, it does increase the annual cost of beneficiaries to the Medicare program. But different from most other chronic conditions, it does not reduce longevity amongst the elderly. Therefore, these beneficiaries tend to have very high lifetime cost to the Medicare program.

Another change may be in the racial and ethnic mix of Medicare beneficiaries, especially an increase in the number of Hispanic and Latino beneficiaries. One thing I want to emphasize though is that Medicare would be affected only if Hispanics and Latinos are different from the average beneficiary in terms of their use preference and sources of

health care.

There also may be a change in beneficiaries' income and wealth. One thing that we do know is that adjusting for inflation the elderly have had increasing incomes. But the rate of increase in this real income has been slow, slightly higher than 1 percent per year over the last 10 to 15 years. If supplemental and Part D premiums continue to increase at much higher rates than beneficiaries' real incomes, beneficiaries may have increasing difficulties obtaining coverage to supplement Medicare or to cover their Part B services.

There also may be a change in the proportion of beneficiaries who are very old. This proportion is expected to fluctuate in the coming decades. First, it is expected to increase through 2010. Then, as the baby boom generation enters the program, it is expected to decrease through 2030. Then after that it is expected to increase quickly as the baby boom generation ages. And the very old are a very important population because we find that they are about 40 percent more expensive than the average beneficiary.

Finally, future beneficiaries are likely to have more formal education. More educated beneficiaries may

present a lot of interesting issues. One thing is they may take a greater role in their clinic decisions. For example, they may ask more questions of their providers or might research alternative methods of treatment for any particular condition.

A changing beneficiary profile can have the following important effects. Number one, it could influence program spending, for example, increases in the prevalence of obesity or the number of very old beneficiaries would increase program spending. Also, it could influence beneficiaries' needs and preferences for health care. Third, it could also influence beneficiary sources of care. For example, a beneficiaries' characteristics could be a strong indicator of whether a beneficiary primarily gets their care from a doctor's office or through the emergency room. And finally, it could influence beneficiaries' financial exposure. In particular, fewer beneficiaries with employer-sponsored insurance may indicate an increase in their exposure to program cost sharing or the cost of non-covered services.

Now I'd like to discuss what will be at the heart of our study. The core of the study will be four questions.

First, what are the most important changes to the beneficiary profile in the coming decades? And second, why are these changes occurring? Knowing the causes of the changes can help determine whether Medicare can help prevent any undesirable impact of the changes. Third, what might be the impact of these changes on Medicare in terms of overall resource use and types of services that beneficiaries' use? And then finally, what are likely to be the appropriate responses to the changes so that Medicare can better serve and protect beneficiaries?

To answer these questions, we have developed the following work plan. We'd like to start by consulting with experts to get their views on which of the changes in the beneficiary profile are the most important? What could be the impact of these changes on the program? And finally, how could Medicare be modified in response to these changes?

We'd also like to do a thorough review of the literature to get a complete view of the issues facing the Medicare program and help us be more engaged in our discussions with the experts. We'd also like to analyze databases such as the MCBS or MEPS to give us a better understanding of the current state of the Medicare program

and to provide a sense of the potential impacts of any changes in beneficiary characteristics. And then finally, we'd like to do a simulation of the effects of the changes to the beneficiary profile and any modifications to the Medicare program we might want to look at. These results would likely be obtained from a computer-based simulation model. We emphasize, though, that this part of the work plan is likely to be a longer term project with results probably in the 2008 production cycle.

Now that concludes my discussion and I'll turn it over to the Commission for their discussion. I'm particularly interested in hearing about any changes in the profile I might have overlooked, and also your overall view of the proposed analysis.

MR. BERTKO: Dan, a question on the statement that you have in there about the greater folks with obesity will have the same average lifetime. Is that based on solid data? Is it based on expert opinion?

I just checked into something, trying to find body mass index among our seniors and it's very difficult. I was wondering if it's a mortality study or another kind?

DR. ZABINSKI: What I'm citing there is a study

from RAND. The idea there is that say somebody becomes obese at a young age. They're likely to die younger than your average person. But the point is if they are able to make it to age 65, their expected longevity at that point isn't any different than somebody who's not obese.

MR. BERTKO: But is that a true mortality study? Because the difficulty to me would be looking and saying this group of people were obese, versus their actual future livelihood at that point.

DR. ZABINSKI: My recollection is that yes, it is a mortality study.

MR. BERTKO: Can you send that to me?

DR. ZABINSKI: Sure.

MR. BERTKO: It sounds contradictory.

DR. ZABINSKI: That's one of those things, I had to read the sentence twice to believe what I was reading.

MS. HANSEN: I'm really glad that we are doing this study on out and I know that it's pretty difficult to get one's arms around it.

In responding to a few of the bullet comments here, one is the difference of chronic conditions. But also, with the whole aspect of race and ethnicity. I wonder

if, in addition to the Latino/Hispanic population, we could probably look at work from the Office of Minority Health relative to health conditions, prevalence of different conditions in different racial groups, as to what that also will do.

Back to the one on chronic conditions, I just wonder if there's any way to -- whether maybe this will come out in the simulation in the future, but looking at diabetes as an example, and maybe obesity and other cardiac diseases with the impact on the ESRD program, in particular, as that changes over time.

And then the whole area of income, wealth and distribution. I wonder along the way here, as health care becomes more expensive for beneficiaries, whether or not there will be proportionally more people who will fall in the dual eligible category over time, just because of the sheer cost of care?

And the amount of savings that baby boomers have. I think one study, ERI, said I believe, that about 50 percent of boomers have only about $25,000 net saved beyond their mortgage of their house.

And then finally, the proportion of old-old will

fluctuate. And once we do have a large group, the fact that some of the medical costs start to spill over into social costs, and whether or not the whole aspect of social care can be looked at here. Let me give you an example of old-old in California has really used this whole method of paying for caregivers to keep people in the home instead of going into nursing homes. And that actually is a movement afoot where the concept of money follows the person. Some of the findings are that people are more stabilized and don't end up having to go into acute hospital care as a result of that.

So there are some confounding kinds of things, but it is about what impact it will have on Medicare cost in the future.

MS. BURKE: Dan, like Jennie, I think this is a terrific opportunity for us to sort of look ahead and think about some of the implications of changes in the population and what that means for the program.

Two, I want to go back to the point I began to raise in the earlier discussion about income. Jennie sort of mentioned this, but the whole question of disposable income, the question of what the capacity will be of these

individuals to finance care, what we might imagine the breakdown of the nuclear family, the fact that historically -- and I suspect this will be true going forward -- that there is a far greater preponderance of single women rather than men in the population, and what that means in terms the nature of the services that they need and their locations. Certainly, race as well as gender make a big difference.

You've noted, in particular, the Hispanic beneficiaries. One of the sort of unique things that I know we've seen, for example, is they tend not to use hospice services. They use a greater preponderance of nursing home services. And what does that mean about the structure of the benefits and how one might anticipate that? And the service and where they are located and how we might service this population. What does it mean about the need for language-related kinds of materials, whether that becomes even more dominant in the out-years, I think are things that we clearly need to consider and look at.

I wonder what the relationship between the change in the race of the population and the level of education issues, as well. Those seem a little at odds, but perhaps not. But I think that that is something that we want to

take a look at as we go forward.

But the income issue, in particular, that again I want to make sure that we pay close attention to is one that continues to confound us and how you incentivize people's behavior and what it is that they respond to. I don't think we should assume necessarily that the easy answer is that you create a catastrophic environment and do away with first dollar coverage. I don't think it's as simple as that with this population. I think that is something that we need to look at very carefully. We began to see some changes in the creation of Part D. But again, I think that structuring the benefit, whether it's around the home care benefit, whether it's around the things that we have traditionally not required copays on, getting rid of the hospital copay because it's less discretionary. Again, I think they are not simple questions, nor will they be simple answers.

So I think an understanding of that will be important to us going forward. I think you've raised some terrific questions. I think it will be a good process to follow.

DR. REISCHAUER: Dan, I think we're headed down a very interesting track here. There are two very different

perspectives or approaches one can take. Or we could do both.

One is what I think a lot of this is, which is take Medicare as a constant program and look at the change that is likely to occur in a demography, economic, social attributes of the participants in the program. Where will this constant program not fit? Will its cost go up or down because of all of these changes? That's all very interesting.

Another way to look at it is to say let's look at these dramatic changes that are going to take place in the population. What kind of opportunities does it open up for changing Medicare into a different kind of program?

One of the things that I thought of immediately, reading this was 30 years from now virtually everybody is going to be computer savvy in ways that they aren't now, which means that information can go directly from CMS to things you can put, probably stuff like the Dartmouth prostate cancer, a little movie and interactive thing, on the Net. And so you could access this stuff from home.

People will be comfortable with different kinds of delivery systems because they've spent their whole life in

network systems or systems that are managing their care and we'll have an elderly population with much larger disparities in distribution of income, which will allow for different kinds of income-related premium charges and all of that.

And so to look at it from both angles in a sense, both as an opportunity and as a need to respond I think would be valuable.

DR. HOLTZ-EAKIN: Bob has made the major points that I was going to make. When I first read this, and the question that was dictated says should we continue to work on this issue? I wrote no.

Because if you take the first few, fixed program, I think there is not a comparative advantage in this group to doing that work.

I'm sure you're familiar with the Congressional Budget Office. I don't know if you've talked to them about the long-term simulation model they've got. But it is exactly the first exercise that Bob described. It takes a representative cross-section of the U.S. population at a point in time. It statistically replicates its marriage, fertility, divorce, morbidity, mortality, immigration

patterns. It matches the cross-sectional distribution of income, the longitudinal distribution of income. And so there are people out there, outside of this group, who can characterize how this existing Medicare program will age along with the population and how much it will cost and things like that.

I don't see a great advantage to us replicating that. Certainly, consulting them becomes an issue.

It's also true that you run into a real problem with the small cell sizes there, when you start trying to identify people who are of a particular racial background, at a certain age, with education, income, wealth. So I don't think there's big returns there.

On the other hand, if we built a flexible, patient-centered, efficient Medicare program that produced appropriate care, the whole point would be you'd do that regardless of who walked in the door. And the people who walk in the door will be different in the future than in the past. And I think the focus should be on the program. I think Bob has made that point very well. I'd go that direction.

MS. BEHROOZI: I wonder if those comments go more

toward where the data could be gleaned from. Among the recommendations is to review the literature. But I think it is important to maintain a focus here at MedPAC that's specific to the work that we do and the questions that we have to answer, because there are so many assumptions that we either share or that we don't hold in common, but they're assumptions.

Like the obesity/mortality issue. That's really important for us to have the data on. So good if it can come from someplace else, rather than having to reinvent the wheel.

And I do think that there are some areas that are particularly important, given the kinds of questions we're asked to answer, as Sheila referred back to the earlier discussion when we were talking about benefit design change. I think it matters a lot whether -- well, it's important to look at income distribution.

I think it's quite irrelevant that overall, on average, Medicare beneficiaries' incomes may stay a little ahead of inflation, because that doesn't give you a picture of a Medicare beneficiary. That's most likely -- and again, this is an assumption -- most likely driven by very few

people at the top. Because we know, for the most part, people are on fixed incomes.

But I really also think that, for our purposes, a couple of other factors that are specific to retirement -- not just general demographic characteristics, but employer-based coverage and the decline of defined benefit pension plans and retirement income security in general, hasn't hit yet. You're not going to see it in the data now. It's not going to be in these -- I wouldn't think it would be in these longitudinal studies based on current -- what people are earning currently or what kinds of plans they have now, but rather projecting forward in a workforce whose expectations of what they can rely on in retirement are changing. I think we need to stay ahead of that curve, or at least keep up with that curve. Because that's huge and that's been fairly recent that those changes have been really taking on some momentum.

DR. SCANLON: One thought about a dimension to include and then a caution. The dimension to include is to think about not how much Medicaid will absorb some of the effects of the changing demographics, but to think about how Medicaid changes may impact on those people. Because

Medicaid is a very different kind of entitlement program. It's not nearly as fixed as Medicare. The states make dramatic changes both gradually and sometimes very quickly.

Over the past 25 years the number of people in nursing homes has declined as a share of the population by about 30-some percent. I think we probably don't appreciate that but it's largely a Medicaid phenomenon. States have said we're not going to have any more beds periods and have had moratoriums in a number of states.

At the same time, there are almost 1 million people getting home care, which was not true 25 years ago. So these are pretty big changes that may have some impact on Medicare. For a while, when Medicare home health was almost a long-term care program, we had states that had laws that said we're going to maximize Medicare. That option is not available anymore, but I think we need to think about it just as much as we're talking about how changes in employer-based insurance is going to impact upon Medicare in the future.

The caution would be about modeling, and it's in the context of what I've been talking about here in terms of some dramatic changes. I'm not familiar with the details of

the CBO model, but some of the longer term projection models, in some respects, start with a cross-sectional static point and say if we take things like demography and we trend them forward, what's going to happen?

We have to also, I think, be very sensitive to the fact that we can have huge changes to the world, like we're not going to have another million nursing home beds, the way that projection would imply. Some of these things are going to be influenced strongly by some other decisions that are going to change the world that we operate in. And how good are our estimates, given that that may be occurring?

That would be another part of thinking about this and maybe that fits well with Bob's suggestion of don't think about Medicare as a static program, but think about as what it could in the future.

DR. KANE: I'm going to try to briefly reiterate some of the things that came to my mind that some people have already touched on.

One is that I think that the under-65 population, the employed population has, for a very long time, been in managed care networks and HMOs and more strictly restricted

networks. We're pretty much, as a generation, much more willing than my parents' generation to accept restriction. I'm probably going to just keep on going with my HMO if they don't turn into a private fee-for-service plan.

So I think that opens a great opportunity up for encouraging that and trying to find ways to make sure that managed care stays a part of it, and not just a network of discounted fees.

Another thing, and it touches on some of the things that people were saying, but I'm on a board of a group of doctors who deal with chronic frail elders now. They're no longer in nursing homes. Actually, that's a good thing. Where they are now is in congregate housing and assisted living facilities.

We have a special program that we fund through foundations and gifts called House Calls, and nurse practitioners, as well as physicians, provide the care. Through that, we're able to avoid all kinds of hospitalizations and unfortunate accidents.

I think that whole where are elderly going to be living in the future and what does that mean for the types of services they're going to be needing and the type of

payment environments you're going to have be creating is another one.

The third thing that came to mind as we were talking is the possibility of a little bit more global influence on our health care. We were talking a little bit about people going to Mexico and India and Thailand, but also the whole where is the manpower going to come from? Because a lot of our physicians workforce and our nurse workforce comes from overseas. And how might that all change in the next 15 or 20 years as well?

So it's not just looking at the population, but some of the housing structure, labor structure that's likely to be coming about, as well.

DR. CASTELLANOS: I did appreciate this and I know that you mentioned that Hispanic is the largest percentage of ethnic minorities now. Being very sensitive, because I am a Hispanic-American, the Hispanic-Americans definitely have different risks. They have different rates of cancer. And if you're going to look at that as an ethnic group, you're going to have to think of different strategies for control and prevention strategies. They have a higher incidence of obesity. Interestingly, they have less

incidence of adult smoking. The cancers are diagnosed a lot less or at a much later stage and their prognosis on treatment is not as well.

But the cancers that are very common in the Spanish American or the Hispanic American are stomach, liver, cervix, gall bladder, lymphomas and leukemias.

DR. MILSTEIN: This is, I think, really a further amplification on Bob's idea.

One of the things that I've been doing outside of Medicare is beginning to use consumer surveys to test with consumers their openness to various innovations, either with respect to health benefits plans innovations or health care delivery innovations.

It occurs to me that one way of further applying Bob's suggestion would be to think about taking some or all of the options that we've put together on our sustainability of Medicare program list and think about how to translate each of those into something that a civilian could easily understand -- and I think it would be doable -- and then take whatever survey activity we're planning to implement, and think about laying out those options for Medicare's long-term sustainability, both to current Medicare

beneficiaries and to, I guess Medicare's farm team, the pipeline of Medicare beneficiaries, so that you have a sense of where the big deltas are with respect to the potential greater acceptability of some of these options with the incoming class than with the current class.

DR. CROSSON: The assumption underlying this is that over this period of time the eligibility for the Medicare program is not going to change.

DR. REISCHAUER: On the second part of my perspective, that would be open. People are getting healthier, there's more ability to work longer. That creates an opportunity. That's why I was saying look at the population and ask what kind of opportunities it opens up for the future.

DR. CROSSON: So the eligibility, you could argue, might end up at some point going in either direction. We could end up with a Medicare program that was predominantly for older individuals. More recently, I think, some have suggested, as a path to universal coverage, applying the Medicare program to a younger cohort of individuals. So is that in scope or out of scope?

DR. REISCHAUER: It strikes me that that's out of

scope because it's addressing a different problem, which is the uninsured.

DR. KANE: But if the age of eligibility goes up, you're walking right into it. I mean, 68-year-olds -- right now 55-to-64 year olds are among the most vulnerable. Now you're going to make it 55-to-70 year olds? You can't ignore the employment trend and the employer-based insurance meltdown if you're thinking about age of eligibility.

DR. MILLER: In a way, I conceive of this work, and particularly at this stage of this work, as I don't know what is in and out of scope. I think part of the exercise here was let's understand what these trends are and what kind of directions they would begin to start to push, where you'd see the tension points, whether it's eligibility or a specific kind of services or income or whatever the case may be that might say well, should we do something about this? And then I think you address the in or out of scope question. There may be disagreement at that point.

We see this really as just trying to cast ahead and starting to see where the tension points that will fall out of the data.

MR. HACKBARTH: Okay, thank you very much, Dan.

Next up is the congressionally mandated rural hospital report.

DR. STENSLAND: I think as you can remember from last time, Congress has mandated that we conduct a study of certain rural provisions of the MMA. Our report is due this December.

Today we're going to start out by answering some questions you raised at the last meeting. Then we'll discuss economies of scale problems at small rural hospitals and explain why a low-volume adjustment is a more targeted solution than current policy. Then we'll discuss the two draft recommendations we brought up last time and hope to hear some feedback from you regarding those recommendations.

Last time one commissioner asked us a question regarding the distribution of total profit margins at CAHs and a second commissioner asked us about the percentage of CAHs that are for-profit. With respect to profit margins, the mean total profit margin for CAHs was 1 percent, the mean for PPS hospitals was 3 percent. And as you can see from this slide there's a wide distribution of profit margins at CAHs. On average, the distribution for CAHs is slightly lower than the distribution for PPS hospitals.

With respect to for-profit status, about 4 percent of CAHs are for-profit hospitals. These for-profit CAHs have roughly the same distribution of total profit margin as non-profit CAHs.

As you know, Medicare margins are set at 1 percent for both for-profit and non-profit CAHs. What you see here are the total profit margins.

We will now shift from CAHs to PPS hospitals so Dan can discuss the low volume proposal for PPS hospitals.

DR. ZABINSKI: Last month we discussed two provisions from the MMA that augment outpatient PPS payments for rural hospitals. One of these is that MMA required CMS to do an analysis that resulted in rural sole community hospitals receiving a 7.1 percent add on to their standard outpatient PPS payments. In addition, the AMA, together with the Deficit Reduction Act extended what are called hold harmless payments for several years. The idea of the hold harmless payments is that hospitals that qualified received the greater of their payments from the outpatient PPS or the cost-based system that preceded it. The hold harmless payments are intended to be transitional and are scheduled to sunset at the end of 2008.

Because they are scheduled to sunset, we are looking to alternatives to the hold harmless payments as well as to the add on for the rural SCHs. Our motivation for considering alternatives to the two current policies is that neither policy efficiently targets hospitals that are in need or are important to beneficiaries' access to care. In addition, both policies tie higher payments to higher hospital costs without asking why hospital costs are high in the first place. In particular, the hold harmless policy, by its design, can produce higher payments for a hospital if a hospital simply lets its costs drift higher.

However, we're also very aware about rural hospitals having, on average, relatively poor financial performance without any supplements to its standard outpatient PPS payments. Therefore, we set out to develop a method of augmenting the outpatient PPS payments that would better target hospitals that are in need or important to beneficiaries' access to care.

We started by analyzing data on hospital's outpatient costs and outpatient service volume and we found that hospitals exhibit economies of scale in their outpatient departments. In particular, outpatient costs per

service tend to decline as outpatient service volume increases. Also, we have a regression model that predicts that costs per service steadily declines as outpatient volume rises and falls below the mean at about 100,000 outpatient services. Therefore, for our discussion, we'll define a low volume hospital as one that has fewer than 100,000 outpatient services.

We also found that rural hospitals tend to have lower service volumes than their urban counterparts, and we believe this low volume among the rural hospitals contributes to their relatively poor performance in the outpatient PPS.

The purpose of this slide is to show that the SCH add on policy does not efficiently target low volume hospitals. Specifically, 25 percent of the hospitals that receive the SCH add on provide more than 100,000 outpatient services, which is our cutoff for defining a low volume hospital. Because of the empirical finding we have discussed on the last two slides, when the hold harmless payments sunset at the end of 2008, we are considering an approach that would give low volume hospitals a percentage increase over their standard outpatient PPS payments instead

of the hold harmless payments in the SCH add on.

A low-volume adjustment would be more efficient than a hold harmless payment or a SCH add on because it can more efficiently target hospitals that are important to beneficiaries' access to care. Also, it can directly target a factor that affects hospital financial performance and is typically beyond the control of an isolated hospital, that being whether the hospital is low volume or high volume.

On the next three slides, we show the effects of moving from the current policies to a proposed low-volume adjustment. Under current policies, the SCH add on is a budget neutral policy that transfers about $90 million primarily from urban hospitals to rural hospitals. But this policy does not increase overall spending in the outpatient PPS. In addition, there's the hold harmless payments that add $70 million to the outpatient PPS payments for small rural hospitals. But these payments go down to zero when this policy sunsets at the end of 2008.

Our proposal is to replace the current policies with a low-volume adjustment beginning January 2009, after the sunset of the hold harmless payments. In your briefing materials, there's an example of a low-volume adjustment

that has a distance requirement that hospitals must be at least 15 miles from the nearest hospital and uses empirically based adjustment rates that are highest among the lowest volume hospitals and decline as hospital volume increases. We estimate that this policy would add about $40 million to the payments to rural hospitals.

We understand though that some may be concerned about the magnitude of the assistance provided by this low-volume adjustment, so we want to be clear that spending under the low-volume adjustment can be increased by changing the policy's parameters such as the distance requirement.

I also want to be clear that critical access hospitals would not be affected by a low-volume adjustment and would maintain their current cost-based payments.

On this table, I want to draw your attention to the first column of numbers which shows outpatient margins under current law that would exist in 2009. Under this scenario, rural hospitals get the SCH add on but there's no hold harmless payments because those expire at the end of 2008, nor would there be any low-volume adjustments. Hospitals that would be eligible for a low-volume adjustment, if it existed, would have an outpatient margin

of minus 20.3 percent under current law in 2009. Larger hospitals that would not be eligible for a low-volume adjustment would have an outpatient margin of minus 12.7 percent. So this is nearly an 8 percentage point difference between these two groups.

Now I'd like to draw your attention to the third column, which shows outpatient margins under our proposed policy, which means hospitals would receive low-volume adjustments but there would be no SCH add on or hold harmless payments.

The difference between the two categories in this column is much smaller than what we saw in column one. Hospitals that are eligible for the low-volume adjustment would have an outpatient margin of minus 18 percent and the larger hospitals that are not eligible for a low-volume adjustment would have an outpatient margin of minus 16.1 percent. So there's only a 2 percentage point difference between the groups in this column, as opposed to an 8 percentage point difference in column one. So the takeaway point is that outpatient margins among rural hospitals would be more even under our proposed low-volume adjustment than under current law.

We developed this draft recommendation that beginning January 2009, the Congress should enact a graduated low-volume adjustment to the rates used in the outpatient PPS. This adjustment should apply only to hospitals with fewer than 100,000 outpatient services and that are more than 15 road miles from another hospital offering outpatient services.

The spending implications would be modest in that it would add less than $50 million to total budgetary spending. And the implication for beneficiaries is that it would help assure their access to care.

Now I turn it over to Jeff again and he's going to continue the presentation on critical access hospitals.

DR. STENSLAND: As you remember, we also had a draft recommendation to provide CAHs with more flexibility to merge. The draft recommendation now read the Secretary shall allow CAHs to merge and retain their CAH status if one or both of the two closes and the new CAH serves both communities. The new CAH should be allowed to staff enough beds to meet the combined 2006 peak acute census of the two closed hospitals. The new CAH cannot be significantly closer to any PPS hospital than the closest CAH.

As I stated last time, we should not expect to see a large number of mergers. Many small town residents often want their hospital in their town. But in some agricultural areas, farms continue to consolidate and populations continue to decline. We may want to give those communities that are changing the option of changing their structure of the local health care delivery system, especially if a new structure is seen as a more efficient way to provide their communities with high quality health care.

You'll note that this recommendation is a little different from last time. It's been refined to make it clear that the merged CAHs cannot be significantly closer to any PPS hospitals than the closest CAH. We're trying to do that to not allow the new CAH to have a significant competitive advantage over any local competitors.

We've talked to several rural stakeholders about our recommendations. With respect to the first recommendation, some rural advocates would like to see the current hold harmless payments extended, rather than have a low volume adjustment. Hold harmless payments are provided to all high cost providers, resulting in larger transfer of dollars to rural communities. Our alternative targets

hospitals that have high cost due to having a low volume of outpatient services.

With respect to implementing a low-volume adjustment, many rural stakeholders are sympathetic to the idea but they have concerns about how CMS would implement a low-volume adjustment. They point to the case of the inpatient low-volume adjustment where CMS implemented a much more conservative adjustment than MedPAC had recommended.

In response to this concern, the draft recommendation now specifically states that the adjustment would go to all rural hospitals with fewer than 100,000 outpatient visits, trying to clarify where the cutoff would be.

With respect to the draft recommendation on CAHs, I think most rural stakeholders agreed with the concept, in that we don’t want to discourage integration of rural facilities, but they felt very few communities would be willing to close their hospital and merge with a neighbor. So I thought we should maybe discuss briefly how many hospitals may be affected by this recommendation.

Back in 2005, when we look at the distance between providers, we noticed there was about 200 CAHs that were

within 20 miles of another CAH. So you have roughly 100 pairs, or used to have roughly 100 pairs that you consider could be candidates for mergers. There's been some growth in the CAH program since then, so we should have more than 100 candidates.

Of course, when they discuss merger, there's going to be conflicting sides. On the one side, there will be the benefits of economies of scale. On the other side there will be concerns about travel time and the local political desire just to have our own hospital in our own town. These two things will be fighting it out. But I think it's important to note that this is not a static kind of a fight.

And that the benefits of economies of scale may change over time. For example, as the population changes, it may be more important to merge. Even over the last five years, talking to rural hospital administrators, they seem to be more concerned about having a pharmacist onsite. They maybe want a pharmacist at the hospital to check for interactions, to check if the dosing is right. Not all CAHs have a full-time pharmacist. By merging they may be able to have more pharmacy coverage.

Technology costs may change. There may be P4P

reporting requirements. The difficulty of recruiting physicians to practice in a three or four person group rather than a six or eight person group may change over time.

So the idea is that despite the benefits of economies of scale and the local political desire to have our own hospital in our own town, the dynamics of that fight may change over time and this recommendation would provide the communities a little more flexibility to make a change in their decision over time with respect to whether they want to merge.

There is one possible answer, rather than actually taking up this adjustment, would say let's just do some watchful waiting and see how many hospitals come up to us and say we want a change in the law. I think the only concern there would be I think a lot of these small hospitals, when they see the law they say well, that's the law and I'll set my policy and set my strategic plan based on the law. They don't think I'll give Washington a call and change the law.

So there might be some concern that hospitals may be building two facilities nearby to each other rather than

merge because in a few cases they're afraid of losing their CAH status. I did talk to one of the pairs. We have 100 pairs that we think may be candidates for mergers. I talked to one of them. They said they had agreed between the administrators that it would be a good idea to merge, from a clinical standpoint, from a financial standpoint. But the communities basically couldn't agree on whose town gets the hospital. And that's probably going to be the case in 95 out of 100 cases. But this would provide those few other cases a little flexibility.

We'll now open it up to your comments on the chapter in general and these two recommendations.

DR. WOLTER: I guess I worry when I look at the margins under both current law and proposed policy, and I don't know if equalizing margins that are that negative is what I would consider good strategy. So that's one comment.

Then I worry that the provision that we would merge two CAHs into bed numbers in one institution larger than 25 really would create the rationale -- particularly when you look at some of these margins on page 11 -- that there are a number of other institutions that are currently on PPS in the bed range of 25 to 50 that might have good

arguments that they should also go to cost-based reimbursement. And they might have good arguments for that when you look at these numbers.

So I think there's a larger discussion and analysis here about where cost-based reimbursement fits. And we could either open it by allowing two CAHs to merge, and then the discussion will unfold. Or we could face it up front before we make a recommendation like this. So I'm kind of reluctant on that second recommendation, just because I think there's a bigger picture discussion that hasn't occurred.

And then on the issue of the low-volume adjuster, I think in concept that makes a lot more sense than ongoing year after year of hold harmless, because at what point does that stop? But would a compromise be that the hold harmless is put in place in a budget neutral way for say two years, so that we can study what's the right way to do the low-volume analysis to make sure that it kind of is distributed in the right way? Because we're taking a fair amount of money out with the proposal as its currently on the table. So that would be one possible adjustment to the recommendation that might move us to low volume but keep

things budget neutral for a couple of years to really make sure we got it right.

MR. HACKBARTH: When you say study how to do it right, just say more about what you mean.

DR. WOLTER: We're talking about going from $70 million -- and it's more than that if you include the sole community hospital piece -- down to $40 million with the way the low-volume adjuster is currently being proposed. There's a little analysis here of how that might change margins on page 11. But I think there's a desire on the part of those who are in the middle of all of this to understand better how are they going to be positioned to deliver care? And in fact, you mentioned in one of the slides, there could be other ways to set the formulas that could put more or less money in.

MR. HACKBARTH: So like the mileage limit and some of the other variables that you could --

DR. WOLTER: Even the amount of money that flows through the low-volume adjustment system. I think it might give people some better sense of security if we had a period of time where we weren't taking quite so much money out.

That's obviously an off-the-cuff thought.

DR. MILLER: You would keep it hold harmless to the money that's currently in, as opposed to hold harmless when it sunsets? That's your point? You said keep it budget neutral for two years.

DR. WOLTER: I was thinking of keeping it budget neutral to current law, including the hold harmless.

MR. HACKBARTH: So you're saying keep the hold harmless for two more years while we study how to properly do low volume?

DR. WOLTER: No, what I was suggesting, go to low-volume adjustment --

DR. REISCHAUER: You want to do the $160 million for the next two years?

DR. WOLTER: You could come up with a rationale that would either keep the entire amount in, including the sole community hospital, or you could at least keep the $70 million. But go ahead and implement the low-volume adjustment but adjust it so that all of that money is part of the distribution. That's kind of what I was thinking, as a compromise.

MR. HACKBARTH: Increase the conversion factor.

DR. WOLTER: Move away the hold harmless but give

people some --

MR. HACKBARTH: Give people more losing low volume.

DR. WOLTER: Yes, some sense that we're -- because we're not talking about large dollars here in the big picture, but that might allow us to fine tune this a little more effectively.

DR. SCANLON: This is along the lines of where Nick ended up, because I was concerned that this table, in some respects, is allocating the $40 million. And that in some ways we'll focus on these numbers and evaluate the wisdom of the low-volume adjustment as opposed to thinking of the wisdom of the low-volume adjustment more generally, and thinking if we funded it at $70 million or $80 million, what would be the impact. And there's still the issue of those that are not going to be eligible and how they're going to be affected.

But for me, the low-volume adjustment is something where we're doing exactly what you've proposed, which is to target the money by some characteristic of the hospital that they don't control that is influencing their costs, which is one of the basic principles behind the PPS. And I think

that's a very positive thing.

The other thing I'd like to bring up is the whole issue of -- and this relates to the overall margins, is that the Commission has been, in the past, an advocate of or recommended a low-volume adjustment on the inpatient side. But we're not seeing much of an impact of that because of the way it's been implemented. Congress did accept it, it went into statute, but very few hospitals are being affected and you can see that here in the hospitals that are being affected.

If it was implemented the way the Commission had said, there may have been a much different overall margin for the low-volume hospitals.

On the merger proposal, on the one hand, there are all the positive benefits of the mergers. The negatives one can potentially discount a bit by the fact that we don't expect this to happen very often. But it does open the door. It opens the door to this consideration of is there a class of hospitals that has characteristics that are very similar to the merged hospitals and should they now be treated differently? It also opens the door to the future. There are, I presume, some areas of the country where

eventually suburban growth is going to take over enough land that we're going to have new hospitals coming into areas and they're going to be competing with one of these merged hospitals.

I would think at a minimum, if we want to create a carrot for mergers, that it be a transitional carrot and not a permanent carrot.

MR. HACKBARTH: Say more about that, Bill. When people are making capital investment and long-term decisions, how do you --

DR. SCANLON: The idea would be that you give them an incentive where they can retain some of the cost-based reimbursement over a period of time. Maybe it's five years. Maybe it's 10. Over that period of time you phase out costs and you move into a PPS base. Something along those lines.

DR. KANE: I'm just taking a longer term view, looking at both the results of the PPS rural hospitals negative overall margins, whether they're low volume or not. And then the negative margins of about half of the critical access hospitals' total margins. I'm just kind of wondering if there's not some kind of propping up here of institutions that are just not financially viable overall. I don't know

whether allowing either one class or the other, propping either class up, is helping the other class survive.

It's a little unclear to me what we're really trying to accomplish by having -- first of all, two different classes of hospitals, one set on 101 percent of cost and the other one on PPS, neither one of whom looks viable for at least half of them.

It's a broader of question of when you look at this, you go geez, there's an awful lot of hospitals here that don't look very viable.

And to the extent that having a CAH neighbor exacerbates the PPS hospitals' financial situation, but then you're freezing the CAH and its size class because if it moves up it has to into that -- I'm just wondering if overall the whole way we've segmented the rural payment to hospitals isn't freezing both sets of hospitals into really financially disadvantaged arrangements. It just doesn't look very viable without special little prop ups.

DR. REISCHAUER: What's the alternative? No hospital?

DR. KANE: One really might be arguing the same thing about why do you want consolidation. Maybe we have

too many low-volume hospitals out there. I don't know. But I know how hard it is to close a hospital. I agree.

But is there are ways to think about -- I know Maine's hospitals pretty well. And I have seen rural hospitals there do quite well when their relationship is with a central hospital that does provide a 24-hour pharmacist and shares services. And that model looked like it worked. But these models don't look like they work.

I guess that's what I'm trying to get at, are there ways that we can create incentives for the rural hospitals to thrive, rather than kind of barely hang on? Does it require regional affiliations instead of staying by yourself in a 25-bed hospital? But are we freezing them instead into that model, rather than saying why don't you find a big partner who expands your scope of services without adding the overhead by either telemedicine or visiting specialists?

It just seems like this payment method of CAHs up to a certain size at 101 percent of costs and then PPS right over that, a whole bunch of hospitals into financial distress and frozen into models that don't seem to be viable the way the payment system works right now.

MR. HACKBARTH: These issues, as Sheila and other people in the room can attest, have been around since the very beginning of the PPS system. And these various adjustments and special payment methods and levels have been added over the years. And the short version is that they reflect Congress' unwillingness to go the consolidation route and have people travel longer distances, even in many cases recognizing that there's increased expenditures, a loss of operational efficiency, and perhaps even some compromise on technical quality available.

DR. KANE: And you're freezing them into a strategic mindset they can't get out of. That's what I guess I'm trying to get at.

MR. HACKBARTH: I very much agree with your point of view and whenever we've discussed these issues I've expressed concern about freezing the system and what's the impact on nearby small PPS hospitals. We create this ongoing momentum to ever expand the exceptions and special payment rules because every time you do it there's a new group of people just on the border, just outside the rules, and now they want in.

I don't know what the solution is, but that

dynamic has been in place for quite some time now.

DR. KANE: Is there a way to say, instead of saying let's do a low-volume adjustment, to say instead why don't we try to reward critical access hospitals who find partners who help them expand their -- or some viable model? There are rural hospitals that aren't losing tons of money, and there are models of rural health delivery that aren't losers. Is there ways to try to push -- just as we're trying to push physicians, encourage physicians to do more group-based virtual group, couldn't we do the same thing for rural health systems rather than freeze them into this lone cowboy out there in the sagebrush? As an incentive instead of talking about these little fixes. It's already clearly a financially dead system.

MR. HACKBARTH: We've got a number of people, I think, who want to explore that further. I suspect Sheila is among them.

MS. BURKE: Nancy, I think you raise a number of good questions. As Glenn pointed out, this is a conversation that began in the 80s and hasn't changed dramatically except for this tortuous adjustment to unique sets of circumstances. For example, if you look at the

Section 406, it deals with five hospitals. That is the nature and history of this attempt to try and figure out what to do with facilities that are located in areas that are sparsely populated.

There is a unique history of this issue in the Senate Finance Committee, and given its current leadership, that I don't anticipate changing, with Montana and Iowa considerable players in this issue.

But the question you raise, which is is there a better way to do this, there's no question there are unique sets of circumstances in every one of these hospitals and every one of these states. In some cases the partnerships with regional hospitals have been quite effective. In other cases, less so.

There are issues around ownership of some of these hospitals that either encourage or discourage those kinds of relationships.

I think it's a question we should certainly engage. But as Glenn suggested, it is enormously complicated, and the politics of this. In many cases, these are the largest employers in those communities. In many cases, they are the only reason that they have kept a

physician or any kind of a health care system within many miles of other activities. People that don't live in these areas are sort of immune to the fact that while we think 25 miles is not a big deal, except if you live in Butte, Montana and it's winter. And then 25 miles is a long, long way.

I feel like Mary is sitting right here on my shoulder, listening to every word that I would say. And she would say it much better than I can.

But I think the question is a good question. It's one that we ought to engage. I don't think there's a simple solution. I don't think you can force these institutions to essentially come together if there aren't ways to do that or reasons to do that.

It's certainly worth talking with the folks on the Hill as to whether there is a way around this. But each of these is a unique set of circumstances. In some cases they have swing beds. In some cases, they have freestanding psych units or rehab units. In many cases, they are the only long-term care facility availability in a large area and people want to stay closer to home so they've adjusted to those circumstances.

I think we ought to look at it. I think we ought to look at moving them off of being stuck in one place because of these sort of strange circumstances. But they came about because of strange circumstances and unique concerns on the part of Finance and Ways and Means that have adjusted to -- just as we did in some urban areas. I remember only too well moving people across state lines depending on the definition of how they were going to be incorporated.

So I think we ought to ask the question. But again, I don't think this is a simple -- any more than anything else is. It's not a simple solution and each of them are sort of unique. Ralph has certainly talked with and seen a lot of these guys. There is an opportunity for some collaboration.

And frankly, as Arnie was suggesting, things are different now than they were then. We can do things now in terms of capacity with computers and a variety of other -- telemedicine that is relatively new, given the history of the program, that might lend itself to things that we couldn't have done 25 or 30 years ago that might lend themselves to solutions today that we might want to think

about or incentivize in some way.

So I think it's a perfectly reasonable question to ask, but it won't be a simple answer and it's fraught with politics.

DR. STENSLAND: Maybe I could make a little clarification on this slide. I don't know if it's clear, but when we're saying all PPS hospitals, this is urban and rural. So the PPS hospitals in general, their margins aren't that much lower than CAH margins. And the CAH margins aren't just stuck there. There's some movement back and forth between categories from one year to the next.

Like a couple of those in the minus 20 category I called and found out what was going on, why were you minus 20. They had some rationales, their billing system was out of whack or whatever. And now they're in the black.

So there is some movement back and forth. And I think if we look at the other slide here, these negative margins you see overall for these small rural hospitals, negative overall Medicare margins, I don't know if they're really any worse than you would find for urban PPS hospitals who aren't getting IME or DSH payments.

So just trying to clarify that these aren't

dramatically worse than --

DR. REISCHAUER: We can put them out of business, too, right Nancy? And solve the Medicare program at large.

DR. KANE: I'm not saying let's put them out of business. I'm saying let's not, through the payment system, freeze them into a mode where they can't do better by virtue of affiliation, consolidation, virtual networks.

MR. HACKBARTH: What's very much the spirit of the merger proposal. Here's an incremental step we can take so that we don't freeze things in place in an unproductive manner.

MS. BURKE: Can I just add one comment on that, just following up on Bill's point. That is, as you suggest the merger, you don't want to discourage the kinds of behaviors that Nancy has pointed out might well make great sense.

But you also don't want to create another set of challenges with a population of hospitals that are just this side of that and suddenly want to move in where you suddenly expand dramatically a group of people that are caught in this set of reimbursement rules.

So I worry about that as well. And one of the

questions I would have is how frequent has this been an issue? How frequently have these sort of rules prevented or discouraged what otherwise might have occurred in terms of a merger? And is it a problem that is substantial and one that needs to be addressed? Or is it one that we think might be an issue? I just don't want to create an circumstance where the unexpected consequences are far worse than the problem we're facing today.

MR. HACKBARTH: And I think that's a good framing of the issue. There's a potential benefit and also some risk. You only want to go after the benefit if the risk/reward is appropriate. What I heard Jeff say is that at least at this point there's not a long line of people clamoring for this merger opportunity. So we're trying to anticipate, as opposed to react to a heavy demand. Is that right, Jeff?

DR. STENSLAND: I think there's a large number of rural hospitals and about 100 pairs I talked about, maybe a little over 100, that might be candidates for this. And a lot of these are old Hill-Burton hospitals and they're both thinking should we build a new hospital? They may decide maybe it makes more sense to build one hospital with one

covered ER, with one CT. So those would be the questions.

I only heard of a couple places. I talked to people in the different states offices of rural health and that kind of thing and they think well, I may have one in my state that might be interested in. We have two hospitals in the county and they might want to do this kind of thing.

So there's just a little bit of interest out there, but it's probably not the kind of thing where the small hospitals are coming up and thinking of this on their own. It's more they're taking the law as given, and then thinking how am I going to work within the law.

MR. HACKBARTH: Under those circumstances, one potential avenue for us would be to stop short of a bold-faced recommendation and just discuss the issue in the text and then reach out and try see if this is a developing problem. But not try to fix something that's not yet risen to that level and incur some adverse consequences as a result of our fix.

MS. BURKE: And also, if it's a couple of very specific instances where it might arise, look at those instances and find out whether, in fact, it would create an issue. Is there another hospital in proximity? Could it be

a competitor?

If we have the opportunity where it's a limited number of circumstances, let's look at what the reality is. Because that's really the question, is do they then essentially compete with someone who's in relative close proximity? Or are they, in fact, simply consolidating, improving the services, doing a better job, reducing one hospital that isn't needed and still servicing that community?

That's really the question, is does it create the problem we're worrying about, which is that you're going to have another group of hospitals that are right there, just over the bed size or just over the line who will suddenly want to move to cost-based reimbursement?

So I think if we've got the chance, let's look at the circumstances.

DR. HOLTZ-EAKIN: I agree those are the right issues but I guess what I thought I heard Bill Scanlon say struck me as exactly the right solution with the transition to PPS. Is there -- if that's really wrong, I'd like to hear why. It seems like a sensible way to go and I would endorse it.

Bill just said look, let them merge. But don't freeze them in this status forever. Make a transition to PPS over an appropriate horizon. That strikes me as exactly the right solution. It allows for the planning and all the issues you're worried out. You know what the future it, but it doesn't create another inequity as a result of this.

DR. STENSLAND: I have talked to a few hundred hospitals out there, and I think they would be reluctant to do that. Because they are going to have some long-term debt here. If they build a new hospital they're going to have a 30-year mortgage.

And I'm afraid they're not going to have faith in what PPS rates will be 10 years down the line. They're kind of making a bet that Congress is going to have reasonable PPS rates for small rural hospitals 10 years down the line and I'm afraid they might be fearful of that.

DR. HOLTZ-EAKIN: That's true in the whole system at some level. And on the low volume, that strikes me as a very sensible way to go. What you like to have people do is deliver services efficiently and also take advantage of economies of scale. And if, as a policy matter, you want to preclude their ability to take advantage of the economies of

scale, then you're going to have to pay them for the difference.

But you want to make sure you get the efficiency first and compensate for lack of economies of scale. This is a good way to do it. It doesn't solve all of the problems but it strikes me as a step in the right direction.

DR. WOLTER: I think the history of this had good motives. It was pioneered in Montana. And at that time these were called medical assistance facilities and there really was the intention that there be a reasonably significant number of miles between facilities and there was some kind of limits on what services could be offered.

I think what's really confounding the situation now is that, as we move the bed size up and the mileage requirements down, there's great concern that is that really an appropriate place for a program like this?

That was discussed, I think, in some depth by us the last time we did a rural report, which by the way I thought was really well done. My sense of where we are on this is I think over this next year or two we should do a fairly good analysis of what is happening to the annual increase in costs in critical access hospitals? How much

new capital investment is there? And are we going to get to a point where we really do need to reconsider is it appropriate to have critical access hospitals 15 miles from one another? How many of them? Do we need to revisit state standards versus national standards? Although the ability to use state standards now is gone.

So I think there is some future analysis here that will be very, very important.

The other thing I'm remembering is that in the analysis done when the program was expanded to critical access hospital, the real issue was outpatient payment. As I'm recalling, that's where the losses really were in these small facilities. Most of them on the inpatient PPS side actually did sort of okay.

And so I think that's another good reason to consider an outpatient low volume adjuster. Because if you do feel there is a place in America where rural health care is important, and you can't create the same economies of scale or have enough volume for a PPS system to create the right averaging, a low-volume adjustment is probably a nice policy. And maybe that's a stepping stone to reexamining what's the future of the program? And is there a place to

bring PPS back in on the inpatient side.

So I don't think this is a definitive final decision for us, certainly. But we're kind of where we are and it's still a relatively new program for many of these facilities. The issues Sheila pointed out, it's not just about Medicare and health care. This has got so many political and economic and other aspects for these communities.

So I think a low-volume adjuster, if we keep the money in the pipeline for a couple of years to really understand what we're doing might make sense. I'm really reluctant on the merger piece because it just raises so many other, bigger questions.

DR. SCANLON: Just quickly, because Nick covered what I wanted to say.

I want to emphasize, we shouldn't think of this as a low-volume adjustment alone. We think of a low-volume adjustment for isolated hospitals that we want to keep. And we've got a parameter in this which is the distance, and maybe not the best parameter in terms of identifying the hospitals that we want to keep. But that's what we need to care about because there are hospitals that are going to be

in a very precarious position financially. Probably even if they were to affiliate, they couldn't necessarily get all of the economies that are going to put them into a positive margin. And yet we want them there because of the point Sheila was making, 15 miles or 20 miles in Montana in the middle of winter is very different than it is around here.

So think of it in those terms. If we can target it even further than just low volume, we'd be better off.

DR. BORMAN: I think the notion of the transition that's been proposed is a good one. I am in a state that has a couple of clusters of population and lots of places that potentially come into these very sorts of categories.

I think, frankly, what needs to apply here, and I think maybe this is part of Nick's idea of the going forward analysis, as we're looking at other aspects of the program in terms of quality, we need to ask are there some quality items here that apply to this group of hospitals to which we can start to tie some of these considerations? Because for example, what I see at the big cluster population is that lots of things are getting done at these kinds of places that end up being repeated at my place because they've not been done in a quality way. And all that is translated to

is a delay in patient care.

I think on the provider side there are some significant issues in that there are some data that would suggest that recertification, that board recertification at the second or third interval, 20 years or 30 years out, is clearly a higher failure rate for individuals in rural practices, on the specialty side, at least. And so I think there are some potential quality issues out here.

That has to be balanced, of course, against the issue of access of care. And of course, that starts to certainly feed into the politics of it. But I think access to what kind of care? That starts to feed in a bit to the coordination, the issue of quality, who many of certain kinds of things do you have to do to do it in a quality way? And the notion that every little place can retain a specialist in everything, or even three primary care physicians, may not be a viable position going forward, particularly if we apply technology, as Arnie has suggested.

So I would like to maybe see this go forward with the idea if there is additional study that it start to look at some of these quality and practice kinds of things as an idea of how do we better shape this in the future?

MR. HACKBARTH: I want to take a couple of minutes to just try to nail down where we are because this is a mandated report that's due in December, December 8th. So we'll need to take our votes on any recommendations next month. So I want to try to make sure that we have the right draft recommendations when we come back next month.

Let me just start with a general comment. I always find these rural issues difficult to deal with personally. In some respects, to me, they're sort of like IME and DSH. The scale is very different, the locations are very different. But in terms of the policy context, there are some similarities.

I sort of think like Nancy. I'm inclined to say let's pretend we could start with a clean piece of paper. How would we want to design the payment systems to reward the development of a high quality, efficient system. But that's not how the political process is working on this issue or this group of issues, or on IME and DSH issue.

In each case, Congress has repeatedly expressed a preference for a different approach, which wouldn't be the one I would take. But it's there.

So what's MedPAC's role in that circumstance? I

don’t think our role in either IME and DSH or in these rural hospital issues is to simply throw in the towel and say well, Congress wants to do it its way and therefore we won’t say anything at all.

I do think though that we need to recognize the political realities and try to suggest ways to better target resources that are being put into the program and get improvements at the margin if we can’t start with a fresh piece of paper and redesign the whole system.

I think that the sort of recommendations that Jeff and Dan brought are in that spirit. Can we target the resources a little bit better on the institutions that we most want to keep. So I think we’re in the ballpark.

Now I’ve heard different options laid out on each of the two issues. Let me start with critical access hospitals. I’ve heard three basic options be put on the table. One is the current recommendation that was presented by -- would you put up the critical access recommendation? This is one of the options.

The second option is to say well, this whole thing isn’t quite ripe yet. We don’t have a lot of CAHs asking to be able to merge and maybe we ought to just let it sit for a

while and monitor the situation and see whether we should do something when there's more evident demand for a change in policy.

And then the third possibility is the one that Bill Scanlon first proposed, which would be to say yes, you can merge and keep critical access status for a period of time, but then you convert over to PPS.

I think those are the three options that I've heard. Any others that I missed?

Hearing none, what I'd like to do is get a sense -- these are not final votes. I'm just trying to get a sense of where people are. How many of us would like to see the recommendation that's on the screen be the one that we consider at the next meeting?

How many would like to see us not make a recommendation at all and continue to study and monitor the situation?

How many would like to go with the temporary CAH status coupled with conversion? You're going to make this difficult, aren't you?

DR. KANE: Could we add coupled with conversion to PPS for inpatient? Didn't we hear that the problem is on

the outpatient side?

MR. HACKBARTH: So convert to PPS after some period for inpatient but allow them to keep cost reimbursement indefinitely for outpatient would be another iteration. Does that change any perspectives?

I think we had a slightly larger number in favor of let's just hold off for now.

DR. REISCHAUER: Does hold off mean not even discuss the issue at all?

MR. HACKBARTH: No, discuss it in the text but stop short of a bold-faced recommendation.

DR. REISCHAUER: I would assume that the discussion would lay out some markers, such as if we went in this direction it would be important to have it a gradual transition, a marker.

MR. HACKBARTH: Yes.

DR. MILLER: I also think the notion of if we're removing barriers, let's talk about barriers broadly, the notion of moving into groups versus just consolidating a couple of hospitals.

I also think there was Nick's point early on about what are the implications for cost reimbursement generally?

We could have a discussion about this without making a recommendation and sort of cover all of those points.

MR. HACKBARTH: Rather than put ourselves in a position where we've got some significantly divided vote, I'd rather take that approach, of discuss in the text and, as Bob says, lay out some markers, discuss some options but stop short of a bold-faced recommendation if people feel comfortable..

MS. BURKE: One of the things that's not clear to me, it wasn't clear in the context of this recommendation or even in the context of let's transition them to PPS. It's not clear to me what we're assuming. Are we assuming that the end result needs to be literally the combining of the two so they're now a big? Or is it that they combine the two but they stay small?

I mean, it sounded like the presumption was if they merged they would simply -- you know, one and one is two, and that's the new one.

DR. KANE: It says combined 2006 peak --

MS. BURKE: My point is what do we think the new thing would be? Would it necessarily be simply a doubling of what exists in each of the independent places now, by

literally the combining because it addresses their peak periods? Or is it that we would imagine they combine, but they combine smarter, they do better systems, they collaborate with somebody?

I mean, one of my concerns about this was it presumed what the end was. And it's not clear to me -- I mean, whether they go to PPS or not, in part, depends on what it is they become. It's hard to know --

DR. SCANLON: I assume that the assumption was that they were going to be big enough after they merged not to qualify as critical access anymore.

MS. BURKE: That's the question.

DR. SCANLON: There's certainly no barrier now to merging and still qualifying.

MS. BURKE: But to Nancy's point, what is it we want to encourage? Is there a way, if we're going to look at this going forward, what do we want to encourage them to do? Is it simply to become big enough that they're now out of critical access? Or is it to remain smallish but to be smarter to collaborate with somebody?

What I'm trying to suggest is that we ought to think about what we want them to become, how we create those

kinds of incentives, whether or not they end up being appropriately treated in PPS or whether they have to stay in a CAH because they're small enough. I don't know what we're presuming we want the answer to be. But that's presumably what we want to encourage is that kind of a consideration.

MR. HACKBARTH: But in terms of what we consider at the next meeting, what you're adding is sort of another dimension of complexity to this, which I think argues in favor of no bold-faced recommendation at this point.

MS. BURKE: I agree.

DR. CROSSON: Another part of the option that we might want to consider would be to recommend -- we heard that there's not that many hospitals that want to do this. We've also heard that we really can't figure out how they would end up. So another possibility would be to encourage a very small pilot or a sunset thing where you could say to CMS why don't you do a pilot of up to five or 10 of these things, and then study them over a period of a few years, and then we could learn more about the dynamic.

MR. HACKBARTH: If I may, I'd like to move on to the low-volume adjustment and recommendation. Would you put that up?

Here I hear two options having been put on the table. One is the draft on the screen. The alternative was the one that Nick offered, which is to say to go with the low-volume adjustment as a way to better target Medicare's investment in these institutions. A low volume, as Bill puts it, plus distance requirement. Low volume for isolated institutions. But ease the transition by temporarily keeping all or part of the additional payment in the system. So it's a middle ground, if you will, between endless hold harmless and immediately to the PPS with low volume.

Who would prefer to see us stick with the recommendation on the screen?

DR. HOLTZ-EAKIN: I'm not clear what Nick's proposal is?

MR. HACKBARTH: It's basically put more money in. Keep at least some of the difference --

DR. HOLTZ-EAKIN: To people who don't quality --

DR. REISCHAUER: Forever?

MR. HACKBARTH: No, they'd only get it if --

DR. HOLTZ-EAKIN: It only goes to the low-volume.

MR. HACKBARTH: Right.

DR. HOLTZ-EAKIN: Who's in transition [inaudible].

MR. HACKBARTH: I don't want to put words in your mouth, Nick.

DR. WOLTER: We currently have what, $70 million that's going related to the hold harmless and how much related to the sole community hospital?

DR. ZABINSKI: $90 million, but that's budget neutral. It's a shift of money primarily from urban to rural.

DR. WOLTER: My thought was part of what might create a little confidence that trying to use the concept of low-volume adjustment, as opposed to endless renewals of hold harmless might be if we tried to keep this budget neutral. Instead of going from $70 million to $40 million, we would try to put more money into what's returned in the low-volume adjustment but recommend going to low volume.

DR. HOLTZ-EAKIN: But some of that $70 million is going to hospitals that won't get anything, that are high volume. So you're more than budget neutral for the people who are making the transition. You're throwing a lot of money at them and then taking it away later. I don't see why we want to do that.

DR. WOLTER: One reason I'd like to do it is I'm

looking at the negative margins that they're facing.

MS. BURKE: The winners or the losers.

DR. HOLTZ-EAKIN: These are the winners.

MS. BURKE: I understand but the question is are you worried about the [inaudible]?

DR. HOLTZ-EAKIN: I'm utterly heartless and I'm not in this. I just want to understand it.

MR. HACKBARTH: So Doug's point is that if you go to a low-volume adjustment, only some of the hospitals currently benefitting from the hold harmless are going to quality. If you take the full pot of money and put it into hold harmless, you're actually elevating the payments further to the institutions who quality for the low-volume adjustment and then the others get zero.

DR. REISCHAUER: You could just phase this in and the first year do a third, the second year two-thirds of both of those pools.

DR. WOLTER: There would be a lot of ways to do it. The other way you could do it is increase the number of procedures that can be done relative to the payment for low volume, and then that would affect more institutions. I mean, there would be a lot of different ways to try to keep

some of this money in the system.

MR. HACKBARTH: Rather than trying to invent those on the spot, let us think about those options. Before the next meeting I'll be talking to you folks on the phone and we'll try to craft something that will work for the next meeting.

DR. KANE: I just want to be sure I understood, that the sole community hospital $90 million isn't in this transfer to the low-volume hospitals? Or is it?

DR. MILLER: It was in the proposed recommendation.

DR. KANE: You were taking $160 million, lowering it to $40 million?

DR. MILLER: Remember, $70 million of it sunsets.

DR. KANE: But you were going from $160 million down to $40 million?

DR. MILLER: That's correct.

DR. KANE: I thought it was $70 million down to $40 million. Now I understand, it's $160 million down to $40 million.

DR. MILLER: That's correct.

DR. KANE: Is what the recommendation is. So the

rest goes back to the urbans.

MR. HACKBARTH: We will come back to this next month, for the last time in this cycle anyhow. Thank you very much, Jeff and Dan.

Now we have another presentation which will be equally easy, IME and DSH.

MR. ASHBY: I'd like to start today by presenting a couple of supplements to the data that we presented at the last meeting, items that commissioners have asked about.

Then, also relating back to the last meeting, our discussion brought out a wide range of perspectives on the current levels of the IME and DSH and we thought we would summarize some of those key issues for you today.

And then finally, we will present the results of two analyses we've done relating to two of the issues that have been raised. That would be the relationship of teaching and low-income patient care to hospitals' cost and the relationship of IME and DSH payments to hospitals' uncompensated care.

And we'll return to others of the issues that you have raised at later meetings.

Our presentation last time included the

distribution of combined add ons for those hospitals receiving both IME and DSH, and that would be the last line on this chart that we have here. But the question came up about how the add on split between IME and DSH for those that received both payments. Over all hospitals, and that would be the top half of the chart, DSH payments dominated over much of the distribution. For example, the 75th percentile of DSH payments among all hospitals is 10 percent, while the 75th percentile of IME is 1 percent.

This mostly reflects the fact that about three-quarters of all hospitals receive a DSH payment while only 30 percent receive an IME payment.

MR. HACKBARTH: Could you say that again? It's 10 percent of what and 1 percent of what in the example you just gave?

MR. ASHBY: Among all hospitals, among all 3,500 hospitals, if you array them from low to high on their DSH adjustment, the 75th percentile would be a 10 percent add on.

If you did the same for IME, if you arrayed them all, many of which are zero. But if you arrayed them all from low to high, the 75th percentile hospital gets only a 1

percent.

MR. HACKBARTH: We're still talking add ons to base payments in this table?

MR. ASHBY: Right, but in the second half of the chart, we're looking solely at the hospitals that get both IME and DSH. And we see, though, that DSH still accounts for more of the add on payments than does IME.

So again, looking at the 75th percentile, you'll see that the 75th percentile adjustment, just among those getting both, is 21 percent and the 75th percentile is 15 percent for IME. At all of the points that we see here, the hospitals are getting more from DSH than they are from IME. But you'll notice that as we move towards the higher end of add ons, the IME begins to play more of a role.

Another question that came up is how hospitals receiving the largest IME and DSH add ons break down by type of control. For reference here, we show the shares of non-profit, for-profit and government hospitals industry-wide at the right side of the table. Then among those receiving the largest DSH only payments, we have a somewhat surprising representation of for-profit hospitals, 36 percent of those DSH only hospitals are for-profit. The IME group is almost

completely non-profits, 94 percent, as you see. And then among those getting both IME and DSH payments, we have somewhat of an over-representation of government hospitals, 36 percent of those are government hospitals. And a number of these are the large inner city public hospitals like Grady Memorial in Atlanta, Bellevue Hospital in New York, that sort of institution.

Turning to the issues that you raised at the last meeting, one side of the argument on the appropriateness of the DSH and IME payments being much higher than the empirically justified level centered on the accuracy and equity of payments. Under this view, the primary goal of Medicare ratemaking is to make the best possible estimates of the cost of services, and that would be the cost of efficient providers to the extent possible. And then to align payments as closely as we can to those costs.

IME and DSH payments have distributed large sums of money in a way that is poorly related to the costs of treating Medicare beneficiaries and the result has been inequitable payment outcomes.

The other side of this issue is -- the other side stresses the importance of the teaching and social benefits

that hospitals provide. This side notes that Congress made a conscious decision to double the IME adjustment rate because analyses conducted by CBO at the time had suggested that teaching hospitals would fare poorly under the PPS.

We went back and located that CBO analysis from actually 23 years ago. We found that CBO had estimated that with the introduction of the PPS teaching hospital payments would go down by 7 percent and payments to non-teaching hospitals would go up by 7 percent. So all else being equal, that would put teaching hospitals 14 percentage points behind on the inpatient margin. And all else being equal, doubling the IME would bring hospitals closer, but not quite to parity with non-teaching hospitals.

We all know that that isn't the way it turned out. In the first year of PPS teaching hospitals' margins were 5 percent points higher than non-teaching and that gap has widened over time. Several observers have suggested that the reason teaching hospitals fared better than CBO was expecting was because they substantially improved their coding of DRGs. We have to remember that before PPS, most hospitals had almost no experience with patient classification.

Returning to the argument, it was pointed out that in addition to teaching hospitals' role in graduate medical education, that hospitals of all kinds, teaching and non-teaching, DSH and non-DSH, provide other social benefits. These include uncompensated care, broad-based community services like patient ed and screening programs, especially services that frequently operate at a loss, like trauma care, burn care, and so forth, and standby capacity for responding to natural disasters, potential epidemics and the like.

Finally, it was pointed out that IME is not the only payment mechanism that serves a broad social goal. We have several rural payment mechanisms, some of which we just talked about, that are aimed at protecting access to care in rural areas. That's sort of the prime example.

If the federal government is to have a role in underwriting social benefits that hospitals provide, the obvious question then is what's the best way to provide the funding? One side of the argument here is that the best funding source is general revenues, allocated through the appropriations process. These are public goods that we're talking about that benefit all patients. In fact, arguably

they benefit the entire population, so ideally society as a whole, through some sort of broad-based revenue source, should provide the funding.

This side also argues that it's not clear how much of the IME and DSH monies have actually gone to paying for social benefits, rather than to improving the competitive position of hospitals that receive them.

Then on the other side of this particular argument, the other side is that IME and DSH adjustments are an appropriate way to fund social benefits, although it is difficult to account for hospitals' use of the funds. Some of the commissioners noted that an advantage of using the IME and DSH adjustments is that they are protected within Medicare's mandatory funding while appropriations are subject to uncertainty and change.

And finally, that if broader based federal programs are to be used for funding social benefits, Congress should create and fund the alternative before the subsidy portion of IME and DSH is redistributed.

Those are essentially the arguments that were laid out. And now we're going to focus on one particular issue, one of the several issues on the table, the effect of

teaching and care to the poor on hospitals' costs.

MR. LISK: Good afternoon. I'm going to tell you about our analysis on the relationship between Medicare costs and teaching and care to the poor. In this study we used regression analysis to estimate the empirical effect of both teaching and cost of care to the poor on hospitals' Medicare costs per case. Our analysis uses 2004 Medicare cost reports.

In looking at costs per case, we were looking at the operating capital cost together. Per case costs were standardized for wages using Medicare's wage index. They were also standardized for case-mix and outlier payments using the Commission's DRG refinement proposal.

Regressions were also run using the 2004 DRGs as they were in place at that point in time, and I will note what differences we have in the results as I go along.

Our analysis controls for cost-related payment factors. On the left-hand side of the regression we include as independent variables resident intensity in our IME regression. And when looking at DSH we also include low-income share as an independent variable.

This approach in coming to the empirical level

allows the resident-to-bed ratio and low-income patient share variables to pick up the effect of any remaining variation in costs not accounted for in the payment system. This approach could lead to result in an upward bias in our estimate of the empirical effects of teaching and low-income care to the poor. Our empirical estimates will be lower if we controlled for other factors such as bed size and standby capacity, for instance.

Let's first turn to our results on the IME analysis. The empirical level of the IME adjustment is a measure of how different teaching hospitals' patient care costs are compared to other hospitals after controlling for payment system factors. Our analysis shows that teaching hospitals' costs increase about 2.2 percent for every 10 percent increment in the resident-to-bed ratio. It's 2.1 percent not accounting for the DRG refinements, so just slightly lower.

Our estimate of the empirical effect is substantially less than the current payment adjustment, which in 2007 is 5.35 percent and will be 5.5 percent in 2008. The current IME adjustment is roughly 2.5 times the empirical level. In 2004 roughly $1.9 billion out of the

$4.9 billion in total operating capital IME payments could be empirically justified. Thus, about $3 billion in IME payments went to teaching hospitals beyond the cost effect of teaching.

This next graph here shows how IME adjustment changes with increases in the resident-to-bed ratio. It provides you with a visual look at the payment adjustment and the cost relationship. The top green line is the current adjustment and the orange bottom line is what the adjustment would be set if it was at the empirical level. As you can see, there is a big difference between these two lines. This difference shows the amount by which teaching hospitals are being paid over the empirically justified level. The higher you go in the resident-to-bed ratio, the wider the gap becomes.

We also show in this graph the yellow line, which is our empirical estimate that was based on the 1999 data when we estimated the relationship to be 2.8 percent for each 10 percent increment in the resident-to-bed ratio. Our research has consistently shown, if we look at our analysis over time, that the level of the IME has been going down consistently from one analysis to the next.

Some policymakers have noted that teaching hospitals are often major providers of standby services, and they have suggested that the IME adjustment covers some of the higher costs associated with these services. In our analysis we added selected standby services to our regression equation, which already included the resident-to-bed ratio, to observe how the provision of these services is related to patient care costs. What we found was the per case costs were higher in hospitals with standby services, roughly 4 percent for hospitals that had Medicaid certified transplant centers, 3 percent for hospitals with certified burn care, and 1 to 2 percent for hospitals with trauma care.

Of course, there were other standby services that could be considered but these were the ones that we could easily do in our analysis.

With the introduction of these variables into the regression, however, the IME coefficient dropped substantially, from 2.2 percent to 1.4 percent, which means that the 2.2 percent empirical IME estimate captures more than just the cost effect of teaching. It’s picking up some of the effect of these other services.

This next slide shows how the provision of these selected standby services are concentrated. We identified teaching hospitals based on the ratio of residents-to-bed, and that's shown on the left-hand side. We find that a large share of teaching hospitals with a resident-to-bed ratio of 0.5 or better provide these services. The proportions fall as you go to hospitals with lower levels of resident intensity or to non-teaching hospitals.

What's also important to get across is that not all teaching hospitals provide these services, and that these services are not exclusively provided in teaching hospitals. 91 out of 143 teaching hospitals with an IRB over 0.5 provided trauma care, for instance. But there were also 143 non-teaching hospitals that also provided trauma care.

Something we also looked at was whether academic medical centers, which are the primary teaching hospitals for medical schools, might have higher costs compared to other teaching hospitals. Costs in AMCs may be higher because of the participation of medical students in addition to residents in patient care delivery and the hospital and physicians, with their close ties to the medical school, may

affect patient care delivery in those settings.

Our analysis separated teaching hospitals into two groups, academic medical centers and other teaching hospitals. We found that AMC costs increase about 2.6 percent for each 10 percent increment in the resident-to-bed ratio, and other teaching hospitals the cost increase was 1.5 percent for each 10 percent in the resident-to-bed ratio. So there was a fair difference there.

We also identified hospitals that received a large amount of research funds as reported on the Medicare cost reports. Research funds may be an indication of hospital's missions, but we did not find a cost relationship here.

Some of the commissioners raised the question of whether better measures of resident intensity are available. Resident-to-bed has been the traditional measure used in most research that examines teaching hospital costs. Some of the criticism of the measure is that it does not reflect actual patient load and that the IME payments can also increase if hospitals take beds offline.

Alternatives to the resident-to-bed ratio include residents-to-average daily census, which does reflect the inpatient load of patients. But one of the concerns with

this measure relative to the resident-to-bed ratio, is that it would provide higher IME payments to hospitals with lower occupancy rates and lower payments to hospitals with higher occupancy rates.

A third measure that has been used in some research is a straight count of residents. An advantage to this measure is that the adjustment is not tied to inpatient care alone. Under this approach, hospitals with the same number of residents would get the same payment add on. A 500 bed hospital with 10 residents would get the same payment add on as a 100 bed hospital with 10 residents, for example, but the 500 bed hospital would get five times as much IME payments, assuming the patient volume in the 500 bed hospitals is five times as great.

All three of these measures produce similar estimates of the total cost effect of teaching in aggregate.

Now I want to move on and discuss the DSH adjustment. In this analysis, we measure what relationship might exist between Medicare costs per case and the low-income patient care percentage used in the current DSH formula. Entering low-income patient share into the regression along with resident-to-bed ratio, we found that

the cost for teaching increases about 0.4 percent for each 10 percent increment in low-income patient share. This is doing the relationship across all hospitals.

A stronger and much larger effect is observed, though, if we limit our look of low-income effect to urban hospitals over 100 beds. In this case, costs increase 1.4 percent for every 10 percent increment in low-income share. The effect, not accounting for DRG refinement, is 1.6 percent per 10 percent incremental in low-income share. So it's a little bit higher under the current system.

The cost effect of treating a large share of low-income patients, therefore, comes to about $1.7 billion. DSH payments in 2004, however, totaled $7.7 billion, therefore about $6 billion over the empirical level.

The cost effect is substantially less than what the adjustment currently is. If we look at this chart, the green line shows the payment effect for urban hospitals over 100 beds. The orange line shows the empirical cost effect for this group. The gap between the two lines essentially shows how much more we are paying than the empirically justified amount for DSH. In other words, the subsidy being provided to these hospitals over and above the cost

relationship. As you can see, the gap widens as we go to higher levels of low-income patient share.

The yellow line shows the payment adjustment for rural hospitals and urban hospitals under 100 beds and our analysis found no positive cost effect for this group. Thus, the difference between the yellow line and the bottom of the graph is really the subsidy being provided to these hospitals above the cost effect.

It's also important to point out that there are some interactive effects of DSH and teaching. With the introduction of low-income patient share for urban hospitals over 100 beds in the regression, the IME coefficient drops substantially from 2.2 percent 1.7 percent, which means that the 2.2 percent empirical IME estimate captures some of the cost effect of care to low-income patients.

The total non-cost related subsidies provided for IME and DSH adjustment in 2004 totaled over $9 billion. In other words, less than $4 billion out of $13 billion total IME and DSH spending in 2004 could be considered cost related, empirical to higher cost in those facilities for Medicare patients.

Before Jack moves on to discuss the relationship

of these things to uncompensated care, I wanted to lastly move on to discuss capital payments and whether a separate capital payment system with separate payment adjustment needs to be maintained. As we pointed out at the last meeting, hospitals have no obligation to spend payments on hospital construction or equipment purchases and that operating and capital payments can be used interchangeably. Thus, there really is no need to maintain separate payments with separate payment adjustments.

Despite this, we wanted to see what differences there might be in the cost relationships and essentially this is what we found. The empirical estimate for teaching for capital costs alone was about half the operating adjustment. That for DSH we did not find any significant cost effect with low income patient share, and this was true for large urban hospitals where the current capital payment system provides a 3 percent payment add on. Again, we found no cost effect here.

So the combined adjustments that we report on throughout the paper are essentially a weighted average of the operating and capital adjustments that you see.

With that, I'll have Jack move on to discuss

uncompensated care.

MR. ASHBY: In this analysis, we compared the uncompensated care hospitals provide -- measured as a share, by the way, uncompensated care costs as a percentage of total costs -- compared those shares to the IME and DSH payments that they receive. Our primary data source for the analysis was the reporting systems of the five states you see listed here, using data that was compiled by GAO.

This source offers several advantages. First, the reporting is mandatory, so we cannot have sample bias within any one state. Second, the hospitals must follow specified reporting guidelines put out by the applicable state agency, although those rules are not necessarily the same in every state. And thirdly, the data are frequently, although not uniformly, audited.

These five states account for about one-quarter of all PPS hospitals, but of course we are left without representation from the rest of the states. So we replicated the exact same analysis using data from the American Hospital Association annual survey where there is less monitoring of what hospitals report as uncompensated care and there’s no auditing but where we do have data from

all 50 states and D.C. We found basically that the patterns that we'll be looking at in the next couple of charts are basically the same with either data source.

In this graph, we divided the hospitals into 10 equal sized groups according to their uncompensated care share. Group one devotes the largest share of their resources to uncompensated care and group 10 the smallest.

As you can see, the uncompensated care is quite concentrated. The top 10 percent of hospitals provide 41 percent of all unpaid care. But we found that IME and DSH payments are poorly targeted to individual hospitals' uncompensated care shares. The decile group accounting for over 40 percent of the uncompensated care receives only 15 percent of the IME payments and only 10 percent of the DSH payments. And then, at the low end of the distribution, the groups are receiving higher shares of IME and DSH than their uncompensated care alone would dictate.

In this next chart, we focus on hospitals with the largest DSH and IME add ons. That was defined as those above the 75th percentile of add ons. This analysis provides more evidence that DSH and IME track poorly to hospitals' uncompensated care shares. The hospitals getting

the largest DSH only adjustments have uncompensated care shares that are below the average of all hospitals. That would be 5.0 versus 6.6 in the first column. And hospitals getting the largest IME-only adjustments have even smaller uncompensated care shares, 39 percent on average. And you'll notice that their uncompensated care tracks below the average of all hospitals throughout the distribution.

Then hospitals getting the largest DSH and IME payments, and we have to keep in mind that in this group every hospital is getting at least a 35 percent add on, these hospitals do have uncompensated care shares well above average at 14 percent. But as you can see, that average is an amalgam of some unusually high shares, the 90th percentile is 28 percent, but also a substantial number of quite low shares.

So it would appear that hospitals most involved in teaching and those treating the most Medicaid and low-income Medicare patients are by and large not the ones that devote the most resources to treating patients who are uninsured or have large copays they cannot pay.

For a number of years now policymakers have been considering options for the federal government to help

hospitals with their uncompensated care costs as a number of states have done. This could be done within the Medicare payment system or, perhaps more logically through a broader mechanism funded by general revenues or a provider tax.

To support such an initiative, Congress, in the BBRA, mandated that CMS collect uncompensated care data from all PPS hospitals and CMS has done so. But as we said at the September meeting, the effort has not resulted in reliable or consistently reported data.

We've been working with CMS on revising the forms and instructions, and we had quite a bit of input from experts in doing that, including Nancy Kane. But even with that effort, we are at least two years away from having usable data.

That completes our presentation. With this new information, particularly the data on the empirical levels and the uncompensated care, you can continue your discussion of the equity and the objectives of the DSH and IME adjustments.

MR. HACKBARTH: I'm guessing Ralph has something to say.

MR. MULLER: I must say after the discussion last

time on critical access, I regret I forgot to bring my cowboy hat today.

But I think one of the concerns we've had over the years were the higher inpatient margins, obviously, in these hospitals. So I just want to make some points I've made before.

Let me start with DSH. The way the DSH calculation is done in statute, by looking at both Medicare and Medicaid patients and then comparing to costs, we obviously, by definition, have a high margin because we don't have the Medicaid patient in the cost base. So by payments appropriately so in the policy for Medicaid patients but not having them in the base, the denominator is obviously lower. So just by definition we're always going to have a high DSH margin. I try to make that point each time we discuss this, that you, in some ways, expect to have high DSH margins because that's the way the program is defined.

Let me talk about the IME. I'm very grateful for the data on page three, because I think oftentimes we look at the high inpatient margins in teaching hospitals. By the nature of our conversation we tend to focus an awful lot on

the IME adjustment. And I think this table shows that it's driven as much, if not more, in most cases by the DSH adjustment. It's just something for us to remember, that it's as much DSH driven as IME driven. So that by just looking at most of our discussion -- I regret I wasn't here last month. But even looking at the discussion last month in the minutes, almost the entire discussion was around IME and the empirical factor, not so much on DSH. But the margins here are more DSH driven than IME.

I think they both have very worthy social purposes, but we tend to focus, in terms of remediation, on what we should do about the empirical factor.

I also want to remind us that while the teaching hospitals and the urban hospitals have higher inpatient margins in Medicare, they do have lower Medicare margins and they definitely have lower total margins. So in terms of our concern, this is in the text as well, that perhaps these high Medicare margins are used for some kind of competitive advantage. I think I'm paraphrasing the phrases in there.

The fact that they have lower total margins and have negative operating margins is an indication that they may not be using this for a competitive advantage but one of

the important purposes that IME has served in these 23 years is, as the original congressional intent indicated, and I think Jack corrected quoted it, was in fact to equalize the playing field a little bit for the relative disadvantage that teaching hospitals have in general in the competitive environment largely because of all of the social functions and uncompensated care that they provide.

I know this commission, in the past, has not wanted to focus as much on total margins. But as I think about the accountability question, I think we should take that very seriously, as the commission as both in the text and its discussion has shown in the past.

One of the ways I think we can think about accountability is looking at the total margin of the hospital. Because I think that, in fact, can show that the broader purposes served by the hospital do not lead to big total margins. They basically run pretty much at a break even or modest margin than other hospitals do.

One way of thinking about the tables at the end, I have a little different interpretation of them than Jack does, is -- I remember when the Commission discussed this three years ago. One of the things that at that time the

Commission was very sympathetic to, or at least was concerned about -- as the text indicates -- was a lot of the IME being used for uncompensated care. One of the things we can do in terms of better targeting of this is, in fact, perhaps consider rather than having some kind of linear form, whether we could perhaps have higher weight on the resident-to-bed ratio for hospitals that have higher DSH or higher uncompensated care. So if one of the social purposes we really want to meet, in addition to educating and producing the next generations of physicians and nurses, et cetera, we also want to support uncompensated care, we may want to consider some ratios that give higher weights on the teaching to bed ratio for hospitals that do more uncompensated care.

MR. HACKBARTH: Let me ask you about that specifically about that, Ralph. If we have a robust measure of uncompensated care, why not just allocate all of the DSH money on that basis, as opposed to Medicaid and low-income Medicare share? Or at least all of it above the empirically justified amount, that is all of the DSH money that isn't based on higher cost for Medicare cases due to low income share.

MR. MULLER: Allocate all of the DSH money or the IME?

MR. HACKBARTH: All of the DSH.

MR. MULLER: I wish we had a better measure of uncompensated care, as the text indicates. In fact, in the DSH measure where, again, it's a measure of Medicare and Medicaid, in fact, I think Medicaid is not as good a proxy anymore of uninsured and uncompensated as it was at the time this formula was put into place. To have a measure of the uninsured now, Medicaid is not the best proxy anymore. So I think having that would be helpful. Obviously, as the text indicates, we don't have that.

I would like to see some measure that takes into account the uninsured as well as Medicaid, if we're going to have that kind of --

MR. HACKBARTH: I think we're saying the same thing in that regard. But what I heard you proposing is change the IME adjustment to reflect uncompensated care, whereas it seems to me a cleaner path is to dedicate all of the DSH money, at least all of the DSH money above the empirically justified amount to uncompensated care, assuming that you've got data that you feel reasonably comfortable

with.

And in keeping with what Arnie often reminds us, you have to compare your new data to the existing alternative, not perfection. You don't have to be very good in terms of uncompensated care data to do a better job of targeting than we are using Medicaid and low income share.

MR. MULLER: Let me also note that in the text I received in advance it points out that the teaching hospitals have done a better job of managing cost growth over the recent years. That, in a sense, makes the empirical factor lower. So in a sense, we may be penalizing teaching hospitals for having lower cost growth by then saying now the empirical factor goes down. I think that's not something we want to do is just penalize people for better management of cost growth.

Let me also note, in the discussion of whether we should fund this from general revenues, the issue of -- to quote from the text -- whether these kind of vaguely defined benefits are any better found in the general revenue calculation versus IME calculations is not clear to me. If we have a problem of whether these benefits are well defined, funding them through general revenue doesn't do any

better specification of those benefits. It just takes them out of general revenues. And one could argue that's the place perhaps for those benefits to be found but it doesn't do any more specification.

MR. HACKBARTH: There are two aspects to the general revenue argument. One has to do with things like the Medicare Trust Fund and what's the appropriate tax base to finance social goods. That's one set of arguments.

A second set of arguments though is if you base these payments on Medicare volume and case mix, that severely limits your ability to get them to serve your social purposes because it's always driven on how many Medicare patients you've got. It's some percentage add on to a Medicare case number. And to me that's the most fundamental problem with trying to use a Medicare payment system to accomplish social objectives beyond the program.

DR. REISCHAUER: The illogical of that would be if 100 percent of your case load was Medicare then, by definition, none of it would be uncompensated care and you'd be getting the highest payment.

MR. ASHBY: Only if you put it on a per case basis, which is not again unnecessarily --

MR. MULLER: I think while we've had -- I'll close where I began. The total Medicare inpatient margin has been going down the last 10 or 12 years and will likely keep going down. So with that kind of reduction, and I think it's been more than 10 or 12 points since 1997, whether this is an appropriate time to keep looking at taking that down even more by going to empirical levels is something that puzzles me as to why we would look at it at that time when it's been going down that dramatically over the course of these years.

But I appreciate that Jack and Craig did take the time to look up some of the questions that I voiced to them over the phone.

MR. HACKBARTH: Let me just pick up on Ralph's point. We discussed this a little bit last time, Ralph, in your absence. Last time we looked at the IME payment, the draft recommendation that I offered was to cut the payment and take it as budget savings. That's not what we've been talking about this time because of what Ralph just mentioned.

There has been, in the intervening years, significant and ongoing decline in the average Medicare

margin. And so the idea that we've been talking about here is different than last time. And that would be to say this is really an issue of payment fairness and equity. We're not talking about budget savings, but rather should some piece of the money be put back in the base to be redistributed to hospitals overall?

I just wanted to underline that again.

MR. BERTKO: I'd like to amplify on the first half of Glenn's comment about the Part A Trust Fund solvency or insolvency. First of all, I would say all your last comments about is the money needed? Sure, I completely agree with that.

But the implications on the trust fund are that in 2018, as of current latest projections, we stop paying for Part A benefits, which won't happen. Or that's got the other implication that payroll taxes go up. Or a third implication, that benefits get cut or some combination of those.

And so whether it's outpatient stuff should have more from general revenue because it goes back to break even margins or something else. This has lots of interconnected implications that we should at least perhaps discuss in

whatever comment we have.

MR. HACKBARTH: Other comments?

DR. KANE: First, I think Craig and Jack have done a terrific job here of trying to tease out the different reasons why the DSH and IME don't really hit the target that they're supposed to hit on social costs.

I just want to address something that Ralph said because I can't let it go by with out a comment, which is that if you're in a better competitive position you wouldn't necessarily have better margins. Many hospitals use their better competitive position to underbid or to add capital costs or to spend in such a way that they can attract doctors and patients back. And so they wouldn't necessarily come out with better margins. But they may come out with a better market position. And I think that is the case in some states where teaching hospitals compete head on with community hospitals that don't have the additional money to play with.

The only other thing I have to say is that total margins are not the right thing to look at if you want to understand -- if you want to compare hospital outcomes at this point, for a variety of accounting reasons that you

probably don't want to hear about. But that's my specialty, so I'm just going to name a couple of them.

One is that some hospitals decide to consolidate into their operations, their losing physician practices, whereas others don't. And so it's sort of a major of choice what's in there and what's not. That's not a comparable apples-to-apples margins.

The other is something that I've noted, is that the hospitals that tend to be the most profitable try to get rid of those through very conservative efforts of what they owe back so that their revenue is slightly below what it really is and what it becomes over time. So it's very difficult just to get at total margin.

Medicare margin, you've got a very formulaic way of getting at it. But when you go to total margin, you're dealing with a lot of estimating of revenue that can throw off the bottom line by a lot. And there is some systematic bias to that that understates for the more profitable hospitals.

So I don't recommend using a total margin comparison to decide whether or not something is equitable or one hospital is disadvantaged over another.

MR. HACKBARTH: Before I forget, I just wanted to associate myself with another one of Ralph's comments, and that was related to the DSH payment and then looking at Medicare margins without the other patients in the denominator. By definition we're saying the DSH payment is being made for non-Medicare patients and you include the revenue in the margin calculation but not the other costs, it of course is going to pump up Medicare margins. So that is, I think, a very legitimate issue that Ralph has raised.

DR. REISCHAUER: Just a question of fact. Was the DSH payment, when it was initiated in Medicare, designed to offset lower payments for Medicaid?

MR. ASHBY: It was not designed to offset lower payments. In fact, the original adjustment was associated rather closely to the added costs of Medicare patients.

DR. REISCHAUER: I confess, I knew the answer.

[Laughter.]

MR. HACKBARTH: The rationale for both the DSH and IME adjustments have migrated, shall we say, over time. Initially, they may have been based on higher Medicare costs per case and a desire to compensate institutions for those higher Medicare costs. But I think most people now believe

that, in fact, they are supporting something beyond higher Medicare costs. There may not be unanimity on exactly what it is we're supporting but there is, I think, a general believe.

The reason I draw that inference is that now for many, many years Congress has seen work like that which Craig represented here today, showing that these payments are not related to higher Medicare costs. And in the face of that evidence, Congress hasn't said oh, wait a second, we have to reduce it. They've said we're going to keep the payments. And that's a clear policy statement to me that they think that they're buying something else other than just compensating for Medicare costs.

The issue then becomes are those dollars well targeted? Do we know what we're getting for them? Are there still some remaining issues of payment equity even within the Medicare system for different types of hospitals?

I'm talking too much. Somebody else raise their hand.

DR. WOLTER: It's kind of a niche question but I understand that there are caps on the number of residents that can be counted for these purposes. When we look at the

shortages of physicians that people are predicting and the need to train more, how many institutions are training residents over the caps? Do we need to be thinking about that, in terms of how we look at the empiric level now versus what it might need to be over the next few years? I don't know if you guys have tried to look at those kinds of issues?

MR. LISK: In terms of how we do the estimate, we based the estimate based on how many residents they actually have, not regarding the capped number, because Congress made decisions on the caps. One of the reasons for the caps is we are paying more than the empirical level, too, so it was one way of controlling some of the growth that was happening here.

You could conceive, if you went close to the empirical level, if you're paying close to the empirical level on costs, then there may not be as much of a reason to have the caps, have this trade off. But when you're paying much more than the cost, you kind of have this incentive potentially for increase in the number of residents, which we saw dramatic increases in the number residents over time.

In terms of the number of hospitals that are over

the caps, I can get you numbers back on those. I've done some stuff on that.

DR. WOLTER: There might be legitimate reasons for want to plan for increasing the numbers of residents. And if we looked at it going forward, plan around how to think about IME, we might want to include that thinking.

DR. MILLER: The only thing I would say about that is we did some work on a cap-related issue a couple of years back. I can't remember how many years back. And I know you know this.

But that issue gets really complex much faster. It's not just caps. You can have hospitals working above the caps but still unable to fill entire disciplines of the numbers of slots that are open to them. For example, primary care, gerontology, those types of things. And what's happening out there and how they define those programs and, of course, all other kinds of issues, some of which we were discussing at lunch, lifestyle issues and those types of things, you could still set the cap higher and still not be filling all of your slots or the slots that you might want to fill in terms of a future supply issue.

But I know you know all this, Nick.

DR. WOLTER: But you could set the cap higher but only count the spots that get filled, too, I suppose.

MR. LISK: That's how the current system is done.

DR. BORMAN: Just to clarify, when you said you counted all residents not the cap number, you counted all people in ACGME accredited resident positions? Or how did you come to the all resident total?

MR. LISK: The total is what would qualify for IME payments if there were no cap. What is reported is they report an uncapped amount and it's basically -- it's the uncapped amount that I have that we put in for analysis.

DR. BORMAN: I would echo Ralph's comment about separating out a little bit the relative proportion of DSH and IME as shown on page three. I do think that's an important thing.

I personally also find page 21 pretty instructive. And as you've made the very well, in the presentations and the text, about the skewed distribution so that the top quartile is getting a fairly substantial, added up, multiple amount. And I think that I've heard a fair amount of discussion here in a short period of time about equity. I think maybe some of this speaks to, if we come to the

assumption that there are social purposes here that the Congress and we, to some degree, agree with that the issue of equity perhaps is one that still transcends whatever political volatility that may be out there.

And some of this started, if I understand right, Glenn, from your concern and other commissioner's concerns about equity at other hospitals. And I think that some of what we're seeing here is that our mechanisms for managing this may not be supporting equity now. And that may relate to some of the statistical or calculated kinds of elements that Ralph and Nancy brought up about what's the right proxy and part of what we're getting here is the self-pay or guarantor group, to put other names on it. And that maybe of our work needs to look at the equity distribution within this, as well.

I personally continue to struggle with the notion of the resident-to-bed ratio, and I'm well aware that it's the historical number and all that kind of thing. But in an era in which so much care is delivered on an ambulatory basis and, in particular when we sit here and talk about beefing up ambulatory care as a piece of better Medicare beneficiary care, to not be looking for, pushing for,

thinking about a better measure or something else to tack this to than inpatient beds -- now obviously that is skewed because this comes under the inpatient PPS, but I think that in the background some creativity about what is a better number to use? Is there a better one? And maybe there just isn't one that we can measure. But I start to wonder about relating this -- particularly for teaching hospitals that have hospital-based clinics where there is a tight linkage to the hospital and there's some ambulatory number that might be able to get dialed into this, particularly as you start to think about the workforce piece that Nick has brought up, that very clearly there's projected shortages in lots of specialties. Even if the projections are 50 percent off, there are still significant shortages in lots of specialties.

Even if we say well, we have capacity related to people in our training systems other than U.S. medical graduates, we start to get into a lot of fuzzy issues there. We do need to look forward a little bit. This is not the place to resolve all the workforce issues. But I do think some flexibility going forward as some real benefit.

MR. MULLER: Let me ask a follow up. Have we ever

made any estimates of IME on the outpatient side?

MR. LISK: No, we haven't. We do know that the outpatient margins for the teaching hospitals are a little bit lower than for other hospitals.

MR. MULLER: Obviously we have no IME adjustment on the outpatient side and I would say they're a lot lower. But it gets obviously reflected in total Medicare margin. Is that something that's very hard to do?

MR. LISK: In the short time frame, it would be -- you could conceive of coming up with what would happen if you just applied let's say the empirical IME adjustment you got to outpatient payments and see what you got from that, for instance, would be one simple way then trying to derive something.

MR. HACKBARTH: You're saying still use a resident-to-bed ratio, just relate it to outpatient department costs?

MR. LISK: Right.

One thing I want to get back to on Karen was to make clear, in terms of the resident-to-bed ratio, the resident count is the residents in the hospital. And that's both the residents who are in the outpatient portion of the

hospital and the inpatient portion of the hospital. So if a hospital has a large outpatient activity and smaller inpatient care, the resident-to-bed ratio is actually going to be even higher than they otherwise would be. So they would actually be getting potentially more money than another hospital where it wasn't as active and they had just more beds.

DR. BORMAN: Only if they have a lot of inpatient Medicare patients, though.

MR. LISK: Right. That's an issue of in terms of where you're making the adjustment to. I just wanted to say, in terms of the resident intensity measure, it is a problem coming up with -- what would you get? I think there would be a lot of controversy over what you'd do if you said resident to average -- to some measure of -- help me, Jack, in terms of some of the numbers that we sometimes used. Adjusted admissions, for instance. There could be a lot of controversy over that.

So that's one of the problems that you arrive at when you come up to considering some of these alternative measures.

DR. BORMAN: My concern is that we don't know, and

I frankly don't know on a database that the proportionate add on of teaching, whether there is some significant variation across the site of service and how that plays out in making some of these projections. As Ralph pointed out when you talk total Medicare margin, perhaps you sweep some of that up. But I think as we continue to push things to the outpatient side of things, also I think that a fair number of teaching hospitals -- and mine may be a little different than Ralph's in this regard -- that a lot of stuff gets done in perhaps a hospital outpatient department setting that in other areas might get done in an ASC or an office or a different site of service setting that perhaps drives some of the teaching costs.

I continue to worry a bit about are we reflecting current delivery systems? And then as we start to talk about what are the measures and the accountability pieces that we should put to this to try and pick those out to the care delivery system that we see? And that is an outpatient weighted one.

MR. HACKBARTH: What I would suggest, I think your point is a good one. I don't think that it's something that we can resolve int his cycle. But we can certainly flag it

as an issue in the text, both for our own future reference and for others.

MS. HANSEN: My point really goes hand in hand with what you brought up, Karen, about the teaching locus that is shifting over time because of the delivery systems, where more and more chronic disease is going to be managed. How do we look at that?

But a broader question, and I know it's not the issue here, per se, because it's more the question of the interrelationship of GME and IME. I'd like to bring it back to the question of what we buy for the Medicare funding and how oftentimes there seems to be such little tangible product of the issue of geriatric care, as part of what we're buying for the Medicare funds.

By that I mean there are teachings within the disciplines of cardiology, urology and so forth. But the whole aspect of looking at the interplay of geriatrics, and since this is Medicare funded, and even on the inpatient side about 40 percent of the patients oftentimes are older patients, the ability to have the accountability for educating for that content.

So again, I know the IME is different certainly

for what you pay for the GME. But on the beneficiary side, which I oftentimes come back to, ultimately are they getting the best practices, the best evidence, the safest care because of their oftentimes comorbidities.

So that is, again, beyond this. But it goes raise both the IME and the GME for me.

DR. HOLTZ-EAKIN: Just briefly, these dollars clearly seem to have suffered big mission drift. At this point, we have this large sum of money that's above the cost of either care in a teaching setting or to low income people. And my instant reflex was yours, which was budget savings.

But if that's not really a feasible route, there are all these situations which we want to have funds to pursue coordination in care, bridging the inpatient and the docs, whatever. We ought to get something, in moving this agenda forward, for this money. We ought to pull them aside instead of plowing them back in the base, and get something specific for the money above the empirical level.

We've got long list of things we started the day with.

DR. CASTELLANOS: I think what we're trying to do

is realign payments to costs.

One of the concerns that I have is a point that when Nancy was here -- Nancy's here -- brought up last time as to whether the underlying policies, the objectives of the underlying policies. Are they still applicable? And is this what we should be looking at before we made some adjustments?

Karen made a very good point about measurement. We've talked about the resident-to-bed measurement. We've talked about a lot of ways of measuring that.

I had lunch with Ralph today and we talked about the costs of post-graduate education. That's a rapidly changing thing. Are we really capturing those costs, what it costs the hospital or the university to teach these residents, the workforce in the future? It's a dramatic change out there.

Karen, I know there's an -- residents now only can work 80 hours.

MR. HACKBARTH: Are you talking about the direct side Ron?

DR. CASTELLANOS: I'm talking about aligning costs to make sure we're capturing the right costs. And

especially in IME, I'd like to make sure that the costs that are being -- it's outstanding what it costs now to teach residents. There are a lot of hidden costs going on now and there's one that residents can only -- residents are our workforce. They can only work 80 hours a week now. After that, they leave and you have to hire somebody to take their place. And that's an added cost to medical education.

I'm very, very concerned about that because of the downstream effect. If we start cutting the residents or putting out the residents or putting out the skilled workforce in the future, we've already talked several times about the effect that that may have on access to care to the Medicare patient.

MR. HACKBARTH: Let me get some help here. If we're talking about the specific example that you raised, that you've got to hire another physician to make up for the fact that residents are only working 80 hours, that would show up in the Medicare cost report. A piece of it would be allocated to Medicare based on Medicare's share of the total.

When you do the empirically justified amount, you would see that hospitals that have more intensive teaching

activity would have higher costs and that would push up the empirically justified amount; right?

MR. LISK: Right.

MR. HACKBARTH: There's a lag in the data. We're doing 2004 data and it may not reflect the most recent developments there. But it should flow through these calculations.

DR. KANE: Glenn, that should actually lower your costs.

DR. REISCHAUER: It should raise your revenues and keep your costs the same.

DR. KANE: You could pay a resident $40,000 a year to see patients, and that was cheap. What's happening is you can't do that anymore. It's not a cost of training. It's a cost of taking care of your patients, that you have limited to 80 hours. The doctor who's coming in to replace it is a full doctor, who can bill as a doctor. That's not a training cost.

MR. ASHBY: But the resident's salary is in GME, though.

DR. KANE: It's not a training cost. It's not a training cost.

MR. LISK: There are two things that happen. One, if it's a physician, the physician may bill for the service where it otherwise wouldn't, so it might show up in Part B services. If it's not a physician, it may show up in higher patient care costs. Not training costs, but higher patient care costs. Our estimate would reflect that, to that extent.

The other things that were being talked about are direct GME costs, which we have excluded from this analysis.

DR. BORMAN: Before we throw out the baby with the bath water on this one, I just need to make one comment. Getting away from this staffing hours business, because there's a whole host of issues wrapped up in that and I don't think we want to go there.

But there are, as Ron has pointed out, medical education, like lots of education, is changing a fair amount. And for example, simulation education is a pretty expensive thing that's not an employee cost, a supply cost. But it is something, for example, all the general surgery programs by 2008 will have to have in place, onsite, a fairly sophisticated simulation laboratory. So the physicians who come out of that will be taking care of

Medicare beneficiaries. So there are some education costs that are, I believe, IME potential costs that are changing. That's important to know.

DR. MILSTEIN: This is, I think, I want to speak in support of at least the text reflecting Jennie's comment about at least putting our toe in the water with respect to getting information on the nature of what we're getting back in exchange for our medical education dollars. For example, one interpretation of Jennie's comment would be that maybe we don't start out linking the payments to the percentage geriatrics training, though I personally would favor us ultimately landing there. But at least getting information on percentage of faculty FTE that specialized in geriatrics.

I feel the same way about this issue that a number of us have commented on with respect to content of medical teaching. So it would not -- maybe the text might also reflect the broader concept, that irrespective of whether we "right-size", what we're paying for this to approximate what it really costs based on the empirical model. I would suggest that the text reflect Jennie's comment and other aspects of information about what we're getting that we believe is important to the objectives we were talking about

this morning, such as the percentage of faculty FTE that reflect a faculty whose primary area of research and teaching is clinical systems engineering, clinical informatics, the things that are key to improving the efficiency of the Medicare program.

MS. BEHROOZI: On the subject of looking at overall margins and mission drift. I guess, in fact, there has been mission drift, and Congress has endorsed it by continuing to maintain the higher than empirically justified levels of payment. And so as we go forward and look at what else we can do with that excess money, readjusting it to meet some of the goals that have now become part of the drifted mission or whatever might be successful. But I think we would need to look at the impact on things like loss of standby readiness or trauma centers or things like that, and not just look at it from the perspective of what are we paying for. But what would we lose if we shift the payments over?

Will there be hospitals whose overall margins go down significantly enough that they can't provide those services, those other social goods that seem to be encompassed in what Congress keeps paying that extra money

for?

MR. HACKBARTH: Just a couple of concluding thoughts. One is Ralph noted at the outset that last time we talked more about IME than DSH. I know I'm guilty of that, if it's a crime. The reason I tend to do that is that actually DSH seems like a much simpler problem to work through.

Conceptually, I think that Congress has made it clear that it sees this not as a Medicare issue but a broader social mission. How do we help to provide support to institutions that care for people that otherwise might go without care? Namely people without insurance and who are a burden to institutions, a financial burden.

The solution to that is relatively straightforward. Let's not use Medicaid and low-income Medicare share numbers to allocate the dollars. Let's get data on uncompensated care and rewrite the formula on that basis. I don't think that's mysterious. I think it's doable. We've had sort of a false start here with the collection of those data.

I would like to see us, in this report, reiterate our eagerness to have those data collected. We support

Congress on that. It had mandated that they be collected. Let's get it done and let's get it done quickly so that we can evaluate policy options for how to distribute those dollars.

That's why I tend not to talk about DSH. At least in my mind it's a pretty straightforward thing to address. I see Doug doesn't think so.

IME, I think, is more complex. I think that -- this is just my perspective again -- is that there's a blend of social missions here, and also some Medicare payment policy involved, if I understood the history of this particular adjustment. At least part of the rationale, as was pointed out by Jack at the beginning, was an expectation that teaching hospitals would fare poorly under Medicare under prospective payment. And a piece of that concern had to do with severity and the possibility or likelihood that teaching hospitals would be handling systematically different patients than the average community hospital, more complex patients and more costly patients.

We know that there are more direct ways to deal with that issue. In fact, MedPAC has recommended multiple times, including very recently, adoption of a severity

measure in the payment system so that we fairly compensate those institutions who do care for the sickest patients.

I think that relates to the IME adjustment potentially and that at least some piece of IME may be appropriately put back in the base concurrent with a severity adjustment that will move money to those institutions.

That's an idea that I think is worth our considering.

So let me just stop there for now. This is an issue on which we won't be voting next month. Any votes we have on this will come in January, so we'll have a couple of other opportunities to get our heads together and decide what sort of draft recommendations we want to consider. I don't think we need to belabor it more right now.

I think we're making progress, but it's going to take a lot longer to get to a destination.

Thank you very much and let's move on to wage index. We're going from the major philosophical to the much more operational, shall we say.

MR. GLASS: Good afternoon. We're going to discuss the wage index, another one of those payment

adjustments, this one a little less arcane. The idea is to adjust because it costs more to hire a nurse in some parts of the country than others. That's the basic idea of it.

We talked about this in April. I'm going to try to hit the things that have changed, the progress since then. But if there are any questions, of course, we can answer them at the end.

The current approach uses data from hospital cost reports. The IG has raised some questions about the accuracy of some of that data. They use that data to calculate an average wage for market areas. The market areas used are MSAs, metropolitan statistical areas and a statewide rural area for all the counties that aren't in an MSA in a state.

The area's average wage is then compared to national average wage and that gives the wage index. There's a separate adjustment for operational mix, which we'll talk about in a minute. And geographic reclassifications, rural floors and such like end up changing about a third of the hospitals' calculated wage index. So there are a lot of exceptions, as Glenn mentioned. Exceptions tend to breed exceptions in the

Medicare program.

What we have been looking at is exploring the idea of using another source of data, namely Bureau of Labor Statistics data and the Census data to form a wage index, to try to get away from some of the problems that have been seen in the current one. What we do is we use the BLS data in our first step to calculate relative wages for each market area. We do that using the data from all employers in an area for each occupation in the area. And then we look at the weight of occupations in a particular industry such as hospitals for the nation as a whole and use that fixed occupational weight technique to create something called a Laspeyres index, which has some nice properties. That would give us a wage index for each market area.

We then use Census county level data to adjust within each market area to a county level. So at the end of the second step we essentially have a county level wage index.

And then finally, in a third step, we smooth between adjacent counties to reach what we call a target difference that we find acceptable between bordering areas. The point of all this is to lesson the need or desire for

exceptions by making sure that areas that border each other don't have profoundly different wages index. This is easier to see, really, than to talk about.

If you look at this, this is the CMS wage indexes, and you can see that there's sharp differences between market areas here. The dark red is the highest wage index here, and that's the Atlanta MSA. This is the state of Georgia.

In the Atlanta MSA, you'll note that it's a dark red and that all the counties in that MSA -- and there's 28 of them or something -- are all the same color. You'll also note that it's right next to the yellow, which is the lowest wage index, and that happens to be the statewide rural value for Georgia. It's those big differences that drive people to seek exceptions to the wage index and that raise questions about it.

The other colored areas there, the red and oranges, are also smaller MSAs in Georgia, and in other states, too.

These differences are more gradual when we move to the BLS/Census kind of county level index. Here what we've done is, within the Atlanta MSA, for example, we've allowed

the wage index to differ by county. And using the Census data we do that. We discovered that the central counties there tend to have a higher wage index than the counties at the periphery of the MSA. This results in less abrupt wage index cliffs between the MSA and the statewide rural and in other bordering regions. That's our step two.

Finally, if we look at our BLS/Census smoothed wage index, as we call it, no sharp difference remain. Here we've taken an algorithm, which we detail in the paper, and basically we've eliminated any difference over 0.1. So here presumably the desire for exceptions from the wage index would be less because you wouldn't be across the border from a neighboring hospital who has a much higher wage index.

So that's generally what we've been attempting to do.

Here's some differences between the approaches, as I mentioned hospital data only versus all employers. That kind of goes to what is the goal of the wage index. Are you trying to account for underlying wage differences or match hospital costs? If you're trying to account for underlying wage differences, then the new approach might make more sense.

One limitation of the new approach is it looks at wages only as opposed to wages and benefits in the current approach. Of course, in the current approach some of those benefit costs, particularly pension costs, are the ones that the IG has found may have some difficulties involved with them.

The new approach, the Laspeyres technique, automatically adjusts for occupational mix. So you don't need to go through the other. In the current system you have to have an additional survey and an adjustment needed for occupational mix.

Occupational mix means that your average wage is different because you are using a different mix of workers, more skilled workers and fewer unskilled workers, for example, would give you a higher occupational mix.

They now have a survey that they're doing to ask hospitals about that mix of nursing in particular. They then use it to adjust the wage index. There's been some issues about that, as well.

Finally, the smooth county approach gives you very little difference between neighboring areas and presumably would lessen the need for exceptions.

So we looked at a couple of measures of performance, if you will, for the wage indexes. And we found that if you look at the year to year changes, they're small under the new approach. You can see here that they're smaller at the median, the 90th and 95th percentile. They're about half, in fact.

Since you wouldn't expect the wage index to change a lot from year to year, that makes sense. It makes sense also because the BLS numbers are a three-year running average so you would expect not to have major jumps.

We also find we have less extreme wage index values under the new approach. Although the two wage index are very highly correlated, the two being the CMS and the one we came up with -- and we're talking about 0.87 at the market level or 0.92 at the hospital levels, they're very highly correlated. The new approach has lower values than the current values when those current values are very high, above 1.2. And it also tends to have fewer very low values. That could be because ours automatically takes occupational mix into account.

So in the next steps we're going to compare it to the new occupational mix adjusted wage index, which was

released Friday at five o'clock or something. So we're going to do some analysis there and try to understand where the differences lie and do things make sense? Does their new occupational mix adjustment move their index closer to ours, and that sort of thing?

We wanted to understand the explanatory power. We wanted to see if we could predict hospitals' costs per case. The results, though very similar, the new approach may explain a little less which again kind of makes sense because payments may influence costs. That is, if you've been paying a hospital a lot they may have raised their costs to match the payments. So that doesn't seem unreasonable. And also, the new data doesn't include benefit costs. So since the costs per case we're measuring against does, that also would tend to explain a little less.

As we said, you don't need an occupational mix adjustment under the new approach. I guess I won't go through this at length. The point is that this was due to a recent court case that they've had to move to 100 percent adjustment to occupational mix in FY '07. Both the survey and the calculation are untested. So we've looked a little bit at this new index that they've come out with and it

seems to not have changed things too much. For half the hospitals, the adjusted and unadjusted are within about 1 percent and there are not too many cases with really extreme values.

That's the current approach. The new one you wouldn't need to be doing any of that.

The final one that I'll talk to a little bit is that the new approach can tailor wage index for other sectors. Currently, most of the other payment systems in Medicare use the pre-reclassification hospital wage index. That's before you make any of the exceptions. There are some difficulties with that. First of all, there really may be no IPPS hospitals in an area where you do have a nursing home or where you have home health residents. And so the index may not be really accurate for those areas.

About half the counties no longer have a PPS hospital in it. And that's partly because CAHs are no longer in the prospective payment system for inpatient and therefore are not in the wage index calculation. So that can be a problem if you're in the far east of the state and the only PPS hospital is in the far west part of the state. That's a difficulty.

Another one that seems to really rankle providers is that the hospital that you're a neighbor to in your area could be reclassified. Now when they get reclassified, they get a higher wage index. However, say the SNF that's neighboring that hospital gets their pre-reclassified wage index and therefore doesn't get the higher wage index. That does rankle providers and they raise that as an issue of equity.

The new approach, you basically can use the same data because the data in the area wages for each occupation would stay exactly the same because they're from all employers to begin with. The only thing that would differ would be the vector of occupational weights that you use for home health agencies or nursing homes or hospitals because they use a different mix of employees.

We also include employer data from all counties so we don't have to worry about this thing that there's no hospital in your areas.

So we think that this would certainly seem to theoretically be a better model for the other sectors. And it would be relatively easy to compute it, not a tremendous amount more burden on CMS.

It also might not make a tremendous amount of difference because the occupations, though different, may not differ by all that much. The indexes may be very similar. We're investigating that.

So in summary, the new approach would have a couple of advantages. The data represents the entire market. It reduces circularity. And by circularity we mean now if your hospital is a very good manager and keeps the wages down, your reward from CMS is that your wage index will be lowered. So some hospitals come to us and say this just really isn't fair. We're keeping our wages under control and every time we do it we get hammered on the calculation of the wage index.

Because this would look at data from the entire market, versus just hospitals, it would resolve, to some extent, the circularity problem.

We find it to be less volatile over time, automatically adjust for occupational mix. Smaller difference across borders, which is very important to reduce the exceptions and the desire for reclassification. We think it would be more equitable for other types of providers, that is SNFs, home health agencies, et cetera.

There would be less data burden on hospitals. In fact, there would be no data burden on hospitals because they wouldn't have to provide any additional data, fill out any additional surveys or anything.

The disadvantage is the data is not hospital specific. That goes to this question of do you want to look at underlying wages or do you want to try to match hospital costs exactly? So if you think you want to do the latter, then this is a problem.

It's wages only not wages and benefits. That's one that we want to look into a little bit more, to see if that really is an important thing.

As we've said, it explains slightly less variation in hospital costs. And of course, it would create new winners and losers, which is the big issue for many people.

Thank you.

MS. DePARLE: This sure seems like it could be a giant leap for mankind. I'm wondering what I'm missing, because if you just took the number of person hours that have been spent by so many staffs around this town and computing these numbers and trying to get hospitals from one area into another.

So on your list of caveats, you've talked about a couple of them. But one of them I wanted you to talk a little bit more about, which is -- well, you just mentioned one, about it not being hospital-specific. But I don't see that as a problem. I think really what you've proposed here gets more to what should be our policy objective anyway. And it's simpler for the hospitals, administratively less burdensome, and creates a level playing field for others who are trying to hire the same people, which is a complaint we hear from other providers a lot. So I like that.

But you make a point in here about the data do not report wages for some occupations in some geographic areas because there are not enough people in the sample, and that you've used some techniques to get around that. Can you elaborate on what that problem is and how significant it is?

MR. GLASS: I should mention that Abt Associates actually did many of these calculations for us, so they know the great details of this.

But particularly in the Census data, Census data is from the Decennial Census long form. If you have a county with a very low population, the sample there is going to be pretty small. So they may not catch every occupation

that we may want to look at, respiratory therapist or something small like that.

So what we've done is, if the Census data is missing a value in say some small county, then what we do is substitute the market area wage for that occupation and then do the calculation from there. I think that works fine.

MS. DePARLE: How big would the market area be? Let's say you are dealing with a rural county and you don't have a number for respiratory therapist.

MR. GLASS: Then it would be the statewide rural market area.

MS. DePARLE: Which would be likely to be higher, wouldn't it? Because it would also include urban areas.

MR. GLASS: Yes. In general, yes.

DR. MILLER: Statewide, not rest of state.

MR. GLASS: Statewide rural, which is the rest of the state. All the counties that are not in an MSA.

MS. DePARLE: Statewide rural.

MR. GLASS: Yes, but if it's the county that's way out in the corner instead of the one right next to the MSA, then the wage we're substituting might be a little bit higher. And that's why we did it that way, because it kind

of retains the integrity of the market area a little bit.

MS. DePARLE: It would be interesting and look at some counties and pretend they don't have that data, and what decision role would you use? And what result would come up with? To see if it really would be unfair.

Because just not having to spend the time collecting this data and calculating it and auditing it and all that would be billions probably.

MR. GLASS: And again, as someone mentioned, you have to compare it to what they do now. And what they do now would be comparing it to the data gathered from hospitals. There's probably not a hospital there either. And if it is, it's a CAH and doesn't count in the wage index. So compared to the current, I don't think you're losing a lot of information.

MR. HACKBARTH: David, the current system hardly seems to justify the term gold standard. But it is where we are. So a practical consideration is how dollars would shift under this system compared to the existing one. And set aside the reclassified hospitals for a second, where you might have quite dramatic shifts.

But if you just take non-reclassified hospitals,

current system versus the new system, do we have any sense of how much money is moving around the system? Or what patterns might exist in that redistribution?

MR. GLASS: The one major pattern is that in places where you have very high wages, the wage index is now above 1.2, those areas will see a lower wage index under the system we've been exploring. That's the real bottom line biggest difference. Otherwise, it's very closely correlated but there's a lot of bouncing around.

DR. HOLTZ-EAKIN: I'm just curious. I gather one of the complaints with the current system is year-to-year volatility. Did you do this for more than one year? Because if you're going to have these small cells and these sampling problems, I could be concerned that from 2006 to 2007 you might very different answers in some of these locations.

Do you know what the year-to-year --

MR. GLASS: We showed the year to year volatility.

DR. HOLTZ-EAKIN: In the new approach?

MR. GLASS: In the new approach versus the old approach. It's this one.

Remember, the BLS data that we're using is

actually -- say the 2005 BLS data includes data from 2003, 2004, 2005. So that cuts it down a bit. And the Census is decennial. It doesn't change at all, which could be a problem.

MS. BEHROOZI: Remember, I provide benefits to a unionized workforce in the health care industry. So starting from there, take this for what it's worth.

Unlike the things that we were just discussing previously, which had a pretty low correlation to the things that they were supposed to compensate for, and you should correct me if I'm wrong, this seems to have a relatively higher correlation to what we think we're paying for. In other words, the money that we're giving institutions, they are passing along to people who do the work of providing care for the most part. More than IME pays for the empirically justified level of IME or DSH pays for --

MR. GLASS: Yes.

MS. BEHROOZI: Two heads nodding, great. I'll move on from there.

So it seems to me to the new method would explain slightly less of the variation in hospital costs or, as you said, those that are currently at a high wage index level

would come down and those that are currently at a low wage index level would come up, you're moving away from the correlation to the actual costs. In other words, people or institutions that are currently paying less, have a lower wage index level, would be rewarded not for passing along that additional payment that they would then receive to their workforce, but it would go into their margin or whatever.

And those that experience the higher cost would have to find some other way to cover those higher costs.

MR. GLASS: Jeff, do you want to talk about the regression results a little bit?

DR. STENSLAND: You're basically right. That concept is right. But I don't want to oversell the difference here. And we're still fine-tuning the regression results. But this is what percentage of the costs can be explained by these different models? And maybe if we switch from the old model to this new model, maybe we're talking about explaining maybe 1 or 2 percent less of the cost, kind of on an r-squared basis for the economists out there. It's a 0.01 or 0.02 difference.

So it's a real slightly less explanatory power.

And it's not clear that you actually would think that's a bad thing. And that gets back to that circularity idea. It's kind of a fundamental, philosophical question that's really beyond what we do. And that's what do you want to be paying fo. Do you want to be paying for the hospital's costs or do you want to be paying for the underlying wages in the area?

MR. HACKBARTH: Even under the current system, since it's a prospective system, the hospital is not being paid for its wage levels. It still has the incentive to pay as little as it can relative to others because the wage index isn't made up of its wages alone, but it's a composite.

So that incentive exists under both the current system and this system. If you pay more wages, you're not reimbursed for those under either system.

MR. GLASS: You can also say do you want to move to --

MS. BEHROOZI: Not directly. I understand.

MR. GLASS: We're trying to stay away from cost-based reimbursement, in general.

MS. BEHROOZI: I understand it's not direct, but

if you're in a market where the employers in the industry have valued the labor that's put into the product at a certain level, for that product, they're going to be able to see the recognition of that in their rates, as opposed to having less recognition of that.

But one of the particular items that you mentioned, I think you list it right there, that benefits are not included in the calculation. And that, to me, that's a big red flag that you're going towards some kind of notion of what's valuable that frankly I couldn't support.

I'm sorry, so explain that to me. It's leaving out the cost of benefits, which we provide health coverage via Medicare. We should want the employers who provide those services to be covering health care for their employees.

MR. HACKBARTH: Basically, you would be assuming that benefits are proportional to wages on a fairly consistent basis.

MS. BEHROOZI: But that's not necessarily true, because especially as health care has gotten so much more expensive there are places -- and again, I'm coming at this from a collective bargaining perspective, where workers and

management negotiate over how labor costs should be allocated. And so you may find in some markets where there is a conscious decision to essentially defer wage increases and put them onto the benefit side instead. And you can't presume that that's consistent across the country or across different industries even within a region, which is all collapsed in BLS data.

MR. GLASS: That's exactly correct. And that's why we raised it as a point. And we're going to try to do some analysis to see really if we can tease out what the effects of that are. One of the difficulties will be that in the hospital cost reports one of those benefits is pensions. And the way that's accounted for, apparently, as I understand it, is kind of abstruse and not only consistent. The IG seems to be finding some -- what they consider, at least, to be incorrect reporting of pension costs.

Your point is right, but we're going to try to understand it a little better. It's not clear exactly how it all works out and whether the wages and benefits being reported in the current wage index are exactly right anyway.

MS. BEHROOZI: One last point, in terms of

adopting BLS data, obviously we would be adopting whatever methodological flaws it had. You were referring to Census data earlier. But in your paper you refer to the fact that they use surveys of employers. I don't know how reliable that is, what the sample sizes are, whether that could be audited. I understand, Nancy-Ann, that it's a nightmare to have to do it all yourself. But to use something else as a substitute, I think we would want to have some -- we would want to be able to rely on it.

MR. GLASS: We went in and we talked to people at BLS to get some understanding of what they do. What was the number? It's in the paper, the number. It's like 200,000 establishments are sampled every six months or something. And this would be six of those, so 1.2 million establishments.

I think they're pretty rigorous about how they do it and they even send people out to the establishments in some cases and see what they're reporting and whether they're reporting the correct thing for each. So as data goes, it's pretty good.

MR. HACKBARTH: Other comments?

DR. REISCHAUER: If you wanted to make an

adjustment which would largely be a social value statement, you could take there are certain fringe benefits that are related to wage levels, pension contributions and things like that usually are -- I'm having a hard time. I'm going to look over here.

[Laughter.]

DR. REISCHAUER: And then there are certain things like health insurance which are flat amounts across all and you can create notional components and just add them on to your system and you'd get a rough adjustment.

MS. BEHROOZI: But if employers are not providing it, then they shouldn't get that adjustment; right?

DR. REISCHAUER: But the same flaw exists now in the system. And the question is are you improving on what you have now?

MR. HACKBARTH: Nick, the last word on this one.

DR. WOLTER: I had the same question you did, Glenn. And specifically are we going to see any more modeling and quantification of the redistribution effects, other than the amount above 1.2? And are there qualitative aspects of that we should look at, rural/urban, large/small, et cetera? Or is it so minor that that's not worth doing?

And then the other question I had, if we do a recommendation on this, would we be accompanying that with a recommendation that reclassification be eliminated, including those that have already been reclassed? Or is that a separate topic?

MR. HACKBARTH: It is a separate topic logically, but it's an immediate topic on the path to actually getting any change. One of the biggest challenges in changing this area of the payment system is that there has been so much reclassification. So many institutions now have substantially higher wage index than either the old system or the new system would give them, that they will resist, understandably, any change.

So even if you have a perfect analytic system, the transition is a very big part of the challenge.

Would you respond to the first question?

DR. MILLER: I think the expectation is we're going to work through a few more problems that David and Jeff pointed out, and that the sense would be that we would give you some sense of what the impacts of this would be. We wouldn't expect you guys to consider it in the absence of that.

To your second point, I hadn't even gone far enough to start thinking about recommendations. Off the cuff, I think you would probably have to think about that at the same time that you were thinking about proposing something like this, because otherwise I think it would defeat the purpose.

But the sense is to work through some of these problems, including the benefit problems and a few other things that we tried to point out here, and then give you a more complete run-through of things, another pass at this. And then get up to so what do you want to do?

MR. HACKBARTH: Mark, is this an item on which you expect to see us drafting a recommendation and voting this year?

DR. MILLER: If we did this, and I'm looking at Sarah for some confirmation here, I would expect it in the second part of our cycle, after the January meeting. Do you agree?

If Sarah says so, then that's what we were thinking.

MR. HACKBARTH: Thank you.

The last item for today is an update on Part D,

trends in enrollment and some payment issues.

DR. SCHMIDT: I'm just glad my husband has daycare pickup duty today.

Today I'm going to brief you on an updated analysis we've done on Part D plans.

Recall in our June reports, that included a chapter that discussed plan offering, including the benefit designs, premiums and formularies of Part D plans. And now that the initial enrollment period for Part D is well over, we can give you a sense of the characteristics of plans in which most beneficiaries enrolled.

You may have heard that CMS released some information late last week about the benefits and premiums of Part D plans for 2007. Let me say from the start here that most of my briefing will be describing what's happening for 2006, not what will be available next year. However, we will discuss some recent decisions about CMS about how it has set payment rates and low-income subsidies for 2007.

Here are the main takeaway points for this briefing. Before the start of Part D estimates were that about 75 percent of Medicare beneficiaries had drug coverage. Today CMS estimates that about 90 percent of

beneficiaries have either Part D coverage or another source of drug coverage that's at least as generous as Part D.

Beneficiaries enrolled in Part D plans tend to be highly concentrated in plans offered by a small number of parent organizations where that organization is offering a similar benefit design across most or all of the country. Part D enrollees are currently paying a premium of about $24 per month, which is much lower than what was originally predicted. So enrollees tend to be concentrated in lower premium plans.

More than half of all enrollees in stand-alone PDPs receive Part D's low income subsidies, which are extra benefits that pay for most or all of the premiums and cost sharing on behalf of those beneficiaries. That's a much larger share of total enrollment than the low-income subsidy beneficiaries make up for Medicare Advantage prescription drug plans.

Under current law, CMS is supposed to use enrollment information for 2006 to help it set monthly payments and enrollee premiums and low-income premium subsidy amounts for 2007. This enrollment weighting would have had the effect of lowering plan payments and increasing

plan premiums for all enrollees. It also would have lowered the number of plans that low-income subsidy recipients can enroll in without having to pay a premium.

Instead, CMS has begun two demonstrations for 2007 to set monthly payments to plans and low-income premium subsidy amounts in a way that's similar to what they did for 2006 when the Agency didn't know any sorts of enrollment levels for individual PDPs. This leads to fewer transition problems for enrollees, but higher Medicare program spending.

Let's take a look at the enrollment levels for Part D. These are data as of mid-June. There is some more recent data for certain categories that CMS has released but it hasn't fundamentally changed this picture.

About 16.4 million beneficiaries -- that's shown in the box up on the screen there -- are people who are enrolled in PDPs, stand-alone prescription drug plans. This includes people who enrolled on their own plus dual eligibles that were auto-assigned into plans by CMS. I'll describe that process in a minute.

Another 6 million are in Medicare Advantage prescription drug plans. So 52 percent are in Part D plans.

Other individuals have other sources of coverage that are at least as generous as Part D. For example, Medicare pays some employers to remain the primary source of retiree drug coverage. Plus there are other sources of creditable coverage. All together, the combination of those other sources and Part D enrollment make up about 90 percent of beneficiaries who have such coverage. Again, that's compared to about 75 percent before the start of Part D.

I'm going to show you several pie charts that based on enrollment data that we got from CMS that reflect enrollment levels as of July 1st. The total numbers of beneficiaries are going to be slightly different from what I just slowed you in the previous slide because we've excluded certain types of plans, employer-only groups, plans in the U.S. territories, cost plans, SNPs, PACE, et cetera. We did this to give you a sense of what Part D enrollment looks like among plans that are open to most beneficiaries.

So in our data file we've got a total of 15.5 million PDP enrollees and 5 million Medicare Advantage PD enrollees.

This chart is showing you that Part D enrollment is highly concentrated into plans offered by just a few

parent organizations. Among stand-alone PDPs, on the left hand side, the top three parent organizations make up nearly 60 percent of total PDP enrollment. Among MA-PDs, on the right, the top three make up about half of total MA-PD enrollment. UnitedHealth, PacifiCare and Humana were the big winners.

Let's take a look at the types of benefit designs in which most Part D members are enrolled for 2006. I won't go over Part D's defined standard benefit structure now, but remember that plans can offer either that benefit structure or one that has the same actuarial value. For example, substituting tiered copayments for 25 percent coinsurance. Both a defined standard benefit and actuarially equivalent benefits are called basic benefits, and they're shown here in the orangish-yellowish sort of color there.

Enhanced plans are shown in blue. Enhanced plans are ones that include both basic coverage and supplemental benefits. That supplemental coverage can, but doesn't necessarily, take the form of filling in the standard benefits coverage gap. In fact, for 2006 the main form of enhancements seems to be including getting rid of the defined standard benefit's $250 deductible rather than

filling in the coverage gap.

Notice that about three-quarters of enrollees in Medicare Advantage prescription drug plans -- shown in the right-hand pie -- have enhanced coverage. By comparison, only about 17 percent of PDP enrollees have enhanced benefits. Notice, too, that many PDP enrollees with basic benefits are in plans that are using actuarially equivalent benefit designs. They don't have the defined standard benefit with its 25 percent coinsurance.

There are two basic reasons for this big difference between enhanced and basic coverage across PDPs and MSA-PDs. One reason is that a large number of PDP enrollees are dual eligibles, who CMS auto-assigned to lower premium PDPs. That means that plans with basic benefits.

A second reason is that organizations that offer Medicare Advantage PDs are allowed to use some of the difference between their plan payments for Parts A and B services and their bid for those services, called rebate dollars, for providing those services to enhance the Part D benefit or lower its premium. So most MSA-PDs are offering low premium enhanced plans.

Remember that Part D also includes a low-income

subsidy and the specifics of this extra benefit differ depending on an individual's income level and whether or not they're a dual eligible. But essentially, the low-income subsidy fills in most or nearly all of the cost-sharing requirements for beneficiaries who have low incomes and low assets. So far about 9 million individuals are receiving this extra help, including about 6 million full duals. This extra help also pays for some of all of the enrollee premiums and fills in much or nearly all of the coverage gap.

CMS auto-assigns duals and other low-income subsidy recipients into Part D plans. Your mailing materials gave you some detail about this process, but in most cases beneficiaries who have been in fee-for-service Medicare are randomly assigned among qualifying stand-alone PDPs. People who are auto-assigned to a plan have a chance to change plans at the time CMS goes through this auto assignment process, and full duals can change plans up to once a month.

Not every plan qualifies to receive auto-enrollees. PDPs need to have premiums that are near certain regional threshold values that are calculated by CMS.

On the surface you may not think that this population would be attractive to drug plans that are bearing insurance risks, especially full duals, who tend to be sicker on average and have higher drug spending. But there are some important reasons that plans want these auto-enrollees.

At the start of Part D there was a lot of uncertainty, you may recall, about how many Medicare beneficiaries would actually sign up for Part D. This auto-enrolled population was at least one group that plans could count on for initial enrollment. And they also were particularly desirable because, from a plan standpoint, they had lower marketing costs. Since Medicare pays for the premiums and most of the cost sharing, plans can be assured that these low-income subsidy enrollees come with a reliable payment stream. And CMS also uses a special risk adjustment factor for plan payments on behalf of low-income beneficiaries to provide even more incentive to enroll them.

So about 9 million beneficiaries are receiving extra help today and CMS estimates that there are another 3 million others who are eligible but have not yet signed up. Recipients of low income subsidies make up about 52 percent

of all PDP enrollees, compared with about 15 percent of total enrollment in Medicare Advantage prescription drug plans. It's really fairly straightforward to explain why. The 15 percent share in Med Advantage PDs largely reflects how many duals and other low-income enrollees MA plans had prior to the start of Part D, and most duals and other low-income beneficiaries who are in fee for service Medicare rather than Medicare Advantage before the start of Part D had been auto assigned by CMS into qualifying PDPs.

I'm telling you this because over time having a high proportion of low-income subsidy enrollees could affect PDPs operate. Since this extra help fills in most of the cost-sharing requirements, plans can't necessarily rely on differential copays to steer beneficiaries towards preferred drugs to the same extent that they can for other types of enrollees. They may have to use other sorts of management tools such as prior authorization, step therapy, tighter formularies to a greater degree.

This is a bit striking because Medicare Advantage drug plans are in a better position to use those sorts of management tools since they already have established relationships with prescribing physicians through their

networks and they have experience administering a drug benefit to their Medicare population. Their networks of providers, they already have some familiarity with the plan's formularies and non-formulary exceptions policies. PDPs do not have that same sort of history or those relationships necessarily.

It's important to keep in mind the trends I just described in the low-income subsidy enrollees for thinking about the issue of Part D's coverage gap. If you compare Medicare Advantage PDs and stand-alone PDPs, MA-PDs are much more likely to offer gap coverage as part of their benefit package. About 28 percent of MSA-PD enrollees have it versus 6 percent of PDP enrollees. But remember that a large proportion of PDP enrollee also receive these low-income subsidies. So essentially, these individuals are bringing gap coverage with them to whatever plan they sign up for.

Among MA-PD enrollees, about 11 percent are in plans that don't have a benefit design with gap coverage, but these employees effectively have gap coverage through their extra help through the low-income subsidies. A much larger share of PDP enrollees are in a similar circumstance,

51 percent, again reflecting the fact that CMS auto-assigned most of these beneficiaries to PDPs.

When plans submitted bids last year for 2006, the average premium offered by plans was $32 per month. But most enrollees are paying less than $32 a month for a couple of reasons. Again, CMS auto-assigned many individuals into qualifying plans, particularly stand-alone PDPs, and those plans had premiums below low-income subsidy premium amounts, so a certain threshold value, they tended to have lower premiums.

The other reason that other beneficiaries tended to pick lower premium premiums. So on average today Part D enrollees are paying about $24 per month.

Here's the distribution of enrollment by the monthly amount of plan premiums. I've got stand-alone PDPs on the left-hand side and Medicare Advantage PDs on the right. For each chart the yellow bars are showing you plans that have enhanced benefits and orange shows you basic benefits.

Notice that the PDP enrollees are paying higher premiums than Medicare Advantage enrollees on average. Remember that MA-PD enrollees get their entire package of

Medicare and supplemental services through the MA plan, and they pay the Part B premium and an MA premium typically for those services. But many Medicare Advantage prescription drug enrollees don't pay any additional premium for their drug benefits.

Also note that there are a lot more MA-PD enrollees in enhanced plans than in basic ones. So MA plans are using the rebate dollars I described earlier to enhance their Part D benefits and charge no or reduced premiums.

Last April Cristina and Jack Hoadley showed you some analysis we did on plan formulary designs and tier structures. For this slide, we asked Georgetown University and NORC to update some of their previous work to reflect plan enrollment by tier structure.

Enrollees in defined standard benefits are shown in orange and they pay 25 percent coinsurance for covered drugs. But just remember that, particularly among the PDPs, a number of these individuals also come with low-income subsidies. So they're effectively paying nominal copayments of $1 to $5 per prescription, rather than the 25 percent coinsurance.

A key thing to note among both PDPs and MSA-PDs,

on the left and right-hand side, most enrollee are in plans that use specialty tiers. Plan sponsors use specialty tiers for particularly expensive products or unique drugs and biologicals. Under CMS guidance, plan enrollees may not appeal the cost-sharing amounts for drugs listed on specialty tiers. Plans also tend to charge higher cost-sharing for these products in specialty tiers, typically on the order of 25 percent coinsurance.

So specialty tiers are a way for plans to limit their financial liability on very high cost drugs. Remember that Part D includes catastrophic protection. So once an enrollees out-of-pocket spending reachers very high levels, the plan covers most or all of that additional spending and Part D has extensive subsidies for that.

Plan sponsors turned in their bids for Part D benefits for 2007 last June, and they can start marketing their 2007 products as of next Sunday. The open enrollment period for the coming year will run from November 15th through December 31st. Late last week, CMS released some information about 2007 benefits and premiums for PDPs, the stand-alone plans. The information for Medicare Advantage PDs is not available quite yet.

I haven't prepared slides on what those plans look like but I can give you a general sense of things. Generally it appears that once again there was strong competition among plans for 2007. There will be about 30 percent more PDPs in the market for 2007 than for 2006. There's a median of about 55 PDPs per region across the country. 17 organizations are offering at least one plan, one plan name, in all 34 PDP regions, compared with about 10 such organizations last year. Some of these new national organizations participated in Part D last year but weren't quite national and they've just kind of broadened the regions in which they're operating. Others are relatively new entrants into Part D.

A larger proportion of PDPs will be offering coverage in the coverage gap for 2007, 29 percent of PDPs versus about 15 percent for 2006.

CMS expects that enrollees will pay about the same average monthly premium in 2007 that they're paying in 2006, which is again about $24 a month. In general, the distribution of premiums for plans offering basic benefits is tighter and more compressed than it was last year. Many of the higher price plans lowered their bids. The overall

average and median, they're a bit lower. So it's a more compressed distribution. But it also appears to be the case that premiums for enhanced plans are a bit higher than they were for 2006, on average.

We've spent most of this briefing talk about what 2006 enrollment looks like. Under current law, these enrollment trends for 2006 should affect Part D for 2007 in a couple of different ways. First, the law says that CMS should take 2006 enrollment into account when setting plan payments and enrollee premiums for 2007. Second, CMS should also use enrollment weighting when setting the threshold values for low-income premium subsidies. CMS did not use enrollment weighting in either of these ways for this current year, 2006, because PDPs didn't exist before the start of Part D and there was no information on which to base the market shares of PDPs.

Under enrollment weighting, several things would happen. First, in terms of plan payments and enrollee premiums, the move to enrollment weighting would mean that monthly payments to plans would be lower and enrollee premiums would be higher than would be otherwise. Also, fewer plans would have premiums below the low-income subsidy

threshold values. This means that enrollees in plans that qualified for auto enrollee in 2006 but didn't qualify in 2007 would either have to change plans or begin playing a premium to stay in the plan that they're in now.

Over the summer CMS announced that it has started two demonstration programs for Part D. First, it will transition to enrollment weighting to set all plan payments and enrollee premiums. For 2007, CMS calculated the national average bid using a composite approach --

DR. MILLER: Rachel, can I just interrupt you for a second. I just want you to go through again the part right before you come up to what they did in the demonstration. So what would have happened with the low income benchmark and what would have happened with the premium. I think that blew by too fast. Just one more time.

DR. SCHMIDT: Under current law, CMS is calculating two different things, two major parts of Part D. One is the national average bid, where all the organizations are submitting their bids for basic benefits under Part D. Under current law that is to be weighted under enrollment levels for 2007.

Without doing that, that means that the national average bid would be higher. That means that since a portion of that is paid to plans on a monthly payment, if it's higher, that payment would be higher and also enrollee premiums would be lower.

Is that a little bit clearer?

So effectively, if you had gone to enrollment weighting relative to current law then plan payments would be lower than would otherwise be the case and beneficiary premiums would be higher.

DR. MILLER: To be clear, the part that the government pays would be lower and the part that the beneficiary pays would be higher.

DR. SCHMIDT: If they had moved to enrollment weighting.

MR. BERTKO: It's like moving a slide rule indicator.

DR. REISCHAUER: If they followed current law.

DR. MILLER: And then the low income piece.

DR. SCHMIDT: There's a second calculation that for each region across the country, these 34 regions, there are these low-income subsidy premium threshold amounts.

Again, CMS looks at all the premiums now for each individual plan operating in a region. And under current law it is to use enrollment weighting, so taking 2006 enrollment into account. If it doesn't do that, that means that these thresholds are higher, more plans qualify to receive auto-enrollees or keep the ones they have for 2006.

If they follow current law the opposite would be true, you'd have lower threshold amounts, fewer plans would qualify to receive auto-enrollees and there would be disruption of low-income subsidy beneficiaries who would need to switch to a lower premium plan that does quality, or begin paying part of the premium.

So over the summer, CMS announced that it's doing two demonstrations with respect to Part D. It's transitioning to this enrollment weighting for the general national average bid, the overall calculation that affects plan payments and enrollee premiums. It's using a composite approach. So it's using 20 percent enrollment weighting and 80 percent of a straight average among PDP bids.

In a second demonstration for the low-income subsidy calculations is that they're not going to use enrollment weighting at all for 2007. We don't know details

about how long -- this is a transition approach, is what CMS has said.

DR. REISCHAUER: What is this a demonstration of? Reduction in political outrage?

MS. DePARLE: Is it under general demonstration authority? Or is there something in the MMA that said they could do this?

DR. SCHMIDT: Yes, under general demonstration authority?

DR. HOLTZ-EAKIN: All kidding aside, has anybody contested whether they have this authority? Seriously.

DR. SCHMIDT: I think there's been quite a bit of debate within the administration but...

DR. REISCHAUER: Does a whistle blower get 10 percent of the savings?

DR. HOLTZ-EAKIN: Can they have a program-wide demonstration? Or is that an oxymoron? And is there somebody who will review this as a matter of course, automatically, the OIG in HHS or anyone like that? Does anyone know?

DR. SCANLON: This is not the first program-wide demonstrate. We had the program-wide demonstration with the

oncology surveys last year. There is an issue that the demonstrations are supposed to demonstrate something for the benefit of the program, that somehow that the program operates better because of the demonstration. So the question we might ask is what has CMS said about what they're learning?

My understanding of the oncology demo was they were learning whether physicians could actually submit information.

The other thing that is a bit of a departure in both of these cases is budget neutrality, which is not in statute or in regulation but has been in tradition. In the past, GAO has questioned both budget neutrality of demonstrations as well as when it has overridden explicit Congressional intent. The Department has said they can do this.

MR. HACKBARTH: As a related but more narrow question, with regard to part of this, you said it was a transition.

DR. SCHMIDT: That's according to CMS documents, but they have not provided details about over how many years of what the next tier might look.

MR. HACKBARTH: That's what I wanted to nail down. Well, transitioning to what the statute says presumably, which is enrollment weighted.

DR. SCHMIDT: Right.

MR. HACKBARTH: I was wondering about over what time period and what the path was.

DR. SCHMIDT: It's unclear.

MR. HACKBARTH: We've got ahead of ourselves. Rachel, why don't you finish off.

DR. SCHMIDT: The last slide here and then I know you're anxious to jump into this.

The Commission may want to consider the pros and cons related to these two demonstrations and CMS's decision to phase in enrollment weighting. On the one hand, this approach leads to less disruption for plan enrollees. Fewer beneficiaries receiving extra help will need to switch plans, avoiding some of the transition issues related to changing formularies, coverage polices, non-formulary exceptions processes and pharmacy networks.

Also, the demo for setting plan payments, the general national average bid demo, means that enrollees won't face steep premium increases that they might have seen

under enrollment weighting.

One could argue that phasing in enrollment weighting could give CMS and plans time to work on information systems and other factors to better prepare for the issues that come up with beneficiaries switch between plans. On the other hand, phasing in enrollment weighting raises Medicare program spending relative to current law. Also, it may postpone but not avoid the transition issues that could come up from year to year under this payment system that's essentially based on bidding. As a result, there's bound to be some of these transitions.

One might also, of course, question whether CMS should use its demonstration authority for this purpose.

MR. BERTKO: Let me make one addition to Rachel's very good summary on this. There was yet one more step, which wasn't a transition. But it was an allowance of plans to waive up to $2 of their premium in order to retain their duals and low income people. That had a not insubstantial effect on perhaps as many as a million low-income retirees.

DR. SCHMIDT: Initially there was a de minimis policy, they call of it, of about $1. So if you're in the low-income subsidy threshold calculation, if you're a plan

and your premium came in within a dollar of these thresholds, you could keep your enrollees. That has been subsequently changed to $2, as I understand it and has lowered the number of beneficiaries affected.

MR. BERTKO: My second comment, I'll argue against our own company's business interests on this one, but mention that in the management of an active market competition process, getting all the companies to bid lower actually is probably the biggest net benefit, which actually happened here. So managing the competition process the way that it was done may actually be a positive and should be a benefit added to the less disruption part of it.

Now you could argue that that might have been done in the absence of this, but managing competition in the way that the FEHBP has occasionally managed competition very quietly, to me, is a possible net good.

DR. HOLTZ-EAKIN: Can you elaborate on that?

MR. HACKBARTH: Help me understand that. Why would enrollment weighted calculations lead to less competition?

MR. BERTKO: Not less competition but to make the whole process a little smoother. In a pure economic sense,

it doesn't increase competition. But in a sense of business pragmatism, in terms of what your next year's enrollment looks like, it makes it a more attractive business proposition to go after the membership if the process is a little smoother rather than being somewhat jagged or cliff-like in terms of the way enrollment would move around.

DR. HOLTZ-EAKIN: So this announcement was made prior to the bids?

MR. BERTKO: It was made about a week prior to the bid and then we had an opportunity for an extra week to rebid something that you thought you might have to do.

MS. DePARLE: Maybe you said this in the paper but how much money was spent on this?

DR. SCHMIDT: No, I did not say that in the paper because there have been no public estimates. CBO has not done an estimate on this. I'm not aware that the Office of the Actuary has released anything publicly on this.

To give you a sense of things, we did a back of the envelope calculation about the costs for 2006. Let me be very clear about this. This is for 2006, where there's no question we would have had to probably use the approach that CMS has done, where PDPs are not enrollment weighted

because there's no data by which to weight them. I have looked at the 2006 bids and 2006 enrollment levels as of July. My back of the envelope calculation is that the cost is about $1 billion for that one year.

Now having said that, for 2007, again I mention that the bids for basic benefits are more compressed and a bit lower on average. That would tend to lower the cost, in addition to the fact that they're using at least a composite approach, 20 percent of it is based on enrollment weighting. So it would be a lower amount in 2007.

And if this is transitioned over time, it would be probably lower still amounts in subsequent years. But again, we don't know exactly what's going to happen.

MR. HACKBARTH: Let me just make sure I understand the $1 billion figure. You're saying that in 2006 enrollment weighted couldn't be used because there weren't any enrollment figures. But if you went back, knowing what we know now about actual enrollment and recalculated, it would have been $1 billion less in federal spending?

DR. SCHMIDT: Yes.

MR. BERTKO: But keep in mind in 2006, I have to say this tactfully, there were a couple of companies that

bid correctly according to how the costs have come in, and a number of companies that bid way too high. And so that way too high goes into the bid.

In 2007, and I took a quick look at everything last Friday just after they were out. The bid compression that Rachel talks about has come into not full effect but a great deal of effect, particularly on an enrollment basis. So the $1 billion, I think -- Rachel said this correctly, because we don't really know the answer yet, either of us. But it's, I think, considerably less than $1 billion for the actual cost against current law for 2007.

MS. DePARLE: When you say too high, too high relative to what?

MR. BERTKO: To what their actual costs would be. But they got no enrollment, so it doesn't matter.

MS. DePARLE: We have enough data to say that? Because I heard that some of those plans actually had very high costs. I may be thinking of free-standing PDPs.

MR. BERTKO: Some plans bid inappropriately and got -- urban legend has it that one plan bid so high, being conservative, and got one member.

DR. REISCHAUER: Huge profit but didn't make it up

on volume.

MR. BERTKO: Except, Bob, no huge profit because of the risk corridors.

DR. HOLTZ-EAKIN: Some questions just to get some magnitudes on the low-income subsidy population. There's about a quarter of it which has not signed up at all for drug coverage? Is that three out of the 12?

DR. SCHMIDT: That's right.

DR. HOLTZ-EAKIN: Given the participation in other programs for similar populations, there's no great expectation that they're going to show up? We're not going to have another 3 million people of this sort that we'd have to...

DR. SCHMIDT: There's a lot of work underway to try to figure out how to get these people signed up. But yes, given history of other programs, it's been a very difficult process.

DR. REISCHAUER: What happens to a low-income person who shows up late? Do they get penalized?

DR. SCHMIDT: No, I think they have a special enrollment period and do not have to pay the late enrollment penalty.

MR. BERTKO: No penalty this year.

DR. REISCHAUER: There's no incentive to join until you meet the...

DR. HOLTZ-EAKIN: Do we know, based on even these preliminary data, how many transitions will have to be managed? There's the clear concern about the trade-off between transitions in this population and the and the formularies they'll have to figure out, versus other consideration. So what are the magnitudes and transitions that will be faced? Do we have some idea?

DR. SCHMIDT: Initially, as this de minimis policy that I mentioned of $1 around the threshold amounts was announced, there were statements out of CMS that seven out of eight low-income subsidy beneficiaries could stay in the same plan. But that leaves one out of 8 that would have to go through this transition.

Subsequently, they've changed that de minimis policy to $2. My understanding is that has brought the number down to practically nil.

MR. BERTKO: To 5 or 6 percent.

MS. BURKE: Separate from the payment issue what, if anything, do we know? Or is it way too early to know

what the utilization has been like in terms of actual prescriptions? Are they yet able to determine anything?

I've had this conversation with them in the course of the work on the FDA that we did, about data and about beginning to analyze that data and beginning to share it. Do we know anything at all?

DR. SCHMIDT: I've not seen detailed data, but from equity research I've read and that sort of thing, I think some plans have been surprised to find lower utilization than they expected. I've heard that generic fill rates are much higher than anticipated. That's the general sense.

MS. BURKE: Do we know anything from CMS in terms of when we, in fact, might be able to begin to see any of that data? Why am I even asking this question? In our lifetimes? Nancy-Ann and I will have retired from MedPAC and gone on to glory.

DR. SCHMIDT: I can tell you that after the end of calender year 2006 there's still a long process that CMS has to go through with plans to kind of recheck some of the prospective payments they've been providing. I think that could be easily a six month process until all of that is

cleaned up.

In terms of our ability to get such data, I know that there is some push from some parts of the Congress to look at legislation that would provide us with that sort of data. It's still in question.

MS. BURKE: I wonder, Glenn, and this was enormously helpful, Rachel. But I wonder, Glenn, what you imagine given this last issue in terms of their making a decision about a demonstration authority. Is it your intention that we would, perhaps at the next meeting, think about whether we want to comment on that?

In that context, I assume that might be the case, I think there is some value in continuing to highlight, in the course of that, the desire for data and the desire for data in some reasonable time frame that can begin to inform us in terms of utilization and behavior. I think we just need to keep saying that and how important that's going to be in some reasonable time frame.

MR. HACKBARTH: Thank you, Rachel. Good job.

We're now down to the very end and we'll have a brief public comment period, with the usual ground rules, which Karen knows by heart.

MS. FISHER: Hi. I'm Karen Fisher with the Association of American Medical Colleges. We represent all 125 allopathic medical schools, as well as most of the major teaching hospitals in the country.

I will be brief, although I did not speak at last month's meeting, with the hope of reserving that time for this month's meeting.

Let me first say that we do encourage the Commission to at least look at and have as part of the discussion the total margins in this discussion. They have always been included in past discussions. They were included in an earlier discussion today with critical access hospitals. We think they should be part of the discussion.

In terms of the empirical level, it was a little bit confusing because while the numbers seem similar there was, at one point well, this is the empirical level with the Commission's recommendations. This is the empirical level with the current law. It got a little confusing.

It's also important to remember that very much is still in flux in the CMS payment methodology. CMS is continuing to look at the DRG methodology to see whether additional changes are needed. They're continuing to look

at DRG refinements. We just had the occupational mix adjustment released, which has an impact on the empirical level. So there's still a lot very much in flux in this area, and I think that empirical level is going to be moving around.

We also support the Commission looking at the outpatient arena and what is happening with teaching hospitals and teaching hospital costs. This is a body and a commission with a technical expertise that there is very little of anywhere else, and we think it's a good staff that could examine this issue that is not being examined by CMS right now.

When the initial OPPS rule came out in 2000, CMS did look at this and did find a significant relationship with teaching hospital costs. It was not very large, but it was significant. But they didn't implement it at the time, one of the major reasons being that it was a new system and they wanted to see what happened.

We'd like to know what happened, too, and we think it's a good time to examine that. We think this is a good body to do it.

On a practical level, I think it's important to

remember what was raised about the resident cap issue in the resident counts. We did an analysis this summer looking at that issue and there was about net about 1,500 residents that hospitals are not receiving IME payments associated with. That in aggregate, when you look at the capped count and the total resident count, the difference is about 1,500. It's about 600 on the direct GME side. There are different counting issues for both of the payments.

The impact of that is teaching hospitals are receiving zero payments associated with those residents, which turns to be actually a cut. Interestingly, about 47 percent of hospitals are over their cap and about 40 percent are under. Very few are actually at the cap, which we think, rather than hospitals looking at this historically as a money generator, which many cynics thought, that hospitals actually are determining what their resident complement should be, what their involvement should be in teaching is based on what their unique circumstances are.

Some institutions believe that because of their mission they must go over their cap even though they are not going to receive Medicare support for those residents. Others believe, for whatever reason, maybe financial, maybe

other, that they are not going to be at their cap or they aren't in the particular year we looked at.

Next to finally, penultimately, we would encourage the Commission to look at the issue of ambulatory area and the Medicare role and policy in that arena. We're very concerned about CMS's policies with ambulatory training and counting residents in the ambulatory arena. In the inpatient final rule, CMS made a pronouncement that said to the extent that didactic and educational training occurs in non-hospital sites, hospitals could not include that time in their resident counts.

We think that didactic and educational training is critical and integral to the patient care development of future physicians. And yet the current CMS policy is that hospitals cannot get paid for that time or receive Medicare support for that. We're very concerned about that.

Finally, there's been discussion, both this month and last month and in various sessions about, the education of future physicians and medical school education, residency education. We're happy to be helpful there, where we can, to suggest people for you to talk to, to provide data. We have a lot of data about curriculum. We have a database

that has the curriculum for all of the medical schools in the country to determine what exactly they are teaching. There's a lot of information and a lot of activity going on with residency programs and residency training, in terms of trying to develop professionalism, systems management, quality, patient safety, all of these arenas. And we think it would be useful for you people to hear about them. We'd be happy to help out with the staff in any way we can.

Thank you.

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

[Whereupon, at 5:37 p.m., the meeting recessed, to reconvene at 9:00 a.m., Friday, October 6, 2006.]

Friday, October 6, 2006

P R O C E E D I N G S

MR. HACKBARTH: I'd like to get started, please. Good morning, everybody. We have a really terrific panel this morning on physician groups. Cristina, do you want to do the introduction?

MS. BOCCUTI: Sure. As you said, we have some very distinguished speakers with us today. I'll first introduce them briefly. You have bios in your mailing materials. Dr. Casalino comes to us from the University of Chicago, but his background includes 20 years as a family physician in a California private practice that he co-founded. Dr. Casalino's research focuses on the organization of physician practice and, in particular, the kinds of organized processes that physicians use to improve the quality and control the costs of medical care.

He has surveyed physicians groups through his own work and through the Community Tracking Survey, sponsored by the Center for Studying Health Systems Change.

Dr. Burns, in the middle, is the James Joo-Jin Kim Professor at the Wharton School at the University of Pennsylvania. He is also the Director of the Wharton Center for Health Management & Economics. Dr. Burns has analyzed physician

organization integration over the past 20 years and his research covers areas such as the structure and performance of physician networks, the market forces that face the growth of group practices and investor-owned networks, and the organizational options for physicians in a consolidating industry.

Finally, Dr. Schneider is the Chief Medical Officer of Integrated Resources of the Middlesex Area and the Director of Community Medicine for Middlesex Hospital where she is a practicing family physician and faculty member. Dr. Schneider oversees Middlesex Hospital's programs in diabetes care, asthma, chronic heart failure and anti-coagulation. She directs other public health and evidence-based medicine initiatives at the hospital.

And finally, she directs the hospital's participation in the Medicare Group Practice Demo, which she's been asked to talk about today.

So I will turn it over to the three of you, but I'll be right back here.

DR. CASALINO: Thanks for having me here. Reading the transcripts of the meetings I'm very impressed by the level of the discussion from both the commissioners and the staff.

So I'm not sure I actually have anything to tell you, but I'll do so very briefly.

Rob Burns and I actually have a lot of the same things to say, I see, looking at his slides. So I'm not going to read my slides to you.

I think, in terms of the organization of physician practice, there's just a few simple facts. We can quibble about percentages, but basically most physicians are still in very small practices in the United States. About 40 percent are in one and two-physician practices and it's even a higher percentage if you leave institutional physicians out and you just look out in the community.

I think the 90 percent that I have there for under nine physicians is probably a little high, but let's say somewhere between high 70s and 90 percent of physicians are in practices of nine or fewer physicians. This is changing, but very slowly over the last quarter century. There's a little bit of movement into medium-sized practices, five, nine, 10, 15, 20 physicians, and a very, very slow movement into larger groups.

Nevertheless, there are a lot of large, and what I might call large medium, 20 physicians or so, groups in the

country. So there is something to work with there and I'll address that in a second. In fact, I'll address that now. In terms of groups of 20 or more physicians, there is at least 700 multispecialty groups that include primary care physicians. As you can see, there are another 150 that are multispecialty but have only primary care only specialists. Specialist groups of 20 or more are still relatively uncommon. Again, as you can see from the slide there, there's only about 155 or so single specialty groups of 20 or more physicians in the country. These are medical groups. We're not talking about IPAs now. During the '90s, there was a bit of a push to form large multispecialty groups and this was because people thought that the California model of capitation and gatekeeping and risk-taking for even hospital services by large physician groups was going to be the future. But when that has turned out not to be the case, we've seen -- and this is really through the Community Tracking Study and other sources -- formation of large multispecialty groups has just about completely stopped over the last six or seven years. Not that it was happening all that rapidly before, but there's just about none now. But what we are seeing is some

movement, although again not rapid, and not in huge numbers. But there is much more interest among specialists now in forming single specialty groups. We're seeing some of that. There's a few advantages to specialists of being in a single specialty group. These are not necessarily advantages for the health system, though. One is you can get negotiating leverage with a health plan even at a relatively small size in some communities if you're a single specialty group. A multispecialty group has to be pretty large almost everywhere to get leverage. But 50 cardiologists, say, could have a lot of leverage even though that's not that many physicians. Investing in an expensive imaging technology, you know that imaging costs are a big problem now. And this is clearly a reason for single specialty group formation.

And then now that they don't need primary care gatekeepers anymore to get access to patients, why should we have to quibble with them about income? And so specialists aren't, by and large, interested in being in multispecialty groups anymore. Rob will, I think, have more detail on some of this.

IPAs and PHOs, the numbers are declining for really the same

reasons as the fact that we're not seeing large multispecialty groups being formed any more. There still are a lot of IPAs and PHOs out there, but a lot of them are fairly non -- they're not doing much now. For one thing, they can't negotiate contracts jointly if they're not taking financial risk or if they're not clinically integrated, and most of them are not either right now. And as some of you probably know, the FTC has been quite active in going after IPAs and PHOs that are negotiating jointly without financial or clinical integration. But there are a pretty small number of quite effective IPAs out there, like Hill Physicians in Northern California. And there are again a handful of PHOs that seem pretty functional, as well, like if you want to call the Partners Health System in the Boston area a PHO.

The advantages, potentially, of large groups I think are fairly obvious. Rob talks about this, as well, I think. They can afford clinical IT, although still it's surprising to see how little clinical IT a very high percentage of even quite large groups still have. They can afford to pay physicians and non-physicians to dedicate their time to implement and organize processes to improve quality and

control costs. Similarly, they can afford skilled managers. And then, of course, there's the old saw about large multispecialty groups which is still true, that consultation among physicians in different specialties in the same spot is useful. And I think that that's true. Also, and this is important, I think, large groups can serve as a unit of analysis for measurement on cost and quality. They can bear considerable financial risk sometimes, which can be useful. Less useful for the health care system, perhaps is the negotiating leverage, the capital to buy technology. And then there are real lifestyle benefits for physicians in being in a large group. I think that's actually still one of the main reasons that physicians who are interested in a large group are there.

Why aren't there more? There are still an awful lot of physicians who seem to prefer autonomy and although they are complaining a lot and angry about their financial situation, they're not hurting so much, I think, that they feel like they have to get someplace where they can try to get some negotiating leverage.

There's not great data on this, but it appears that there

are substantial number of physicians and patients who actually prefer the small practice setting. There's a real lack of skilled physician leaders and there's a real lack of reward to physicians for creating or leading a group. It's like if you're a physician and you want to get a bunch of physicians together and form a medical group, a large bunch, good luck. They're not going to want to pay you. They're not going to want to invest any money in it. They're going to criticize everything you do. It's almost like common good or a free rider problem. We need more medical groups but it's not in very many individuals' interest to make the effort to create them. There are diseconomies of scale and scope, pretty clearly in large groups. They may be outweighed by the benefits. There is quite a bit of data to suggest that younger physicians are more likely to practice in medium and large groups. This varies around the country but some large groups, for instance Kaiser in Northern California, definitely are having more applicants, including applicants from community physicians who want to get out of their small practices, than they can accept although it's not true everywhere and it's not true in every specialty.

So we probably are going to see some movement, maybe a little bit more rapid, to medium and large groups over the next 20 years than we've seen over the last 20. But I still think if we didn't change the current payment system, for example, I don't think it will be very rapid at all.

I'm not going to say a lot about IPAs and PHOs. Theoretically, they have some advantages. Ideally, they'd have the best of both worlds of a large practice and a system where -- a small practice setting for physicians and patients. But in practice, it's very hard to govern them or to have physicians committed to them.

You'd think there would be good data on which type of physician organization performs best, but that's really not the case. There are theoretical and anecdotal reasons to think that the larger groups perform better. But as I'll show you in a second, there isn't a lot of good data one way or the other for that. And just my own personal bias is I think it's fairly obvious that larger groups do have more potential to do more good things and that some of them are.

There are also advantages to smaller practices. The personal relationships with patients and close interactions among staff should not be under estimated as a possible

benefit. Particularly in areas of quality that are not likely to be measured in the next quarter century, those things may counts. Things like diagnosis or getting patients to cooperate with treatment. So although I myself think that larger groups probably do better, I think it's a mistake to assume that. And also, I don't think we know how large is right. Is it 20? Is it 50? Is it 200? Is it 2,000?

Clearly, larger groups use more clinical IT. There's a few studies, pretty good studies now, that probably use more organized process of what I'm calling CMPs or care management processes to improve quality.

This third bullet, tend to have lower patient satisfaction. As I was going over the data again yesterday I thought that may be a little exaggerated. There is some data to suggest that overall, probably clearly not true with some of the brand name groups. Also, patients probably pretty much sort themselves, insofar as they have freedom to choose, into the setting they choose. Some people love Kaiser, some people want to be in a practice where there's one doctor.

The economies of scale literature is not very good but as you can see from the slide here, it shows surprisingly small

groups. But this is really kind of based on what gets the physicians the most income. It doesn't really include considerations of where can you get the highest quality, for example. So I don't think that literature is really worth very much.

There's been some question before I came to talk here, should there be deliberate attempt in payment policy to foster a formation of a kind of medical group, large integrated groups or whatever? Perhaps, but you can't really justify it with the evidence right now because there just isn't evidence. So it might be better to encourage activities, to get physician groups to try to do things we want them to do. And if those activities are sufficient reward, then the kind of groups that can do them both just by natural selection natural selection or competition will presumably become more prevalent.

It's fairly obvious the things that we want. Although if you look at this list, quite a few of them are things that are not going to be paid for by pay for performance anytime soon, such as accurate diagnosis and, in most cases, appropriate therapy. That's, to me, a concern.

Care management processes, these are the kind of things that

go on between visits and not during visits, by and large, a lot of which isn't done and probably shouldn't be done by physicians but should be done by the physician organization. So again, pay for performance shouldn't just be thought of as a way to get an individual physician to try harder with the individual patient in front of them, but actually to get the organization to do better.

Medicare is already moving towards, at least in discussion, a lot of the things on this slide. I haven't seen a lot of discussion of the fourth bullet, trying to use medical education to actually -- medical education right now still teaches doctors that quality is what I do for the patient that's in front of me while the patient is in front of me, which is important. But I think physicians need to learn that if that's all I do, I'm not a high quality physician. And they're not really learning that yet in medical education.

The last bullet, I honestly believe that if Medicare is going to do much to improve quality in the country, there's going to have to be some administrative funds for CMS to do that Just relatively trivial amounts of money compared to the size of the program to help Medicare do pay for

performance or public reporting well would have an impact far beyond their expenses, at least on quality and perhaps on cost, as well.

I need to wind up, but just to really make clear, the problem is, I think, in trying to devise a payment system or an incentive system to reward better care is that it's fairly easy, I think, to think of ways to do that with large groups. But again most of the physicians in the country are in small groups. So what can you do with the smaller physicians?

On this slide, I just want to emphasize that the demonstrations so far are with very large groups of physicians, 150, 200, often part of larger integrated systems. And there aren't really so many of them. So I think one question to think about, maybe more than has been thought about so far is how far can it be driven down, a payment system that would reward quality to groups? Or how small can groups be in demonstration projects?

I know there's one in process now that is aimed at smaller groups and I think that's good.

For smaller practices, I think it's going to be really easy to get pay for performance wrong for individual physicians

and that will be a disaster if that happens. It will be another managed care backlash kind of thing. So I think it's going to have to be done but it's going to have to be done carefully.

Just the last slide, again to the lack of what we know, this is a very good editorial by David Lawrence a few years ago where we really don't know what the combination of organization type, payment type, and organized process to improve quality, what the best combination of those things or what good combinations are. We have ideas about it but we don't have data. And that's something that's very badly needed.

DR. BURNS: Thank you for inviting me to speak. First off, let me apologize for the lengthy paper I wrote that was sent you as background reading. I didn't know that was going to happen. Larry actually, I think, is the only person who's ever read it. He claims to like it, so that's good enough to me.

DR. CASALINO: He claims to have read it. No, I really did.

DR. BURNS: You cite it and that's good enough.

I was asked to talk about four topics. One was the financial incentives to form group practices. Secondly, the

lessons we've learned from the formation of IPAs, PHOs and PPMs. Sorry for the three-letter acronyms. Third is what is clinical integration and how does it affect physician performance? And fourth, how do financial incentives work in groups? I'll try to cover these very quickly here.

These are the basic consolidation options for physicians. They run the gamut from horizontally integrating with other physicians, forming the group practices that Larry talked about; vertical integration with hospitals where hospitals acquire physicians, purchase their practices, sponsor hospital-based group practices; virtual integration with hospitals using IPAs and PHOs. And finally, partnering with Wall Street and venture capital firms. This was an experiment we conducted in the 1990s that had tremendous failure.

These are the incentives for physicians to consolidate and they're not put in any necessary order or priority. But one of the things we did in the background paper is show that everybody else in the health care system is consolidating, what about physicians? I think physicians got caught up in that in the 1990s, and that's when the Wall Street firms and

the physician practice management firms entered the industry. There was sort of a herd effect. The health industry, in particular the provider sector, is vulnerable to these herd effects. Hospitals and doctors do these things all the time.

A second reason that doctors consolidated was seeking bargaining power relative to payers downstream, trying to charge higher prices or withstand discounting pressures. And as Larry as mentioned, trying to enjoy greater autonomy and discretion and the thinking that if we're a large group we'll have more autonomy.

Larry was right in mentioning that there are some limited scale economies there in forming these groups, but they're not very big. Forming large groups can help. It doesn't necessarily lead to the development but it can help to lead to the development of infrastructure for clinical integration, which might improve quality. Add on ancillary services, just the convenience and ease, factors that Larry talked about. There are also professional development opportunities for those small number of intrepid doctors who want to take leadership and management positions while maintaining a full practice. And then finally, the vacation

and the call coverage.

This just shows that physicians are basically the center of the universe in our health care system. They're in the middle of the providers, right between the payers and the producers of products. The reason I put this slide here is that doctors and hospitals, at the end of the day, have to figure out how to balance the reimbursement pressures from the left with the unending innovation coming from the right. And they basically collide in the middle. Doctors and hospitals have to jointly figure out how to ration all the technology with the limited funding they get.

But the doctors are in the middle for another reason, and that's because they basically are the only ones, I think, on that picture except for the government that has a monopoly, a government-granted monopoly in this sector.

These are the data on what's happening with physician group practice over time, and I want to thank the American Medical Association for supplying these data to me on a just-in-time basis. It shows you that the number of physician group practices, according to the AMA's data, has been pretty stable over the last 10 or 11 years, around 20,000 groups. And the percentage of non-federal physicians who are in

groups has also been fairly standard, in the low 30 percent. That's been dropping a little bit.

If you look at how group practices are distributed by type, 70 percent of all group practices are single specialty, 22 percent are multispecialty. The balance, that's not on there, are the general and family practice. You can see that's also been pretty stable, and that's stable over a 25 year period of time. It basically demonstrates that this is a pretty stable industry. And physicians, by nature I think, are fairly conservative and stable, too. We don't see a whole lot of change taking place here.

One slide that I didn't put in here is the average size of a group practice. That also has been stable, both in the single specialty and in the multispecialty area. As Larry mentioned, the average size of a single specialty practice is six doctors. That's been stable over time. The average size of a multispecialty practice is between 20 and 25 doctors. That's been stable over time. I don't think it's any surprise that that's where the economies of scale are, according to the limited econometric evidence that Larry has talked about.

The one thing I would say is I put a little bit more

credence in that evidence than Larry does only because we have multiple limited studies of economies of scale. They all come up with the same results. But the thing that really convinces me is what the econometric evidence finds is the minimum efficient scale for a doctor's practice is exactly what the doctors have done.

I don't think these doctors are stupid because basically they're spending their own money if they're inefficient in their practices. So what we observe as the average size of a group is actually where the minimum efficient scale is, and I think that's on purpose.

Why are the majority of physicians in single specialty groups? I have two slides here which sort of lay out the laundry list of reasons. It's easier to do it. The doctors know one another. They're easier to control. They're small groups. Much less of a free rider problem, as Larry has correctly mentioned. They have much lower overhead because the doctors are all in the same business. You reach the scale of economies at a very small size and small group of four, five or six doctors is much easier to manage than a group of 30, 40, 50 doctors. They have common interests, services. There are protocols available for these doctors.

There's some evidence in certain areas that a specialist provides superior care to generalists. It's consonant with the whole focused factory model that's been advocated elsewhere in industry and in health care. I won't go through the rest of these things but there are lots of reasons why 70 percent of group practices are single specialty.

Another reason would be obviously because 70 percent of our doctors are specialists. That's probably another reason why.

There are some advantages of multispecialty groups, and Larry has already mentioned this, the scope economies being one. They have the financial advantage of adding on ancillary services, offering a care continuum, potentially greater market recognition for a small number of those large groups. There may be, although this hasn't been demonstrated, a competitive advantage in meeting the six challenges to delivery systems that was posed by the IOM's report a few years ago. And just because of their size, they may have a greater ability to make use of information technology and management tools. I think the big problem they have there, which Larry's research has already

demonstrated, is the lack of capital.

Despite all the trends in group practices, physicians still remain fragmented. I don't think physicians are that concerned about this. One doctor told me we haven't changed in 30 years, and we're proud of it. I think that's the mentality out there. We still have nearly 150,000 solo practitioners, 240,000 physicians in groups. These are AMA data. Larry's data is from a different database but they're consonant, 77 percent of groups have fewer than 10 doctors. What that means is that we have a large number of very small groups out there, a very fragmented industry and only 1 percent of all groups have 100 physicians or more. But that accounts for almost one-third of all group practice physicians.

Why do physicians remain fragmented? Here again, Larry has mentioned all of these things: desire for autonomy, independence. I think there's also an anti-management and anti-organizational sentiment out there, and I don't think that's cured by hospital-based training. I think it may breed some of that. As Larry mentioned, I don't think doctors have been sufficiently impacted by economic pressures. I don't think they feel enough pain to want to

do anything differently than they've already done. The specialty orientation leads them to more fragmented practices. Larry has mentioned there are antitrust issues. Specialists can't form large groups in local communities unless they have the financial or clinical integration. And as Larry has mentioned, most of those groups can't demonstrate any of that. They haven't had the capital or taken the time to develop it.

I think one area to look at is how physicians could get more capital to grow this infrastructure, and perhaps we ought to explore other avenues for allowing physicians to retain earnings without being subject to double taxation to allow them to invest that in some of the infrastructure that they need. So I think that's an alternate solution to some of the things that have been discussed.

A definite lack of physician leadership. We have more physicians going through MBA programs but I can tell you right now, when they go through Wharton's MBA program, they don't go back to practice. They go out to where the money is really being made, and that's in venture capital. And the unwillingness of group colleagues to financially support a physician administrator in their midst.

What is financial integration? We'll go through some of the definitions of financial and clinical integration, just so we're all on the same page. Financial integration could be either you have a capitated contract with a payer or you have a risk contract with a self-insured employer that includes bonuses and withholds for performance, and those bonuses and withholds are tied to individual performance or you have salaried physicians. But Larry and I have both served as advisors in some of the FTC actions against these physician networks. I can tell you most of this financial integration is sadly lacking in most of the IPAs and the PHOs out there. It just doesn't exist. Part of that is because capitation has gone away.

On the clinical integration side, borrowing on Larry's work and the work of others, there are a whole host of things you could lump under the title of clinical integration. I won't go through all these things. But here again, most of these things are lacking in IPAs and PHOs as well. So the clinical integration and the financial integration just don't exist very much out there in the landscape right now.

And finally, what went wrong with the physician practice management companies? Basically everything. Uwe Reinhardt

published an article in Health Affairs in 2000 that basically summed it up as a huge Ponzi scheme. In addition to that, there were so many other things and all of the major players in this industry went bankrupt. So not a whole lot of great lessons here to draw on at the moment.

DR. SCHNEIDER: I'm the test care here for virtual integration, I think. Those were two really great presentations. But shifting gears from academics to the real world now.

The question I was asked to address was really can this kind of network environment, virtually integrated group support pay for performance in Medicare?

I need to tell you a little bit about who we are and what we are because I think that probably does affect the replicability of our model. I know you're probably familiar with the PGP model, but I'll tell you a little bit about how we're implementing it. I think probably my last four slides are the most important and will kick off a discussion nicely. So I will try to get to them quickly.

So here we are, Middlesex County, Connecticut and surrounding towns. Long Island Sound down on the bottom there, New Haven down to the left-hand corner, Hartford up

to the top of the screen, Connecticut River going through there. Middlesex Hospital is the sole community hospital within this system. Within Middlesex County proper, which is 22 of those towns, about 85 percent of the FTE physicians are on our medical staff and are solely on our medical staff. So it really is kind of a cohesive community, very good hospital-medical staff relations, as well.

About 10 plus years ago the IPA and the hospital came together to form IRMA which is not quite a PHO, technically, but mirrors many of the goals of the PHO in that it was formed to do joint contracting under what we thought was going to be a risk environment that was coming. What's a little unusual about it is that the hospital actually carved out all of its quality improvement, medical management, UM discharge planning, risk, all of those functions into IRMA as well. So we really did try to cover the gamut of the continuum of care. And our mission statement, which has stayed really the same throughout dramatic market changes within our region, is to provide the tools, expertise, and management necessary to develop and demonstrate the best possible patient care in an ever-changing environment.

Initially we thought capitation was coming. That never

really panned out within our area. Then it became a clinical integration model but all of the same infrastructure we had set up still applied. And now we're actually no longer doing contracting on behalf of the IPA. We're doing it for our own hospital-owned physicians only. But in this era of pay for performance, public reporting, all of these things are still very important that we're doing.

So why did we get into the PGP? Actually, to be honest, it was because we really felt that it was important to prove that we were clinically integrated. There was a lot of debate about what does it mean? What do you have to do? Are we sufficiently clinically integrated that if the FTC came knocking we'd be able to show them real substantive programs? So we thought it was great to be recognized for having this virtual integration model in place. But really, the hospital supported and encouraged this, and I think that's very important because the low-hanging fruit here is avoiding inpatient care to save the money.

All of the physicians on the medical staff actually signed individual opt-ins to participate in this, with a couple of very minor exceptions. So it really does represent our

physician community within a geographic market area. We felt the synergies for this were wonderful and aligned with all of our other strategies that we were using with commercial payers. And also, in my community medicine hat, it included our strategies for the uninsured, who are our biggest risk population, if you will. Many of our disease management programs actually were formed both with the commercial population as well as the uninsured in mind. We actually outreached quite a bit to the uninsured over the past 10 years.

Again, the hospital care is the low-hanging fruit. A focus on continuum management, which we think we're very good at, and with the full support of the medical staff, and to support the medical staff because it's very important for the hospital to have a successful physician community to work with.

So our overall strategy was to save the money through improved quality and safety and coordination of care. Very importantly, we are not taking any kind of a UM approach. That really was not successful for us under the limited time that we were in a financial risk environment. And from our perspective on the hospital side, we really feel it's

important for our physicians to be successful, and what we know is this world of public reporting, pay for performance coming up, and we prefer to be gently introducing them to that at the leading edge of the curve.

I'll go quickly through some of our strategies. It's all the same kinds of things that the big fully integrated groups are doing: diabetes registries, quality data collection. And I will say this is just an interesting anecdote of can it be done within this kind of virtual network? We had to collect data on 10 diabetes quality measures. A few of those were claims-based measures. But initially, when we signed everyone up for the PGP, it was going to be a total of eight claims-based quality measures that were collected, so we wouldn't have to do any work collecting that data. After we all signed on, the number of quality measures went up to 32, and the balance of those were all chart-based. There's no money up front for this, so this is all kind of figure it out on your own. Thankfully, we convinced CMS that we should do this as a sample and not 100 percent, which was their initial intent. But this kind of thing makes it difficult to get the physicians buy-in and trust.

But the end of the story was our baseline year diabetes data collection, I actually ended up sending out to the doctors 500 single page data sheets, saying I know I said I wouldn't ask you to do any of this, but I'm asking you to do it now. Give me anywhere from two to six pieces of data on how you do with your diabetics. I'll give you $10 for filling this out. And you don't even have to do it, have your medical assistant do it. We sent out 500, we got back 483 within two weeks. This was not a big financial incentive but they know they're going to have to start doing this kind of thing. They've been extremely cooperative.

Also, anecdotally, out of those 10 measures, when we compare how we've done compared to the nine other groups in the demo, we were best practice on two of them, above threshold on seven of them. And the ones we weren't best practice on we were right up there or middle of the pack. So in terms of the quality, again, it can be done in a community like this.

We do have several disease management programs, as you heard in our introduction. We're a real believer in provider-based disease management. Bob Berenson actually wrote us up in a recent report published last week by the California

Health Foundation. These are really care management programs of the train wreck patients, and very labor intensive. We don't get reimbursed for this at all. The hospital supports these programs as a community benefit, even though again their primary outcomes are avoidance of hospitalizations and ER visits.

Electronic record adoption is just kind of at the starting point within our community, so we believe that in the next three years that will become more widespread. But I think importantly, to get them to opt in, I really had to promise the physician offices that we're not going to ask you to do anything that's going to burden the office, other than make sure you post a beneficiary notification.

And what's been very interesting is that our IPA has actually applied for the next iteration of the Medicare demos, the 646. And they're proposing radical practice change. So we'll see how that goes.

One reason that we applied for this is we really felt we do good things in this community. The hospital is participating in all of these quality and safety initiatives. And if all the theory actually works out, we should be saving some money by avoiding complications and

having anti-coagulation services, all of these kinds of initiatives. So this was an additional motivator for us, but honestly it's stuff that we want to do anyway. Transition management, we do have a home care agency. That's been very innovative and working with telemonitoring and so forth. We have to be a little bit careful to make sure we don't steer patients to our own home care agency, but it's difficult when we've got one big one that offers all kinds of interesting and effective programs and others that really don't offer the kind of innovation within the community. We've done more collaborative outreach to skilled nursing facilities within our region. We don't own any of those. We've implemented a new heart failure care management program. Our cancer center has picked up the ball on care management and is offering some great programs. Again, these are all free of charge to the patients and not reimbursed. And numerous safety initiatives, as we've mentioned.

Putting my community medicine hat on, several community-based strategies that we also think they're the right thing to do, and eventually something should trickle down in the way of savings on all of these.

Getting into how is this working and what should you be considering as you're looking at different models that are out there, within my own community we do have a lot of small practices, the onesies, twosies. We have some larger practices. But my view is just because they have a unified tax ID really doesn't mean anything in terms of how integrated they are from a clinical perspective. We have one primary care group that is actually the hospital-owned group that is probably about two dozen primary doctors. But it was formed by the purchase of a lot of little onesie, twosie practices and they've essentially continued to operate in that function, other than for administrative purposes.

So what's been interesting over the past year or two with both the CMS demo as well as what's going on with our commercial payers, is that group was actually motivated to go out and hire a full-time quality coordinator for the first time to look at any kind of clinical care uniformity and processes. And that was absolutely motivated by the pay for performance initiatives that are in our community now. So it can motivate change. And just because they're in a group, they're not necessarily integrated.

We do have some special challenges in terms of how to administer the PGP; i.e., I have to keep track of who's in the community, who's out in any given year. It gets very complicated because I can't just track them by who's charging claims to that tax ID number. How we distribute any bonus, should we end up getting one. We had to give CMS a very specific model of how we would plan to do that. It was very interesting conversations with my physician steering group. We're basically doing kind of pay for participation and recognizing yes, there's free rider effects and all of that. But we're all in this together. And if we try to nickle and dime it down to be very specific and complicated, none of the physicians are going to believe it. Keep it simple was the message I got from the docs. We are doing all of our quality reporting again at the community level. So I think there's less incentive to be getting rid of your patients that's non-compliant because they're just going to go to the guy next door and you're still going to get penalized within this kind of community-wide system.

Again, I think we have quite a bit of true substantive infrastructure to do clinical integration. And a great

piece of data to support this was that we have such market penetration within our region that CMS had to come up with a unique model to find a control group for us. Because out of all of the 10 groups, basically there is virtually no Medicare beneficiary within our service area that has not received some care from one of our physicians. That was not the case with some of the other groups that span a much wider geographic area or a very specialty-specific base, such as some of the academic centers. So we have our hands around these beneficiaries very effectively, I think.

I also want to just point out that in those little tiny practices where the CFO, CEO, COO and CIO are all the same person, and that's the solo practitioner, those are the places where we really see some radical innovation, very early adoption of electronic records, open access, all of that kind of thing.

Special challenges for us, this is often billed as a pay for quality demo, but it's really not. It's a shared savings model. I think the reward, it's a complicated method comparing to this control group. There's risk adjustment. It's very hard to explain it. It takes me about 15 minutes to explain the model to a well-educated physician. So I

think there's quite a bit of cynicism that there may or may not be a reward. It's unpredictable. It's very delayed so even if we get one it's going to be three years after the fact. So it doesn't have that kind of nice Pavlovian incentivizing effect on the physician's behavior. Certainly it's compounded by all of the SGR issues that you're well aware of. The physicians will just sit back and say I hear they're going to cut my payment by 40 percent over the next five years. What's the point of this?

The midstream changes that we got after we signed up for the program certainly had a very severe effect on physician acceptance and cynicism, both on the quality measures that I had mentioned earlier, as well as there were some significant changes in the financial model that again just kind of raised the cynicism level. But none of our physicians dropped out after all of those. I think the feeling was hey, we're in this to try it out and see what happens.

I mentioned our data collection efforts, which were very successful. We'll see if the others are as easy to do because we had a lot set up for diabetes specifically. Replicability, I think anyplace that you have some kind of

credible trusted community infrastructure, you can pull this kind of thing off. It might be a hospital medical staff structure. It might be a tightly integrated IPA network, the large physician group. I'm not sure it really matters. I think it's who's got the tools? Who's got the trust from the physicians? And who's got the credibility among physicians?

Certainly, when payers go in looking for HEDIS data collection they're not getting back 483 within two weeks. The physicians know me. They know yes, we're trying to make an effort, that these are their patients, that the data is coming out of our own systems. And I think that helps.

Certainly, the degree of market penetration and standardization of pay for performance within that region are very important. Again, that's driven a lot of change in what I think is a good direction. But the more fragmented that these programs are, if you're trying to answer to 10 or 15 or 20 different sets of standards, their definitions are all different, it gets to be very difficult.

Even within my own practice I was asked to come and report on how are we doing on these various P4P programs. I had to bring in five different report cards and they all had

similar measures, but not quite the same. Doctors will just glaze over at that point. So we're actually hoping to work on a big data aggregation project through a Robert Wood Johnson grant, and we think that will help.

A final caution, this is something I feel very strongly about. Pay for quality is wonderful. Pay for outperforming the other guy is probably not the way we want to go in health care. For us, the biggest bonus for participating in this has been sharing of best practices. I really think that if you're incentivizing just out-performing somebody else, that's going to go away.

I just wanted to add one other thing to follow up on an early comment about medical education. I'm also a faculty member in a family practice residency program where we actually do this. The physicians are trained you use registries, you use care management processes. And so this is normal for them.

So the ace up my sleeve is that over the past several years, I've put out a couple of dozen young physicians into my own community that think this is normal. And they do it. So I really think that's a huge issue that more attention should be paid to.

That's it.

MR. HACKBARTH: Thank you. Excellent presentations. Let me just start the discussion with just a statement about the context for this panel. As you know, we have been asked by Congress to look at alternatives to the existing SGR system. They gave us a specific list of options that they wanted us to evaluate.

Among that list were two that I think are directly relevant here. One is based on medical groups and the other hospital medical staffs. I just wanted to say a little bit more about the discussion that we've had on that.

There are a number of reasons why you might want to allow organized groups of physicians, whether it be multispecialty groups or hospital medical staff-based systems, out from under a broader SGR system. One reason that has been discussed by various commissioners is fairness. A basic problem with the SGR as it applies now is that everybody is hit, regardless of whether they contributed or the degree to which they contributed to the problem. That's a basic issue of equity. And also, it doesn't create proper incentives for a system that operates in that across-the-board manner. So one possible reason for an opt out for organized systems

is fairness.

A second is that performance might be more readily assessed for organized systems, as opposed to individual clinicians in a fragmented system. Providing good high quality efficient care is not necessarily the act of individual physicians. They contribute to it. But groups of physicians. They may or may not have formal relationships for one another, but many providers put their hands on the patient, especially when we're talking about the most complicated patients that account for the largest portion of Medicare expenditures.

So a second reason for creating an organized opt out, if you will, is that it would move the system towards better assessment of performance.

A third reason that I've heard as we've begun this discussion is that allowing this sort of opportunity might itself prompt desirable changes in the organization of care. So the model is that changes in payment drive organization, as opposed to saying the payment needs to conform to the existing organization of care.

And then finally, the most optimistic people might say if you do all of these things you may actually have a cascading

effect that in the long run alters cost trends. You get not just changes in cost trends but perhaps organizational changes that improve quality in the long run for Medicare beneficiaries.

So that's the basic discussion that I've heard to this point about the affirmative case for this. I'd like to just get you to react to that basic case. Are there pieces that sound plausible, implausible? What do you think?

Don't everybody rush at once.

DR. CASALINO: To me, I think the idea of if you're taking a large group or a relatively integrated system like the Middlesex system we just heard about, and allowing that organization to opt out of whatever kind of SGR there is and be paid in some other way. And then, of course, there's the question is it a matter of just opting out of SGR or are they actually going to be paid differently period? In other words, not be paid by Medicare fee for service but by some other method. So that could go either way.

To me that idea is attractive and should work, except that there are a few problems with it. One is, of course, if you make it more attractive then if physicians in other forms of smaller practices see that physicians in larger forms of

practice are getting “a better deal” you can imagine the political ramifications of that, even though it would in fact drive physicians into that kind of structure. On the other hand, if it’s a worse deal then it’s unfair to the larger groups. So it will be a little tricky to get it right, is something that I haven’t seen discussed I don’t think but probably has to be thought about.

The other question on the group side or the integrated system side is how big do you have to be? If you have to be really big, then we’re talking about a relative small number of physicians and patients in the country. If you can do it if you’re relatively small, then we’re talking about say a 50 physician group or a 25 physician group, then we’re talking about an administrative burden on Medicare. That would have to be thought about carefully.

Personally, I wouldn’t want to see it assumed without thinking that the administrative burden would be undoable. I’d want that thought about, I guess. And again, what I said during my presentation, it may be that for the expenditure of what, in relative terms, is a small amount of administrative dollars, benefits might be very large.

Another possibility would be to group a number of small

groups, 25 physician groups, in an area into a payment pool. But that has some of the same problems as the SGR as it is now.

I'll say one more thing and then I'll be quiet. In terms of paying at the hospital staff level, my initial reaction to that when I first saw it was pretty negative because so many hospital medical staffs, if not the great majority, are highly dysfunctional, to say the least.

On the other hand, just about all physicians are in hospital medical staffs. Hospitals do have some resources. We actually do want physicians in hospitals to cooperate in improving care, because some of the payment models, as you'll know, if the hospital's not part of it the hospital actually can lose money by the good things the physician group does.

So I guess dysfunctional as hospital medical staffs are, if there was pay being directed through a hospital medical staff, and essentially that was the SGR, was the hospital medical staff, there's no question that it would lead to real attempts to improve the way things are done among the physicians and within the hospital. I think the fighting would be bitter at many places, I think.

But the more I think about it, aside from some dead hospital administrators -- and some physicians would think some of them deserve to be dead probably -- but the results could be good in the long run. And it has the advantage that you then have something you can do with the great majority of physicians who are in small practices.

DR. BURNS: I was just going to pick up on Larry's last comment. I've spent most of my professional career studying the relationships between physicians and hospitals. Larry is dead right on, in terms of, at best, the ambivalent relationship between the two of them. So any payment mechanism that goes that way is probably going to run into a lot of obstacles.

I think the classic definition of a hospital medical staff is a group of anarchists united by a common parking lot.

[Laughter.]

DR. BURNS: So the ability to get consensus between these two parties that have a deteriorating relationship, where the whole shift is to outpatient and ambulatory care and the physicians are increasingly competing with the hospitals. I think trying to affect some payment mechanism through that is going to be really tough.

Now there are some illustrations where that's actually been successful, in going back to the Medicare CABG demonstration where you gave the hospital and its medical staff one bundled rate. Three out of the four of those practice sites that were funded actually seemed to work. There are people out there now suggesting that's actually a pretty good model for trying to affect changes in how to pay physicians. I think the whole Bridges to Excellence model is largely predicated on things like that.

MR. HACKBARTH: I think I heard a little difference of emphasis. I heard Larry say that at first blush he thought the hospital-based model probably wasn't a good idea. But he closed on a more optimistic note that maybe if the incentives change the dynamic of the traditional dysfunctional relationship can change with it. I heard a little emphasis on you. I just want to make sure I'm hearing accurately.

DR. BURNS: He's probably a little bit more optimistic and I'm probably a little bit more pessimistic. But hospitals and doctors have had 100 years of trying to make this thing work and they haven't done it.

MR. HACKBARTH: Katherine, anything you want to add?

DR. SCHNEIDER: I think those were all good comments. And I'm thinking of myself as one of the dead hospital administrators, probably.

I think what made it an easy sell in the PGP was that essentially it really did kind of preserve the fee for service and it was an add on to that, as far as the physicians' viewpoint. I think as soon as you introduce anything that is kind of complex and distribution models that need to be -- I think the devil is in the details on how that new model of payment would really be implemented. And I think there would be bitter fighting, even within a highly functional hospital medical staff relationship. The other thing to throw in there is where does all of the quality measurement come in? I mean, I've heard loud and clear from CMS that quality, quality, quality, public reporting, pay for quality is the direction that they want to go in. The difficulty we have right now is that most of the quality measures are very heavy on primary care and the primary care docs don't even come into the hospital anymore. From a medical staff perspective, we're always trying to find ways of continuing to engage the primary care physicians when they're all admitting to a hospitalist's

service. So how do we promote that? So where does the quality measurement fit in? The devil is in the detail, I guess, is my final comment.

MR. MULLER: Those were superb presentations. Rob and Larry, both you noted, and I think Katherine showed it in her illustration, that in the 90s we had these various efforts to aggregate physicians largely around dollars and payments, the California capitation efforts,. The roll up of the physician practice management groups like Caremark and MedPAR, et cetera, FICO that all, for the reasons you noted, fell on hard times and collapsed. As you said, they were not well structured to begin with. In the last few years we've had the efforts to try to get physicians organized more around quality.

In each of your presentations you also pointed out that the thing we don't talk about as much but it really is shaping this is how do you manage these practices? How do you manage care? How do you get the infrastructure? How do you get the kind of coordination of these processes? As you noted, you can in some ways make that more implicit when the groups are six or 12. But once you get beyond that, you have to have a real managerial structure and so forth.

I think we've shown that trying to do this just around dollars alone doesn't work. I could easily argue, and I think it's in some of what you said, trying to do it just around clinical quality is probably not sufficient either because there may not be enough of a motivating traction there.

But let's speak a little bit about how one gets this system more managed and more organized so it can achieve either financial ends or quality ends. I think, to go back to Glenn's opening comments around alternatives to SGR, one has to deal with both quality issues and financial issues. My sense for many years has been until you figure out how to manage these relationships in a more powerful way -- and as Rob said, in 100 years of trying this, it isn't exactly that we got it right.

But perhaps could you speak a little bit about how one thinks about these what are I call the management issues and interrelationship with the financial issues and the clinical quality issues?

DR. BURNS: I'll take a first stab at that. It's a big global question.

I think we're going to have to be patient for these things

to happen. I think the biggest changes that take place in the practice of medicine may have to do with subsequent cohorts of physicians coming out of medical schools and residency programs. Larry talked about how medical schools need to be training physicians and the residency programs need to be training physicians more in the management side and the quality side and things like that. And I know those are now part of the American College guidelines. But those were just put in place a couple of years ago and we may have to be waiting several cohorts for new physicians coming into this industry to have that sort of training and have that kind of mindset.

So in the short term, I don't see much changing. I think this is a very stable, resilient industry that doesn't change very much. I remember talking to the physician CEO of the Northwestern Health Care Network, may it rest in peace. But he said what would it take to be able to pull all of these things together? Because he had multiple hospitals with different kinds of physicians all over the place. He said it would probably take about 20 years of genetic reengineering to make all these people work together.

And I'm thinking or the alternative is cohorts later on down the line of physicians who have been trained differently, to think of some of these issues and who get practice earlier on maybe in the kinds of settings that my two physician colleagues have talked about, have them have experience in doing this.

But boy, I don't see anything happening in the short-term. But here again, I could be pessimistic and I'll yield to more optimistic voices here.

DR. SCHNEIDER: Just a comment on linking the quality and efficiency. The difficulty or what makes me bristle about the PGP being described as pay for quality is that the quality measures, they tend to be underutilization kinds of measures. And so there's very little in our 32 quality measures that if we did well are going to save us within that short-term time frame.

On the inpatient side, I think that's easier. But on the outpatient side, more breast cancer screening, more testing, which yes, 10 years down the road may have a significant impact. But we're in a three-year demo. And there's very little linkage between those two. So that's a challenge.

DR. CASALINO: It's interesting to find myself perhaps more

optimistic than Rob. I think that in the one sense, I have a sense of urgency. Because I honestly think that if you just read the studies that if you just think that your own experience as a patient may be exceptional, and if you're not actually out there in the health care system like I spent 20 years doing, you don't know how really bad it is and how pathetic the quality is compared to what it ought to be.

I'm not talking about individual interactions between an individual doctor and patient or an individual surgery or whatever. There are marvelous things that can be done. But in general, it's terrible. It really is. And it's so far from what it could be.

The same with costs. There's so much waste. You can almost say that most of what is spent is waste, without it being too much of an exaggeration. So on the one hand I'm impatient to have something be done.

On the other hand, what Rob says makes a lot of sense to me. I think that clearly things can be done, as Middlesex shows. In certain situations they can be done.

But I think that as long as there's no real financial reward for investing in quality, it's just not going to become the

rule. It will always be the exception because the majority of people over time are just not going to invest money that they're not going to get back. It's just not going to happen except in exceptional cases. So again, the trick is to find a way to do that.

I'm impatient to see that happen. But on the other hand, I think it's quite possible, in fact likely, that CMS and others may move too quickly to payment models without sufficient -- there are some great demonstration projects underway in CMS now, and I think there probably need to be more. I'm particularly concerned that pay for performance at the individual physician level could be put in by CMS fairly quickly and I think it's going to be very hard to get that right. I think the consequence of getting it wrong for the whole health care system will be lasting and negative.

So on the one hand, I don't want to wait a couple of generations of physicians. On the other hand, I am willing to wait two or three or four years to try to get things right. We've had them wrong for a long time and I think a few more years of having them wrong to get them right sooner is probably worth it.

DR. MILLER: If I could just ask you to say just a few more

things. I definitely understand the point about how bad things are, and I've talked to enough physicians to have a sense of the feeling between the physician and the medical staff and physicians with insurers and that type of thing. But I wonder if you could just say a few more words about the point that you were making about marvelous things happen, there's good transactions from physician to physician, but quality is so bad. Can you just say more about where in the system, when you make a statement like that, what you see specifically as being bad?

DR. CASALINO: The list is long, I would say. And some of the things are things you've talked about here. Certainly, transitions of a patient between physicians or across settings generally are terrible. And the academic medical centers are by far the worst offenders with this, by and large.

I think that in terms of all of the things that could be done for patients with chronic illnesses between visits, in other words everything that could be done separate from the 10 minute encounter between the physician and the patient. By and large, that doesn't get done because it doesn't get paid for. And also, physicians aren't really trained to

think that it's important.

I kind of naively, in my own practice started doing it. I was in a nine-physician primary care practice. And basically my nurse or medical assistant and I did it, the two of us, without any assistance for 20 years. And really the result was that, without exaggeration, we went home about 10 o'clock at night and that's when we ate dinner for 20 years.

And I don't think we did it as well as we could. And yet I still knew, as I started to go around and interview California medical groups, that I wasn't doing it as well because we didn't have an organized system. We were just substituting our own labor with no infrastructure.

So all of that, for patients with chronic diseases, or to do preventive care in an organized way, it just isn't there. It isn't being paid for.

I'll say one more thing because this is something that probably one could list -- I could spend the rest of the day talking about problem areas. I think the whole model actually of how physicians spend their time is probably wrong. The model that physicians are just going to go through patients as fast that they can all day long, whether

they’re primary care physicians or specialists, is a mistake. In a utopian world, I’d like to see people sit back and say we have these very, very highly trained people whose time is very valuable. What’s the best way for them to use their time?

Again as a primary care physician, and just very naive, probably in 1982, after a couple of years in practice, I thought if someone would just pay me to be on the telephone with my patients -- in those days we didn’t have e-mail -- and maybe see six or seven patients a day, and spend the rest of my time supervising staff and communicating with patients in other ways, I could take so much better care of my patients. They wouldn’t have to come into the office and sit there with their kids and get a babysitter and leave work and be around sick people and wait for an hour and so on and so forth. Everybody would be happy. But nobody would pay for that.

Now I’m not really recommending that e-mail or phone calls be paid for. I think that’s probably a mistake to just add on more fee for service silos, so to speak. I think you want to really pay for results and have groups themselves figure out what the appropriate mix of visits, e-mail, phone

calls, other methods of communication would be.

MR. BERTKO: I'd like to aim this at Katherine and follow up a little bit on Glenn. This is just to get your reaction. You're not committing yourself.

Let's suppose that one of the alternatives to the current SGR were smaller pools. And my consulting experience overlaps that of Larry and Rob, to some extent, in California. But my experience now tells me that most parts of the U.S., 80 percent of the population, looks more like Middlesex County in one way or another.

So if the revised SGR, with administration assumed -- I'll pretend I'm an economist here -- and other quality measures. And your choice, as Middlesex, was the current national SGR by default, whatever new model looked like, the state of Connecticut, or the Middlesex delivery system, which do you think your docs would opt for?

Three. National as now, whatever that residual national is; the state of Connecticut; or your Middlesex, Connecticut delivery system.

DR. SCHNEIDER: This would be to determine what's the pool?

MR. BERTKO: Yes.

DR. SCHNEIDER: And it would be by residence of the

beneficiary? Or what's the attribution model?

MR. BERTKO: It would be by groups of physicians and DEA numbers, tax IDs, however, UPNs.

MR. HACKBARTH: I think Katherine was asking a different question. I think what I heard Katherine say is the results are based on the costs of what group of people? And so it would be based on the residence.

DR. SCHNEIDER: You would say county or service area. I think they would take the latter, just because I think we have enough data that we do it at least a little bit enough better. The objections would be we can't steer the patients, there's leakage everywhere, they still have choice to go anywhere. And by the way, we don't do any tertiary care. We don't even do open heart. So they're going to Yale or Hartford or Boston or New York or they're snowbirds going to Florida. Those would be all the kinds of objections I would hear.

But I guess if we're being pitted against beating national essentially, is what you're saying, I think that they would choose that.

On the other hand, if you're comparing it to the way it's done now, where we have a cut across the board but then it

gets repealed -- I guess devil in the details. But my sense would be that they would go for where there is at least some control.

DR. REISCHAUER: John, you're describing the localized SGR, no quality or performance --

MR. BERTKO: My comment about making the economist assumptions was to say there's all the other parts of it. But on the payment financial end of it, it would be as I indicated here. So it's just what's the pool that does it? But there's quality measures, there's financial measures, et cetera. The choice there is which of those three alternatives would they choose?

DR. SCHNEIDER: If I could just add to that, too, I'm thinking about the issues we're struggling with right now, in terms of physician manpower, planning, how do we make it attractive to recruit physicians into our area. It would have a huge impact not only on the cost of care and patterns of care but just even who we are as a health care delivery system.

DR. MILSTEIN: I think there's probably general agreement that it's hard to find industries that fundamentally and continuously reengineered their basic processes when the

participants in that industry did not face either a burning platform or a very competitive environment. And in your presentation you indicated that one of the characteristics of physician practice today is that it's not a highly competitive environment.

Is there anything, or what are some of the things that Medicare is not thinking about that you think would have the highest probability of leading to the evolution of something equivalent to the Southwest Airlines of American health care? In other words, half of the current cost at equal or higher levels of quality and customer services/

While you're thinking about that outlandish question, let me also make the observation that folks like Clay Christianson, in observing fundamentally disruptive innovations that have delivered big value in other industries have made the point that they generally come not from the mainstream players but from the margins, from small players.

Southwest Airline is a great example. That model was not invented by any of the major carriers. It was invented by an organization that initially was very small, maybe the airline equivalent of a one or two doctor practice, and was initially laughed at as something that is not really as good

as the mainstream airlines.

Is there anything Medicare is not thinking of that it should be thinking of, if that's the vision we'd like to get to not in three or four generations but in five to 10 years?

MR. HACKBARTH: Will we be able to get seat assignments in this?

[Laughter.]

DR. REISCHAUER: No baggage but everything else is okay?

DR. MILSTEIN: How much are you willing to pay for the seat?

DR. BURNS: First off, let me agree with your general premise that most of the radical change does come from the periphery. I think that some of the things that show up on the periphery are the demonstration projects that Medicare is funding. And Medicare's been doing this over a series of years. The earliest one I remember that was like this was the CABG demonstration, which I actually thought was pretty interesting. It fits into a model of paying doctors based on case rates where the doctors actually have to coordinate their own activities with other specialists. And then they're essentially taking on risk at the small group level to manage cases in a defined area.

That whole issue of case-based rates has been out there a

long time. And a lot of people still believe in it. And actually, if you look at it as an economist would, it actually makes some sense for doing things that way. I'm not exactly sure of all the reasons why that hasn't gotten off the ground. It could be maybe the demonstration funding is removed and then there's some inertia in the provider settings, things like that. But we've had continued experiments in things like that.

One thing is I would encourage Medicare to continue funding demonstrations basically because they're all these little pilot projects. They're demonstration projects or development projects, whatever you want to call them. The literature on innovation shows that that's where the subsequent big ideas come from. And later on we ought to take credit for it and say that was our strategy.

But really, you're just basically throwing a lot of balls up in the air and a couple are going to hit. And programs like the one Katherine is in is such a thing. But I think the case-based rate is another one that's probably worthy of revisiting only because it makes so much sense theoretically or conceptually in terms of what we do. But implementing it, given our fragmented specialist oriented medical

community is, I think, one of the big transition problems. There are probably some other reactions, too.

DR. KANE: About demonstrations, when the demonstration is done, what happens at CMS? I mean, do we have any -- I know On Loc sat around demonstrating for 25 years or something before anybody said we're going to now mainstream it. What is the method at CMS for taking demonstration and trying to turn it into more diffused practice?

DR. MILLER: I love getting questions like this, the ones that don't have any answers.

There is generally no clear mechanism that often -- either a demonstration is created internally. But often externally, it's asked for in legislation. The demonstration runs. There's supposed to be an evaluation, and then something has to happen. Usually, if you're going to mainstream it, it takes a change in law.

There is one recent change in that. The disease management demonstration, which has gone through three different name changes and I can't remember the current one. Health Support.

MS. THOMAS: Medicare Health Support.

DR. MILLER: That one actually is cast as a pilot with the

notion that if it is successful the Secretary has some flexibility to go forward. That is a little bit different.

DR. SCANLON: That was in statute as a pilot.

DR. MILLER: The Secretary was given that path in statute, that's right, explicit.

DR. CASALINO: Arnie, as usual, you have this talent for asking this question in a way that first makes the respondent think oh come on. And then it's like no, you really have to think about this. It does force one to think. I think it's a very good question.

I think that, let's say CMS were to say beginning three years from now, or whatever, the equivalent of the SGR is going to come to each physician, either because they're a member of a medical group of a certain size -- whether it be 50 or more or 100 or more or whatever -- or through their hospital medical staff. And that's the way it's going to be for everybody. And also, in the first year we're going to pay 2 percent of -- you couldn't just do that because it would leave the fee for service system untouched, and that's no good.

But you could say that a very small percentage of fee for service payment, that pool is going to be shifted into pay

for quality, also at the level of your group or the hospital medical staff. And that's going to increase each years at such and such a rate.

It's a doable thing. I think there would be a lot of kicking and screaming. But doctors don't like the current system and it actually would force people to -- there would be consternation and you would see hospitals and their medical staffs screaming at each other but working together because they have to to try to do something about this. So it could be done. That kind of thing, combining a shift to SGR kind of mechanism at the group or the hospital staff level, doing both at the same time, and then gradually increasing the amount that goes to pay for quality around fee for service, I think it would promote relatively rapid change of the kind that I know you'd like to see.

MR. HACKBARTH: Can I pick up on that? Implicit is this is an A and B system, as opposed to the current SGR which is a Part B only.

DR. REISCHAUER: A part of Part B.

MR. HACKBARTH: A part of Part B, the fee schedule piece of Part B. Do you think that is an important part of driving, encouraging constructive organizational change, that

whatever Congress decides to do it ought to break out of the Part B only model and think about A and B together?

DR. CASALINO: Yes. I think that would be one way to -- hospital physician cooperation is important, especially for some of the most expensive things. And that would be a way to do it. Gainsharing is another way. And I haven't thought this through far enough to know, if you did what I just perhaps rashly suggested in response to Arnie's question, I don't know if you'd have to make gainsharing exceptions to -- if you were going to shift the SGR to a hospital medical staff model.

But yes, having these be separate silos obviously doesn't really make sense, the A and the B.

DR. BURNS: When you think back, the whole integrated delivery system movement started right after prospective payment was passed. I remember I was working -- I did an internship at Hospital Corporation of America and they were right on top of the legislation at the time. And they said my gosh, hospitals are being paid differently now than physicians are because hospitals now get this fixed budgeted prospective payments, doctors are getting retrospective fee for service. What's wrong with this picture? The

incentives are not aligned.

And that's what launched 15 to 20 years of efforts by hospitals to try to integrate their delivery systems with doctors, basically because you had two different silos of payment with differing incentives to it. And those human behavior management techniques to try to engineer what had been broken asunder through the separate payments and the different incentives, those just didn't work.

Going back to your original question about whether changes in financing could drive changes in organization or behavior, it might be worth experimenting with pooling those two funds, the case-based payments as one of them. This might be another one.

I think the problem going forth, and here again I don't mean to be really negative, but I think the trend data shows that physicians are spending less time in the hospital now than they used to. And so hospitals are going to have to work with their doctors as a group who are spending less and less time in the hospital.

And I see that as one of the fundamental challenges for anything we do here.

DR. SCHNEIDER: I think it's very well said and the silo

issue is very important. In fact, in thinking about the SGR and the previous question, I actually had on my PGP model hat where it wasn't just Part B. I'm thinking total pool because the incentives really do need to be aligned. And I think that's where the PGP Demo, I think Herb Kuhn from Medicare described it as the first attempt to demo better alignment between Part A and B pools.

If I could take a politically incorrect attempt to answer Dr. Milstein's question, I don't see anything in Medicare around the whole kind of consumer directed health care model and patient incentives. That just may be impossible. But certainly from the provider point of view, that's the other piece that we need to align in there somehow. And I don't know how to do that politically.

DR. CROSSON: I'd like to thank the panel for really fine presentations, and also helping us, I think really quite quickly, get to the core of some of the issues that we have to address as we get ready for this mandated report.

I'd like to ask you one question. It's a little similar to Arnie's question but I think a little bit broader. In so doing, I'm going to use again the assumptions that the economists like to use, as John said. We have a tradition

here we're developing on the Commission, and that is that the economists like to talk like doctors and the doctors like to talk like economists. So I feel perfectly free to do that.

DR. REISCHAUER: There's more of you.

[Laughter.]

DR. CROSSON: I won't talk about how evenly we're matched. We'll leave that for later.

So the assumptions are that we're going to think about a 10-year period and we're assuming -- and while there is urgency, the level of change here we're talking about is going to take some time. So assuming a 10-year period of time, and assuming that the Medicare program not only has the opportunity to change itself for the purposes of making a better program, but it also has the opportunity to lead change in the broader health care environment in the country as a very larger payer and bully pulpit and all the rest of that.

And the third assumption is that we're going to assume that somewhere along the line somebody decides that there is a compelling public policy reason to promote the kind of organized delivery systems that we're talking about. Now we

haven't gotten to that point and we understand the data is missing. And we also understand we really don't know what we're saying when we say organized delivery system. But I'm going to suggest that there are some elements to it, and one of those is having physicians actually working together across specialties.

I'm not going to say anything about size because I think Larry has pointed out there are still some questions about size and economies of scale or diseconomies or practicality or the like. But another element is that the hospitals and the physicians are also working together. So I would say that when I'm saying organized delivery system, I would mean a model that contains those characteristics.

So here's the assumption, that over a 10-year period of time, at some point somebody decides that it's in the interest of the country to evolve to a point where that is the majority model 10 years from now.

So the question is, if you accept all those assumptions, what could CMS do? What could the Medicare program do over time to lead and shape that outcome? If you could start with a blank slate and say if only Medicare would do this or that, we might be able to get to a better place in terms of

how delivery of care is organized.

DR. BURNS: I'll scratch the surface on that. I think you'd probably want to hold out to aspiring physicians or smaller groups that are thinking that might be the way to go how do they actually get there? I can't think of too many case studies that actually show how you develop these kinds of large or medium-sized multispecialty networks. We've done one on Hill Physicians, so I'm familiar with how they did it. But it took them 20 or 30 years to do that and you're talking about a 10-year period. So you'd probably want to look for some illustrations of groups or collections of physicians partnering with whoever who have been able to do that.

I think Larry's research shows that the single biggest barrier is IT. But even before you get to the IT it's even having the capital to afford the IT. And one of the things you're going to have to address is where the money's going to come from to finance the aggregation of physicians into these larger groups? Where's the pot of money?

One pot of money I think that's been overlooked is the fact that -- or not been allowed to develop is that physicians and physician groups can't retain earnings. And why not

allow -- and maybe it's some change in the tax code, I don't know, whatever -- but to allow physicians to retain earnings such that they could invest themselves if they so wish in developing these kinds of things. That's sort of a radical proposal and that's not something that CMS can do.

But I'm looking at physicians have the incentive but they don't have the ability to grow.

DR. CASALINO: One way to encourage the formation of let's say large multispecialty groups, whatever large means, would be just to pay them better. That is a political non-starter probably; right?

But another way would be, as I tried to suggest in my presentation, to pay for results in some way. And then if, in fact -- and in a meaningful way, so it isn't just a tiny fragment of a physician's income.

If that were done and a certain kind of group, say large multispecialty groups, were able to get better results and therefore higher pay for its physicians and/or hospitals, presumably we'd see rapid migration of physicians into that kind of group. But this would be politically much more acceptable because you're not saying we're going to pay a certain kind of group better. No, we're going to pay for

results. We may think that bigger groups are going to do better.

So I think that's a pretty good way. I think if every physician was paid through Medicare, either as part of their hospital medical staff or as part of a large group, it's quite possible that many large groups would do better and that would lead to a movement of physicians into that kind of group.

So those are the three best things I can come up with. Only two of them are viable.

I think, in terms of retaining earnings or the double taxation that physicians have that Rob has mentioned a couple of times, I have mixed feelings about that. It's very real for physicians. Our group and every other group I've talked to, people sit there and they say we can't have any money left over at the end of the year. We're damned if we're going to be taxed twice on this. It does keep physicians from retaining earnings. There's no question about that.

On the other hand, that's true for every business and why should physicians be an exception? There actually is potentially capital there. Most physicians are fairly

highly paid and they could retain some earnings if they wanted to. But really, even if you try to get a physician who's earning $400,000 a year to kickback $1,000 or $2,000 that year for their group's growth, you're going to have a hard time about it. And I'm not exaggerating. It's amazing what this is like.

So that's a problem that I think probably shouldn't be solved by giving physicians a special exemption to the tax code, but by just making the incentives to perform well so high that they see -- as Kaiser physicians I think understand -- that no, we have to, in effect, retain some earnings because this will let us do things that are good for our patients and that don't cost us money and may even make us some money.

If I can ask you a question back, what would you do if you were going to try to encourage the formation of large groups?

DR. CROSSON: I have a lot of ideas but I think some of the commissioners have heard them and don't particularly need me to reiterate that.

But I do agree with you, I think, that as we saw in the '90s, although as you pointed out it gave rise to some

pretty odd stuff, PHOs that did not make it, the whole practice management industry which was a terrible catastrophe. Nevertheless, it began a process -- that is rather the prospect that the payment system was going to be changing, that it was going to be prospective and it was going to be blended in such a way that hospitals and physicians needed to work together, began a process which then died.

So it suggested to me that it is possible. It needs to be thought out. It needs to be done in a more considered way. I think, personally, it could be led by Medicare. But the payment system, to me, is the core of it. And that is to create a better payment system, one that pays physicians who can aggregate in the way that Katherine has described, who are already aggregated or who can aggregate, creates common incentives between physicians and hospitals as much as is possible to do, and fundamentally then incents quality and efficiency.

And if we could develop over time the understanding to create such a payment system, then I think the delivery system organization would rationally follow that.

DR. SCHNEIDER: I think we’re very focused on what’s the

model. But really the question fundamentally is what's the outcome that you want, even from the beneficiary point of view? What is rational care at the end of life? What is rational evidence-based care of chronic diseases? And that's what you want to incentivize somehow. If you're going to build it from scratch, what do you want it to look like? And then kind of let the market find its way.

MR. HACKBARTH: At least some commissioners, and I know Jay is in this group, some commissioners as well as people outside are saying one basic characteristic is that we need providers to work together to collaborate to provide better care and more efficient care. And the current fee for service payment system in Medicare actually pushes in the opposite direction. And so one basic design feature would be to urge that collaboration, reinforce that collaboration. Or at a minimum, create an option that rewards people that voluntarily engage in that collaboration. That's the genesis of this whole group opt out notion.

DR. BORMAN: Notice the surgeon was patient.

MR. HACKBARTH: This is the second time, I think, Karen.

DR. BORMAN: That's right, in my lifetime.

[Laughter.]

DR. BORMAN: Just a couple of things. Number one, great presentations. Very thought provoking. A couple of things that you said certainly, I think I want to make sure that I iterate them correctly because I think they're important. One, the honesty that data about some of these issues is sorely lacking. I was once told that surgeons use the literature much like alcoholics use lampposts, more for support than illumination. And I do think it's important that we try to go back to what are the things that we're building on. Sometimes we have to take the big leap, but I think that we need to acknowledge that a lot of these issues don't have great data.

In follow up to that, I would say the demonstration project issue is, I think, a very important one. CMS has invested money in it. There are things to be learned. And I think we should be maybe perhaps considering for our report a better process to see those results, particularly as we're facing the sizeable issues to make recommendations about. I think, particularly Katherine talked a fair amount or implied a lot about getting it right, as you guys did, as well. I think from working doc end of this, this is going to be just hugely important and that the backlash will

indeed be substantial if it's not. And so that's the tension between the urgency and the caution and perhaps where the demonstrations can help.

I think one thing that Katherine said really resonated with me, which is the be careful about this turning into outperforming the other guy. This is really not what this is about. That reinforces the notion that's kind of growing out there, that quality is just another name for taking money out of the system or cost reduction. And that will be the fastest way to lose the practitioner of any way that I know. And I think the outperforming the other guy concept is a huge one in here.

The piece about that physicians haven't felt enough pain, I'm going to offer you an alternative construct, which is we're getting pain every day anyway, so why should I sign on to yet a different version of pain? And whether there's rationality to that or not, I think I can tell you -- and I think perhaps Ron would agree -- that there's a fair amount of that kind of sentiment out there. And so we need to be a little bit careful about how we characterize it.

My questions relate about, number one, you've made some comments and observations and raised good questions about

the behavioral qualities of physicians, if you will, in terms of the autonomy versus at times the herd effect that you talked about. Do we have anything from social science that you're aware of that links the autonomy with a behavioral cluster that is different when autonomy isn't a strong portion of somebody's personality or makeup? Because if we change the piece of physicians that is driven by autonomy, will we be selecting people for characteristics that may, in fact, be inimical to the kind of health care system that we want physicians to be a part of?

And so my guess is we don't know that but I'd be interested in any data that you have. That's my first question.

DR. BURNS: I have a short answer, and that is I think you could leverage the natural autonomy and entrepreneurship of physicians and marry it to small startup projects, development projects, pilot projects, whatever you want to call them. There's a natural fit there.

I think the problem physicians have is that they either aren't paid for or they're not given the time to or they don't feel like they have the time to engage in these things.

There was an article written how several years ago how

physicians could actually be the innovation engine in health care. Because most of the innovation in health care takes place in the product sector, pharma, biotech. We don't have a whole lot of innovation taking place in the provider sector. Physicians are natural people to lead an innovation effort in the provider sector, just because of the clinical autonomy and the strong need for entrepreneurship and the bent that they have there. It's just a question of can we unleash that in some way and support it?

Going back to one of Arnie's comments about changing coming from the periphery. It's not just coming from the periphery. Any change effort has to be sustained over a period of time. And you're looking for two things here, which you may not have. And that is time and money. But most innovations, the really significant innovations, gestate over a long period of time. They're given continued seed funding. They're nourished. They're someone who's championing the effort. This is what all the innovation literature shows.

And oftentimes the things that really pay off in the long term are things that you sustained in terms of interest, time and money over a long period of time. Rather than

looking at it in terms of the short term.

I'll just give you one illustration, a very interesting statistic. That is they compared American firms and Japanese firms in terms of their commitment to total quality management. Now I think most people would still agree that the Japanese cars are probably made a little bit better than ours. But American firms devoted roughly two to three years to total quality management programs, may not have seen the results, then they drop it and they move on to the next thing. The average Japanese firm committed 30 years to total quality management. I think they saw the results. That's why I'm suggesting oftentimes I think it's a question of time and money and sustained interest to see any of these kind of development projects take off.

DR. CASALINO: I think that once again I'd go back to the training. We don't want individuals to be selected who aren't able to function autonomously, nor do we want them to be trained in such a way they don't feel that the buck stops with them. This is particularly clear with surgeons, but with all physicians. I mean, you don't want your surgeon turning around and saying well, I'm sorry things didn't go well, it was the nurse's fault.

That is probably the strongest aspect of medical training, that the buck stops with you, you use your own best judgment, don't ever make an excuse. We don't want physicians to ever be any different about that. But we need to train physicians equally strongly that that isn't the only thing that physician professionalism is about. It's not the only thing that quality is about. It's equally important to pay attention to the organized processes that your practice, whatever size it is, uses to improve quality for patients. And if you're not doing that, it's just as bad as not getting out of bed at three o'clock in the morning when a patient calls or when a nurse calls. So that's the training side.

I think in terms of the other side, I think that physicians are, in fact, naturally, I think pretty entrepreneurial and pretty creative when they need to be. And also, they have the most intimate knowledge of the health care system. But the average physician rank and file, that isn't really unleashed because, as I said earlier, physician organizations by and large don't want to pay anyone to lead them. And there isn't a strong enough impetus yet, as Arnie was getting at, to make them say we really need to pay

somebody to lead us. It's worth our while to do that.

So on the one hand, we don't have very many physician leaders with the time to create change. And the rank and file physician, there's really very little room for any kind of innovation to come from there because they're just slogging from one patient as fast as they can until late at night. And then they don't have the time or energy or training to think of how things could be done even in their own little narrow sphere.

So again, I think we want a payment system that will encourage physician groups of whatever size to be willing to pay people to lead, and those groups to pay their own physicians for something other than churning patients as fast as they can.

DR. BORMAN: In the vein of the question of what would you have Medicare do, we've had some discussions about what the program should benefit, for example, from graduate medical educational support as delivered through the program. What would you propose is a program to identify or to help generate physician leaders? Katherine obviously probably has some thoughts about that, as well.

If you were going to say okay, to get your full IME

allotment you would need to show us what you're doing with X percentage of your residents to encourage them in acquisition of leadership skills.

DR. SCHNEIDER: I think you could build exactly the same incentives for the training programs that you build when you're in practice. We've talked a lot about this within my residency program, that maybe we should pay our residents on some kind of quality incentive program. Because they walk out the door, they've been salaried employees, and suddenly they're out there and they're getting report cards, they've never seen any of this before.

So in a surgical program, for example, the American College of Surgeons has a wonderful bench marking voluntary quality program. Why not have the training programs adopt some version of that and be able to demonstrate the same kind of outcomes and so forth?

The trainees have to be very cognizant of the skills they're going to need once they step out the door. And this goes back forever and how bad we do with practice management skills in general in training folks.

I've asked big academic centers how many of your third or chief residents in internal medicine have ever heard of

National Quality Forum or safety measures or Leapfrog? It's zero. Where do you build that in?

DR. BORMAN: I would just throw out just as an example, at my own place we use the NSQIP 30-day occurrence measures as the platform for our monthly morbidity -- conference that's focused only on morbidities and moralities for just some of the reasons that you outlined.

With regards to just a couple of comments about education. I would say to you that one of the things that will accelerate change actually will be the evolution in our current graduates. I think it's going to be a bit shorter than perhaps you folks implied that you believe, or at least that you implied.

I see tremendous difference now, in terms of focus not necessarily for good or for ill but in terms of how one invests oneself. And so I think -- and they will be some of the drivers of IT. These will be people that don't know how to function without IT and they will demand it as part of practice.

Now that doesn't necessarily get it all funded, but it will start to set expectations for practice. And as graduates come out who have been in a primarily hospitalist versus

other environment, they will expect to go to environments where there are hospitalists and other kinds of things, and there's the sort of surgicalist kind of splinter thing happening, as well.

So I think those things actually are going to accelerate the pace of this change perhaps more than we think it's going to accelerate.

My last is a very specific question for Katherine. You mentioned that you had all these claims-based measurements and you had hoped to confine it to that, and then you had what had to be chart-based measurements. Were you able to look to see that if there were one or a composite of the claims things that could have served in retrospect as a proxy for what you measured with the chart things?

DR. SCHNEIDER: That's a great question and I don't have enough data to be able to answer that. But I will give CMS credit for having listened to the participants on this point, in that they weighted the claims-based measures at the fourfold weight, compared to the chart-based measures, recognizing that there are some things that we just may not ever be able to capture, like blood pressure at every visit for a 12-month period for a heart failure patient. When

I've got a 600 square mile radius that the charts are all spread out in it's just not possible. I don't know. That's a great question.

I think administrative burden of collecting this data is just a huge, huge issue. So where there is something that's a pretty good proxy, certainly using that. That would be a great evaluation question at the end of this would be to look at how did the groups do? If they're doing great on the eight measures, does that have a correlation to doing well in all of those others? That's an excellent point.

MR. HACKBARTH: A quick question for Katherine and for Nick, who also participates in the group practice demo. Looking at that model, and you've had some experience with it now, based on that experience, any suggestions for change in the model that would make it more powerful from your perspective?

DR. SCHNEIDER: Again, I think it depends on what's the outcome you're looking for. So this kind of unlinkage of the savings piece with the quality piece where, in fact, we could score 100 percent on all of the quality measures and go to extreme lengths to not only collect all of the data but make improvements and not get anything financially at

the end of the day because you have to jump through the savings hoop first. That's kind of a difficult thing to explain to the physicians.

I think the delay in the feedback, I don't know anything around that. Our baseline year was 2004, we've been talking about this since 2002. We won't know how we did in year one until some time in the middle of 2007. It's almost old news at that point. So I don't know a way around that, just with the way that these models are so heavily reliant on claims data when you're looking at the economic impact.

There were some things that were disappointing to me personally along the way. Hospice was just carved right out of it, which was not our expectation at the beginning. I think the feeling was the physicians have less control once someone is enrolled in hospice. But one reason the program appealed to us is we have a wonderful hospice program that's been in the community for decades and we think we do a good job at end of life care.

In fact, if you look at that Dartmouth Atlas data that came out a couple of months ago we're an extreme outlier to the good side in terms of end of life care. So the fact that it just gets taken out of our denominator doesn't make any

sense to us. But I'll defer to Dr. Wolter.

DR. WOLTER: The data lag is a huge issue. In fact, we didn't see the bas year data, the data from the year before the program kicked off until almost one year into the program, something like that. So that really makes it hard to respond well.

I think the financial model is very flawed also because you have to achieve 2 percent savings relative to the comparator group to even share in any savings. But then you only share in the savings beyond the 2 percent. And so by design, I think, when you consider the cost of investment in infrastructure to manage care differently, there's really almost no way to break even on this program. And so I think the financial modeling over time has to be different.

But I think all the groups feel that there is tremendous value in participating. There's going to be a lot learned. And I think our capability at managing care differently will improve.

I just have to take every opportunity I can to say this: I think all the groups are creating focus in terms of what they're tackling. I couldn't agree more with Dr. Casalino. There's a huge danger right in front of us in terms of how

P4P is being unfolded for physicians. It's likely not to be effective and there's likely to be a huge backlash. There isn't focus. It's too mixed in with the issues around fixing the SGR.

I know that wasn't the question you asked, Glenn, but I think when you look at what's going on in the PGP demo, there's really focus on how to manage care differently in sort of that low-hanging fruit way. And we're not seeing that same thing in the physician P4P that's now unfolding.

DR. MILSTEIN: In the Crossing the Quality Chasm Report, the IOM offered the opinion that we weren't going to get major improvements in either affordability or quality without -- I think their wording was fundamental changes in the basic methods of clinical work.

I'd be interested in any of your comments on Katherine's observation that the most radical changes that she saw within her organization were within the smallest, not the larger physician practices.

DR. BURNS: I've seen the same thing. I remember we spent time out at Intermountain Health Care. They have a very large salaried group of physicians. But they also have a lot of satellite clinics outside of Salt Lake City. I

remember interviewing the top physicians leader there and that's where all of the changes came there, as well. It wasn't in the core group. It was in the satellite clinics where a lot of the experimentation takes place. Then over a period of time if they can accumulate the results and demonstrate the benefits, then they can perhaps persuade other parts of that delivery system to make it. But it's again, changing coming from the periphery, smaller groups being willing to experiment and doing some different kinds of things.

Basically, I think you're banking on finding some maverick physicians who don't mind doing this differently.

DR. SCHNEIDER: If I could just add to that, I think some of it depends on how does the internal payment system work within some of the larger groups, because if they're strictly a productivity-based model then they have the same discussion that you're having but on a smaller scale. Where I've seen it work is where a physicians says wow, group visits for diabetics, wow, that's a great idea. I think my patients will like it. I think it will be more fun for me, but I don't have to go through some bureaucracy of internal politics to get a nurse assigned to this task in a very

different model.

So I think what are the incentives within a group? How much bureaucracy do you need to get through internally to make change? And how does that all fit together?

DR. CASALINO: Arnie, this is a slight tangent to your question, but I think again to unleash those energies you have to recognize it's not talked about enough, I don't think, that most of the patients who are seen in any given day by most physicians do not need should be seen in person. And many of the patients who do need to be seen should be seen for a lot longer than they're seen.

So a very high percentage of physician and patient time is paid for but wasted. The patient's time isn't paid for. And again, we want to incent the systems that will allow groups of whatever size to not do that and have physicians have some time to actually use their brains.

MR. HACKBARTH: Okay, thank you very much. Terrific presentations. It was a real pleasure to have you with us. Thanks.

We need to dramatically switch gears here to a congressionally mandated study on the impact of changes in payment payments for Part B drugs.

We need to press ahead here or we'll start to lose commissioners to airline schedules. So Joan, Carol, who's going to lead the way?

DR. SOKOLOVSKY: Good morning. It's our sad task to move from the highly theoretical and conceptual to the incredibly specific, but I think we're prepared.

I just want to say before we start that although Carol and I are presenting today, Sarah Friedman is an integral part of our study team and this presentation could not have been done without her.

Beginning in 2005, Medicare implemented a completely new way of paying for physician-administered drugs based on the average sales price. This new system not only reversed the trend in spending for these drugs, which had been growing at an annual rate of more than 20 percent, but actually resulted in a decrease in Medicare spending for drugs in 2005.

Congress directed MedPAC to evaluate the effects of this new system on beneficiaries and physicians, and today we are presenting some initial results from our second congressionally mandated study. Commissioners may want to discuss whether they want to make any recommendations about

ways to improve how ASP is calculated.

On the screen you see our congressional mandate. Last year we completed a study on the effects of the payment changes on chemotherapy services for Medicare beneficiaries. As you may recall, we found that access to chemotherapy remained good, but that some beneficiaries without supplemental insurance were more likely to move for care to hospital outpatient departments.

This year we have been asked to study the effects of the changes on other specialties that provide physician-administered drugs. We focused on the experiences of urologists, rheumatologists and specialists in infectious disease because these are specialties with some of the highest Medicare expenditures for physician-administered drugs, after oncologists. We have also continued to meet with oncologists and beneficiary advocates to continue to track access to care for beneficiaries receiving chemotherapy.

Our analyses have combined claims analysis with interviews with physicians, practice managers, hospital administrators, specialty group associations, wholesalers, manufacturers and other stakeholders.

Today we'll present some initial findings based on what we heard from our interviewees. First, they suggested ways that calculation of the average sales price, or ASP, could be refined. Then, as we heard last year, they told us that the payment system has had an effect on where some beneficiaries receive care. We found that there were few common measures to determine if quality of care has been affected by the payment changes.

Next month, we'll present results from our analysis of 2005 claims data and discuss changes in physician practices.

Starting in 2005, Medicare began paying for physician-administered drugs at a rate of 106 percent of the average sales price. ASP is the weighted average of manufacturer's sales prices for each drug that falls within a Medicare billing code when you take into account rebates and discounts. Manufacturers submit data quarterly and the payment rate is set prospectively based on prices from two quarters prior. CMS updates the payments quarterly.

In the first quarter of 2005, the new system produced dramatic price decreases for many drugs as Medicare payments came closer to purchase prices. By 2006 payment rates were more stable. In cases where there was competition between

drugs, payment rates continued to fall. In other cases, payments increased.

Overall CMS reported that the payment rate rose in the third quarter of 2006, but significantly less than other outpatient drug prices in general. Based on our interviews and continuing studies by the Inspector General, most physicians can buy most drugs at the payment rate, but all report some drugs that they must pay more for than the Medicare payment rate allows.

Since ASP is an average price, we would expect some purchasers to pay more and some to pay less for any given product. For example, larger purchasers often get better prices than small purchasers. The payment rate takes this into account since Medicare pays more than the average sales price. However in interviews physicians and other stakeholders identified some structural issues with the way ASP is calculated that can lead to a difference between the data reported by manufacturers that goes into the calculations of ASP and the average price that physicians pay.

We can classify these issues into three categories. First, there’s a lag between when data is reported and when the

Medicare payment rate changes. Secondly, there can be a gap between the average price the manufacturer receives for a drug and the average price physicians pay. And third, the way discounts for bundled products are allocated in the calculations of ASP may create a dislocation in the system. Remember, ASP is based on prices for two quarters prior. If manufacturers raise prices in the succeeding quarters, purchasers may have difficulty buying the drug at the Medicare payment rate until the ASP catches up. On the other hand, if the price goes down, either because of competition between branded drugs or because a generic product enters the market, purchasers may buy the drug at a rate well below the payment rate, again until ASP catches up.

Here you see an illustration of this. In this illustration, the average price in quarter one, you can see the blue dot there, becomes the payment rate for quarter three, which would be the ASP plus 6 percent. Say that the average price goes up 1 percent each quarter in the succeeding quarters. Since the payment rate is ASP plus 6, and that’s based on the first quarter price, most purchasers will still pay less for the drug than they receive from Medicare but not an

additional 6 percent.

Medicare could require manufacturers to provide data more quickly and update the payment rates more frequently. On the one hand, this would allow Medicare to pay more accurately for the drugs. But on the other hand, more frequent updates could have an inflationary effect and lead to more price increases.

I'll come to the second issue. ASP is based on payments manufacturers get for their products. When manufacturers well directly to physicians the average amount they receive should be the average price physicians pay. However, drugs often pass through a larger distribution chain. For example, wholesalers and GPOs may be involved in drug shipping, storing, handling, and price negotiations. Each link in the distribution chain receives a payment. If there is a gap between the price manufacturers receive and report, and the physician purchase price, ASP may be lower than the average price that physicians pay. This can happen in two ways. ASP may include discounts that are not passed on to physicians or ASP may not include charges that physicians pay.

Here we see three hypothetical examples, and I stress that

these numbers are made up. In the first case, you can see the yellow highlight, the purchaser buys the drug directly from the manufacturer, the manufacturer charges an average of $100, the physician pays an average of $100, and Medicare pays ASP plus 6 or $106.

In the second case, when the drug passes through a wholesaler, the drug is still priced at $100, but the manufacturer may give a 10 percent prompt pay discount to the wholesaler if the wholesaler pays for the drug within a particular time frame. Since the manufacturer only receives $90 for the drug, the payment rate of ASP plus 6 will equal somewhat over $95. In this case, the physician pays an average of $100 but receives $95 back, although it is true that the wholesaler could pass on and does pass on some part of the discount they receive.

Finally, the third case, the drug again is sold for $100, the payment rate is $106, but in some parts of the country the physician is charged some sort of sales tax or gross receipts tax. Say the tax was 2 percent, so the physician would pay $102. Here the payment is still higher than the purchase price, but again not 6 percent higher.

Some manufacturers make discounts for one of their products

contingent on the purchase of one or more other products. Many oncologists spoke about a particular example of this kind of bundling that they said created particular problems for them. Let me give you an example. Say we have two drugs, drug A and drug B that are very similar products and they compete for market share. The manufacture of drug A also makes drug C, which is a lifesaving product that has no competition. All oncologists must provide this drug to at least some of their patients.

Now it's very unusual to get a large discount on a drug that has no competition. But in this case, the manufacturer may provide a significant discount on drug C to those purchasers who choose to buy drug A instead of its competitor, drug B. These bundled discounts result in a lower ASP for drug C and a lower payment rate. Let's see how this looks.

Let's say that the list price for drug A is $100 and the list price for drug B is also $100. The list price for drug C is $300. This is the drug without competition. If the physician gets the bundled discount, which in this case is 10 percent for A and 30 percent for C, there's no trouble purchasing either drug at the Medicare payment rate. As you can see on the left side, the bottom left of your screen.

However, if they happen to prefer drug B, then they will lose money, as you can see on the right side there, every time they buy drug C.

In the short term, this bundling arrangement has resulted in lower Medicare payment rates for all three drugs. But in the longer term, it could drive drug B out of the market, leading to higher prices for both drug A and drug C.

Additionally, physicians believe that the practice is hurting their ability to choose a drug based on clinical factors. And other manufacturers of single source drugs might also use this method to increase their sales on products that have competition.

CMS could refine this situation by requiring that bundled discounts be allocated to sales of the drug that the discount is meant to increase. So in this case we look and we can see about a 40 percent discount overall in the bundle if you buy both A and C. CMS could require manufacturers to allocate the bundled discount to drug A, the drug with competition, in their calculations of ASP. This is because remember, the discount is intended to increase market share for drug A. Physicians must buy drug C in any case.

If the allocation was changed so that, for example, 30

percent went to drug A and 10 percent went to drug C, instead of the other way around as is currently the case, purchasers would be likely to get both drugs at prices below the payment rate, and payment rates for A and B would likely continue to fall.

Remember, Medicare payments are based on averages and no system is going to be totally accurate. But by ensuring that ASP reflects the average physician costs, Medicare would be in a better position to determine what the appropriate payment rate really is.

Now Carol is going to talk to you about our initial results from physician interviews on how the payment changes has affected where beneficiaries receive physician-administered drugs and how the payment system has affected quality of care.

MS. CARTER: In our interviews with physicians, we asked whether patients had been shifted from one site to another.

We found that beneficiaries continued to have access to physician-administered drugs. Most physicians who treated patients needing physician-administered drugs in their offices continued to do so, treating the majority of them in their offices.

However, many practices reported that they were sending certain patients to hospital settings. Most practices said they were sending the same proportion as last year but some indicated that this year had increased. For example, one practice last year said that they had sent only patients needing IVIG to hospitals but this year they were sending all beneficiaries without supplemental insurance.

Less frequently, beneficiaries had been sent to other settings besides hospital outpatient infusion centers or were considering it. For example, infectious disease physicians told us that they had sent some patients to inpatient acute hospitals, skilled nursing facilities, and long term care hospitals. I should note that these settings have always been used to treat some of these patients. The beneficiaries most likely to be shifted included those without supplemental insurance and those who required expensive drugs or biologicals such as Remacade or IVIG.

Depending on the level of Medicaid reimbursement, dual eligibles were also more likely to be sent to the hospital.

Interviewees did not agree on how the care furnished in physicians' offices compared to that in hospital outpatient centers. Physicians generally thought that the setting

where they practice had the higher quality of care. Physicians who preferred the office setting gave the following reasons: there was more continuity to the care because fewer different clinicians saw the patient. This might mean, for example, that a nurse would detect the beginning signs of an adverse drug reaction. They also thought they had more control over the care actually delivered. Hospitals do not always stock the drug that was prescribed. In these cases, the patient will be treated with a clinically equivalent alternative, which may not work as well for that particular patient. They also thought the staffs in their offices were more specialized. Another concern was the greater risk of infection posed by hospital settings, particularly for immune compromised patients. Hospital outpatient infusion centers do not always have separate areas to infuse these patients and so they will be infused alongside other patients or end up being admitted as inpatients to ensure a sterile environment for the infusion. Physicians also noted that registration and waiting times were shorter in their officers. In contrast, clinicians who practiced in hospital outpatient

settings had very different views about the quality of care in their settings. These practitioners considered the care they provided as comparable to that furnished in physicians' offices. Last year we found similar differences in views among oncologists. Differences appeared subjective and dictated by where the physician practiced.

Finally, many physicians thought that hospitals are better able to handle serious adverse drug reactions.

The mandate asked that we examine the effects of the payment changes on quality of care. For each specialty, we looked at the most common condition that requires physician-administered drugs and found, not surprisingly, that there's not a uniform set of quality or outcome measures across them. There's just too wide a range in the diseases treated, the treatments pursued, and the risks associated with each. For example, the measures appropriate for a chronic condition such as rheumatoid arthritis vary from those that are relevant to an acute episode such as a bone infection.

Further complicating the evaluation of quality of care is the lack of convincing evidence about the most effective treatment for some conditions such as prostate cancer. The

uncertainty about the best course of treatment will result in wide variation in practice patterns. When evidence is mixed, patient attitudes towards the risks associated with each treatment option may play a larger role in their decision making.

For each condition, we found that appropriate quality measures are available but that Medicare does not collect information to track many of them. There are large private datasets that include these conditions but the data are collected at only selected sites. Thus, while the data may include a mix of practice types, they will not be representative. For databases that track patients over time, and many of them are longitudinal, we would also need to understand the patient follow up techniques and drop out rates so we can assess potential biases.

For each condition, we did examine the measures that might be used to evaluate the quality and outcomes of care. For urologists the most common conditions treated with physician-administered drugs are prostate and bladder cancers. Outcome measures for these conditions might include things like survival rates and complications and side effects from treatments.

In addition to these measures, Medicare might gather information about the extent and aggressiveness of the patient's disease. This information, which is used to guide patients to the most appropriate treatments, will be very helpful for risk adjustments so that valid comparisons could be made across patients and the physicians that treat them. For a chronic disease like rheumatoid arthritis, outcome measures include changes in functional status and pain management. A process measure could include whether the patient exam included assessments of both of these. Quality measures for infectious disease include whether the infection was successfully treated and vascular access complication rates. Other process measures might include how well a practice or outpatient center screens out high risk patients who are not suitable for outpatient care. This concludes our presentation this morning. In future presentations we will present results of claims analysis and further findings from the structured interviews to see if access to care has been affected by payment changes. This morning, commissioners may want to discuss possible recommendations for refining the ASP.

DR. SCANLON: Let me start with a little background because

ASP plus was actually a GAO recommendation in 2001. I don't want to appear defensive about that, but let me tell you why we got to that point.

We were studying the situation then which was average wholesale price, which we talked about as neither an average or a price, and just a number that Medicare was paying, and that there was incredible profits that were associated with supplying Part B drugs.

In looking at the provision of drugs, one of the things that I think we don't appreciate, and it did not come across -- and this is not a criticism of anything that you did. But the common sense of the drug market is it's relatively straightforward. You've got a purchaser and a supplier. And the reality is you've got middlemen all over the place, some of whom touch the drugs and some of whom don't. And there are financial flows that are sometimes called rebates, sometimes called discounts, sometimes not really labeled but there's money going back and forth. And they may be going to people that touched the drugs or didn't touch the drugs. So sorting all of that out is a very difficult thing to do. One of the huge issues that we were facing in thinking about how do you reform this AWP system is where can you get

information? Where can you get data?

And what we settled on was the leverage point that could potentially be used was the manufacturer. We had experience with the Medicaid rebate program to go to manufacturers and get information on sales prices.

Thinking about some of the intermediaries that are involved in this process, Medicare doesn't have a relationship with them. It's not impossible for the Congress to say you have to do this. I mean, we used to have a military draft. But it was unlikely that they were going to do this. The other potential source of information was the physicians, which would also be unprecedented in terms of the Medicare program, to say to physicians -- unlike other providers -- to say we want some information about your costs. And in this case, it also wouldn't be all physicians. It would have to be certain specialties that would have to do this. So those are the reasons why we settled on the manufacturer as the best source of information for this.

The plus 6, and we actually did not come up with the 6. Our idea was plus, that you needed to do something beyond the average sales price at the manufacturer level to reflect the fact that physicians were not buying from manufacturers in

all cases, that there were going to be additional costs for different purchasers, that an average is an average, there's a distribution, some people pay more, some people pay less. You needed a cushion that was going to assure access for Medicare beneficiaries.

It was not meant to be a profit. We knew that the average sales price at the manufacturer level was not going to equal the average purchase price at the physician level. We weren't trying to say that there should be sort of a profit margin that physicians got for administering Part B drugs. In fact, what we argued was you should pay for the drugs appropriately and you should pay for the administration appropriately and suggested that the administration fees be looked at, which has been done.

So that was the logic of it. And that, I think, deals with one of the three problems that you identified, which was that the average sales price is not equal to the average physician purchase price.

The plus 6 is the issue, I think in part, to deal with the second problem, which is the lag. You have two choices. You can either try and shorten the lag, as you've talked about, or you can say is the six enough to deal with the

lag? Or does the six actually, in keeping it where it is, create some incentive for there not to be as rapid an increase over time. And that's going to vary by drug. So that's a real issue.

The third issue that you raised about bundling --

MS. BURKE: Bill, can you pause on that issue for just a second? Help me understand. In the normal course, when you're trying to neither encourage escalation nor ignore reality, does developing some kind of a rolling average rather than updating every month so that you did it over a period of time, does that help soften the sort of bumps up, but -- does that help in that second instance?

DR. SCANLON: I would argue or respond that I think that it can, in many circumstances. But again, one of the problems -- and actually it comes up in the bundling example, one of the issues in the drug area is that we're dealing, in some cases, with considerable market power on the part of a particular drug.

MS. BURKE: No question, of particular unique drugs.

DR. SCANLON: What's the dynamic there? I think I, at least, don't know what the dynamic there is going to be like.

MS. BURKE: I'd like to separate out the bundling thing for a second because I think there is a real substantive and a real quality issue there which concerns me.

But just on the pricing issue, like you, I am concerned with something that would essentially basically create the incentive for escalations to occur if they're going to be tracked immediately. This is probably one of the few places in Medicare where we actually are relatively on time in terms of pricing, as compared to working off three-year-old data.

But having said that, the question is is there a way to do that, deal with that lag issue, by moderating it with some kind of a rolling average rather than simply just accepting what the bump up is in that time frame.

I don't know. It would be something to think about that would discourage the full escalation or the full acceptance of whatever the increase is.

DR. SCANLON: For me, your question falls into a similar category as the bundling in the sense, not the substance of the question, but the fact that I think we need to model, at least conceptually, in more detail what would be the potential outcomes of a change in policy and actually have

more data to inform the model. How many times are we experiencing a problem where the lag that we currently have is creating a situation where physicians are not able to purchase at a price.

MR. HACKBARTH: Bill, this issue of the timing of the updates interests me in the sense that I'm not sure that frequent updating is as much a problem as some people fear. Certainly, if you were reimbursing fully for whatever price increases occur, then frequent updates create a powerful inflationary incentive.

This is a prospective system, though. The purchasers each have the incentive to get it below the ASP plus 6 and get the best bargain that they can. So as in any competitive market, there's downward pressure on this price. The payment system isn't constantly pushing it upwards.

MS. BURKE: But it is. In fact, the suggestion is that it -- I think that's the question. A, I think Bill is exactly right. Is it a problem? To what extent, in fact, are we seeing people confronted with this against a cap essentially because the prices haven't kept current? And is the solution to make the payment more current? Which then leads into the inflationary incentive, I think. Even though

you're not paying the absolute, you're still seeing an escalation, I think.

DR. SCANLON: I agree. A prospective system with rebasing creates more of an incentive to be an efficient purchaser than a retrospective system. But a prospective system with rebasing is a lot less effective than a prospective system without rebasing or with trending. Because you need to look at what a person is going to earn in revenue over time versus their cost. And it depends upon the pattern of these increases that would be coming from the manufacturers and how they're going to get incorporated into the prices.

DR. REISCHAUER: The longer the lag, the more push back there will be from physicians.

DR. SCANLON: Right.

DR. REISCHAUER: And it's a matter of balancing that pressure against equity, which is I can't buy the drug that I need because I'm not reimbursed 100 percent of whatever the real price is.

MR. HACKBARTH: But if you have a long lag and there's downward pressure on the price, then it means that you're not keeping up with falling prices.

DR. REISCHAUER: What country do you live in?

[Simultaneous discussion.]

DR. SCANLON: A very important part of this market is not generics. They are brands.

I think if you're a business in doing this, that you've got certain relationships with your suppliers and that you may be willing to incur a short-term loss because over time you're going to be fine. And your interest in negotiating stronger with your supplier is muted by the fact that the rebasing is occurring.

I think we've said in the past that gee, prospective is so much better than retrospective, and it's true, but on a relative basis. Only when it's trended and truly independent of costs does it become as effective as we've given it credit for.

I wanted to say something about the issue about the complexity of the bundling question, which I think is another thing that needs to be sorted out, which is because again we've got these multiple flows going among different parties. And we're also going to have, I think, a fair number of situations where we may not only be talking about Part B drugs that are involved in bundles. That adds to the complexity of how do we think about the right allocation of

discounts? That's the challenge that we may face. I don't have an answer to this at all. This is not something GAO looked into.

DR. HOLTZ-EAKIN: Can I ask a detail question? What constitutes a sale? This is an average sales price. What is the sale? Delivery? Sign a contract? I don't know the answer to this question. What goes into that calculation? And when does it occur?

DR. CASTELLANOS: Can I answer that from a practicing physician's viewpoint? It's really easy, it's direct when you're buying it from the manufacturer. He's asking the question on the cost of the drug. And the way it's done is when you're buying it from the manufacturer and the manufacturer is directly delivering it to the physician, there's no intermediary. There's no wholesale, there's no update, there's no that.

In my field, most manufacturers do not do any kind of problems like you're talking about. We do get some bulk discounts if we buy in large amounts.

Where the problem comes in is when you're buying it through a wholesaler. That's the real problem. And another real problem is when the volume of the drug really isn't very

much so there's no incentive for the drug company to really use market prices or let market forces develop. And we'll get into that when I talk about bladder drugs.

MS. BURKE: I'm sorry, Ron. That's not the question. He's asking a very specific question. [Inaudible.]

DR. CASTELLANOS: Can I answer that then? They do it by the average sale price and they go back for two quarters. In other words, every quarter of the year each of the manufacturers provide a cost basis to the drug. And that's given to CMS. And they go back two quarters. And the average of the sale prices, that's how they determine the price of the drug for that quarter.

Now subsequent quarters, if the prices go up, the price will go up. If it goes down, it will go down.

DR. KANE: But sale to whom and how final is the sale is the question?

MS. BURKE: What constitutes the sale?

DR. SCANLON: It might be better to phrase it instead of a sale, what is a completed transaction? There's an issue -- and I don't know the answer to this, maybe you can help us. There's an issue in terms of the ASP regulation. A completed transaction may occur a year later because there's

accumulation of how many purchases did someone make? And there's some type of rebate for the total volume that you made over that whole period of time. How that gets factored into something where, in some respects, Medicare has already closed the books, is an issue. Because Medicare may make an approximation -- again, I'm operating not on knowledge -- make a decision as to here's what ASP is based upon all the information we have to this point. That rebate, even though it's due to something that occurred prior to the next time period, may get applied to the next time period. It's those kinds of things that make -- I guess this is the issue with respect to the bundling. There's a w hole can of worms here.

DR. SOKOLOVSKY: Let me try to answer what sounds like a really easy question and, in fact, is really difficult. In some cases, it is when the drug manufacturer sells it to the wholesaler. In some cases the purchase price has been negotiated with a GPO or a PBM who never takes possession of the drug but there is a charge back mechanism. So it still may be going from the wholesaler but the manufacturer is counting what they got from it from the basis of what they have negotiated.

The new regulations, and these regulations have changed in the course of a year-and-a-half, says we know that your rebates and your discounts you really don't know at the end of every quarter because of a lot of it is prospective. We want you to estimate them and divide it by 12 so that we don't have sharp rises and falls in ASP as they had in the first couple of quarters.

So some of it is an estimate that has to be reconciled later on when they actually pay.

DR. HOLTZ-EAKIN: So those are the prices. When they do the weighted average what volume of sale goes into each quarter? Actual deliveries or ...

DR. SOKOLOVSKY: It's actual deliveries but with estimated rebates that may not have actually been paid that quarter.

DR. SCANLON: I'll stop by saying I really think that in order to feel comfortable about making changes here we need a lot more information. The idea that all physicians are reporting some problem I find a little difficult to understand because we are supposed to be paying this average. We're supposed to be having a 6 percent markup. That's supposed to be a sufficient cushion.

When we were dealing back in 2000 with some of the

intermediaries, the idea was that most wholesalers were only marking up 1 or 2 percent, and that may have been in an AWP world and things may be different. But I think we really need some better information to guide whether there's a need to make a significant change.

DR. REISCHAUER: I didn't get the notion that all physicians were complaining. You said some.

DR. SCANLON: All said they had some problems.

MR. HACKBARTH: Some drugs. Most physicians can buy most drugs at the payment rate but all report some drugs that they cannot purchase at the payment rate.

DR. KANE: Are they reporting the ones that they can buy for a lot less than the payment rate? What's the bundle? How does it come out as a whole? I think that's why we can't really -- some are above, some are below. But what is the net profit on their drug business? Or is it a break even? I don't think -- are they reporting what they're paying below the sales price, too?

DR. SOKOLOVSKY: This is not an area where we have good information. Particularly, we have no information on discounts and rebates. The IG does periodic investigations. We wish they'd do more because they're the only ones who can

get at those discounts and rebates.

But in general what I hear is that this has become much more of a grocery type business. All the margins are slim. And there's some evidence, for example, that people buy much fewer drugs. The inventory they keep on hand at any one time is much smaller than it was.

And when we talk next month about changes in practice, you can see that the margins are slimmer.

But again, most physicians can buy most drugs at the payment rate. But sometimes the disadvantages, the ones who can't, they may be cumulative. Each time we're talking about a 1 percent or 2 percent difference. But if you're on the disadvantaged side each time, then you have problems.

DR. KANE: Unless it's offset by a 1 or 2 percent on the other side. I just think you need to look at the whole instead of the pieces.

DR. SOKOLOVSKY: We talked about do some drugs go down. In 2005, for example, two very popular chemotherapy drugs went generic. There was a six month period then, nobody particularly talked about it, but we saw that in the data that we bought, that there were very big margins on those drugs.

And then there are the cases of brand name drugs where they're not the same but they do similar enough things that they compete and those prices may be falling. For example, many physicians told us that they choose a drug for treating anti-nausea basically based on price. And that's driven many of them down.

So it's definitely not that they're all going up. And nobody is telling me that they're all going up. But the focus is much more on -- of course, as you would imagine, if I'm interviewing people, they're telling me about the ones they're having problems with.

DR. KANE: Wouldn't it be an incentive for the manufacturers to not keep increasing the price if people started saying I can't buy it because of the price? Isn't that the essence of what you want them to do?

DR. MILLER: I think that the lag does create a drag on the manufacturer raising the price because you can't raise it so fast that no one can purchase it. That's why, at least on the lag issue, you've got to -- and you guys are all touching on the issue. You've got to think really hard about how much real time you want on this because you then, I think, are incenting upward inflation in the price.

Joan, one other point to bring out in this. In some of the discussions that I had with you, some of the places where it was difficult to buy at this price had to do with the low price generic drugs that were handled through a wholesaler, where the fee would kind of outrank, almost in some instances, literally the cost of the drug.

DR. SOKOLOVSKY: This is an issue I didn't have time to go into but came up very, very frequently in the course of conversations. Physicians are buying a lot of extremely cheap generic drugs. They tend to buy them through the wholesaler. The wholesaler may have a 2 percent markup plus charging shipping and handling. In some cases, the drug itself is so cheap that that shipping and handling and 1 or 2 percent increase really take is above the Medicare payment rate. And they use a lot of those drugs.

It was striking to me, when I would ask for a list of drugs, how often the list of drugs was dominated by these cheaper old generic drugs.

DR. MILLER: And of course, these are not the big, expensive cancer chemotherapy. This is the ones that have been around for a long time.

DR. HOLTZ-EAKIN: I think this one is easier. We talk about

the average sales price but it's actually not for a single drug. It's for all the drugs in a billing code; right? How do you decide what goes in the code? Or how is that decided? I realize you're not the...

DR. SOKOLOVSKY: As far as I understand it, CMS makes those decisions. It usually takes a couple of years, or at least a year after the drug comes on the market. There is a HCPC code for unclassified drugs. And to get your own code takes a certain amount of time.

If there are generic versions of a brand drug, they will all be in the same billing code. There are some older biologicals -- for example IVIG, it's not a generic drug but a bunch of manufacturers make it. And up until this past year they tended to all be bundled within one billing code. This year CMS divided it into two different billing codes because of a lot of issues about what was actually going into each code.

DR. CASTELLANOS: First of all, just to remind you, this is the non-oncology drugs that we're talking about. We're not talking about the drugs that are distributed by the oncologist or hematologist.

I would like to put my comments to the quality of care and

patient satisfaction area. First of all, from a physician viewpoint, ASP, I think, is a much fairer way of paying for the drug. You're actually paying a price that's very close to the acquisition price. Prior to this we had AWP. I didn't write those rules. I can tell you right away that the physicians made a lot of money on that. And I think today the ASP is a much fairer way of reimbursing the physician for the cost. I certainly would not want that changed. Maybe the percentage changed, but the concept I think really, really, really works.

The quality of care issues, I think, are pretty good. I think you mentioned some of them now. A big one is really shift of setting or where you get the treatment. And obviously this is based on cost or how -- in other words, if I can't buy that drug for ASP plus 6 percent, or if that patient doesn't have a coinsurance, or in some cases the patient has Medicaid where I'm not reimbursed adequately, in today's market I can't afford to take that loss anymore. So that patient is then transferred to the hospital and is being given medication in the OPD. I don't like it anymore than anybody else. I think it disrupts care, the continuity of care. It's a lot more expensive for the government,

also.

What I would like to say now is in my field, we have a specific drug that treats cancer of the prostate. Technically it's an LHRH agonist. And there's several competing drugs in that field, and they're all put in one code for calculation of payment.

Unfortunately, when they had AWP there was such a -- this class of drugs was probably the most common drug administered in chemotherapy. Not that the urologists give more drugs than anybody else, but that one single class of drug is the most common drug given in oncology, urology, et cetera. They used a concept called LCA or least cost alternative.

What they said is that all of these drugs are basically the same. They all have the same mechanisms of action. They didn't think there was any significant difference on these drugs. So they said, and probably right so under AWP, we're going to pay the cheapest or the least cost alternative. It's a form of price fixing, but that's what it was under AWP.

Unfortunately now, under MMA, when we went into the ASP, MMA's policy is let market forces dictate the price. Let

market forces dictate the price. Unfortunately CMS, in their wisdom, has kept LCA policy. It's not a national policy. It's not a national directive. It's a local carrier directive. And there's been such a wide variation in how that's applied all over the United States and there's a wide history of that.

As best as I can tell at this time, most states are LCA states except Montana. We'll get back to that. But most states come under that.

Now the issue here is very simple, is that what's happening is that the treatment is tied to the cost. And you say well, they're both the same. What's the difference? Well, this is where we're going to get into patient satisfaction and quality of care. One is administered intramuscularly in the hip, and one is administered subcutaneously in the abdominal wall. I don't have to ask any of you which you would prefer. I don't have to do that. I think you would all make a judgment that, from a patient viewpoint, I want the least painful application.

But as I said, the treatment is tied to the cost, rather than the benefit to the patient or the patient's individual needs. As I said LCA policy is totally against MMA.

When I was on PPAC at CMS, we had a lot of disagreements over this, a lot of contentions, a lot of discussion. And CMS basically said it's not a national decisions, you have to go to the local carrier.

Well, I have gone to the local carrier and the local carriers, for the most part, have changed, gone back and forth, changed. But Joan, I think -- and I hope you looked it up. I think Montana still has an LCA policy.

What's so important about that? It's important in this respect. As you know, Medicare is changing from carriers to MACs and there are going to be 15 MACs. And the first MAC is J3, which happens to include Montana.

So now what they've done, in May they had a meeting of all the carriers, involving I think five or six states. And they talked about what they can do about that. And they made a policy that they're going to use, not just for this drug but all local carrier decisions, they're going to use the least restrictive or best care policy. And that's how they're going determine whether they're going to use that drug or not or any LCD, local carrier decision.

So my problem here is that in urology or in any drug for any specialty, I really like a level playing field. I like the

physician to be able to one, buy the drug at the same price anybody else is buying it or have it available at the same price anybody else is available. And that's not happening under LCA.

And two, I like the physician or the patient to decide which forms of treatment they want. Quite honestly, I have had a lot of patients that come down -- I live in Florida. We have a lot of winter visitors and I have a lot of patients that come down for treatment. And they've been on Zolodex, which is the drug that's on the abdominal wall subcutaneously and they want to continue that. Why? Because that's what they've had and they don't know any different and that's what they want.

I've had a lot of patients that have been on the other drug, which is an intramuscular drug, and they like that. When I tell them that I have to change their treatment based on cost, they don't like it. And I can tell you, that happens all over the United States.

And I can give you a very good example here in Washington, D.C. where the professor of urology at a very prominent university told a patient we're going to change you because we don't lose any money and we make more money on it.

What I'd like MedPAC to do is seriously consider making a recommendation to CMS to drop LCA.

MS. BURKE: Joan, I want to focus in particular -- I mean I want to concur with Bill's comments about I think we need more information to decide on some of these other issues with respect to pricing.

But I want, in particular, to focus on the section of the report which I found quite useful that deals with the bundling question and in particular, the description that you just gave us and is referenced in both the text as well as your slides.

And that is in this case there is a bundling arrangement that essentially is forcing a decision on the purchase of a drug that, in fact, may not be the drug of choice for purposes of quality, and that it is being driven by essentially the ability, because they are sole source for one drug, to force a decision on a separate drug that, in fact, may not be the drug of choice, or in fact the better choice.

I am concerned about a policy that essentially allows the application of a discount to be used essentially to force a market behavior because in this case they are sole providers

of a particular drug. And so you have to deal with them. The course, as I understand it from the materials, you have to deal with them on the purchase of this lifesaving drug. The other drug, which is a marketplace drug and is available by more than one provider, ought to compete in its own right and they win or lose based on their competition and essentially the experience with that particular drug. I am wondering what it is, and I should say at the outset I am not adverse to and, in fact, am generally quite positive about the concept of bundling where we essentially use that to our advantage in terms of looking at a range of services that are provided for a particular condition. But in this case it would appear to me that's really not what this is about. This is really about using a essentially sort of a predatory action to essentially prevent a decision unrelated to the quality of the choice being made. It's raised, query whether or not there is something that we ought to say or do about that? Query whether there are other questions? I know I've mentioned briefly this to Glenn in the past and agree with him that bundling in and of itself, intervention into the market, is not something that

I generally am supportive of doing or of preventing bundling. But in this case, it seems to me, it's not at all about the kind of bundling that we fundamentally support. So the question is what is it -- from the purposes of the staff report, what is it that we might do or say that would make clear that we believe this, in fact, ought not to be a practice that's permitted.

DR. MILLER: If I could just say something here, Joan, and this is to give you some time to get ready.

The first thing is I just want to be absolutely clear, Joan, that this is correct. The statements that we make in the paper that we put in front of the commissioners about the quality issues are statements that you gathered from your site visits in talking to the physicians; is that correct?

DR. SOKOLOVSKY: That's true. This is an issue that there's no independent evidence about this. This is entirely --

DR. MILLER: That's true and I just want to be crystal clear on that, that this is not a conclusion that we, the staff, have drawn. This is something that physicians have said to us.

Now to the second part of your question, what could be done? You know how this process goes. Sometimes we kind of bring

problems and then collectively we start thinking about them with you guys.

But I think what Joan was trying to say here is that we could have a conversation that's very much about quality, bundling philosophy, those types of things. And it could get into some fairly complicated issues pretty fast.

Another way to think about it is really more from an arithmetic point of view, and I think that's what Joan -- and I know you guys are getting this, but just to make sure everybody is getting it. Another way is to think about it just from an arithmetic point of view, which is we're not going to make any judgment on bundling, per se. We're just going to ask that the arithmetic of the ASP apply to the drug that -- that's really more the question.

MS. BURKE: I don't disagree with that at all. Tell me where we are, and I'm asking because I don't know the answer to this question. Are there regs in draft that relate to this issue that we ought to be apprised of?

DR. SOKOLOVSKY: In the current proposed physician fee schedule, CMS mentions that they've heard that there is an issue with bundling and they would like to hear more about it. They don't propose any solutions.

MS. BURKE: So it's simply a reference to the fact they want to know about it but no specific intention or suggested solution to the question. Which raises then, I think again, the solution that has been suggested, which is the arithmetic solution for the time being until we get a better understanding.

Like you, I don't want to pronounce on bundling as a general matter. I don't think that's what this is about. The question is whether to deal with what is essentially an issue of inequity and then let the quality issue play out and the broader bundling question play out.

MR. HACKBARTH: Doug had a question about the arithmetic. Do you want to ask that or do you have it resolved? Do you want to just do it offline?

DR. HOLTZ-EAKIN: We'll do it offline.

MS. DePARLE: I agree that my focus is on the bundling. We talked about this briefly at our last meeting, and I think it was in the context of the proposed rule at that point, and several of us were concerned about it.

Now, Joan, that you've shown us the arithmetic of how it works, I'm even more concerned. And based on what you reported about the physicians you've interviewed saying that

this could be driving them to make decisions that weren't based on clinical factors, it leads me to be more concerned. And also, I think it could be impeding competition, which is not what we want to do here.

So I would endorse making a recommendation that would at least deal with the arithmetic on this, and then preserve for a later day maybe the bigger question of bundling. In general, I think how could MedPAC be against bundling; right? We sort of like that idea from a payment policy perspective. But this concerns me.

MR. HACKBARTH: Maybe we need to develop an alternative terminology.

MS. DePARLE: Maybe so.

DR. REISCHAUER: This is not bundling.

MS. DePARLE: It's really not. This is what I think your economist friends -- and since I'm a lawyer, Glenn and I would say tying, using your market power and leverage in a way that I think we would think may not be appropriate.

MS. BEHROOZI: Just briefly, I'm concerned about something that you said, Joan, and it appears in the text. That we seem to be disincenting the purchase of generic drugs. Because if the physicians can't afford it, if they're not

going to be reimbursed for it, they're going to end up having to pay more than the ASP plus 6. Doesn't that work as a disincentive to purchase generic drugs, and may incent them to buy the more expensive drugs where they're not going to lose money, and then Medicare ends up paying more. Am I understanding this correctly?

DR. SOKOLOVSKY: No, it's my fault. The kinds of generic drugs that we're talking about are really very cheap drugs and they're only part of a drug regimen. And nobody's going to lose money -- even though they lose money on these particular drugs, they don't lose money on the drug regimen. When a new generic, not very inexpensive generic, enters -- a generic will be in the same code as the branded drug. So in fact, the incentive is all to get the generic drug because the branded drug will drive up the price within that.

DR. REISCHAUER: Are there certain of these cheap generic drugs that like 99 percent of them are gotten through wholesalers? So you could say anything that's less than $10 we don't give ASP plus 6 percent, we give ASP plus $11 or whatever the average markup and mailing costs are.

DR. SOKOLOVSKY: One of the things that came up most

frequently, which kind of amazed me, was saline solution. That's the kind of thing we're talking about. Everybody has to buy it. It's dirt cheap. But not so dirt cheap that you don't have to have it shipped and sent. So yes, there are.

MR. HACKBARTH: Okay, thank you very much.

We will have a brief public comment period with the usual rules. Comments no more than a couple of minutes. If someone else is saying the same thing, don't say it.

MR. SCHUMACHER: Dale Schumacher. I'm the External Quality Compliance Officer for the Long Island Health Network. And I thought I'd cast a little bit of clinical integration sunshine into today's gray meeting.

This is a 10 hospital group of clinically integrated, relatively independent hospitals in Nassau and Suffolk Counties in Long Island. We've tracking performance there for almost five years. And clinical integration does seem to work. We bench it versus the other Nassau-Suffolk hospitals.

It's a combination of guidelines, conformance to guidelines, both positive incentives and financial penalties. As the External Compliance Officer, I can financially penalize hospitals that don't hit guidelines after a year's time,

that are internal pay for performance initiatives and along with pay for performance programs with insurers. There is a single integrated quality committee across the 10 hospitals that seems to work, in essence the sharing of trade secrets among the hospitals. Again, the program seems to work.

The question about the Southwest Airlines alternative for how can we do this better and quicker, that's a great question. I would encourage any incentives for merging and linking data and information systems. There are huge numbers of data systems that exist there. On one side of the aisle you could be struggling to find out data about performance in the cardiac area. The other side of the aisle, there will be a cardiologist that has money from a drug company and is following these same patients over two or three or four years and you just can't link or get together. So you have to build those people -- I think it was Davenport in the Harvard Business Review wrote an article about competing on analytics about a year-and-a-half ago. I think that speaks well to what we have to be able to do.

So clinical integration, at least in this particular

situation in these hospitals, does work.

MR. HACKBARTH: We are adjourned. Thank you very much.

[Whereupon, at 12:07 p.m., the meeting was adjourned.]