

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
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Washington, D.C.

Thursday, September 9, 2004
10:36 a.m.

COMMISSIONERS PRESENT:

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MARY K. WAKEFIELD, Ph.D.
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* September 10th proceedings begin on page 155.

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MR. HACKBARTH: While we're rounding up our last Commissioners let me just welcome our guests from the public attending the meeting. As you can see from the agenda, much of our work today and tomorrow will be addressed to various mandated reports that the Commission has been asked to prepare by the Congress. In total, we received 16 such requests in the Medicare Modernization Act and about a half-dozen of those are due quite soon, as early as December. So that means that the schedule that those of you who have followed our work before you are used to, where in the fall meetings we're usually principally focused on preparing for our update recommendations in the March report, that's not going to be true this fall.

In addition to that work to prepare the update recommendations, we've also got to squeeze in work on these mandated reports that are due in December. So today, as I said, most of our time will be spent discussing mandated reports, and then we will, however, have two sessions related to another continuing interest of the Commission, namely, paying for quality. So we will have sessions on paying for quality the case of home health agencies and skilled nursing facilities surrounded by a number of sessions on various mandated reports.

So that is what is to come. I welcome you all. As has been

1 true in the past, at the end of each session we will have a brief
2 public comment period. I do emphasize brief. We have got an
3 extraordinary amount of work to do and comparatively little time with
4 the Commissioners to do it. If you have a comment to make, I'd ask
5 that you go to the microphone and keep your comments very, very
6 concise. If someone has made essentially the same comment before you,
7 I urge you not to repeat it. You can just simply say, me too, I agree
8 with the preceding speaker.

9 Ultimately, I know your goal is to make the maximum
10 contribution to our work, and following these guidelines will help you
11 do it. Commissioners get very restless if the comments go on for too
12 long. I really want to emphasize, we strive, the staff strive to be
13 open to all points of view. Don't feel like that microphone is your
14 only way to contribute to our process. There are lots of other avenues
15 available to you and I urge you to depend on those more than the
16 microphone here.

17 So with those comments, let's proceed to the first topic,
18 which is benefit design and cost-sharing in the Medicare Advantage
19 program.

20 * DR. SCHMIDT: Good morning. Jill and I are going to present
21 some of the work underway for a study that MedPAC was mandated to
22 complete under the Medicare Modernization Act. Although they are not

1 sitting up here at the table with us, Susanne Seagrave and Sarah Kwon
2 were also very instrumental to the analysis that we're going to show
3 you today.

4 Here's some of the actual language from the mandate. It
5 specifically asked us to look at benefit structures in Medicare
6 Advantage plans to determine whether cost-sharing requirements are
7 affecting access to care or being used to select enrollees on the basis
8 of health status. We're looking to see whether there are observable
9 biases in the cost-sharing requirements of some plans. For example,
10 relatively higher cost-sharing for dialysis services or radiation
11 therapy.

12 We're also to report on whether such behavior is widespread.
13 And if so, how the Medicare program might address it. This report is
14 due at the end of the calendar year and the Commission is to provide
15 recommendations if you think it is appropriate.

16 This is our first presentation about this topic and we're
17 about midway through the analysis. As with a lot of MedPAC research,
18 we're bringing you the results in pieces, so please keep in mind that
19 there is still more of this to come.

20 Recall that the mandate asked about access to care and
21 evidence of using cost-sharing to select enrollees. To get at those
22 questions, we're using several research approaches that are shown on

1 this slide. Those that are highlighted are steps that are farther
2 along and some of which you'll hear about today. In particular, I will
3 describe the findings of an expert panel that MedPAC staff convened
4 last March for this study, and Jill will present some of the
5 preliminary results from our analysis of plan benefit packages.

6 At another meeting this fall we'll also present to you
7 analysis of plan risk scores, a look at survey data on why
8 beneficiaries disenroll from fall from Medicare Advantage plans and
9 some comparisons of how out-of-pocket spending can vary among MA plans
10 in the same market area for a few categories of prototypical
11 beneficiaries.

12 Let's review the current process that CMS uses to approve
13 proposed plans. Generally, plans have broad flexibility to design
14 their benefit packages so long as they meet certain requirements, such
15 as including all services covered by Parts A and B, and returning
16 payments above allowable cost to beneficiaries, usually through extra
17 benefits or lower Part B premiums.

18 CMS starts by issuing guidance for plan proposals in the
19 spring of each year. Since 2002, CMS has included guidelines for cost-
20 sharing because of concerns about beneficiary liability for dialysis,
21 chemotherapy and other services like inpatient stays. Managed care
22 organizations then submit their plan adjusted community rate proposals,

1 made up of their proposed benefit package and premiums. CMS reviews
2 and approves or disapproves all of that information for coordinated
3 care plans. They must also review and approve private fee-for-service
4 and medical savings account proposals, but their premiums are not
5 subject to review or approval.

6 When reviewing a plan's proposed cost-sharing, CMS wants to
7 ensure that the combination of basic premiums and cost-sharing is
8 actuarially equivalent to, or more generous than, fee-for-service
9 Medicare's cost-sharing, which is estimated to be about \$113 per month
10 for 2004. And also that the proposal doesn't discriminate, discourage
11 enrollment, or hasten disenrollment on the basis of health status.

12 Notice that you can meet actuarial equivalence to fee-for-
13 service cost-sharing and still have some cost-sharing for particular
14 services that is relatively high since CMS is comparing overall average
15 amounts of cost-sharing. To evaluate discriminatory behavior, CMS
16 looks to see that cost-sharing for individual services is no higher
17 than what it would be in fee-for-service, although it does allow higher
18 cost-sharing in some cases. It also looks to see whether cost-sharing
19 for some services is higher than the plan's general level of cost-
20 sharing.

21 CMS has said in recent years that it thinks that increases it
22 has seen for cost-sharing for services like chemo and dialysis are of

1 concern to it. It suggests that plans adopt a cap on out-of-pocket
2 spending, which is set at \$2,560 in 2004. If plans adopt that cap, CMS
3 says it will allow them more latitude in setting cost-sharing for
4 individual services.

5 There are a number of changes underway to the Medicare
6 Advantage program that may affect the mix of enrollees and plans, and
7 it's not yet clear what the net effects of all of these changes will
8 be. Let's review a few of them.

9 CMS's new risk adjusters will be fully phased in by 2007,
10 which should provide larger payments to plans for enrolling sicker
11 beneficiaries. Beginning in 2006, local or county-level Medicare
12 Advantage plans may begin competing with regional or multi-county
13 Medicare Advantage plans. These regional PPOs must use a combined
14 deductible and an out-of-pocket cap in their benefits design.

15 For some beneficiaries, outpatient drug benefits have been a
16 particular reason to enroll in Medicare Advantage plans. Beginning in
17 2006, MA plans will be competing with stand-alone drug plans to
18 administer the new Part D drug benefit.

19 Also in 2006, CMS will move from the adjusted community rate
20 proposal process to one where plans bid their price for delivering a
21 benefit package based on fee-for-service cost-sharing or cost-sharing
22 that is actuarially equivalent to it. If the plan's bid is less than

1 the benchmark payment amount, in most cases 75 percent of that is to be
2 rebated to enrollees in the form of supplemental benefits or lower Part
3 B or Part D premiums, and 25 percent will be returned to the trust
4 funds. This may constrain the ability of plans to use cost-sharing
5 that is as generous as some plans offer today.

6 The MMA gives CMS authority to negotiate with most types of
7 plans, with the exception of private fee-for-service and MSAs over
8 their bids, similar to the authority that the Office of Personnel
9 Management has for administering the Federal Employees Health Benefits
10 Program. This includes authority to negotiate plan federal cost-
11 sharing requirements.

12 Now let's turn to some of the findings of an expert panel
13 that MedPAC staff convened last March. That panel consisted of 15
14 people representing beneficiary advocates, academics, private plans,
15 and consulting actuaries to employers. The panel agreed that there's
16 quite a bit of variation in cost-sharing requirements among plans that
17 are competing within the same market area. They thought there was even
18 more variation across plans, primarily because of differences in
19 payment rates, but still considerable variation within markets.

20 The general consensus seemed to be that cost-sharing
21 requirements were not affecting access to care of plan enrollees in a
22 widespread manner. But many of the panelists were aware of certain

1 plans that had put relatively high cost-sharing in place for some
2 services such as chemotherapy.

3 There was also general consensus that variation in cost-
4 sharing among competing plans can be confusing to beneficiaries and
5 make comparisons difficult. CMS has tools, such as the web-based
6 personal plan finder, to help beneficiaries compare their options.
7 Nevertheless, plan cost-sharing can differ quite a bit across many
8 different dimensions, so it can be hard for a beneficiary to understand
9 the financial implications of their options.

10 One panelist described plans that continue to use 20 percent
11 coinsurance on chemotherapy with lower cost-sharing on more routine
12 services and no out-of-pocket cap. Even though a cancer patient
13 without supplemental coverage would face the same cost-sharing under
14 fee-for-service Medicare, the panelists thought that plans should
15 protect sick enrollees from such high cost-sharing. Other panelists
16 thought that such a comparison was unfair, that MA plans shouldn't be
17 held to a different standard than fee-for-service, which can have open-
18 ended cost-sharing liability.

19 There was no consensus among the panelists on whether
20 Medicare should use a standardized benefit for MA plans. Some thought
21 it would make comparisons easier for beneficiaries and might promote
22 competition more on the basis of premiums and networks rather than

1 premiums, networks, and benefits and cost-sharing. Other panelists
2 thought that beneficiaries are better off when they can find a plan
3 that best suits their individual needs.

4 Panelists agreed on the importance of providing beneficiaries
5 with information about their plan options that is easy to understand so
6 that they can evaluate their choices clearly.

7 DR. BERNSTEIN: To provide a sense of what cost-sharing looks
8 like across the plans we examined data submitted by the plans to CMS's
9 plan benefit package file, the PBP file. A subset of that information
10 is used in the Medicare personal plan finder that's available to
11 beneficiaries on the Internet. Whether beneficiaries are able to sort
12 through these data successfully is one of the issues we may want to
13 come back to when we talk more about whether cost-sharing affects
14 beneficiary decisions about enrollment or disenrollment.

15 We used individual plans as the unit of analysis because a
16 variety of plans with different benefit structures may be offered by
17 the same market by a single parent group. In this analysis we omitted
18 plans that are not actively enrolling beneficiaries from the community,
19 including special plans and demonstrations like S-HMO or PACE. We also
20 did not look at employer-only plans. We estimated the enrollment in
21 the plans by using the projected enrollment figures submitted by the
22 plans in their ACR proposals. The plans we included account for over

1 90 percent of Medicare enrollment.

2 This is an excerpt taken directly from the personal plan
3 finder on the Web. It's one section of a chart that compares three
4 plans in one county. Section one, which shows the plan premiums and,
5 if the plan has a cap, the out-of-pocket cap that covers Medicare-
6 covered services is listed in this section with the services that fall
7 under the cap. I'm showing it because it shows you first that some
8 plans have caps and some don't, and how a cap might work.

9 In plan one there's a cap that's set at \$3,500. The other
10 two plans do not have a cap. Plan one's cap lists 25 distinct
11 Medicare-covered services that fall under its out-of-pocket cap.

12 Second this chart illustrates that the available details on
13 cost-sharing still leave some holes because you don't know what's not
14 there. For example, there's no information here on Part B drugs. In
15 this case, plan one does not list Part B drugs as falling under its cap
16 because it does not require cost-sharing for Part B drugs. But that
17 information is nowhere on the plan finder, either under the Medicare-
18 covered services descriptions or in the description of the plan's
19 prescription drug benefit. There's no information on cost-sharing for
20 Part B drugs for the other plans either. One of these has no cost-
21 sharing for Part B drugs, the other charges 20 percent cost-sharing for
22 Part B drugs.

1 In this little excerpt here we see information on radiation
2 therapy across these plans. One charges \$25 per treatment, the second
3 is \$40, the third is 20 percent coinsurance. Beneficiaries may find it
4 particularly difficult to estimate their costs in plan three because
5 they don't know it's 20 percent of what. The out-of-pocket cost for
6 radiation therapy is not included on a list of services covered by plan
7 one's cap.

8 Let's talk about caps just for second. Cost-sharing involves
9 an interaction between out-of-pocket caps and cost-sharing requirements
10 for specific services. This chart shows that about half of the plans
11 enrolling about half of beneficiaries in MA plans altogether have some
12 sort of an out-of-pocket cap. About 30 percent of the plans have a cap
13 on out-of-pocket costs that apply to some, most, or all Medicare-
14 covered services, another 18 percent that apply only to cost for
15 inpatient hospital care. The amounts covered by the caps vary from
16 plan to plan. The median size of the caps is \$2,560, the level
17 suggested by CMS in its letter, and the other caps generally cluster
18 around that figure. Some, however, are considerably higher, \$4,000 or
19 more.

20 DR. NELSON: Can I ask a question at this point? It would be
21 helpful for me to know whether the plans are talking about the same
22 out-of-pocket costs. That is, are they all talking about coinsurance

1 plus deductibles plus copayments? Or are some talking about just
2 coinsurance and not the others? And what are we talking about when we
3 are talking about capping out-of-pocket costs?

4 DR. BERNSTEIN: Most of the plans include the cost for
5 deductibles and coinsurance for the specified Medicare-covered services
6 that is unique to that -- it's different from plan to plan. So in plan
7 one that we were looking at before, most of cost-sharing is copayments,
8 and those are included -- if they are for services listed in that
9 column, they apply to that. In other plans there's 20 percent across-
10 the-board coinsurance for most services. And if those plans have a
11 cap, the 20 percent applies there. In some plans there's a combination
12 of coinsurance and copayments, and some are included in the Medicare
13 cap and some are not.

14 There's no way to -- it's almost unique to plans. But we've
15 tried to get as much as we could -- in every table or chart we tried to
16 figure out what was included and what wasn't, because they code them
17 separately, so we added them.

18 DR. SCHMIDT: But we are talking about the combination of all
19 kinds of cost-sharing, so copayments, coinsurance, but not premiums.

20 DR. BERNSTEIN: But they may be counted differently in
21 different plans is the complication.

22 In the plans that only have caps on hospital-covered

1 services, those caps range from \$200 to about \$2,500. As we mentioned
2 briefly, inpatient costs for hospital care also vary a lot among the
3 plans, from zero to as much as \$400 per day for some number of days.

4 But caps are only one part of the story. Some plans have
5 very little cost-sharing but have caps, and some don't have caps. Some
6 plans with relatively high cost-sharing have caps and others don't have
7 caps. To understand how all this works, we're going to look at just a
8 few of the services that we've mentioned briefly.

9 The first is Part B drugs, and this is the hardest.
10 According to the plan benefit file data, about 18 percent of MA plans
11 and a similar percentage of enrollees, are in plans that say they do
12 not impose any cost-sharing for Medicare-covered Part B drugs. Most,
13 however, require either copayments, coinsurance, or some combination of
14 the two, usually based on where the drug sits in their formulary or
15 other criteria. About 30 percent of the plans report that they require
16 a copayment for Part B drugs, which is not shown on this chart. Most
17 of the copays were in the \$100 range, some were somewhat larger than
18 that.

19 Coinsurance requirements are more common in the plans. As
20 the chart shows, most of the plans that have coinsurance require
21 coinsurance at the rate of 20 percent for Medicare-covered drugs.
22 However, after calling a number of plans and talking to people who

1 actually code their plan's data we confirmed our suspicions that there
2 are some inconsistencies in the way that the information was reported
3 in the plan benefit file data, especially when it comes to physician-
4 administered drugs provided in office settings.

5 Some plans, for example, consider physician-administered
6 drugs as part of the office visit and do not code coinsurance or
7 copayment information on the PBP file. Cost-sharing for office-based
8 drugs may be determined by individual plans reflecting negotiations
9 with network physicians. There's additional information on how all of
10 this works that an individual beneficiary can get from the printed
11 explanation of benefits brochure that their plan supplies. But even
12 that is not going to give them information on how specific drugs might
13 be charged.

14 So the bottom line is that neither we nor CMS have data that
15 will tell us answers to questions that we would like to be able to
16 answer. This chart should therefore be viewed as a ballpark estimate
17 of what cost-sharing for Part B drugs also looks like. The takeaway
18 messages are, first, there's a lot of variation in coinsurance and
19 copayments and cost-sharing for Part B drugs; and two, this is hard for
20 anybody, CMS, beneficiaries, or us to figure out.

21 The next two charts are easier. These show radiation therapy
22 and dialysis services. The distribution of cost-sharing among the

1 plans is similar; about one-fifth of the plans do require some kind of
2 coinsurance at 20 percent. The PBP file indicates that the plans
3 charging 20 percent for radiation therapy for the most part do not have
4 caps on that spending. For dialysis, about half the plans charging
5 coinsurance do cap beneficiary costs. Some plans also charge flat
6 copayments for radiation therapy; also not reflected in this chart.
7 The plan finder information also tells beneficiaries that they may be
8 charged additional facility fees by some plans or under some
9 circumstances.

10 DME services as a whole are of concern to the plans and to
11 CMS because of high levels of utilization of some services and
12 continued issues of inappropriate use for some services. In the case
13 of oxygen, however, cost-sharing could impose problems for some
14 beneficiaries. We found that the majority of plans charge 20 percent
15 coinsurance for DME services; more than one-third of plans waive
16 coinsurance for Medicare-covered DME. Most plans that charge
17 coinsurance do not have caps that cover out-of-pocket costs for DME.
18 There's also a couple plans that require 40 percent coinsurance for
19 DME, and these plans do not limit out-of-pocket spending for those
20 services. Those are both private fee-for-service plans. Another
21 private fee-for-service plan charges 30 percent for DME, and that has a
22 cap of total out-of-pocket spending for Medicare-covered services of

1 \$5,000.

2 So in summary, there is considerable difference among plans
3 in cost-sharing, although cost-sharing for most beneficiaries is lower
4 than it would be in fee-for-service Medicare without supplemental
5 insurance for most services. Some plans require as much, or in a small
6 number of cases, more beneficiary cost-sharing for specific services.
7 Some of the services for which cost-sharing requirements could be of
8 concern are services that are used by beneficiaries with serious health
9 problems, such as inpatient hospital care, Part B drugs, oxygen or
10 radiation therapy.

11 Understanding the implications of these variations from the
12 perspective of informed beneficiary choice, beneficiaries' cost of
13 care, market competition among plans, et cetera, will require careful
14 consideration. So additional analyses will seek to determine if
15 there's evidence that cost-sharing requirements are a factor in
16 beneficiaries' decisions about disenrolling or joining Medicare plans.
17 We'll also look more closely at the range of out-of-pocket costs for
18 prototypical beneficiaries, and with your input we will try to address
19 the questions posed by the congressional mandate.

20 DR. SCHMIDT: Thank you.

21 MR. SMITH: Thank you, that was helpful, if troubling.

22 Is there any lookback analysis at how well people choose

1 among competing plans. Given their utilization and the structure of
2 the improvisation of costs and coinsurance, how many people make the
3 right choice?

4 DR. SCHMIDT: I'm not really aware of analyses along those
5 lines. There's some information, for example, from disenrollment
6 survey data that CMS collects to take a look at why people are leaving
7 and that is one thing that we'll be presenting to you in the near
8 future.

9 DR. REISCHAUER: I cannot resist making a comment on the
10 right choice notion. To do this correctly, the right choice would have
11 to be what you expect your needs to be, as opposed to what they are,
12 and that makes it very complicated.

13 I enjoyed this paper, but it struck me that there's this
14 terribly complex issue of what is fair or what is acceptable, and
15 looking at all Medicare Advantage plans maybe isn't the right way to do
16 it because we have some which charge supplemental premiums and some
17 that don't. One could argue that those that don't are really providing
18 an alternative to fee-for-service only. So in determining fair or
19 acceptable, we should be comparing the cost-sharing in those plans with
20 fee-for-service only. For those that charge premiums we should do a
21 separate analysis and compare it to fee-for-service plus Medigap,
22 although even that probably isn't totally appropriate because what you

1 are doing in terms of the size of the premiums at least that you
2 mentioned in here is really Medigap light. It's really a premium
3 that's about 30 percent of what the average premium is.

4 But it would be interesting to see, if you took out those
5 that charge no premium, whether there were fewer bad apples in that pot
6 versus the group as a whole.

7 DR. BERNSTEIN: Just to clarify that, would that also include
8 -- there are not very many zero premium plans in here. Would you also
9 want us to look at low premium?

10 DR. REISCHAUER: Because this at the nadir of this. If you
11 had 2004 it would be probably a little different, in many ways. The
12 cost-sharing would be different.

13 DR. BERNSTEIN: The problem is there are a lot of low premium
14 plans that have very different benefit structures from each other.
15 They don't tend to just be, we cover Medicare-covered services and we
16 don't charge you an extra premium. It's, we charge you little or no
17 premium, we cover Medicare-covered services with high coinsurance and
18 then give you some extra stuff that Medicare doesn't cover. So we
19 might have three classes rather than two classes of plans.

20 DR. MILLER: Are we able to look at the premiums?

21 DR. BERNSTEIN: Yes.

22 DR. MILLER: Then why don't we think of looking at a

1 distribution to try to address the question.

2 DR. REISCHAUER: You could do the plans that are clearly
3 charging heavy-duty premium so they should be providing cost-sharing or
4 supplemental benefits that are at least equivalent to fee-for-service
5 plus a Medigap policy, and then the lights, which you are saying
6 there's a lot of, and then the few which charge no premium at all.

7 DR. MILSTEIN: There is a relationship between the
8 evaluability of this information by seniors and their ability to
9 identify a plan that might have a benefit structure that would indeed
10 give them access to the services they need. Is the relative
11 evaluability of this information by seniors within the scope of what we
12 should comment on? Based on the nods, I'm assuming so.

13 I would like to, in some ways reiterate my prior comment when
14 we discussed the evaluability of different drug plans. I think for
15 many of us it's the low moment of our year when our parents call us to
16 say, which one should we pick because we can't -- the cognitive burden
17 associated with doing this right exceeds human brainpower. So I think
18 it's an opportunity within this study to comment on this, and I
19 personally would tee up for us the notion that this is not what human
20 brains were ever designed to be able to handle, irrespective of whether
21 you are above or below age 65, and this is what computerized solutions
22 or what the rest of the world uses to try to deal with cognitive

1 burdens of this order of magnitude.

2 DR. MILLER: Just along those same lines and I think this is
3 the same point. I think as we've going through this, what is actually
4 being reported when we're looking at this also varies along the plans.
5 So even from the agency's point of view, the notion is trying to get
6 what data elements commonly reported so that you can make these
7 judgments. Then I think there is also the concern of how the
8 beneficiary processes the information.

9 DR. CROSSON: I would like to also compliment you on the
10 paper. I think it is very good and it is an important issue. It seems
11 to me the central point of the problem is the concern about substantial
12 copayments for individuals who are in a position clinically where they
13 have really no discretion about using those services. It gives a lie
14 to the purpose of having coinsurance in the first place one might say.

15 It also seems from your analysis that it's to some degree
16 limited to a small number of plans. I'm most interested in the issue
17 of the recommended cap. It sounded to me from the comment that CMS has
18 come up with that more or less by taking a mean or a median of the
19 existing caps in the marketplace.

20 My question is, either mathematically or practically, is
21 there in fact a cap which would make more sense from the perspective
22 that if the cap was appropriate and provided what appears to be a

1 relative safe harbor, is there a level of a cap which would obviate the
2 problem that we are concerned about and that was listed in the report?
3 The copayments for people with dialysis, or copayments for people with
4 cancer chemotherapy. It seems like there ought to be a relationship
5 between the worst case of those situations and a certain cap. It might
6 not happen to be the mean or the median of what is in the marketplace.
7 If Medicare is going to use that as a safe harbor, more or less
8 aggressive, it would seem to me that it ought to have some science
9 behind it as opposed to just an average of what exists.

10 MS. RAPHAEL: Two points. We're looking at this very much
11 from the point of view of the plans and their structures. Do we have
12 any information at all on beneficiary out-of-pocket costs for those who
13 are enrolled in plans compared to those in fee-for-service? I know in
14 the past we've looked at that issue.

15 DR. BERNSTEIN: When we have looked at it in the past, on
16 average, beneficiary out-of-pocket cost for people in MA plans are
17 lower than they are for either employer-sponsored or people who had
18 supplemental insurance. We look at that most years.

19 MS. RAPHAEL: Is it possible at all to somehow stratify it?
20 I guess building on what Jay was getting at, I thought part of the
21 focus of this was on certain categories of patients who have a
22 particular health status that requires heavy use of certain services

1 that they might be discouraged from using. So is it at all possible to
2 see what the utilization patterns are for those particular categories
3 or what their cost-sharing might be, their out-of-pocket expenditures
4 might be?

5 DR. SCHMIDT: The data that Jill was referring to are the
6 Medicare current beneficiary survey data. Those are the sorts of
7 comparisons that are available. There is a bit of a lag in those data
8 for some of the comparisons.

9 But one thing that we will be bringing you in the near future
10 is what I described as cost-sharing among plans for prototypical
11 beneficiaries. So for example, we might take an average, relatively
12 healthy 65-year-old who lives in a certain area and compare the cost-
13 sharing that they would face among certain plans with someone who has
14 colorectal cancer, to bring it home.

15 MR. HACKBARTH: Rachel, did you have a comment on Jay's?

16 DR. SCHMIDT: I just wanted to clarify. I don't think that
17 CMS is solely using market information to set its proposed cap levels.
18 It's using a few pieces of information including looking at the
19 percentile of out-of-pocket spending among fee-for-service
20 beneficiaries and trying to take a look at Medigap premiums. That is
21 probably where you're making your comment about looking at averages.
22 So it's not solely looking at the market. That is difficult to do,

1 given that there is imperfect data on Medigap premiums out there. It
2 does try to look at several pieces of information.

3 DR. REISCHAUER: I would like to build on something that
4 Arnie said and open up a possibility. You have shown us that there's a
5 tremendous amount of variation in the way plans, even within one
6 region, impose cost-sharing. A free marketer could say, this is
7 maximizing consumer choice. This is wonderful. An agnostic could say,
8 this is creating a lot of innocent confusion. And somebody who is more
9 cynical might say, there is a lot of malicious misleading going on for
10 marketing purposes.

11 If you are not in the first camp you quickly get to the point
12 where you say, maybe something should be done to improve the situation
13 that we have now, much like what happened a decade and a half ago with
14 respect to Medigap policies. Should Medicare Advantage plans have 10
15 standardized cost-sharing regimes which they could choose among so the
16 people would not have 1,000 alternatives bearing on every single
17 dimension, which one does not know, but a more simplified structured
18 set of alternatives which the consumer can more easily understand and
19 compare prices for? And do we want to go there?

20 DR. SCHMIDT: As I said, in the expert panel the issue came
21 up. Some of the beneficiary advocates in particular argued along the
22 lines, that would be a good idea. I think other panelists thought that

1 would lead to more price competition and that might be a good thing.
2 As I said, there was no consensus on that issue, and some folks pointed
3 out that even in the Medigap world where there are standard policies
4 there is still selection problems.

5 MR. DURENBERGER: I think Bob asked my question and it goes
6 to this issue of, is it possible to standardize the benefits? Do we
7 have examples in the private world in which employees, for example, are
8 asked to make choices of comparable plans?

9 DR. SCHMIDT: I think that CalPERS, for example, does use a
10 standard, so there is one example. FEHBP does not, although my
11 understanding is that OPM has used its negotiating authority to make
12 plans more similar than they have been in the past.

13 DR. MILSTEIN: Standardizing the plans would move in the
14 direction of lowering the cognitive burden associated with assessment.
15 But optimization, if you're trying to coach your mom really also has to
16 do with interacting, even in a non-standardized benefit plan with prior
17 health history and its implications going forward for subsequent
18 demand, which is more of a computerized calculation. That is what
19 modeling software does.

20 The second point is building on Jay's point. I would be
21 interested in knowing, if it is within the scope of our resources, the
22 degree to which any of this cost-sharing is rooted in available

1 distinctions between discretionary and non-discretionary services. For
2 example, mandatory significant consumer cost-sharing that would apply
3 to a hip fracture has different implications for access and senior
4 health than a tenth return visit within a month for rheumatology, to
5 take an extreme example on the other side. So I would be interested to
6 know whether any of these plans in formulating their cost-sharing
7 structure took into account discretionary versus non-discretionary,
8 close utility, cost-effectiveness, et cetera.

9 MR. BERTKO: Just to add a bit to the debate on standardized
10 plans, I would alert you that even folks like CalPERS have found a need
11 to move the plan standardizations over periods and that current Medigap
12 I would call obsolete designs, and in this forum with Medicare it might
13 be very difficult to change a formal standard is it didn't, by design,
14 first have at least ranges within which cost-sharing might change over
15 time.

16 MR. HACKBARTH: Can I ask a question about the rules that are
17 going to apply under the drug benefit versus these rules? As I
18 understand it, under the drug benefit, specifically with regard to the
19 formulary rules, there is the notion that the formulary ought not to be
20 constructed in a way that is discriminatory towards patients with
21 certain types of clinical problems. Do we have different playing rules
22 for the drug benefit as opposed to this? Arguably, loading on the

1 cost-sharing for chemotherapy would be discriminatory towards patients
2 with cancer.

3 DR. SCHMIDT: I think this is part of CMS's review and
4 approval process. Bear in mind that things may be changing a bit as we
5 move towards 2006 and there's greater negotiating authority, or not.
6 That remains to be seen how well CMS is able to implement that.

7 But currently, the process is to review proposed benefit
8 packages, including cost-sharing provisions, and generally look to see
9 whether it's the same sort of cost-sharing across different types of
10 services. So if it were particularly high for chemo and not for
11 others, that would appear discriminatory. CMS, we understand from
12 talking with some people, has in some cases encouraged plans to adopt
13 caps to constrain overall liability. We've also heard from some
14 beneficiary advocates that it has not been so successful in other
15 cases. So I think there's a mixed bag out there.

16 MR. HACKBARTH: I have been a long-standing advocate of
17 private plans in Medicare, and the core reason for that is I believe
18 that private plans potentially have opportunities to do things
19 creative, beneficial to patients in terms of how they organize care
20 delivery, pay for providers, structure benefits, and the like. So I am
21 very much in favor of giving private plans appropriate flexibility.
22 Whether this particular issue of selective higher cost-sharing,

1 although perhaps not higher than traditional Medicare, the higher cost-
2 sharing on patients with certain types of clinical problems, I'm not
3 sure that that's not beyond the pale of what appropriate flexibility
4 might be.

5 I would like to second the observations that Jay and Arnie
6 made; the notion of cost-sharing, appropriately applied, is that you
7 apply it to discretionary services, hopefully to alter utilization
8 patterns in an appropriate way. When you're talking about loading it
9 on for chemotherapy, I do not think you're talking about cost-sharing
10 in that sense. So from my perspective the trick here is, we want to
11 allow appropriate flexibility for private plans. That is part of the
12 core principle of having the program of the private plan option. But
13 it seems to me that we ought to be able to draw some boundaries on what
14 appropriate flexibility is. I think this is, from my perspective,
15 getting close to the line.

16 I also generally favor the notion of some standardization,
17 although with standardization potentially comes some problems if it is
18 not updated appropriately over time.

19 DR. NELSON: As a matter of principle it seems to me that if
20 we make recommendations with respect to a cap, absent standardization
21 and with the cacophony that is out there in the market, our
22 recommendation ought to be framed in the context of total out-of-pocket

1 expenses. I do not see any other way to get around the variability in
2 terms of what people have to pay out-of-pocket.

3 MR. HACKBARTH: Other questions or comments on this topic?

4 Okay, thank you very much. Good job.

5 Next we have a presentation on Medicare+Choice or Medicare
6 Advantage payment rates, payment areas and risk adjustment. This also
7 is a mandated report.

8 * DR. ZABINSKI: Today I'm going to discuss work that we
9 completed on a study that is mandated by the MMA that analyzes some
10 features of a payment system in the Medicare Advantage or MA program.
11 Our work on the study is far from complete so we will be presenting
12 additional work at upcoming meetings.

13 Local MA plans are facing several changes to the system that
14 sets their payments. First, the MMA has reestablished use of adjusted
15 average per capita cost, or AAPCC rates, which are linked directly to
16 local per capital fee-for-service spending. Also there is a new system
17 for risk adjusting payments to MA plans, the CMS-HCC risk adjustment
18 model. Finally, there will be a new payment system in 2006 for local
19 plans which will use plan bids to help determine their payments.

20 The MMA directs MedPAC to study three issues related to these
21 changes in the payment system. First, we are to look at the factors
22 that underlie geographic variation in AAPCC rates and determine how

1 much the variation in the rates is attributable to each of these
2 factors. Also we are to identify an appropriate payment area for local
3 plans. And finally we are to assess the predictive accuracy of the new
4 risk adjustment system, the CMS-HCC in predicting costs for different
5 groups of beneficiaries.

6 This report is due by June 8, 2005. We have begun work on
7 it, but as I mentioned earlier, our work is far from complete. Over
8 the next few slides I will discuss each of these issues and the results
9 from the analyses that we have completed so far.

10 First I'd like to talk about our analysis of the variation in
11 AAPCC rates. AAPCC rates are linked directly to local per capita fee-
12 for-service spending which has much variation among counties which
13 currently serve as the payment area for MA plans. Prior to 1998, the
14 Medicare risk program used AAPCC rates as a basis for all payments.
15 The geographic variation in AAPCC rates, however, became a problem.
16 That is, the level of AAPCC rates was shown to be correlated with local
17 availability of plan and plan generosity. That is, the counties that
18 had relatively high payment rates tended to attract many more plans
19 than the counties that had low payment rates, and the generosity of the
20 plans with the high payment rates tended to be much better than the
21 generosity of the plans in the low payment areas.

22 These discrepancies between counties led to perceptions of

1 inequity. Therefore, by reestablishing a direct link between local
2 fee-for-service spending and payment rates the new payment system in
3 the MA program may increase geographic variations in payments,
4 availability of plans, and generosity of benefits.

5 In our all estimates of how much different factors affect
6 variation in AAPCC rates we simplified our method by analyzing five-
7 year averages of counties per capita fee-for-service spending adjusted
8 for county-level differences in health status where the county-level
9 differences in health status were measured with average risk scores
10 from the CMS-HCC risk adjuster.

11 We found out about 15 percent of the variation in per capita
12 fee-for-service spending is explained by differences in the cost of
13 inputs to care and special payments to hospitals including IME, GME and
14 DSH payments, and the remaining variation to three factors. First of
15 all, providers' practice patterns and then beneficiaries' preferences
16 for care, and finally, mix of providers. An example of how mix of
17 providers affects variation is that Medicare makes different facility
18 payments for the same procedure whether it is performed in a hospital
19 outpatient department or an ambulatory surgical center. Therefore,
20 variation in spending can be affected by physicians' use of ASCs rather
21 than HOPD more frequently in some areas than others.

22 Now I would like to move onto our analysis of the appropriate

1 payment area for local plans. Counties currently serve as the payment
2 area for MA plans. But we have found that using counties as payment
3 areas does create some problems. First, by using a four-year moving
4 average of per capita fee-for-service spending we found substantial
5 changes in AAPCC rates from year to year for many counties, especially
6 those who have relatively small Medicare populations. These large year
7 to year changes can make certain counties unattractive to plans because
8 of uncertain revenue streams.

9 Also we found that adjacent counties often have very
10 different AAPCC rates. In these circumstances, plans may be attracted
11 to the county with the high rate and may try to avoid the county with
12 the low rate, creating appearances of inequity between neighboring
13 counties.

14 Our quantitative analysis of the appropriate payment area
15 consist of comparing counties to a larger payment area comprised of
16 statewide rural areas and then what I call within-state MSAs, which are
17 defined as the following. If an MSA lies entirely within a state's
18 boundaries, that MSA would serve as a single payment area. But if an
19 MSA is divided by a state boundary, such as the Minneapolis-St. Paul
20 MSA which is divided by the Minnesota-Wisconsin state border, the part
21 of the MSA within each state serves as a separate, distinct payment
22 area. One thing I want to emphasize is that this larger payment area

1 we are using strictly as an analytical tool. I want to say that we are
2 continuing our work on identifying the appropriate payment area.

3 Our comparison of counties to the larger payment area reveals
4 that large year-to-year changes in per capita spending are less
5 frequent under this larger payment area. For example, on this chart we
6 show that under the county system, 23 percent of counties have a change
7 in per capita spending 2001 to 2002 of 3 percent or more. But under
8 the larger payment area only 3 percent of counties have a change from
9 2001 to 2002 of 3 percent or more.

10 We also found that the large differences in AAPCC rates
11 between adjacent counties are less frequent under this larger payment
12 area. For example, under the county system of the payment area, 23
13 percent of beneficiaries live in counties that have an adjacent county
14 with per capita spending that is at least 15 percent higher than that
15 county's rate. In contrast, under the larger payment area, only 10
16 percent of beneficiaries live in counties that have an adjacent county
17 with per capita spending that is at least 15 percent higher than that
18 county's rate.

19 The reason why we see this result is that using the larger
20 payment areas tends to increase rates for counties with low rates and
21 depress rates for counties with high rates. In the end we found that
22 47 percent of beneficiaries live in counties that have higher rates

1 under the larger payment area and 53 percent live in counties that have
2 lower rates under the larger payment area.

3 Now lastly I'd like to talk about our assessment of the
4 predictive accuracy of the CMS-HCC risk adjuster. First a little bit
5 of background on why risk adjustment is important. If a risk adjuster
6 does not accurately predict beneficiaries' cost, plans may be overpaid
7 for enrollees who are in good health and underpaid for those enrollees
8 who have poor health. Therefore, plans who attract relatively healthy
9 enrollees would be rewarded and those who are attracting sick enrollees
10 are punished. A good risk adjuster would reduce these payment
11 inaccuracies.

12 We analyzed how accurately the CMS-HCC predicts costliness
13 using predictive ratios from 2002 where a predictive ratio for a group
14 of beneficiaries is the mean of their costs as predicted by the CMS-HCC
15 divided by the mean of the group's actual cost. The closer a
16 predictive ratio is the one, the better the risk adjuster has
17 performed.

18 In our analysis of the accuracy of the CMS-HCC in predicting
19 cost, our database consists of beneficiaries who participated in fee-
20 for-service Medicare in 2002. We grouped these fee-for-service
21 beneficiaries by indicators of health status, including the diseases
22 that they had diagnosed in 2001, how much the program spent on them in

1 2001, and the number of inpatient stays they had in 2001. For each of
2 these groups we compared the predictive ratios from the CMS-HCC to
3 predictive ratios from a model that uses beneficiaries age and sex to
4 predict costliness. This age/sex model has been used in several other
5 studies as a point of comparison for other risk adjustment models. It
6 is similar to a demographic model that CMS currently uses to risk
7 adjust payments and has used for a number of years.

8 Now for each group of beneficiaries we found that the
9 predictive ratios from the CMS-HCC are closer to one than are the
10 predictive ratios from the age/sex model, indicating that the CMS-HCC
11 performs better than the age/sex model in general. For example, on
12 this diagram we divided beneficiaries by conditions that were diagnosed
13 in 2001. For each of these conditions you can see that the predictive
14 ratio is closer to one under the CMS-HCC than under the age/sex model.

15 At this point one thing I want to mention is there's another
16 statistic that is often used to measure performance of risk adjustment
17 models, that being the r-squared. What the r-squared tells you is how
18 much of the variation in beneficiaries' cost is explained by a risk
19 adjuster. In other words, it tells us how well a risk adjuster
20 predicts costs for an individual, while the predictive ratio tells us
21 how well a risk adjuster predicts costs for a group of beneficiaries
22 with similar circumstances.

1 We know that the CMS-HCC explains about 10 percent of the
2 total variation in cost, or about half the variation in costs that are
3 not due to random events; that is the predictable variation. What that
4 tells us is that for any randomly selected beneficiary the CMS-HCC is
5 likely to make a fairly large error in predicting their cost. However,
6 I think it is more important that the predictive ratios on this slide
7 indicate the CMS-HCC actually predicts costs quite well for groups of
8 beneficiaries with specific conditions. That is a key result because
9 what that indicates is that there's little for plans to gain or lose on
10 average if they have beneficiaries with these conditions as enrollees.

11 Finally, I would like to close by discussing our next steps
12 in this analysis. At the beginning of the presentation I said that the
13 work presented here is only a beginning for our overall analysis.
14 Additional work we intend to do includes examining how well AAPCC rates
15 reflect plan costs. This will indicate how well plan payments match
16 their cost of providing care and will use data from adjusted community
17 rate proposals to approximate plan costs.

18 Also we will complete our analysis of the appropriate payment
19 area. We will consider a number of alternative payment areas and
20 consider how well each of them stacks up against a number of criteria,
21 such as the availability of data for each alternative, whether the
22 number of beneficiaries in each alternative is high enough to obtain

1 reliable payment rates, and finally, how well each alternative matches
2 to plan market areas.

3 Now at this point I want to say I am not very hopeful that
4 we, or anybody else for that matter, can actually identify an ideal
5 payment area. Instead I think the best that we can do is to identify a
6 payment area that is the best of several alternatives.

7 MR. HACKBARTH: Let me just pick up with that very point.
8 You mentioned two factors that we want to be sensitive to, the
9 stability in the rates over time in the geographic unit we're talking
10 about, and that obviously mitigates in favor of larger geographic
11 units. Then the second is that we want to, to the extent possible,
12 reduce boundary problems, defined as big changes in payment as you move
13 across the unit boundaries. That too argues in favor of larger units.

14 In the past, the other consideration that people have worried
15 about is that the larger the unit gets, the more heterogeneous it
16 becomes, potentially creating an opportunity for plans to set up
17 operation in the low cost part of a high-cost payment area, and through
18 that process to take advantage of the system. Theoretically, I guess
19 that is a risk.

20 The question I'd like to ask is, is it just a theoretical
21 risk or is this a real world problem to be concerned about?

22 DR. ZABINSKI: I assume you're talking about the final point

1 I made. Scott might be able to speak better to this but I'll give it a
2 shot. In some sense it's theoretical because plans aren't supposed to
3 do that. They're supposed to serve an entire area that they move into.
4 But on the other hand, what that might do then is, if you mix these
5 heterogeneous markets and you require them to serve the whole thing,
6 that may dissuade plans from moving into certain areas that they
7 otherwise would if you had a little bit smaller area.

8 MR. HACKBARTH: And requiring plans to serve entire large
9 units could be easier for some types of plans than others. Plans like
10 Kaiser that are facility based have less flexibility in that regard
11 than network plans that use a contract delivery system.

12 DR. HARRISON: I think we were thinking of making sure that
13 the areas we looked at an appropriate size that plans would be able to
14 serve the entire thing. We would look at alternatives. I know CMS is
15 now going through this is the regs trying to figure out what kind of
16 network adequacy to put on the regional plans to make sure that they
17 serve the whole thing, and we will think about that.

18 MR. BERTKO: First of all, I think this is a very good study
19 and illuminates many of the problems, and risk adjustment is pretty
20 clear. I guess I would comment on the stability issue. I know that
21 Dan and Scott's study over time, I think that is an appropriate
22 solution, particularly with smaller population counties that might have

1 blips over time. They can be evened out using moving weighted
2 averages.

3 On the area of having big MSA type things I'd only point out
4 that some of the large, urban MSAs are really huge, and that in the
5 commercial world, under-65 employed populations there frequently are
6 rating areas and the delivery systems and the delivery system costs can
7 be quite different. So in addition to the heterogeneity that you
8 pointed out, you actually have to worry about what are you paying, are
9 you paying the right amount so you're getting the right revenue in
10 there.

11 In the absence of a much better solution I would say,
12 particularly for 2006 as we move into a new bidding mechanism as
13 described earlier, we may want to be restrained on how promptly we call
14 for a change, given everything. We're going to continue to have
15 discrepancies and the question here I'd ask our panel and the
16 researchers is, is something new better, as opposed to living with the
17 current things that we know more about?

18 MR. DURENBERGER: I was pleased to hear your conclusion at
19 the end about we're probably going to come up with the best of several
20 alternatives, because it strikes me, and I've been somewhere in this
21 AAPCC world for 20 some years now, that that really is the way the
22 Medicare program ought to work over time. That there is not one ideal

1 geographic area as we move in this direction. It will be so helpful if
2 we can, through an analysis, present the several alternatives in ways
3 that make sense in different areas and different parts of the country
4 and so forth, and then allow the decisions about best of to be left to
5 some other part of the process.

6 If I understand it this is still correct, since this data is
7 all premised on residence of beneficiaries, right? It is always
8 confusing till you get that point because we think about it as
9 reflecting what are the costs in Minneapolis, even though maybe half of
10 the expenditures for were costs in Minneapolis are reflected in the
11 cost in some rural county because people are shipped in to get their
12 tertiary care.

13 So for those of us who come from, like this little example of
14 the Three Musketeers sitting here in the Upper Midwest, it also might
15 be informative to look at some experiences that we have had with large
16 integrated systems. One that comes to mind is the Marshfield Clinic in
17 the middle of Wisconsin, which also has an MA plan. And to the point
18 of what you expressed, the concern about making money here and moving
19 it over there, these obviously are things that integrated systems deal
20 with all the time, as well as how much money ends up with primary care
21 folks and specialists and things like that. But it's not necessarily a
22 bad thing.

1 Again, the relationship between the plan and the practice in
2 that community and the way in which people are referred from one place
3 to the other, I would suggest, would be informative to at least
4 demonstrating that there are alternative ways to approach the
5 decisionmaking. I know it is getting complicated as we get into this,
6 and I know you've got a short deadline and things like that, but it
7 strikes me that those are important issues today as we move towards
8 regionalization generally. Those are really important illustrations
9 that we can make as people examined the conclusions we're going to come
10 to.

11 MR. HACKBARTH: So under the geographic issue, the end
12 product, particularly given this time frame, is that we are not seeking
13 to come up with the right geographic unit. In fact almost by
14 definition I guess there isn't a single right. You're talking about a
15 problem of trading off different goods, if you will. But rather
16 looking at a product that says, here are some different options and the
17 strengths and weaknesses of each.

18 DR. REISCHAUER: On that very point, both the paper and your
19 presentation was a bit enigmatic about what the alternatives are. We
20 have county, we have MSA. Presumably there's the geographic units that
21 Wennberg uses, but I don't know what kind of data is collected that
22 way. And I'm scratching my head thinking, what else is there out

1 there? These have their deficiencies, but aren't the things that if we
2 can't even think about or don't even though we should be thinking
3 about, probably having even greater deficiencies? How much more is
4 there to go?

5 DR. ZABINSKI: I know one geographic unit that's been studied
6 by researchers at CMS for a number of years is something called
7 empirical market areas. The concept I think is very sound. What they
8 try to do is link together counties where there is a lot of border
9 crossing by beneficiaries to get care for one to the next. The idea is
10 to get payment areas that closely match plan market areas or insurance
11 market areas.

12 The problem is they found it almost necessary to use a
13 complete trial and error method. There wasn't real concrete thresholds
14 on this border crossing idea to form a particular payment area. It was
15 so cumbersome to do it they've only been able to do one state. But
16 like I said, in terms of theoretical I think it's very sound but I
17 can't see it working practically.

18 DR. REISCHAUER: I'm just thinking off the top of my head so
19 this may be absolutely crazy, but what about having a choice between
20 where people live and where they get services? I'm thinking of my own
21 experience. I live in Montgomery County and to my knowledge I've never
22 been to a medical facility in Montgomery County. Everything is in the

1 District. So why shouldn't I be in a District plan? Just cutting this
2 thing totally differently in calculating payments by where people get
3 their services as opposed to where they live.

4 DR. MILLER: I think the kinds of things we've been thinking
5 of trolling through are counties, different versions of MSAs, private -
6 - I was waiting for one of you to mention -- we are going to look at
7 private plan service areas. There is probably referral-based types of
8 area which are sort of the Wennberg stuff.

9 I will speak on this. I have to say, we have not thought
10 about this idea and I'd really have to spend some time thinking about
11 what the implications of that are. It's not to say no, but this is the
12 first I've ever thought of it. But I don't know.

13 DR. HARRISON: I think the only constraint we have is we need
14 to use counties as building blocks because I do not think we have
15 enough data for any other type of geographic building blocks, like
16 census tracts or anything.

17 MR. MULLER: I would be somewhat cautious on that because
18 when you see all the efforts people have made to link themselves to
19 geographic areas for labor adjustments and so forth, you start bussing
20 patients to get into empirical use patterns, though I'm glad to see
21 that Bob is endorsing large, urban providers as a place of choice.

22 DR. CROSSON: I guess in the end I would just wonder whether

1 the benefit from changing to a larger area, which appears to decrease
2 the year-to-year variability for one thing, which as John said could be
3 potentially fixed in another way, perhaps a simpler way, whether that
4 benefit is worth, in the next few years, the disruption potentially
5 that would take place by changing it, given the fact, as already
6 indicated from the discussion, that there is no obvious way to do that.

7 MR. HACKBARTH: Just a clarification. As I recall, the
8 current county level is based on a five-year moving average. So we
9 already try to reduce the variation due to small size by using a moving
10 average. But even after you do that, you get results that were
11 described earlier. There still is substantial variation. Some of the
12 counties are so small in terms of population of Medicare beneficiaries.

13 DR. ZABINSKI: There is a county in Texas that has 20
14 beneficiaries.

15 DR. REISCHAUER: When you think about this though from a
16 business standpoint, nobody is going to set up a plan for 20 people.
17 They're going to be part of a much greater unit, and no matter what
18 happens to the payment in that county it's not really going to affect
19 the bottom line because only two of those 20 people are going to join
20 this plan. So we can get all worked up about great variation in very
21 unimportant numbers from a business standpoint.

22 MR. HACKBARTH: I think that is an extreme example.

1 DR. REISCHAUER: For every year they are woefully underpaid,
2 there is a year that they are woefully overpaid. Over time this should
3 average out.

4 MR. MULLER: I think going back to some of the AAPCC is a
5 good thing when you see some of the efforts coming out of BBA when we
6 went to the national averages and so forth which started bringing up
7 whole parts of the country to payment patterns that were inconsistent
8 with their costs, I don't think that is a good way to equalize, dealing
9 with the issue of variation in costs. To go back, despite the famous
10 or infamous Minneapolis, Miami-Dade comparisons and the twofold
11 differences in cost, to go back, because I don't think one is going to
12 change that overnight. It takes generations, if ever, to change the
13 underlying reasons for that variation.

14 So to have the plans in fact reflect the cost of the region,
15 understanding that it may be different in Minneapolis, may be different
16 in Miami, may be different in San Jose. But to go more closely back to
17 what the costs are in that region as a point of comparison, rather than
18 having certain localities and states being moved up to national
19 averages, which has been part of the politics of the last seven, eight
20 years in a whole variety of our payment areas. So I think if we can
21 move back to some kind of local standardization rather than moving
22 towards national standardization and the kind of arbitrariness in

1 moving people up to the national average, I think that is a good thing
2 that we are going towards.

3 MR. HACKBARTH: I just want to make a clarification so I'm
4 not misunderstood. I wanted to be clear, I agree with Jay's basic
5 point that in addition to looking at the analytics of this, I think the
6 timing of these changes is important. I think John was making the same
7 point. Even if there was a unit that we could come up with that
8 offered some additional benefit in terms of our criteria, I think you
9 need to take into account what is happening at the same time, and that
10 may argue in terms of not making this the highest priority change for
11 the Medicare Advantage program right now.

12 DR. HARRISON: In the regs, CMS is actually looking for some
13 guidance about how to pay for payment areas. They are saying that they
14 are not wedded to going back to weighting things by county. In other
15 words, if a plan is serving more than one county, they may not go back
16 and pay based on county. They are thinking about other alternatives.
17 So in 2006 the timing may actually be right to come up with something
18 different because they are looking for something.

19 MR. HACKBARTH: Any other comments?

20 Okay, thank you very much.

21 What we will do right now is go to our public comment period.
22 We are a little bit ahead of schedule. Any public comments?

1 Hearing none, we will adjourn for lunch and reconvene at
2 1:30.

3 [Whereupon, at 11:52 a.m., the meeting was recessed, to
4 reconvene at 1:30 p.m., this same day.]

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18 AFTERNOON SESSION [1:35 p.m.]

19 MR. HACKBARTH: Sally and Karen are going to lead off with
20 the discussion of skilled nursing facilities and tools to assess
21 quality.

22 * DR. KAPLAN: In this session, we discuss the Medicare's

1 program current ability to assess quality for skilled nursing facility
2 patients. Currently, except for three indicators on CMS's website,
3 most information on SNF quality is not specific to short stay patients,
4 the Medicare patients. Yet experts tell us that because the goals of
5 care are so different, it's important to collect information specific
6 to these patients.

7 In this analysis we are looking at what is available to
8 measure quality, and whether this information captures the concerns
9 about quality for SNF patients. First, we'll describe the important
10 differences between short stay patients and long stay residents of
11 nursing homes. Then we will describe the currently available quality
12 indicators, including their limitations. Finally, we will discuss
13 other types of information experts told us would be useful for
14 measuring SNF quality.

15 For this analysis, we interviewed CMS representatives,
16 industry groups, researchers, clinicians, quality and quality
17 improvement experts.

18 One big question is why is it important to collect SNF-
19 specific quality information? Generally both SNF patients and nursing
20 home residents are in the same facility but the patients, the goals of
21 their care, and the care they receive are very different.

22 This table shows some of the differences between SNF patients

1 and nursing home residents. Medicare SNF care is always post-hospital
2 and involves daily skilled nursing or rehabilitation care. Nursing
3 home care is not post-hospital and it is custodial or non-skilled care.
4 The goal of SNF care is recovery or improvement to the patient's
5 highest level of functioning. The goal of nursing home care is
6 maintenance of functioning to the extent possible.

7 The average length of stay for SNF patients is 25 days. In
8 contrast, the average length of stay for nursing home residents is two
9 years. On average, SNF patients make up 8 percent of a nursing home's
10 patients. Nursing home residents make up the remainder.

11 Most facilities have designated all of their beds as SNF
12 beds, but SNF patients fill only a few of those beds. The average
13 facility has seven short-term patients and 84 long-term residents.
14 Half of nursing homes have five or fewer SNF patients per day. Large
15 national chains have a larger share. They tell us that up to one-
16 fourth of their patients are SNF patients.

17 Given all the differences between short-term patients and
18 long-stay residents, experts tell us that quality for nursing home
19 residents is not necessarily related to quality for SNF patients. The
20 small number of SNF patients compared to long-stay residents has
21 implications for patient care and quality and supports the need for
22 collecting SNF-specific information.

1 Much of the research on quality makes no distinction between
2 short-stay patients and long-term residents. But the Medicare program
3 and MedPAC need separate measures for several purposes. CMS must
4 monitor quality of care for SNF patients as part of their
5 responsibility for the Medicare program. Implementation of a
6 prospective payment system raises concerns about whether providers have
7 incentives to improve or reduce quality under PPS.

8 Every year MedPAC assesses payment adequacy for SNFs and
9 recommends an update to payments. Change in quality is one factor we
10 use to determine if payments are adequate.

11 Finally, Medpac has recommended that CMS explore tying
12 payment to provider performance on quality. Well accepted measures are
13 critical to pay based on quality.

14 MS. MILGATE: CMS currently uses two sources of information
15 on quality for short-stay patients in nursing facilities, first the
16 minimum dataset and secondly, OSCAR, the Online Survey Certification
17 and Reporting System. The first three indicators from the minimum
18 dataset are also the ones that the National Quality Forum endorsed for
19 short-stay patients in their process for looking at measures in nursing
20 facilities.

21 The minimum dataset was developed primarily as an instrument
22 to try to standardize the assessment process in nursing facilities, but

1 has over time been used now for a couple of different purposes in
2 addition. That is, for determining payment as well as for developing
3 quality indicators.

4 For the short-stay patients, they are all assessed -- or the
5 percentages of the residents that have the incidence of delirium, pain
6 or the prevalence of pressure sores is derived from the 14-day
7 assessment. So because it's derived on the 14th day the patient's in
8 the SNF, that means, in fact, you lose some patients because some
9 patients actually are discharged before the 14th day.

10 So the indicators look at, on the 14-day assessment, the
11 percentage of patients that show symptoms of delirium different than
12 usual functioning, the percentage of patients that report they have
13 moderate or severe pain. And then for the prevalence of pressure
14 sores, it's actually a change in time. They look at what the scores
15 were on the five-day assessment. And if there was a zero and then it's
16 progressed to a pressure sore, that's noted. Or if they had a level
17 one or a level two, they see if it has progressed to a higher-level.

18 So those are the three primary indicators that CMS uses for
19 SNFs.

20 The second source of information in OSCAR. This is
21 information that's reported for the whole nursing facility. So again,
22 you get some information that might be useful for short-stay patients

1 but it's not broken out so it's unclear what the information here might
2 mean for those short-stay patients.

3 In the OSCAR you have survey reports on deficiencies that
4 look at the severity of the deficiency as well as whether they were
5 resolved. It also reports on complaints. And that there's also some
6 staffing levels reported. And it's broken out by registered nurses,
7 licensed practical nurses and certified nurse assistants.

8 Since the primary information comes from the MDS, we asked
9 our expert interviewees to tell us a little bit about what they thought
10 were the limitations of the MDS and to suggest some improvements, given
11 that's a tool that is currently being used in nursing facilities.
12 Here's what they said to us.

13 Because it was designed for long-stay patients, they
14 suggested there's really too few useful indicators for short-stay where
15 patients are expected to actually improve, which is a different way of
16 looking at the patient, as Sally mentioned earlier.

17 While current indicators provide some useful information,
18 they thought all of those areas were really important to measure, they
19 said that there are some important ways that they're designed that
20 might actually mislead those that are reading the information.

21 One example that struck me was that nurses are supposed to
22 report a patient's actual experience with pain, whether they are on

1 pain medication or not. But nurses are hesitant to code a patient on
2 medication as not having pain. So they are nervous, the experts are,
3 that in fact these are not being filled out correctly because the
4 nurses don't want to say well, there's not pain but they're on some
5 sort of pain medication.

6 Further, a high score on pain is supposed to indicate poor
7 pain management, but several of our interviewees suggested that high
8 scores could actually mean the facility is doing a better job at
9 assessing pain. So this isn't to say that you shouldn't assess pain or
10 you shouldn't look at pain management, but that they wonder if, in
11 fact, this is the best way to do it.

12 In addition to looking at the substance of the measures, they
13 say the timing of the MDS assessment also limits its utility. In
14 particular, you need to have an assessment on admission and discharge.
15 So while there is a five-day admission assessment, perhaps there should
16 be one that's earlier than that so you can really look over time at
17 what happens to the patient.

18 In particular there were concerns, though, about not having
19 some type of picture of the patient at ad discharge so you could really
20 look at what happened before the patient was discharged. They said,
21 however, that this did not mean that there needed to be another
22 assessment, an MDS assessment, but it could even be done on a tool that

1 would be more specific to quality and have fewer indicators on it or
2 fewer areas to fill out than the MDS actually did.

3 In terms of validity and reliability, there was a GAO report
4 that did some digging into this and found that while on a national
5 level the error rates for filling in the various sections of the MDS
6 were 11 percent, that on the short-stay patient indicators, in fact,
7 two of the three short-stay indicators had error rates quite a bit
8 higher than that. So they questioned whether this would actually be an
9 accurate picture at the facility level, in particular.

10 There was 18 percent error rates for pressure sores and 39
11 percent for the moderate pain and 42 percent actually for the intense
12 pain.

13 So we asked them, in addition or besides the MDS information
14 that is collected, are there other quality concerns that they thought
15 were important to be measured. These were the ones that really rose to
16 the top, in terms of talking to our interviewees. I would say the
17 first one was probably mentioned by about everyone we talked to and
18 there was a couple of different ways. There was all
19 rehospitalizations. And then there was also hospitalizations for
20 conditions that really have been found to be associated with good
21 quality of care or poor quality, depending on how you want to look at
22 it. MedPAC actually used the rehospitalization for specific conditions

1 in our March 2004 report when we were looking broadly at SNF quality.

2 The second one is discharge destination. This was looked at
3 as an outcome which really captured a broad core of the types of things
4 that need to be done for patients to reach their goals of care. Since
5 so many SNF patients do have rehabilitation, one of the key goals of
6 care is actually to go home. They said that looking at how many
7 actually do go home, or where else they might have gone, was really a
8 critical feature also of looking at quality in SNF.

9 The other was functional improvements. Again, this was kind
10 of an over time look at how SNF patients did in their care. Again,
11 because so many are getting rehabilitation services that you really
12 should look at whether a patient has improved over time. This is
13 really tied into the concern that there's no discharge assessment
14 because there wasn't really an ability to measure over time.

15 And then the fourth we heard was that it might be useful to
16 start exploring the use of standard or best practice protocols for
17 these types of patients. That while it was useful to look at the
18 incidence, for example, of pain there might be a more direct way to
19 actually look at the pain management process and if there were key
20 processes that were actually being followed. Was the patient's pain
21 actually assessed on a regular basis, for example. So they suggested
22 we might want to start looking at that.

1 At this time, that concludes our presentation. We would ask
2 you to give us feedback on the strategies that are suggested by these
3 experts for obtaining better information on SNF quality.

4 DR. MILSTEIN: This list of potential increments appears to
5 be very promising and likely account much better for quality of care.
6 But some of them would not come at low cost. Were there any associated
7 estimates of what the information collection burden might be associated
8 with some of these measures?

9 MS. MILGATE: We didn't ask specifically the cost but the
10 method for getting the information, for example, rehospitalization
11 overall as well as for particular conditions, there are some programs
12 that run on claims. I don't know how much the analysis of the claims
13 will cost, but in terms of data collection burden it would not be high.
14 And then the discharge destination is something where there also exist
15 programs to look at that.

16 The process, I doubt, would be a bigger project.

17 DR. MILSTEIN: The process and the change in functional
18 standard, which I think would be the gold standard, would be not
19 inexpensive.

20 MS. MILGATE: I don't know enough to say definitely about
21 this, but there are some fields in the MDS already that look at
22 functioning. So I don't know if it would be possible or not or a good

1 idea or not to use those. As long as you had the discharge assessment,
2 perhaps they could be used. But I don't want to say that definitively.

3 DR. CROSSON: I don't think I'm intemperate enough to suggest
4 one quality measure over another and we probably would not finish the
5 meeting today if we did that.

6 But I was struck by something. That was in addition to
7 needing improvements in quality, needing to differentiate between SNF
8 patients and nursing home patients or custodial patients, was the
9 observation that in fact the SNF patients are admitted for some very
10 different reasons. I think the distinction that was made was that some
11 are admitted for functional recovery, presumably to get back to an
12 independent living situation. Others for something that's more like
13 comfort and palliation, individuals with a fatal disease. And a third
14 category that is basically involved with medical stabilization,
15 presumably to then be discharged to some other care setting, a lesser
16 care setting including home care.

17 If that's the case, it seems to follow logically that if
18 you're going to measure the quality for those three classifications,
19 you ought to have quality measures that are in some way related to the
20 difference in outcomes that are expected for those three groups. What
21 those ought to be, I would not comment on.

22 But I do think the logic of the paper suggests that if that

1 distinction is real and can be applied, then it kind of drives a
2 quality measurement process which is relevant to those classifications
3 and should start early in the admission.

4 DR. NELSON: I like the way your chapter is developed and I
5 respect your use of your panel of experts to vet these items with.

6 But if may be that they were looking at things from a 30,000
7 foot level. As I took a look at the quality reporting on the SNFs in
8 the area where I practiced and tried to determine whether they had
9 discriminatory value in terms of which long-term care facilities I
10 thought were good when I was in practice, and I could not get from the
11 data the same kind of discriminatory information that I got as a
12 practitioner when I either would visit patients there or hear from
13 families or the patients themselves on their experiences.

14 So my comment is around a reality test of some of these data
15 with a couple of focus groups comprised of discharge planners or
16 physicians in a local area to get their ideas on how useful the quality
17 reporting is and whether it either agreed with or disagreed with their
18 ideas on the quality of the skilled nursing facilities in the area.

19 That may be far-fetched. It may not be practical or it might
20 not give any information. Certainly you wouldn't want to use discharge
21 planners from facilities that were attached to a SNF. But nonetheless,
22 those folks do formulate pretty clear ideas on what's good and what

1 isn't good in their local area. And I think that it would be really
2 helpful if indeed they thought that there was some concordance between
3 the quality data that are reported for these facilities and what their
4 actual perceptions were from being on the ground.

5 DR. KAPLAN: Alan, your story is not an uncommon one, by the
6 way. It is a story that I have heard a lot about, that I have heard a
7 lot from various informants.

8 My concern is that one of the things that we're really trying
9 to do is get at what is the quality of care for the SNF patient. I
10 think what you are really talking about is to help consumers choose a
11 nursing home, the consumer or their family or a professional perhaps,
12 choose a nursing home.

13 One of the things we heard from every single one of the
14 experts that we talked to was that quality for nursing home residents
15 is not necessarily related to the quality of care that the SNF patient
16 receives in that same place, that same facility. So I'm not sure we
17 can really do both.

18 DR. NELSON: I have respect for what you say, Sally, and I
19 would not argue with it. But some of these measures are so susceptible
20 to interpretation, pressure sores for example. And the really best
21 facilities in an area may look worse on paper because of superior
22 identification and reporting. If indeed, there was some points of

1 agreement between both of these directions, selecting a good facility
2 based on its quality data to me isn't a lot different from measuring
3 the quality within the home.

4 MS. MILGATE: I just want to say, Alan, that's basically what
5 we heard from our experts is that the current measures, maybe they say
6 something but in fact that there are some really limitations and they
7 really should have some additional information to make an accurate
8 decision about where to go or for Medicare to make an accurate decision
9 about the quality of care of that setting.

10 So I think we found in our expert discussion, and maybe we
11 did not make it quite plain enough or clear enough, that in fact they
12 would agree with you 100 percent that the current information does not
13 really give you enough to assess accurately.

14 But the other factor was Sally's, which is a lot of it is
15 currently on the whole nursing facility so it is hard to ferret out for
16 the short-stay patient.

17 MR. HACKBARTH: So to put this in context, last year we
18 looked at ESRD and M+C. And in each of those cases we concluded that
19 there were reasonable measures, a fairly strong consensus that there
20 were good measures, the data were collectible, et cetera, et cetera.
21 And we were prepared to move ahead towards using them as a basis for
22 paying on quality.

1 Here, however, we have a very different circumstance. And I
2 think the takeaway here is that our analysis and the experts say that
3 we really don't have a set of measures that meet those tests for the
4 skilled nursing facility patients.

5 And probably on top of that there are issues about the
6 measures used for the non-skilled patients, as well. But that is not
7 the immediate question before us. So we have got a ways to go here.
8 There is work to be done. We're not going to be recommending paying
9 for quality at SNFS any time soon, I think is the bottom line.

10 DR. WAKEFIELD: You listed NQF's three measures that they
11 were recommending for short-stay patients. When I read this, I was
12 struck by the difference between that and your expert panel and the
13 directions that they went. They seemed, to me, to really move in very
14 different directions, expert panel focusing more on some process
15 measures, et cetera. Just lots of differences.

16 Do you know whether NQF limited their scope of what they
17 reviewed to just MDS? Or did they look outside of MDS, as well?
18 Because I'm really struck by the difference here.

19 MS. MILGATE: They did primarily limit it to MDS-derived
20 indicators because most of the information they were relying on for
21 validity and reliability was information that had been done on MDS.

22 They did tell us though, because we asked them that question

1 actually, they did say in their report that we really could use some
2 more research and development of measures for the short-stay patients.
3 They did not suggest that these three were sufficient in and of
4 themselves. But these were the three that rose to the level that they
5 felt they could recommend for post-acute patients in nursing
6 facilities.

7 MR. DeBUSK: A couple things. I want to go back to the MDS.
8 From my understanding, the MDS has never really been that successful.
9 You've got 300 items to mark or what have you on that sheet. It seems
10 to be voluminous in trying to do this job. But looking here at the
11 quality concerns that could be measured, if you look at
12 rehospitalization, discharge destination, functional improvement, those
13 are after-the-fact measurements. That's after the incident has
14 occurred. You go down to the use of standards or best practice
15 protocols, that's the process. It looks like the place to go on the
16 front end would be to establish the process and measure the process
17 which ultimately is going to give you your outcome.

18 Is there a set of standards that exists out there now for
19 nursing home?

20 DR. KAPLAN: Our experts tell us that there are some
21 standards. I think we were looking at rehospitalization and discharge
22 status and improvement in functional status as being outcomes, and then

1 the processes being process measures, and not to use one necessarily to
2 the exclusion of the other. But the process measures would take more
3 work to develop. The others, two of them could be readily measured
4 from existing data, and the change in functional ability, you would
5 have to have a discharge assessment of functional ability.

6 MR. DeBUSK: It's almost like we've got to start somewhere.

7 MS. RAPHAEL: A couple of points. First of all, I believe
8 that there is some overlap between the short-stay and the long-stay
9 patients and they're not always so clearly in one camp or the other,
10 because people who are admitted for short stay sometimes end up staying
11 for the 24 months or the 18 months. So I think we need to just be
12 aware that the lines are not always clear. Even though we don't pay
13 for the longer stay patients, I will say quality is more important when
14 you're spending 24 months in a nursing home than if you are spending
15 eight days in a nursing home. So I do not want to lose sight of that
16 and we should be careful not to have two-tier systems here that we are
17 contributing to creating.

18 For me, what I'm trying to grapple with is, if we take what
19 Glenn posited that we are not ready for prime time yet here with the
20 measures, the question for me is where do we go? Because we have
21 raised issues overall about the efficacy of the classification and the
22 payment systems for SNFs. We have talked about the need for

1 redistribution toward the more medically complex, et cetera. So I'm
2 trying to understand how we put this all together and where does this
3 take us? And what could we begin to recommend that could help to move
4 us toward a more effective way of purchasing services from SNFs? I
5 don't really yet understand from all that you've done so far what you
6 think might be a lever that could most help us to move along.

7 MS. MILGATE: Sally may need to answer that more broadly, but
8 the purpose of this exercise wasn't quite that broad. It was more a
9 matter of not just looking at the ability to do pay for performance but
10 also monitoring of quality in general. That there just wasn't enough
11 tools to do that, and that is was important for the Medicare program to
12 have a better toolbox for measuring quality in SNFs.

13 Now what that would be used for is another question that I
14 think you're raising more broadly, and what we feel like we got from
15 our discussion and analysis was some suggestions for how you might be
16 able to get some more information that would be useful. So it wasn't
17 really at this point at least in a broader context.

18 MS. RAPHAEL: But if we are going to refine the systems that
19 we have currently, shouldn't we embed some of this into any efforts to
20 refine and collect data on patient status?

21 DR. KAPLAN: Your question is good and I think part of the
22 whole thing is that most of the measures that we talked about, that we

1 are thinking could be used to measure quality in a SNF are not
2 necessarily specific to the existing -- there don't necessarily have to
3 have the existing or have to get rid of the existing instrument. We're
4 not really saying anything at this point about that. And they aren't
5 necessarily related to one classification system versus another.

6 For example, if you've got a whole different classification
7 system, these are still measures that you might want to have for SNFs.
8 That is what our experts told us. This is what we would be concerned
9 about for SNF patients. We started from scratch. We did not say, tell
10 us about if you had the MDS or if you had RUGs. We said, what are you
11 concerned about with SNF patients? So for the clinicians, they're in
12 the SNF. They are not thinking about MDS or RUGs.

13 I think your question on payment is good. As you know, I
14 know I have been telling you this for five years, that there is a
15 report that is due to Congress in January 2005, which is only a few
16 months away on alternatives to the classification system. So I think I
17 have to ask you on that question to ask you to be patient for a little
18 bit longer, and hopefully we can get to that after that report is to
19 Congress.

20 But I feel like this is part of that issue, but it is not
21 just related to that issue. This is really just related to quality of
22 SNFs. Yes, it is in the context of performance for SNFs. But if I

1 tell you the real motivation of why I wanted to look at this was
2 because I wanted something that we could use in our payment assessment
3 analysis on quality. Every year we struggled to find anything that we
4 can use to say something about change in quality for SNF patients. Not
5 for NIF patients, not for the whole facility, but just for SNF
6 patients. We struggle with that every single year. That is my first
7 motivation. Then as we learned more then it moved into other areas.
8 But that was first and foremost what I wanted to do was has something
9 to say about SNF quality.

10 DR. REISCHAUER: Carol raised an issue that I wanted to ask,
11 and that is if we have any information about the fraction of long-stay
12 nursing folks who at one time or another where a SNF patient? I have
13 three bits of anecdotal evidence from parents and parents-in-law, all
14 three of which at some point in the nursing home were a SNF patient. I
15 can see that the needs are different and all of that, but I don't know,
16 maybe 75 percent -- I'm just making this up.

17 DR. KAPLAN: Seventy percent of patients who are admitted to
18 SNFs go home.

19 DR. REISCHAUER: It's a very complicated thing that I'm
20 thinking which is, during a lifetime or doing the last X years of life
21 when people are in and out as a SNF, as a nursing patient, and you just
22 track the same people, what fraction have this experience is what I'm

1 wondering.

2 DR. KAPLAN: I don't think that information has ever been
3 studied. I think there's information on what the odds are of being
4 admitted to a nursing home, an institution. There's that information.
5 Then there's information that 70 percent of the people admitted to a
6 SNF go home. But there's not this other information that I think
7 you're looking for.

8 DR. REISCHAUER: The other point I wanted to make was really
9 the same one that Pete made. I was quite surprised, and maybe I should
10 have known, that the MDS was as hefty an instrument as it is; 300
11 questions, 500 data points. I was wondering how many of these are
12 things that don't change? This thing is filled out twice over the
13 first two weeks, and how many of them are like address, or name of next
14 of kin, or height, or things that are not likely to change, as opposed
15 to something that would change.

16 And secondly, how long does it take to fill this out? If
17 these were all changeable items which you had to get observation or
18 information about, this is a day-long process to fill one of these out
19 things out, it strikes me. I can't imagine that that much specific,
20 different information is really necessary for whatever purposes this is
21 point to, but I might be wrong.

22 DR. KAPLAN: As far as I know, nobody has done an analysis of

1 how much changes from one assessment to another on the MDS, and I am
2 not even sure that anybody has done anything on how often a group
3 changes on the payment system, because that determines your SNF payment
4 for that period per day.

5 The amount of time that it takes to do an MDS, memory is 2.5
6 hours, but I may not be exactly accurate about that.

7 MR. HACKBARTH: That is a comment that we have made in past
8 reports, about the burdensome data collection, and we need to
9 streamline and have common elements for different types of post-acute
10 care.

11 DR. MILSTEIN: This discussion for me has some important
12 generic elements that always underlie the question as to whether or not
13 current measures are good enough to go forth or they're not good enough
14 to go forth. Maybe I could just briefly comment on this.

15 It seems to me, if you categorize some of the comments made
16 to date they really come out on different sides of the following
17 balance. On one side of the balance is the value of delaying pay-for-
18 performance until we have a good enough measurement set. On the other
19 side of the scale, reflecting Carol's comments, is this implicit idea
20 of the opportunity cost to American Medicare beneficiaries of being in
21 facilities in which quality is not a basis of payment. Those two
22 interests need to be weighed and sometimes there's a tendency to look

1 at the inadequacy of measures and say, let's just wait. But I for one
2 think we have to be equally mindful of the opportunity cost of
3 continuing what has apparently been a multi-year tradition of lack of
4 pay-for-performance.

5 Some thoughts I have on how this gets resolved in other
6 situations -- and this is for the staff, a question of what is known
7 about -- do we have any research evidence on the correlation in
8 facilities ranked using today's highly imperfect quality set with a
9 robust set? If there's any evidence to suggest that facilities ranked
10 using today's thin set with a more robust set are reasonably good, then
11 that would weigh on the side of the scale towards going forward with an
12 early version of P-for-P rather than waiting.

13 The second thing that occurs to me is that we have some
14 wisdom or an opinion on this expressed in Congress in its decision with
15 respect to hospital pay-for-performance. If anyone were to step back
16 and say, what percentage of hospital quality is captured by the 10
17 process measures that we are now not insignificantly rewarding
18 hospitals for, it is not a very happy answer. I'm not sure it's a
19 better answer than the current measures we have available for SNF
20 patients in nursing homes.

21 So one way of essentially moving forward, if that's the side
22 of the balance we decide we might want to act on or be relatively

1 impressed by, would be to model that and, for example, suggest a P-for-
2 P that's based on the SNFs collecting and reporting this more robust
3 measure set that's been proposed. So then when we want to move to pay-
4 for-performance in another two years we aren't bemoaning the fact that
5 we are still where we were five years ago. Or deciding if there is
6 reasonable correlation between thin measures and good measures that is
7 good enough, maybe not to go forward with plus or minus 20 percent, but
8 maybe plus or minus 0.3 percent or 0.4 percent as a way of beginning to
9 address the opportunity cost of having a quality insensitive payment
10 system for nursing homes.

11 MR. HACKBARTH: I fully agree with your balance statement,
12 your initial statement. Indeed in our past discussions of this, our
13 past reports in congressional testimony, we've made much the same
14 point, that there is a cost to the current system. The phrase that
15 we've used over and over again is that the current payment system is at
16 best neutral towards quality, and indeed often hostile. So people
17 ought not feel comfortable with the status quo. There is a dramatic
18 need to change, in our collective perspective, what we do here. So I
19 think your statement fits quite well with where the Commission has been
20 in the past.

21 Now having said that, I think there are some types of errors
22 that are worse than others. So if we have poor quality measures,

1 inadequate quality measures that create an incentive for people to do
2 the wrong things with patients and further compound the problems that
3 we have got, I worry more about that than measures that of wrong just
4 in degree. They are pointing directionally in the right direction but
5 it's just a matter of degree.

6 The way I interpret some of the discussion here is that in
7 SNF care some of the measures might actually point in the wrong
8 direction and reward behavior that actually we don't want to reward. I
9 worry about that.

10 DR. MILSTEIN: I wonder if anyone can address the question of
11 whether or not facility ranking using more robust measures is
12 reasonably well correlated with facility ranking using these currently
13 available less good measures. Because that would really help for me
14 resolve which side of the balance I'd like to come --

15 MR. HACKBARTH: I think that is an excellent question. The
16 begs though, do we have the comparison set? You need the more robust
17 measures against which to compare.

18 MS. MILGATE: I do not think we can sit here and promise that
19 but it is something that we could take a look at. For example, the
20 rehospitalizations, we have run those before. We haven't done rankings
21 and I do not know if rankings for the MDS measures are available to us
22 either.

1 DR. MILLER: I think some of the fundamental question that
2 we've brought up here to be discussed is, a lot of the conversations
3 that occur here and out in the field is when people start talking about
4 this, they're all talking about different things. You say quality of
5 nursing homes and people start thinking nursing facilities. We're
6 often talking about SNF. So the comparison that you're looking for,
7 even if the analysis are done, are the measure sets that you would
8 actually do that on, is there agreement on what those would be? Much
9 less, has the work been done?

10 I think a fundamental point we're trying to lay out for you
11 here is, we're starting to parse that distinction and we're going to
12 pursuant it in a particular direction and trying if you agree and
13 whether that's the direction we're going to go in.

14 DR. MILSTEIN: What I'm suggesting is, there is a body of
15 health services research on quality of care in nursing homes. All we
16 have to do is find one piece of prior research using these more robust
17 measures that occurred concurrent with, and focused on SNF patients as
18 opposed to the nursing home patients, that occurred concurrent with a
19 time when these less good but available measures were calculated. If
20 you tell me that no such research exists --

21 DR. KAPLAN: There's a large body of research on quality for
22 nursing home residents, long-stay residents. Usually the short-stay

1 patients are excluded from that research, so there is nothing. The
2 experts tell us that someone that ranks high on quality of care for
3 nursing home residents is not necessarily going to ranked high on
4 quality of care for SNF patients.

5 DR. MILSTEIN: The idea is, there is no such thing as a well-
6 done piece of health services research that evaluates SNF patients
7 within nursing homes with respect to any of these more robust measures
8 of quality that the expert panel recommended. It's just never been
9 done.

10 DR. KAPLAN: Exactly; never been done.

11 MR. DURENBERGER: I was going to suggest that maybe one of
12 the reasons is we haven't fixed -- we are fixing accountability on
13 institutions which largely are doing nursing home work, and they are
14 doing some SNF work and so forth, as opposed to focusing the
15 accountability for my health or my mother's recovery or whatever the
16 case may be on a doctor, or on the hospital from which he or she was
17 referred. All I want to do is plant a seed in the longer-term research
18 that we ought not to be looking separately at the facility
19 reimbursement but in capturing this pay-for-performance in a payment to
20 the person or the facility that is responsible to the beneficiary for
21 the delivering the series of care that ends up in recovery, improved
22 function, whatever the case may be.

1 I don't know how practical it is, but I am saying, get off of
2 trying to rate an institution which is really in another business,
3 people who are in there for eight days or 12 days or whatever the
4 average, 25, and put that accountability and the rewards for it on the
5 professional or the institution that is responsible for the recovery or
6 improved function of the person that is involved, and let them help you
7 develop the measures for recovery.

8 MR. HACKBARTH: Thank you very much.

9 Next up is measuring quality in home health care.

10 * MS. CHENG: This afternoon I am going to be addressing
11 measuring quality in home health. I'm going to power-walk us through
12 some background slides and our criteria for judging the feasibility of
13 measuring quality in a sector. Then I'm going to spend most of my time
14 on looking at the home health sector specifically and the measures sets
15 that we have available and identified for this sector.

16 I think we have hit a lot of this in the previous sessions so
17 I'm not going to go into it. MedPAC has found the current system,
18 generally speaking, to be neutral or negative toward quality, so our
19 agenda has developed, taking its first step in June 2003, after we
20 surveyed a number of private plans that had come to the same conclusion
21 really. We asked what they were doing and what direction they were
22 moving and found that they were taking the step of linking performance

1 to payment. We recommended that Medicare consider this strategy.

2 We established then criteria that we felt applied
3 specifically to Medicare and was based on the experience of these
4 private payers, but a set of criteria we would use for determining
5 which settings within Medicare were ready to take this step. Then in
6 March 2004 we found two settings, dialysis physicians and facilities,
7 and Medicare Advantage plans, were ready for this step and met our
8 criteria.

9 The criteria that we developed are the four you see here. We
10 felt it was important for a given setting there be a set of well-
11 accepted evidence-based measures. By that we mean we would like to see
12 a set that the providers that were going to be scored on this and paid
13 on this would be familiar with them before they saw their payments
14 change. By evidence-based we mean reliable and valid. And for process
15 measures specifically, we mean that there is evidence that suggests if
16 we are going to incent a process that we've got scientific backing that
17 that process is going to lead to improved outcomes of care for the
18 beneficiaries. And for outcome measures, along the lines of what
19 Senator Durenberger suggested, we want to hold the right entity
20 responsible for the quality that we're measuring.

21 Our second criterion is that there be a standardized
22 mechanism for data collection. There are a couple of thoughts here.

1 We want to make sure that the burden is not undue on either end of the
2 pipeline, so that it is something reasonable for the providers to do
3 and it's also reasonable for CMS to do. They cannot process a bunch of
4 unstandardized data that comes in. We need to make sure that the
5 process is not an undue burden on either end.

6 We also are looking for standardized data collection so that
7 we have an assurance that we're getting something consistent. We want
8 to ask the same question and get the same answer as often as we can
9 from the providers that we're measuring.

10 For risk adjustment, our criterion is that we have adequate
11 risk adjustment. In some cases perhaps we might find that risk
12 adjustment is not as necessary. For example, maybe a patient
13 experience measure of a process measures that is not likely to be
14 affected by the case mix of the patients that the provider is caring
15 for.

16 Or in the case of outcome measures, we want to make sure that
17 we have adequate risk adjustment for two reasons. We certainly want to
18 make sure that as we set up this incentive we're being equitable to the
19 providers that we are measuring. And we also want to make sure that we
20 don't develop or cause an access problem. If a provider feels that
21 they can improve their score and improve their payment by denying care
22 to a patient that might benefit from that care but is not likely to get

1 a terrific outcome, we want to make sure that we've got something that
2 is doing to take that into account.

3 Finally, we are after a set of measures the providers can
4 improve upon. This goes back to the idea of holding the right entity
5 responsible. But it also goes to an idea that I think brings all four
6 of these together, which is if we go to measuring quality and attaching
7 payment to it, what we want is to make sure we have identified things
8 where making an improvement is going to affect the care of a number of
9 beneficiaries. We'd like to get a lot of beneficiaries, and we'd like
10 to make a substantial change. We're not so interested in moving from
11 98 percent compliance to 99 percent compliance. We'd rather go for
12 something where maybe the compliance is 60 percent and get that up to
13 70 percent or 80 percent.

14 So in home health we've identified four indicator sets that
15 we'd like to explore to determine whether or not it's feasible to move
16 the agenda in this setting. The four indicator sets are the outcomes-
17 based quality improvement set, OBQIs, the outcome-based quality
18 monitoring set, the OBQMs, assessing care of vulnerable elders, the
19 ACOVE set, and patient experience surveys.

20 OBQIs are a set that are comprised of nine measures of
21 improvement or stabilization in activities of daily living, such as
22 what percent of patients who could improve, did improve in their

1 ability to bathe during their home care episode? There are 12 measures
2 in the set of instrumental activities of living, such as a patient's
3 ability to do their own laundry, 14 measures of clinical improvement or
4 stabilization, such a shortness of breath or the frequency of
5 confusion, and there are three utilization measures, such as the use of
6 emergency care during the home care episode.

7 In terms of familiarity, the OBQIs have some strength here
8 because they're currently in use in the Medicare program. In fact the
9 OBQI set pre-dates the PPS payment system that we're using right now,
10 and in this setting, the idea that measuring quality and monitoring it
11 has been one that has been on the forefront of development here for
12 actually about 10 or 15 years. The OBQIs are used in the Medicare
13 system currently in reports that flow back to the home care agencies so
14 that they have an idea of their performance and can benchmark it
15 against peers. It's also used on a web site that allows consumers to
16 make choices among home care agencies called the Home Care Compare web
17 site. So it's publicly reported data.

18 We have heard some concerns about the reliability and the
19 validity of the measures in this set. I would like to address those
20 concerns head-on in just a moment, and also right now, discuss a little
21 bit of the research that we have on this. We have two studies that
22 have looked at reliability and validity. In the first study we have a

1 measure of the inter-rater reliability of OASIS. That's the tool that
2 they're using to derive the OBQI. The researchers compared two nurses
3 who were looking at the same patient to find what level of congruence
4 they got on taking this tool twice. They found that the level of
5 congruence on the items that we're talking about here was between 60
6 and 80. As we looked across health services research that was
7 generally felt to be good or very good.

8 In terms of validity we also have another group of researcher
9 that asked, what we are measuring, is that congruent with the patient's
10 own assessment? So they compared nurses and therapist assessment of
11 patients with their own self-reported ability on activities of daily
12 living and instrumental activities. Here again they found a level of
13 congruence of about 60, which we might characterize as a good level of
14 congruence. So it speaks to the validity of the data that we're
15 deriving the OBQIs from.

16 MR. DeBUSK: May I ask, you are getting some coherence or
17 what have you in comparing the data, the collection of data. Did all
18 this come out from the OASIS assessment system?

19 MS. CHENG: The OBQIs are derived from the OASIS system,
20 that's right.

21 MR. DeBUSK: Now how long does it take to fill out an OASIS
22 report?

1 MS. CHENG: We have heard estimates -- OASIS has been used in
2 the field now since 1999. When it came out, we understood that it was
3 taking nurses and therapists over two hours in the field to complete
4 this tool. We have heard anecdotally, and I don't have a study on
5 this, since 1999 we've been doing this on every patient that Medicare
6 has paid for, so I think that the time it takes has become more
7 integrated in the plan of care in what a nurse would normally do during
8 that first visit. So it might be taking some time but it is also
9 regarded as a pretty integrated part of assessing the patient and
10 planning their care.

11 MS. RAPHAEL: I think it takes an hour or about an hour and-
12 a-half to do it generally. That would be the average amount of time.
13 It's a 29-page document.

14 MS. CHENG: We also have some evidence on the reliability and
15 the validity of the OASIS from two other groups that have looked at
16 this set. The first group that I'd like to talk about is the National
17 Quality Forum, and I would like to again mention as I speak about their
18 work, we are relying currently on work that they have done in a
19 preliminary fashion. The National Quality Forum has not yet formally
20 endorsed or given their final rating to these measures. But according
21 to the work that they have done up to this point, they gave their
22 highest rating for validity and reliability to 18 measures from the

1 OBQI set.

2 Another group that's looked at this set is the Agency for
3 Healthcare Research and Quality, and they went through a similar system
4 of looking at reliability and validity and the feasibility of measuring
5 these, and also whether or not they made sense, because AHRQ was also
6 concerned about the public reporting. AHRQ id endorse 14 of the OBQI
7 measures. The other good piece of news here is that there's some
8 congruence between those two groups and they endorsed 10 of the same
9 measures from this set.

10 These indicators, as I mentioned in response to Pete's
11 question, are derived from the OASIS assessment tool, so we already
12 have a standardized tool that's currently being used in the field and
13 being collected by CMS for this set.

14 Risk adjustment is available for the OBQI outcomes. The
15 University of Colorado is a group that developed the risk adjustment
16 for this set. For some of those outcomes they are able to apply up to
17 50 different patient characteristics to determine the expected outcome
18 for that patient. In addition to the usual suspects that you would
19 look for in just about any risk assessment, we've got diagnosis, age,
20 and sex. But because of the richness of the OASIS tool, we're also
21 able to apply patient prognosis, functional limitations of the patient
22 currently, the presence of a caregiver informally to support that

1 patient in their home, and some cognitive and behavioral information.

2 We have some evidence that there is room for improvement and
3 that this is under the power of the home health agencies to improve.
4 We have had two measurement periods now for the publicly reported Home
5 Care Compare, and we found small but consistent improvements in the
6 level of performance on the OBQI set.

7 The next set I would like to bring to you is the OBQM set.
8 You can see from the examples how they're a little different from the
9 OBQIs. An example of an OBQM might be, what percent of patients used
10 emergency care from injury caused by a fall or an accident? What
11 percent of patients had an increased number of pressure ulcers? Or
12 what percent of patients were discharged to the community at the close
13 of their care who still needed assistance with toileting?

14 Like the OBQIs, the OBQMs are currently being used in the
15 Medicare program and are similarly derived from OASIS data, so the
16 observations that I've made about OASIS as a tool apply here. In
17 addition to being derived from OASIS, the OBQIs would have the
18 possibility or the potential to be audited from other sets because they
19 also address contacts with other parts of the home care system, so we
20 could audit this by looking at ER use for beneficiaries, or we could
21 audit it perhaps by looking at physician visits and the nature of
22 physician visits.

1 The OBQMs are less frequent, which is a very good, than the
2 OBQIs, because they are adverse events. They don't happen to most
3 patients. Because they are far less frequent, the risk adjustment that
4 we have for these are less available. They do, however, have a risk
5 adjustment system in the sense that we've measured their frequency and
6 we can gauge age, sex, and perhaps diagnosis -- maybe not -- on the
7 likelihood of the expected rate of some of the events in this set.

8 One important difference between the OBQIs and the OBQMs is
9 that in both sets we have those utilization measures. Did somebody who
10 was under the care of a home health agency go to the ER, or go to the
11 hospital during their stay? The OBQMs have a little bit of a
12 differentiation because they are trying to only count hospitalizations
13 or ER use that follow what is called a sentinel event. So perhaps this
14 use of the hospital or the ER is more indicative of quality than would
15 be a measure of any use of a hospital ER. The sentinel events would be
16 an injury caused by a fall or an accident at home, a wound infection or
17 a deteriorating wound, improper medication administration, side
18 effects, or toxicity of medications, or diabetes out of control.

19 My final point on the OBQMs, here too we have some evidence
20 that there is room for improvement and the capability to improve. Both
21 a study by Shaughnessy and our own work with the national database
22 concur that home health agencies can improve their performance on

1 measures in this set. For example, though the rates were small, both
2 studies found a decline over time in the rate of hospitalization for
3 home health patients.

4 The next set are the ACOVE measures. This is again a
5 somewhat different set. Examples of this would be whether or not the
6 home health agency evaluated reversible causes of malnutrition. Did a
7 professional of the agency ask a patient about falls? Was the patient
8 screened for alcohol use? And did the home health agency document
9 advance directives, care surrogates, or preferences for end-of-life
10 care? The developers of the ACOVE set believe that the medical system
11 generally places too great an emphasis on treatment and too little
12 emphasis on taking thorough histories or providing preventive care.
13 Thus, they felt that the processes that they have identified here could
14 have a significant impact on improving the quality of care.

15 ACOVE up to this point, unlike the OBQMs or the OBQIs has
16 only been used really in the research setting. It is not currently in
17 the field, nor is it widely used in home care. The National Quality
18 Forum has looked at the ACOVE measures and found the evidence base for
19 these measures was good for the set of measures that they deemed
20 applicable to home health. ACOVE is actually a very large set for
21 assessing care of elders in many different settings with about 207
22 measures, but only a subset of them apply to home health. The NQF gave

1 seven of the measures from ACOVE their highest rating for reliability,
2 validity, and feasibility.

3 The ACOVE, also unlike OBQIs or OBQMs, doesn't run from
4 administration data. It's derived from medical records. It's a very
5 detailed set, and definitions really try to hone in on processes. But
6 because of that it would not be possible to run this set from
7 administrative data that we have now. For example, the fall ACOVE
8 indicator is defined as whether a patient reports two or more falls in
9 the past year or one fall that required medical care. And then if that
10 is available from the records, then did that patient receive an
11 evaluation for falls. So it is a pretty narrowly defined and precisely
12 defined set.

13 We do have a study that suggests that there is room for
14 improvement in the measures that we are taking here in ACOVE. Wenger
15 studied two large groups of elders in managed-care organizations and
16 found that vulnerable elders received appropriate treatment an
17 encouraging 81 percent of the time once they were ill or injured.
18 However, they often did not receive other indicated medical care.
19 Wenger found that 63 percent of patients received the follow-up that
20 would be indicated from the medical records, only 46 percent of them
21 received appropriate diagnostic care, and 43 percent received
22 preventive care that would have been indicated.

1 The final set that I would like to discuss is patient
2 experience. Some examples of patient experience could be, did you know
3 what to expect from your home care agency for the episode of the care?
4 Do you understand how to operate medical equipment that is in your
5 home? Or how often were you and your family adequately involved with
6 decisions regarding your care? These would all be measures of the
7 patient's experience of home care.

8 They are a familiar sounding set and they might be similar to
9 patient satisfaction questions that you might see perhaps for a
10 doctor's visit. But one distinction that you might make here is that
11 while a doctor's visit would affect a patient's experience for an hour,
12 and hour and-a-half in a day, a patient might be in contact with their
13 home health agency for several weeks, simple months, or the balance of
14 a year. So this experience is actually going to be measuring something
15 that's a contact with a patient for a long period of time.

16 Satisfaction surveys are common, we understand, throughout
17 home health agencies but there is no single public tool that measures
18 satisfaction and we do not have research on patient experience. So
19 satisfaction might be questions more like, were you satisfied with your
20 home care agency? Experience, such as the questions that we just
21 talked about, we really do not have much research on at all.

22 We do know that satisfaction ratings for home health agencies

1 are consistently very high. Certainly encouraging, but it means there
2 isn't much variation if we're trying to differentiate among different
3 home health agencies. One researcher that looked at this satisfaction
4 question in the Journal for Healthcare Quality found that though there
5 are consistently high satisfaction ratings, questions such as the one
6 that we suggested on the previous slide, might yield a little bit more
7 variation than we see in just satisfaction globally and might identify
8 areas where there would be room for improvement.

9 Now I would like to talk just a little bit about where we are
10 staff-wise on this research. One of the things that we have done and
11 will do over the next several weeks or months is to talk to the
12 provider community about these sets and their experiences with them and
13 their reactions to them. So far as we've spoken with representatives
14 of the industry we have heard concerns that nurses, therapists and
15 other professionals in the field still have questions about how to use
16 OASIS, and some feel that they still haven't mastered the tool in a
17 reliable, consistent fashion. The tool is being continuously
18 clarified, updated and tweaked by CMS so it is undergoing changes to
19 improve the tool, so it's not the same tool that it was four years ago.

20

21 We also heard some hesitancy as we discussed the ACOVE
22 measures that I think I might characterize as largely driven by

1 unfamiliarity with the ACOVE measures, although we did get a positive
2 response about considering process measures in this area. We also
3 heard concerns that the same goals for improvement and recovery that
4 might be relevant to somebody recovering from an acute illness or
5 injury would not be the same as the goals of care for a chronic
6 patient, so they felt that as we look at sets and especially if we were
7 to move toward identifying a set upon which they were going to be paid,
8 we should try to get measures that would encompass a lot of the
9 different goals and the different kinds of care that's going on in the
10 home care setting.

11 We've spoken with researchers, we've looked at preliminary
12 work by NQF and AHRQ, and these groups have identified issues with
13 reliability and validity for some indicators in all of the measure sets
14 that we've spoken about here this morning. But there does just seem to
15 be a consensus that is forming, and perhaps a subset of these
16 indicators across some of these measure sets, that are viewed as
17 generally valid, reliable and feasible.

18 We will also continue our work on process measures. In the
19 course of doing the work to prepare for this meeting we have run into
20 some groups that we understand are currently working on other process
21 measures, and one of those groups that we would like to talk to in fact
22 is the Center for Home Care Policy that we understand is working on

1 looking at processes of care. So we're going to continue to look in
2 that area and see what else we can find for process measures.

3 At this point staff seeks the Commission's guidance on this
4 topic, and specifically the question that we opened with, is it
5 feasible to make valid comparisons with the measure sets that we have
6 available of home health agencies, and where does this sector fit into
7 our agenda on quality?

8 MS. RAPHAEL: I think you've done a very good job of giving
9 us this state of the union for home health care quality measurement at
10 this point. I think that the Commission ought to be aware that this is
11 a period where CMS is looking at OASIS and refining it and taking it to
12 the next generation. There is a lot of work going on around that which
13 Sharon has tried to capture.

14 I think some of the most important work that we need to await
15 the results of has to do with the risk adjuster. I'm not expert in
16 this area but I think there are questions about the risk adjuster. One
17 has to do with the ability to prognosticate. I guess it's somewhat
18 akin to what we have found with hospice and end-of-life care, that
19 physicians do not necessarily do a good job of giving us the prognosis.

20

21 Second set of issues has to do with long-stay versus short-
22 stay patients. If you are dealing with someone who is a paraplegic and

1 is in his thirties or forties we find that the outcomes are very
2 different than someone who is a short-stay, post-acute skilled care
3 kind of patient. I think the risk adjuster I believe doesn't
4 adequately measure that.

5 Thirdly, we find that the risk adjuster doesn't measure
6 accurately dually eligible Medicaid patients, for whatever reason,
7 whatever it is that we are missing in their regular care that affects
8 their home health care episode needs to be better captured.

9 Secondly, I am a great believer that rehospitalization and
10 emergency room use are very important outcomes to measure here. But
11 right now I know that from my own organization, a lot of our clinicians
12 don't fill that out in OASIS because they often do not know why someone
13 ended up in the ER. They really can't say that it was directly related
14 to whatever the episode had to do with. So they don't want to put in
15 inaccurate information.

16 We actually did an interesting study of rehospitalization
17 rates and we found tremendous variation. In fact we have one hospital
18 that has very high rehospitalization rates and another that has very
19 low rehospitalization rates. So the question becomes, to what degree
20 can we control rehospitalization, or does it have to do with patterns
21 in the hospitals themselves?

22 In addition, we find that in certain parts of our urban area

1 where people do not have a primary care physician or any ongoing
2 relationship with a physician, we are more likely to send that person
3 to the emergency room. And that's a good thing. Very often we have to
4 get that person seen and if we do not have a physician to refer them
5 to, that is the right clinical decision. But that raises your emergent
6 care rate, and we would never want to have a situation where you avoid
7 doing that because it's being measured and it can affect you
8 negatively.

9 So there seem to be a number of issues that influence
10 patterns around rehospitalization and emergent care that I think need
11 more exploration and more testing and research. I think some of it is
12 going on and you can lead us toward whatever it is that we can learn
13 from that is ongoing.

14 I do believe process measures are very important because part
15 of what you do in home health is try to pick up things earlier. If
16 someone is losing sensation in their feet, you want to pick it up
17 early. You want to avoid complications. That is really one of the
18 benefits to the Medicare system that we can bring. So I think it is
19 important to try to get some process measures and I think there's some
20 work there that can be helpful.

21 I do not know how to tackle the patient and family
22 satisfaction. I've been racking my brains about it because I want to

1 underscore what Sharon said, which is you see a physician for 15
2 minutes or half an hour and you have experience, which may be a good
3 experience or a bad experience. When you have home health care, you
4 have someone coming into your home for an extended period of time.
5 Capturing that patient and family experience I think is very central to
6 quality, because it is much more than an intervention. It is much more
7 really dealing with a whole set of issues. The patient has a very
8 personal experience.

9 I do not know how to do it. I do agree with you, the global, how
10 did you feel about your home care experience generally yields very high
11 satisfaction rates. We've been doing something with Press Ganey which
12 has been painful but has really tried to break it down to a lot of
13 subcomponents and we've learned a lot. But I think we have to think
14 about, down the road, trying to capture that because I think it is a
15 very important quality measure for the Medicare program as a purchaser
16 of care.

17 Then the only other thing that I have been thinking about, and
18 I do not know how to get at this, we just looked at some thinking on the
19 SNFs, and the Commission has been trying to do some work toward
20 integrating post-acute care. I'm wondering if there isn't some way to
21 think about that. For example, when we looked at SNFs we talked about
22 pain levels. We talked about delirium. There are the same issues in

1 home health, trying to really reduce pain and discomfort. We get a lot
2 of people coming out of the hospitals with high levels of delirium.

3 So I think maybe we should also at least take some steps
4 toward consistency of quality measures here as we try to think about
5 ways to integrate and compare post-acute care sites.

6 MS. CHENG: Just to hit on that, one of the measure sets that
7 the National Quality Forum collected and considered was a measure set
8 that has been developed by the National Hospice Care and Palliative
9 Care Association. It was measures of, did you to achieve comfort and
10 pain alleviation? That's a set, if you would like staff to look at, we
11 could.

12 MS. RAPHAEL: They did something that probably some people
13 here know, they actually give patients a face and you actually put in
14 how you feel, your grimace level, and that is how it is scored.

15 DR. CROSSON: We have looked at the ACOVE measures in our own
16 organization. Earlier this year I was on a reactor panel when they
17 were released so I spent time with our geriatricians, who are by and
18 large very enthusiastic about them, for the same reason that Carol
19 mentioned, that they seem to feel that many of them are a linchpin to
20 prevention. Some of those linchpins are just not being done in common
21 practice, and I think the ACOVE that was published bore that out.

22 On the other hand, if you look at the study it was rather

1 expensive to get the data on a relatively small number of patients
2 because it involves rather tedious chart review. So one of the things
3 that we're looking at is to what extent can at least some of them be
4 accessed from existing data systems, including the clinical systems
5 that we're going to put in place, or to what extent can we modify
6 clinical systems to get at the information?

7 So the question is, if they are that valuable and if that is
8 what the folks feel, to what extent when applied to home health care
9 could they be done in an efficient way? And to what degree are they
10 modifiable or what? Or is there a cost trade-off there that is not
11 going to work?

12 DR. MILLER: When we discussed this ourselves internally, the
13 very set of thoughts that you're going through now were one of the
14 conversations that we were having. That if you to move to these
15 process measures and to pick up some of the ACOVE stuff you would have
16 to be thinking about a different mechanism to pick them up, because I
17 think if it comes from chart review it's a real barrier. But Sharon
18 has had the thought herself.

19 MR. BERTKO: I just would only add something there, that I
20 know the RAND researchers who have been looking first at chart reviews
21 are now trying to find proxies for quality measures that would come
22 through administrative systems and there is some work being done.

1 DR. WAKEFIELD: Could we at some point see the overlapping
2 measures that you said existed between NQF on the OBQIs with AHRQ. I
3 don't know that I saw AHRQ's ten. I believe you said that there were
4 10 measures that they converge around.

5 MS. CHENG: I didn't want to read all 10 but I will pass them
6 along.

7 DR. MILSTEIN: I'm struck by the fact that with the
8 acknowledged imperfections we do have a set of quality measures here
9 that have been both approved by the National Quality Forum, which has a
10 pretty structured process and multi-stakeholder involvement, as well as
11 AHRQ. So I think this pushes right back to where we were on the prior
12 discussion which is -- I call it the all things considered question.
13 All things considered, imperfections in the current measures, the
14 advantages of waiting versus the disadvantages of waiting, do we have
15 enough for openers, as it were, to begin?

16 Again, if we use the 10 process measures that we are now
17 using for measuring all hospital care, the question is, are we at least
18 no worse off than using the 10 process measures that we are currently
19 using for hospital payment?

20 MS. RAPHAEL: The strongest part of this, if we can get the
21 risk adjuster right, seems to be on measuring functional outcomes. The
22 OBQI part of it seems to have the greatest strength. Then I think the

1 question would be, is it enough to go with that when you do not have
2 the adverse events yet in a state, and you don't have the process
3 measures? That would be, to me, a question that the Commission would
4 be to answer. Do you feel if you have one of three prongs here, and
5 hopefully with a risk adjuster in good enough shape?

6 MR. HACKBARTH: Let me turn it back as a question. If you
7 just have one of the three prongs, I think the essence of what Arnie is
8 saying is, are you going to make the world worse by proceeding with one
9 of the three prongs or will you move modestly in the right direction
10 and keep momentum going?

11 MS. RAPHAEL: I would want the risk adjuster to be in better
12 shape. While I could wait on the process measures, I would want the
13 whole rehospitalization and emergent care to pay better understood,
14 because I consider those really important outcomes. So I don't know
15 enough about what research or the state of research in those areas.

16 MS. CHENG: Are your risk adjustment concerns on the OBQI and
17 the OBQM, or do you see a difference?

18 MS. RAPHAEL: The OBQI, I think. On both. I do not know
19 enough about it, but I know there are some real concerns about it.

20 DR. WAKEFIELD: Do those concerns translate to the 10
21 measures that we see congruence between AHRQ and NQF on, do you know?

22 MS. RAPHAEL: I don't know.

1 DR. WAKEFIELD: I'm back to Arnie's point and what I asked to
2 take a look at where we're seeing that, what that set of 10 happens to
3 be. I guess probably it would be useful to go back to AHRQ and/or NQF
4 and see the extent to which they looked at risk adjustment. To Arnie's
5 point, they're just terribly thorough it's hard to imagine that they
6 did not assess that. We certainly did in the other NQF work that I've
7 been involved with on hospital performance measures. So it would be
8 nice to have that information.

9 MR. HACKBARTH: Any others?

10 DR. NELSON: But risk adjustment isn't so critical is you're
11 talking about quality improvement. It is very critical if you are
12 talking about rewarding performance with payment differences, because
13 it can lead to adverse selection if you don't have it right.

14 DR. MILSTEIN: I hope I'm interpreting these QI measures
15 correctly, but as I understand how they are using QI, they're not using
16 it in the sense of whether or not the home health agency improved.
17 They are using it to track patient improvement, which is a little
18 different use of the term QI than one that we are used to I think.

19 MR. HACKBARTH: Generally speaking, isn't it true that if you
20 are trying to measure outcome, that then there is extra weight on
21 having appropriate risk adjustment for the different start place of the
22 patients. If you are measuring process steps then risk adjustment is

1 less of an issue. So to the extent that these are measuring the
2 outcomes of patients then risk adjustment is relatively more important,
3 although I guess I'm with Mary, it seems to me that the National
4 Quality Forum and AHRQ are quite sensitive to these matters and I think
5 it really bears looking into whether they considered adequacy of risk
6 adjustment in their evaluations. I would think they did but I don't
7 know that for a fact.

8 DR. REISCHAUER: As Arnie says, this is an imperfect exercise
9 we're in and the question in my mind is, even if we can do it rather
10 poorly, sending signals is important. Signals not necessarily with
11 respect to home health but with respect to Medicare overall, and
12 looking down the array of Medicare providers and benefits and saying
13 which are close to prime time for this and let's let them out on the
14 stage for an overture. It can be not a whole lot of money, but it's
15 very symbolic.

16 In listening to what people are saying I've come to the
17 conclusion that we are not running a bigger risk here that we're going
18 to make things worse off. The risk is that we're not going to reward
19 all the people who should be rewarded. But that is okay because they
20 will begin to scream, and that is what causes measures to improve is
21 the howls of injustice that prove to be justified. So I would go
22 ahead.

1 DR. WOLTER: I might just tack on to that. I do think
2 there's some value in tying some amount of payment to reporting of the
3 measures. And if we did want to make the comparison to the hospital
4 reporting, not only is the payment tied to reporting 10 relatively
5 narrow measures, but it is not tied in any way to the results. In
6 other words, the reporting in and of itself, at least at this moment in
7 our evolution, is really triggering the payment. I think we all would
8 agreed that is not adequate. We've talked about, should reporting be a
9 condition of participation, and really the payment itself then is only
10 triggered when certain results are achieved. But getting started I
11 think does have a tremendous amount of value and certainly this will
12 evolve over time into something more sophisticated.

13 MR. HACKBARTH: We need to move ahead. We are running a
14 little bit behind schedule here.

15 Sharon, are you going to introduce the next subject?

16 MS. CHENG: Our next speaker is Dr. Christopher Hogan, the
17 head of Direct Research LLC. Dr. Hogan is an economist, a policy
18 analyst, and I would like to note, a data wrangler extraordinaire. I
19 would like to just take a moment here to acknowledge that we have been
20 working with Chris now for a couple of years to build the dataset that
21 goes behind the analysis that he is about to present. I would like to
22 thank him for putting the tool together that got us to this point. It

1 has been a treat to work with him on the analysis that we've been able
2 to run off this tool. I hope in a lot of ways it is a marker for more
3 work that we will be able to do in looking across post-acute care
4 settings in the future.

5 MR. HACKBARTH: Welcome, Chris.

6 * DR. HOGAN: Thank you.

7 I am here to talk about an update of work that you saw
8 before. I realize now that not all of you have seen the previous work,
9 but rather than bore those who have seen it, I'll just briefly go over
10 it. The outline of the presentation is the following. I'm going to
11 review the methods very briefly, update the trends through 2002. That
12 was the most recent set of data that was available. And then look at
13 the end points on post-acute episodes, which is the only new work in
14 this analysis.

15 If you will turn to the third slide I'll briefly go through
16 the methods.

17 My contract would to put together a database of episodes of
18 all post-acute providers so that you could have all the providers on
19 one page. It takes a 5 percent sample of beneficiaries, which is about
20 2 million people, constructs episodes of care, which sounds easy but is
21 not because post-acute care episodes can be complex, although they fall
22 into relatively few buckets in this analysis. Then measure what

1 happens; how many episodes are there, how much do they cost, how many
2 people use what types of care. And finally, look at the end points of
3 the episodes, where do you end up when the episode is done. And then
4 look for changes from 1996 to 2002.

5 If you will move to the first slide you pretty much get to
6 the punchline. The first slide has two stacked bars on it. I've
7 stacked the bars so that everything having to do -- the bars should
8 1996 versus 2002 and I've stacked the bar so that everything having to
9 do with home health is on top and everything not having to do with home
10 health is on the bottom. The bottom line is that everything not having
11 to do with home health increased from 1996 to 2002, and all of the
12 services related to home health, either community referral, home health
13 as the sole modality post-acute, or home health in conjunction with
14 some other modality post-acute, all of those shrank from 1996 to 2002.

15 That is no surprise. These would not look that different if
16 I'd shown you 1996 and 2001 the last time.

17 If you want to see that in a more continuous series you can
18 turn to the next slide which just looks at the trends. The trends in
19 the number of episodes, episode length, cost per episode, and users of
20 care and you can see the trends from 1996 to 2002. What I was supposed
21 to do is put together a continuous database.

22 The following slide then discusses what actually happened.

1 The bottom line is in 2002 all the trends began to turn up. So as of
2 2002, the number of users, the number of episodes, the length per
3 episode, and the spending in particular all began to rise after hitting
4 a low point in 2001. In 2002, with no adjustments for population
5 growth, with no adjustments for change in the value of the dollar, the
6 total spending by the Medicare program for these post-acute episodes
7 was 3 percent higher than it was eight years previously in 1996. So
8 basically by the time you go to 2002 spending was where it was before
9 in dollar terms plus 3 percent.

10 The only bit of analysis of the prior work was to answer this
11 question, can you characterize how those changes occurred across the
12 whole spectrum of post-acute providers? I did two things and for this
13 analysis I just updated them to 2002 to make sure that what I did last
14 time still held true. I did the following. For truly post-acute care,
15 care that follows a PPS discharge, I took the discharges that had a
16 high rate of post-acute use in 1996 and stacked the discharges from
17 highest to lowest in terms of their 1996 rate of use, and looked to see
18 what the rates of use of post-acute care looked like in 2002, and I got
19 the same results that I got last time.

20 Discharges that were likely to use post-acute care in 1996
21 remained likely to use post-acute care in 2002, and the reductions in
22 post-acute care occurred for those discharges for which post-acute use

1 was unlikely in 1996.

2 For community referral home health it's a lot harder because
3 there's no discharge to flag people with. For
4 community referral home health I did a different thing. I generated a
5 risk adjustment model. So I predicted any person's use of home health
6 or any person's quantity of home health used all based on 1996 patterns
7 of care and then applied that prediction model to 2002, found that
8 people who looked like they were likely to use home health. You can
9 guess the diagnoses that are predictive of home health use. They would
10 be basically diagnoses that indicate frailty. And found once again
11 that the reductions in home health were disproportionately on people
12 who had a home low probability of use, not people that had a high
13 probability of use.

14 So this is all by way of saying, up to slide seven, not much
15 changed from the presentation that you saw the last time.

16 The new work you're going to see now talks about the end
17 points of these episodes. Even as the episodes are complex, the end
18 points are complex. You can have people who are readmitted to the
19 hospital and immediately die. You can have people who die while they
20 are in the skilled nursing facility. You can have people who
21 apparently go home and then die soon thereafter. So there's all kinds
22 of different end points that may occur, some good, some of them not.

1 So I ordered the end points hierarchically in the following
2 fashion. First I flagged all the people who died within 31 days of the
3 end of the episode, then all the people who were admitted to hospice
4 because largely they're expected to die soon. That's the criteria for
5 entry to hospice. Then if neither of the above, then readmitted to an
6 acute care facility, and finally, the people who apparently had a
7 successful return to home.

8 I need to give you one more slide of caveats. Now you
9 realize that this is a very simple way of looking at the end points of
10 the episodes. I'm going to give you some caveats before I show the
11 numbers. This is the short-term outcome. It does not address the
12 long-run, doesn't address the people who do not use post-acute care,
13 doesn't address their functional status at all. So there are
14 undoubtedly other, more refined measures of the performance of the
15 system.

16 All I am going to do here is two things. I'm going to show
17 you what actually happened in 2002 for the actual mix of persons and
18 diagnoses using care in 2002. Then I'm going to do something a little
19 tricky. I'm going to show you what I predict to have happened in 2002
20 based on the mix and diagnoses of cases in 2002, and based on the
21 outcomes that occurred on average for those cases in 1996. So with
22 some trepidation I'm going to show you one slide that shows you the

1 actual 1996, the actual 2002, and then what I expect to happen in 2000
2 based on the mix of cases and modalities used.

3 Here is that slide. When you compare the actual end points
4 they do not look very good. In 2002 there are more deaths, there are
5 more people admitted to hospice, there are more people readmitted to an
6 acute-care facility and fewer people successfully return home or return
7 to whatever their prior living arrangement was. The only point I want
8 -- and all of those are statistically significant at a 5 percent level.
9 The only point I want to make is that that appears to be due -- if you
10 were to think of this as either being due to a shift in the mix and
11 modality care, or shift in the performance of the system, this analysis
12 comes down very strongly to say, no, this is a shift in the mix and
13 modality of care. This is not a degradation of the performance of the
14 system as far as I can tell at this point.

15 The death rate is -- so instead of comparing the top two
16 lines of numbers, the actual 1996 to the actual 2002, if I compare the
17 actual 2002 to what I would predict based on the diagnoses and based on
18 what types of care they were getting you'll see the predictions are
19 very close to what happened. There is no difference in the death rate
20 from what we predicted. The use of hospice, the actual use of hospice
21 is above what's predicted. That's because hospice wasn't used much in
22 1996, which is the patterns of care I used for the prediction.

1 Readmits are actually a little bit lower, and returns to home are
2 actually a little bit higher than I would have predicted based on
3 modality.

4 So that's pretty much the end of the speech and I'll sum up
5 in a minute. But the bottom line you should take away from the slide
6 is, that as far as we can tell in the aggregate the system is
7 performing, in terms of the end points, in terms of where people end up
8 at the end of their episodes, just exactly as it did in 1996.

9 So let me summarize. Spending and total use of care began to
10 rise in 2002 after a seven-year decline. The patterns that you saw in
11 the prior study continued to hold true. There is a concentration of
12 care among persons who have a high probability of use, and most of the
13 reductions in care came from people whose probability of use in 1996
14 was relatively lower. Episodes ending in death went up. Episodes
15 ending in return to the community went down. But as far as I could
16 tell, that outcome change was entirely due to a change in the mix of
17 the cases being treated.

18 Questions?

19 MR. BERTKO: I would just ask, were there any exogenous
20 events between 1996 and 2002? I cannot remember whether BBA did
21 anything to the payment stream at the time. If it did, what would be
22 your interpretation?

1 DR. HOGAN: Yes. I should have brought that slide with me.
2 Everything changed from 1996 forward. So it started with the interim
3 payment system for home health and the last thing to go was the long-
4 term care hospitals. Every payment system changed.

5 MR. BERTKO: Interpretation, please?

6 DR. HOGAN: Thank goodness for the professional ethics of the
7 medical profession because not much changed in terms of those end
8 points.

9 MS. RAPHAEL: If I am understanding this right, the first
10 part of this shows that those who had high use in 1996 of post-acute
11 care had high use in 2002. But this isn't saying that those who should
12 use post-acute care are in fact using it.

13 DR. HOGAN: That's correct.

14 MS. RAPHAEL: It's not as if we're taking a hospital database
15 of discharges and saying that we would predict that a certain
16 percentage of those discharges would result in post-acute care, or that
17 a certain type of case should result in a post-acute care episode. You
18 are looking at patterns of utilization historically and then using that
19 to predict what you would have expected? Do I have that right?

20 DR. HOGAN: Right, think of it as a risk adjustment model
21 with one variable in it and that's the DRG. So all I said was, 80
22 percent of hip cases used post-acute care in 1996, then 82 percent used

1 them in 2002. So it is a risk adjustment model with one DRG. It's no
2 finer than that. You would like for me to have some measure of
3 functional status upon discharge. I don't have anything with that
4 level of sophistication. So I do not have any measure of need. All
5 I've done is said -- you had it characterized correctly.

6 MS. RAPHAEL: Then the second thing that I do not fully
7 understand is your predictor of what happens at the end of 31 days.
8 Given changes in medical practice that have occurred even in those six
9 years, how did you predict what would happen, how many people would end
10 up in a hospice, how many people would be rehospitalized?

11 DR. HOGAN: Once again it's the average. But here it's the
12 average by modality of care and principal diagnosis from the first
13 post-acute bill. So if you were discharged from the hospital with a
14 hip replacement and you went to a SNF, that was your category. I found
15 in 1996, the average end points for those people ended up being 75
16 percent went home, 15 died, and 5 percent went elsewhere. I am making
17 this up, obviously. I then found all the people in -- so this is 1996.
18 I have the average end points for the episodes that occurred based on
19 what type of modality they used and diagnosis.

20 I simply went to 2002 and found all the hip replacements that
21 were discharged from the hospital and I stuck that end point onto those
22 people and then averaged them up. So it's no more than saying, if

1 nothing had changed based on the -- if the mean rate of end points had
2 not changed based on what type of care you got and what your diagnosis
3 was, what would your 2002 picture have looked like? The answer is, it
4 looked exactly like the actual 2002, almost exactly like the actual
5 2002 picture.

6 MS. RAPHAEL: I think I got that. My third question is, and
7 I don't know if you can answer this, did you see any shifts, like a
8 higher percentage of patients going to nursing homes in 2002 than went
9 in 1996, a higher percentage in rehab facilities, or any kind of shift
10 in the mix of post-acute care?

11 DR. HOGAN: Yes, and that is principally why the actual 2002
12 is quite different from the actual 1996. What happened was, a greater
13 fraction of your patients are skilled nursing facility patients.
14 Nursing home is an ambiguous term to me. I certainly saw more people
15 get skilled nursing facility care as their post-acute care. Whether at
16 the end of that they went back into a nursing facility or not, I
17 couldn't tell.

18 MS. RAPHAEL: But you saw a larger percentage going into the
19 SNFs in 2002 than in 1996.

20 DR. HOGAN: Absolutely. You can look back on that -- in
21 theory you could look back on this slide and infer from that -- you
22 don't have the percentages there but the percentages should be in the

1 table. Everything on the top is home health, everything on the bottom
2 is everything but home health. Everything on the bottom grew.
3 Everything on the top shrank. So, yes, the proportion of that 2002 bar
4 that is nursing facility and other facility-based providers is clearly
5 a higher proportion of all the cases. So the answer to your question
6 is yes.

7 DR. MILLER: What you're saying is that the amount of
8 facility care, as a proportion, in the second bar is higher.

9 DR. REISCHAUER: I'm wondering if we cannot say something
10 more about Carol's question. The volume of home health services fell
11 dramatically. The outcomes of the folks who had some kind of post-
12 acute care doesn't seem to have changed much from what you would have
13 predicted. While we do not have all the dimensions we would like to
14 have, as a first conclusion you would say, things are pretty much the
15 same there. So then the question is, what happened to the people who
16 would have had home health only and didn't have anything? If you could
17 find the answer to that you could answer the question of, was there
18 overuse in 1996, which is what precipitated a lot of the changes in
19 1997 and 1998.

20 DR. HOGAN: We started to go down that road but -- so what
21 you would like to do is find some people in 2002 who would have been
22 candidates for home health; they sure look like they would have used

1 home health but they didn't. The only problem is, I can go back to
2 1996 and I can find people who I would have predicted would have had
3 home health but didn't use home health.

4 So we were considering going down that road and giving you a
5 comparison of the 1996 -- because it's not a comparison to only shown
6 you 2002. My prediction is not perfect. I'll show you both and see if
7 it shows you -- I can see the questioning looks around the table.

8 But by the time I got through explaining to people, here are
9 the people who should have used it in 1996 but didn't, here are the
10 people who should have used it in 2002 and didn't, look how they're
11 different or aren't different, we decided that it wouldn't move matters
12 along. But I completely understand the question, but we could not
13 figure out a feasible way to get at the people who by 1996 practices
14 would have used the care but in fact didn't get the care in 2002. If
15 that is the issue, if that is the missing population that needs to be
16 studied, we'll think about that some more. But our best shot ended up
17 being so complicated that we didn't even believe it.

18 DR. MILSTEIN: Understanding this was not within the scope of
19 what you looked at, but as I understand your analysis you were looking
20 at your cost, you were looking at billings from these post-acute
21 providers. From the point of view of the Medicare program and total
22 spending on Medicare patients there is obviously a larger stream of

1 cost per episode than simply what the post-acute provider is billing.
2 There are bills from physicians, and from Medicare supplemental payers,
3 there's bills for drugs.

4 On the face of it, holding cost constant in any aspect of the
5 Medicare program is a victory. Do we have any clue as to how this
6 victory would look if we were to bundle back into the cost analysis the
7 various other aspects of health care spending for these patients during
8 this period that was not accounted for by this analysis?

9 DR. HOGAN: The short answer is all of the claims costs can
10 be put back in. What I was scratching my head over is how hard it
11 would be to put that back in. I don't think it would be hard. I think
12 that was actually part of the original plan, was to capture the
13 physician and other bills. You won't capture any hospital bills
14 because that will terminate the episode. You might capture some
15 outpatient care, because that wouldn't necessarily terminate the
16 episode. You might capture some DME.

17 My guess is it would be a small amount of money. We could
18 certainly check that out and show it to you, that's it's just not a
19 whole lot of money in terms of the overall scope of things.

20 The stuff that's beyond Medicare, the only source we have for
21 that that we can get our hands on is the MCBS. So we can do it. It is
22 so small sample. We can do it and see -- we'll look at the drugs and

1 stuff. Having had to deal with the drug benefit for my mother who is
2 now in an assisted living facility I can tell you, all the coinsurance
3 goes up as soon as you're not in the mail order benefit any more. So
4 now she pays in coinsurance what she would have had to have paid for
5 the drugs for themselves not four months ago. So, yes, we can
6 certainly look at the out-of-pockets from the MCBS on a small sample,
7 and look at the Medicare paid, including coinsurance, for everybody in
8 the 5 percent of the claims.

9 MR. HACKBARTH: Anyone else?

10 As always, Chris, very good.

11 Next up we're going back to mandated reports and talking
12 about the effect of implementing the resource-based practice expense
13 payments for physicians.

14 * MS. RAY: Good afternoon. Cristina and I are here this
15 afternoon to discuss a study mandated by the MMA. It asked MedPAC to
16 examine the effect of implementing resource-based practice expense
17 relative value units, RVUs, on several factors, including RVUs and
18 payment rates, access to care, physicians' willingness to care for
19 beneficiaries. The mandate specifically asked us to look at the effect
20 by specialty. This study is one of our 16. This one is due to the
21 Congress December 8 of this year.

22 Just to briefly set a little context here, beginning in 1992

1 a resource-based relative value scale fee schedule for physician
2 services replaced the reasonable charge system of payment. The intent
3 of the resource-based relative value system is to rank services on a
4 common scale according to the resources used for each service. The
5 relative value scale for physician services is comprised of three
6 components: physician work, physician practice expenses, and
7 professional liability insurance expenses.

8 When the fee schedule was first implemented, the work RVUs
9 were resource-based, that is based on time and effort of physicians,
10 while the practice expense PLI RVUs were still based on physicians'
11 historical charges. The 1994 statute called for developing resource-
12 based practice expense RVUs, and the BBA mandated that they be phased
13 in between 1999 and 2002, which they were. They were phased in,
14 according to the statute, in a budget neutral fashion.

15 So the challenge here was to estimate practice expenses for
16 each of the more than 6,000 services paid for under Medicare's
17 physician fee schedule. CMS went final with this method in the fall of
18 1998 in its 1999 final physician fee schedule. The agency's approach
19 is commonly referred to as the top-down approach.

20 The starting point is estimating aggregate practice expense
21 pools by specialty, and the data source for doing that is the American
22 Medical Association socioeconomic monitoring system survey. Expenses

1 are allocated to each service using data derived from the clinical
2 practice expense panels, also called on the CPEP. Fifteen expert
3 panels were convened by CMS in the 1990s. The CPEPs were organized by
4 specialty. Each panel had about 12 to 15 members, and the panels
5 estimated, made judgments about the direct resources, such as nursing
6 time and medical equipment, needed to deliver each service.

7 I'm going to take you through the three steps of how
8 resource-based practice expense RVUs are derived very quickly.
9 Aggregate practice expenses are estimate for three direct categories:
10 clinical labor, medical equipment and medical supplies, and three
11 indirect categories: namely administrative labor, office expenses, and
12 other expenses. The aggregate practice expense pool is derived by
13 multiplying the SMS practice expense hourly data by specialty by the
14 total physician hours treating beneficiaries.

15 In step 2 then involves allocating direct expenses and
16 indirect expenses to each of the some 7,000 services in the physician
17 fee schedule. For the direct expenses, the CPEP data is used. For
18 indirect expenses, however, it's allocated based on a combination of
19 physician work and the direct practice expense values. Then to derive
20 the practice expense values by simply adding the direct and the
21 indirect estimates per service per specialty.

22 Finally in step three, for services provided by multiple

1 specialties -- because remember this was done by specialty -- CMS
2 calculated a weighted average. So specialties that perform a given
3 service frequently have more weight over that payment than specialties
4 that rarely perform it.

5 Now of course there is always one exception to the rule.
6 Sometimes physicians bill for services that involve little or no
7 physician work and are performed by other staff. In response to
8 provider concerns that payments for these services were too low, CMS
9 developed an alternative method of calculating practice expense
10 payments. In the alternative method, the cost of non-physician
11 services are aggregated into what is known as the zero work pool for
12 all specialties. Then practice expense payments are calculated for
13 each non-physician service, as they were for other services, but with
14 the exceptions noted in this slide. I will also add that specialty
15 societies may request CMS to have their services removed from the zero
16 work pool.

17 Now going onto the impact of implementing resource-based
18 practice expense RVUs. The agency included in their final rule for the
19 1999 fee schedule a regulatory impact analysis of the effect of
20 implementing resource-based practice expenses. They did look at the
21 impact by specialty and they concluded that it depends on the mix of
22 services and where the services are performed, but that specialties

1 that furnish more office-based services are expected to experience
2 larger increases in Medicare payments than specialties that provide
3 fewer office-based services.

4 To fulfill the mandate MedPAC's analysis used 1998 and 2002
5 Medicare claims data to assess the effect of the transition on RVUs and
6 payment rates per service, use of services, and changes in assignment
7 rates. Our contractor, Urban Institute, did this analysis for MedPAC.
8 We also used beneficiary and physician services to examine
9 beneficiaries' access to care during the transition.

10 To assess the effect of the transition on RVUs and payment
11 rates we used a price index approach. That is essentially a weighted
12 average of current year to base year prices, holding quantity of
13 services constant. To be clear, when we're looking at changes in the
14 payment rate, it does reflect the 1998 and 2002 conversion factors.

15 So just like the CMS impact analysis, our analysis also shows
16 that some specialty gained and some did not. We found that the impact
17 of implementing resource-based practice expenses increased payments
18 across all specialties by 0.7 percent between 1998 and 2002, and during
19 that time the payment rate overall increased by 1.9 percent.

20 We found that for most of the specialty groups we looked at,
21 that the payment rates did not change by more than 2 percent. We did
22 however find, just like CMS, that payments for certain office-based

1 specialties like dermatology increased the most and payments decreased
2 the most for facility-based specialties, thoracic surgery and
3 gastroenterology.

4 So our results suggest that the implementation seemed to
5 happen as the agency predicted. That the effect on a given specialty
6 is related to the mix of services it furnishes and the kind of service.

7 So this table was included, or these data were included in
8 your mailing materials, but we looked at the effect of implementing
9 practice expense RVUs by the major BETOS categories. CMS in its final
10 1999 rule did not have these data stratified by the major BETOS
11 categories. They had it done by specialty group. But again, it's
12 consistent with the expectation, we found that payments and practice
13 expense RVUs varied across the major BETOS categories with increases
14 for E&M services and other procedures and decreases for tests, imaging,
15 and major procedures.

16 We noted in our paper that sometimes the practice expense
17 RVUs and payments did always change in the same direction in a given
18 BETOS category. I specifically used the other procedure as an example.
19 For example, the practice expense values for other procedures increased
20 for dermatology but decreased for gastroenterology.

21 We're going to do additional analysis of that and have that
22 in our report, but we are thinking that it is due to both -- there are

1 a lot of different services included, different, varied services
2 included in the other procedure group, and it also may partly be linked
3 to sight of care differences.

4 We looked at the effect on the use of services by measuring
5 volume two ways. By service volume, which is per capita use of
6 services, and RVU value, which is per capita use weighted by each
7 service's relative weight. What we found here is that the volume
8 increased most specialties and volume increased for each of the major
9 BETOS groups.

10 As we show here, in this slide we're looking at changes in
11 volume by type of service, and then the last bar for each of the types
12 of service is the change in the payment rate due to the implementation
13 of resource-based practice expense RVUs. Here the changes in the
14 volume don't seem to be related to the changes in the payment rate.

15 Now Cristina is going to summarize our findings on access to
16 care.

17 MS. BOCCUTI: First, I'm going to start a little bit with
18 issues about assignment rates.

19 Part of our congressional mandate includes examining changes
20 in physician participation with Medicare that may relate to the
21 transition into the RBRVS. Using the same claims data for the analyses
22 that Nancy described, we also examined changes in the share of services

1 paid on assignment by specialty and BETOS group. Recall that for
2 claims paid on assignment, physicians agree to accept the Medicare fee
3 schedule amount as the full charge for the service and may collect
4 payments directly from Medicare.

5 Also, participating physicians agree to accept assignment on
6 all allowed claims in exchange for a 5 percent higher payment on
7 allowed charges. So here on this slide you see that the overall share
8 of services paid on assignment were high in 1998 and increased slightly
9 from 97 percent to 90 percent in 2002, which is our study period of
10 interest.

11 By specialty, all BETOS service groups within all specialties
12 had shares greater than 90 percent, with most greater than 95 percent.
13 The shares stayed constant or increased for most BETOS service groups
14 within most specialties.

15 So to analyze the effect of the RBRVS on beneficiary access
16 to physician services, we examined beneficiary and physician surveys
17 that spanned the applicable years of the transition. Most of the
18 information that I will present about beneficiary access to physician
19 services is really not new to you, especially considering that the
20 relevant study period for this mandated report is from 1998 to 2002.
21 However, in contrast to some of our work for our update analyses, the
22 information we present for this report focuses more on specialties.

1 In general, beneficiaries reported good access to physicians,
2 including specialists, between 1998 and 2002. Analysis of the Medicare
3 current beneficiary survey shows that access measures remain relatively
4 high and steady during this time period. Specifically, most
5 beneficiaries reported that they were even satisfied or very satisfied
6 with the availability of care by specialists. Similarly steady between
7 1998 and 2002 was beneficiary ability to see their first choice of
8 physician.

9 So now we're looking at physician surveys where physicians
10 are asked about their willingness to accept new patients. Average
11 across all patients, overall shares of physicians accepting any new
12 patients fell slightly, about one percentage point between 1999 and
13 2002. That is not just Medicare. That is all patients, when we're
14 looking at multiple surveys. Although a small decline was detected,
15 results from a MedPAC-sponsored physician survey indicate that among
16 open practices the share of physicians accepting new Medicare fee-for-
17 service patients remained high, above 90 percent.

18 Using a larger survey, the National Ambulatory Medical Care
19 Survey we call NAMCS, which included both open and closed practices,
20 shows a small decline by 2002 in acceptance of new patients across all
21 insurance types except to their charity care patients. Specifically,
22 the share of physicians accepting new privately insured patients fell

1 from 92 percent to 86 percent, and the share accepting new Medicare
2 patients fell a little less, from 90 percent to 87 percent.

3 So when looking at trends in physician acceptance of new
4 patients during our study period, both surveys suggest that
5 proceduralists and surgeons were more likely to accept new Medicare
6 patients than non-proceduralists, namely primary care physicians. In
7 the NAMCS surveys, surgeons were most likely to accept new patients
8 across all years and all patients types. This survey found that the
9 share of surgeons who accept new Medicare patients slightly increased
10 to 96 percent in 2002. The NAMCS survey also found that the share of
11 Medicare physicians who accept new patients dropped at the same rate
12 for both Medicare and privately-insured patients, which was just a few
13 percentage points.

14 Nancy will continue.

15 MS. RAY: Thank you. So we want to summarize our findings of
16 our data analysis and present these draft conclusions for your
17 consideration, that changes in the practice expense RVUs and payments,
18 what we found is consistent with CMS's impact analysis. Our analysis
19 shows that the transition had the expected effect, and that payments
20 for most specialty groups did not change by more than 2 percent.

21 We also found that changes in volume do not seem to be
22 related to changes in practice expense RVUs or payment changes.

1 Beneficiaries are not facing systematic problems accessing care, and
2 assignment rates remained high and mostly unchanged during the
3 transition.

4 Just to very briefly touch upon some future MedPAC issues
5 that we can take on after we finish all of our mandated studies. With
6 respect to practice expense, the first is the need for updating data
7 sources, the SMS and the CPEP, to have current and up-to-date data to
8 derive practice expenses, and then exploring alternative methods to
9 calculate practice expenses. Many policymakers have focused in on the
10 allocation for non-physician services.

11 With that, we are finished.

12 MR. HACKBARTH: Questions or comments?

13 DR. REISCHAUER: I realize that these questions were, in a
14 sense, mandated by the law, but the notion that the shift in this index
15 would have a big effect on physician participation is ludicrous, given
16 all the other things that go on. I would hope that in our report,
17 which I think you did a first-class job. I don't say that just because
18 the Urban Institute was involved in this, but we say there are lots of
19 things that affect volume, and some of them are big and important, and
20 lots of things that affect participation. Some people might think this
21 does too, but clearly whatever effect it might have had has been
22 swamped by all the other things that are going on.

1 DR. NELSON: I hope that we mention a requirement for all
2 physicians to submit cost report data, as is done with institutional
3 providers. I hope we mention it only to deplore that notion, because
4 for solo and small group practices whose office manager may or may not
5 be a spouse, that could be the straw that broke the camel's back.

6 MS. DePARLE: I agree but I just want to underscore the last
7 issue you raised about the data. The SMS, as I recall, the house of
8 delegates of the AMA voted not to do that anymore. At least the AMA is
9 not doing it now, and the data is now four years old that we are using.
10 So even though this report is not supposed to necessarily deal with
11 that issue, I think we should note in the report that the Secretary
12 needs to find another source of data. When this all started I think
13 the agency tried to do a survey of doctors and that didn't work. But
14 we've got to find some better way. I don't think the cost report is
15 the right way to do it, but there's got to be some better way to get
16 data. Even what they're using now is inadequate for some of the
17 different procedures, as I understand it.

18 DR. NELSON: I think it's really important for MedPAC to talk
19 to the AMA and find out what and under what circumstances they would be
20 able to continue to provide the necessary data.

21 MR. HACKBARTH: I think we are very near the end of this
22 particular study and close to ready to send our report. What we will

1 do is hold it open until the next meeting, in keeping with our general
2 rule of allowing commissioners time to think about things and have
3 ample chance to get in their comments. But I think that we are in
4 pretty good shape on this one and would hope to get it to the Hill
5 before the deadline. So I'm not sure exactly how Mark will want to
6 handle it at the next meeting. There will not be an extensive
7 discussion of this unless something surprising happens in the
8 intervening weeks, and we'll maybe just have a very cursory follow-up
9 report and a draft out.

10 We are to the last item for today, I think. This is a final
11 mandated report. Not a final one, but another mandated report on
12 certified registered nurse first assistants and their eligibility for
13 payment.

14 * MR. GLASS: Yes, that is correct. Again as one of our
15 mandates we're supposed to study the feasibility and advisability of
16 paying certified registered nurse first assistants directly from Part
17 B. It's due January 1.

18 The current situation is that only physicians and specified
19 non-physician providers can bill Medicare separately for first
20 assistant at surgery services. The list includes physician assistants,
21 certified nurse midwives, clinical nurse specialists, and nurse
22 practitioners, though physician assistants account for much of the bulk

1 of the first assisting done by NPPs who are paid separately. Those not
2 on the list cannot bill separately. That includes CRNFAs and also
3 surgical technologists and others.

4 NPPs are paid 13.6 percent of the physician fee schedule
5 amount, which is 85 percent of the 16 percent that physicians get if
6 they perform first assistant services. They get that 16 percent for
7 every service. There is no distinction between different kinds of
8 procedures or anything. It is always 16 percent of the physician fee
9 schedule, and therefore 85 percent of it is always 13.6 percent.

10 Background here. The Omnibus Budget Reconciliation Act of
11 1986 allowed the physician assistants to bill as first assistants and
12 they were paid 65 percent of the physician first assistants fee at the
13 time. The expenditures were to be subtracted from the hospital
14 payments. This did not happen. In fact in OBRA '90 they rescinded
15 that payment subtraction. It's an important point though. From the
16 beginning, the payment for physician assistants and first assisting
17 services were recognized as duplicating hospital payments. PA first
18 assistants, along with OR nurses and other OR personnel were considered
19 part of the services the hospitals were providing, and therefore were
20 considered to be included in the hospital payment.

21 Now BBA of 1997 removed some of the geographic restrictions
22 on nurse practitioners and clinical nurse specialists. Before they

1 could only do some things in rural areas and get paid separately for
2 it. Now this was extended to all areas. It also made uniform this 85
3 percent payment. So instead of being 65 percent for first assisting
4 and 75 percent for some things and 85 percent for others, they just
5 made it 85 percent across the board.

6 What does this all add up to? Since BBA '97, the payments
7 for physicians providing first assistant services have gone from \$166
8 million to \$104 million in 2002, and for non-physician practitioners it
9 went from \$16 million to \$54 million. So the total actually has gone
10 down over this period. I want to note here that most surgeries do not
11 use separately billable first assistants at all. The assistant is
12 simply supplied by the hospital, and that is still true. The people
13 who could be doing that might be residents, and they are not allowed to
14 bill separately because they are considered to be paid under GME. And
15 it could be others such as CRNFAs.

16 We cannot really tell if this is substitution of NPPs for
17 physicians or not, but it's certainly not out of control and it doesn't
18 seem to be big dollars in Medicare terms, even though the NPP part is
19 growing.

20 So who are those CRNFAs who would like to be separately
21 billable? They are people who are licensed as registered nurses in all
22 50 states. They are certified in perioperative nursing, which is an OR

1 nurse, which requires two years and 2,400 hours of practice in itself,
2 and then another 2,000 hours as RN first assistant. There is a formal
3 RNFA program, and there is a certification by the certification board
4 of perioperative registered nurses.

5 Right now they have to have a bachelor's or master's in
6 nursing, but that's a fairly new requirement and only about 38 percent
7 currently have that qualification. Finally, this is a very small
8 number. There are only about 1,700 in the US. As we showed in the
9 issue paper, there would be a small effect on the payment if they were
10 added to the list. We would like to point out though that more could
11 seek certification if it became more valuable.

12 So the question is, should they be added to this list of
13 separately payable? The problem with answering the question is that
14 there really aren't any explicit criteria for Medicare separate
15 payment. We could infer some things from the current list. We can
16 look at the current list and say that they're all state licensed and
17 have a certifying board, and they meet that requirement. There's no
18 surgical experience required explicitly for the current list, and
19 education varies. So it is hard to say -- there is no criteria to meet
20 in those cases.

21 Once on the list, certification requirements could be changed
22 by the group, which is an interesting thing. For instance, the CRNFAs

1 just increased the education requirement in their case.

2 So you really cannot answer the question, should a group be
3 added, by simply looking at the current criteria, either the explicit
4 ones, which are none, or the ones that that we can infer, though we do
5 have some experience to guide us. The Commission has taken some
6 positions on this in the past. In looking at non-physician
7 practitioners, we discovered that there really was not any empirical
8 evidence for the amount of payment for first assisting by physicians,
9 or by implication, by non-physician practitioners. All procedures were
10 paid the same at 16 percent to physicians no matter what they do.

11 We also discovered there didn't seem to be any clear
12 difference in outcome with physicians or NPPs, but there certainly was
13 less educational input for the NPPs. And we have recommended that --
14 so the 85 percent seemed to have some justification. We recommended 85
15 percent for all NPPs. The certified nurse midwives are still at 65
16 percent for first assisting.

17 Now the Commission also did not add to the list when it was
18 asked, orthopedic physician assistants or surgical technologists. The
19 issues were really licensure and duplicate payment. Orthopedic
20 physician assistants were only licensed in three states and surgical
21 technologists only in one. As we pointed out earlier, all the NPP
22 first assistant payments were included in hospital payments, so that's

1 the duplicate payment issue. That was an issue when the Commission
2 looked at this in the past.

3 Now GAO really came up with some of these same issues when
4 looking at this question of adding CRNFAs to the list and concluded
5 that payment for first assistants is already in the hospital payment
6 and should not have a separate at all. CMS' position when they were
7 responding to the GAO study in a letter said it's important not to
8 disrupt the existing relationships, and therefore they weren't planning
9 on changing policy, although they recognized that current policy had
10 some inconsistencies.

11 So where do we go from here? You have to bear with me a
12 minute. It seems like a large reaction to a small question, but where
13 logic would carries on this, and the preferred solution would be to
14 combine the global surgical professional fee and the hospital payment.
15 The reason is that we would like to recognize the complicated reality
16 that is out there. Some surgeons routinely bring staff with them.
17 Others don't. And different types of providers are used by different
18 surgeons; technologists, CRNFAs, PAs. And different hospitals employ
19 different people, and they have different capabilities, and some have
20 residents. So there is no one way of doing this.

21 Under this idea, the surgeons and hospitals would determine
22 who should assist and who would get paid. They would figure out who is

1 the best person to be doing it and they would divide the payment to
2 reflect who supplies the assistants. If the physician brings the
3 assistants with them, then he would get a larger share than if the
4 hospital supplied the people.

5 Another advantage of this, it would link payments to global
6 outcomes. So in terms of our quality work we would be able to say,
7 what's the quality of the entire outcome and we would not have to say,
8 this much of it is the surgeon's responsibility, and this much is the
9 hospital's, and this much is first assistant's responsibility for
10 quality. I think that is something that came up a little while ago.
11 So it would have some benefit there. And it may allow more rapid
12 response to new circumstances and technologies.

13 It could be that some new technologists, maybe a surgical
14 technician is the best person to do it because it requires a lot of
15 intense training on a very specialized thing. This would allow the
16 surgeon to go ahead and employ that person if he thought they were
17 best. Medicare wouldn't have to choose, would not have to set lots of
18 criteria, would not have to get involved in all these really clinical
19 decision issues. But it is clearly a major departure and there are
20 lots of issues with it. There's the anti-kickback question. If a
21 hospital is splitting a payment with a surgeon, that could be a
22 problem. But we see it's already being done in some cases. The

1 hospital is reimbursing, or they call it leasing, staff from surgeons
2 who bring their own assistants with them. So we think that would be
3 something you can overcome.

4 You would have to figure what to do with the existing first
5 assistant payments. You could consider them all duplicates and just
6 take them away, or you can add it to the bundle, or if you wanted, you
7 could put it in a quality pool. You'd have to decide whether this was
8 going to include the physician first assistant payments as well as the
9 NPP payment. Then you'd have to design your quality program and figure
10 out quality measures and all that sort of thing.

11 By why do such a major redesign in response to small
12 question? We think that logic draws us there, because the current
13 system is inconsistent and unsatisfactory. It could be also a useful
14 test case for paying for quality and for coordinating care between
15 silos, between Part A and Part B, which are both major Commission
16 priorities. From the beneficiaries's perspective, they really don't
17 care if the person taking care of them works for the hospital or the
18 surgeon, or what kind of practitioner it is. They want to know they
19 will be safe and well cared for and get well as soon as possible. So
20 if changing the payment system makes that more likely, it might be
21 worth trying.

22 But recognize it's kind of a big recommendation to rest on

1 this small of a study, so in the interim we could consider the
2 following draft recommendation which would recognize that right now
3 there is no sound basis for extending the list of separately billable
4 NPPs at this time. There's no clear criteria. We can infer that
5 CRNFAs are not disqualified, but we can't say they should be added with
6 certainty.

7 To cope with the constant demands for additions to the list,
8 it might be useful for CMS, through a regulatory process, to develop
9 explicit criteria for licensure, education and experience. They would
10 have to say how much experience and training qualified each type, and
11 perhaps have rulemaking, complete with comment period and all that sort
12 of thing, which could bring more information to light or start a foot
13 fight between types of providers, but it might be a good way to do it,
14 though it would probably be more bureaucratic and somewhat unresponsive
15 to technical changes, for example. We would want to do it in a budget
16 neutral manner.

17 It would be different from how Medicare treats physicians.
18 Typically it says in law who can bill by type, M.D. or a P.A. or
19 whatever, and it lets the states tell Medicare who is qualified under
20 state rules to do one of those things. It doesn't say that surgery can
21 only be done by physicians with so many years of training and
22 experience. It simply says if someone is an M.D., they've been

1 licensed by the state, then okay, they can do whatever services M.D.s
2 can do in that state.

3 It also would not address the duplicate payment issue.

4 So anyway, we recognize it's not an optimal solution, but
5 that's where we have arrived at here. We would like some direction
6 from the Commission on how to proceed with, and do you like one of
7 these approaches or some other approach to be sent to Congress.

8 DR. WOLTER: This is kind of a niche question, but I'm
9 wondering if there are any more remote areas with a general surgeon
10 where the supply of these personnel would be enhanced by the extension
11 and where they don't have availability of residents or other first
12 assistants. You might imagine that as a niche issue that this might
13 affect some unique locations.

14 MR. GLASS: Yes, if you are concerned about access -- some of
15 these people are already there, they're just not getting paid
16 separately, and they're already assisting at surgery. One issue might
17 come up if the new work rules for residents go into effect, there may
18 be fewer residents available to assist. If other payers paid for
19 CRNFAs, whereas Medicare did not directly, then there could be some
20 question of access for Medicare beneficiaries. But that's speculative.

21 MR. MULLER: I share your sense that what you call the
22 preferred conclusion, it may be too big a response to too small an

1 issue, and it takes on much more than we need to. So I think I share
2 Nick's sense as well, maybe here and there, in some settings where
3 there's an access issue we might consider that, combining the surgical
4 payment and the hospital payment in response to this. I think we need
5 a bigger issue to go to that kind of conclusion.

6 DR. MILSTEIN: I hate to be repetitive in my comments, and I
7 think my comments do reflect, I'll call it the perspective and perhaps
8 relative desperation of my constituency, people purchasing health care.
9 But I'd obviously like to, as you might expect, applaud the more
10 innovative recommendation. I think it aligns beautifully with what the
11 IOM is telling us about the need for payment reform, and then giving
12 the delivery system flexibility as to how a given service is
13 manufactured.

14 It also would dovetail beautifully with an extremely
15 progressive initiative by the American College of Surgeons called their
16 surgical complications improvement program, which essentially is
17 building off a highly successful risk-adjusted outcomes monitoring
18 program for surgery that was pilot tested by the VA and is now firmly
19 ensconced, generated big improvements. So they've now teed that up and
20 they have it ready to go outside of the VA. But the history of the
21 uptake of these programs is that if there isn't any economic incentive
22 to go through the agony of information collection and reporting, the

1 uptake has historically been very disappointing and resulted in a
2 number of cases in progressive specialty societies shutting down a
3 system just do to lack of subscription.

4 So I think the time is right, and I certainly agree with
5 comment that it's a big change, it's a big recommendation relative to
6 the scope of what we were asked to answer. But I think we need to be
7 opportunistic and the hour is late.

8 MR. HACKBARTH: Let me just pick up on that for a second. My
9 concern about the more conceptually attractive approach of bundling
10 everything together is not so much it's scale relative to the mandate,
11 but rather it's scale relative to the resources available to do it. My
12 take on this is that CMS has other fish to fry that are of greater
13 importance right now than reshuffling this particular deck. Reasonable
14 people can disagree on that, but that is my particular take.

15 MR. SMITH: I end up where you do on that one. I prefer the
16 preferred solution, but I think that is an awful weak mule to try to
17 carry this large a recommendation.

18 But I do wonder, David, you're right, the law doesn't give us
19 any particular guidance here, but wouldn't the inference be that these
20 folks are more like people who can now bill separately than like those
21 who can't now bill separately, and that we talked about when we talked
22 about the surgical assistants and the orthopedic?

1 MR. GLASS: Everyone else can not now bill separately who
2 isn't on the list.

3 MR. SMITH: I understand.

4 MR. GLASS: But in the sense that they are licensed in states
5 --

6 MR. SMITH: That they're licensed in all states, they have
7 some specialized training to serve as a surgical first assistant.

8 MR. GLASS: Yes.

9 MR. SMITH: Actually, I think a recommendation that said,
10 yes, they ought to be able to bill separately is more consistent with
11 the notion that we ought to allow the providers to organize the
12 manufacture of the service in the way that they think fits best, and
13 that there is no particular reason to exclude this group of nurses with
14 advanced training beyond the licensure, from participating as a
15 physician's assistant or an otherwise now eligible individual can. So
16 I would be inclined, with exactly the same argument that you lay out,
17 to come to a slightly different conclusion based on equity grounds.

18 DR. WAKEFIELD: I'd just say on the front end, I agree with
19 David. I just wanted to comment on Arnie's point and yours, I think
20 your comment about, clearly CMS has bigger fish to fry than moving
21 toward picking up maybe the preferred solution. But I don't see CMS
22 pursuing this draft recommendation anytime soon either, not that I'd

1 have a clue about how their internal workings operate. But I would be
2 shocked if they moved into trying to develop explicit criteria around
3 licensure, education and experience of different types of non-physician
4 providers. If they do it in this century I would be surprised, in part
5 because of your argument. That is, they've got so many other things.
6 So I don't see this as any more palatable than the other, first of all.

7

8 To me there seemed to be this underlying issue that you
9 talked about about bad policy. That is, that we've got redundancies in
10 payment built into the system already. That is part of what we could
11 use this to talk about. Notwithstanding David's earlier remark too but
12 there is that inherent, it seems duplication of payment, although you
13 caveat it a little bit in the text, can be thought of as duplicative.
14 It sounds like it is. So that is another issue.

15 I guess all I'm saying is, I personally am not compelled by
16 the draft recommendation that we've got here. In the short term I'd
17 agree with David about another alternative, but still there are these
18 other big issues out there.

19 MR. BERTKO: I can only say amen to Mary's last comment, that
20 if we go forward with anything except status quo we've got to equally
21 emphasize being budget neutral.

22 DR. REISCHAUER: I think I asked this same question the last

1 time we were in a topic like this, which is, do we have any idea what
2 private plans do, the extent to which they separately reimburse?

3 MR. GLASS: Yes, some do, some don't. In 10 states they have
4 to reimburse.

5 DR. REISCHAUER: They're required to. Am I right in
6 inferring from what you say that for virtually all procedures, a
7 minority involve a physician assistant of any kind? I mean, an
8 assistant in surgery of any kind?

9 MR. GLASS: No, that is not quite right. There are certain
10 procedures that --

11 DR. REISCHAUER: Always have them?

12 MR. GLASS: Yes, the American College of Surgeons says should
13 always have been. But they are not often separately billable. They're
14 not always separately billable people. They could be a CRNFA who works
15 for the hospital, and they wouldn't be separately billable, but they're
16 still assisting at surgery. We don't have visibility of how often that
17 happens.

18 DR. REISCHAUER: But we don't know how often that is.
19 Because I'm sitting here trying to square the current procedure and
20 what we are considering with our mantra, which is we want to pay the
21 efficient provider. If 80 percent of the cases it's done without an
22 assistant and 20 percent it isn't, then you have to say, which is

1 efficient?

2 We don't know enough to know the answer. The assistant could
3 be there to improve quality, could be there to make the surgeon's job
4 easier so he can get on the golf course, could be there because the
5 hospital wants to make the procedure faster so it can run more things
6 through the operating room. In some sense we need to know the answer
7 to that before we know what our policy should be with respect to paying
8 in a way other than that budget neutral.

9 DR. NELSON: I don't have any problem with the preferred
10 solution if the combined global surgical professional fee and hospital,
11 if the check is written out to the surgeon. There are indeed a lot of
12 surgeons, or some surgeons who enjoy working for the hospital. But
13 there are a lot who don't. I think if we even hint at that being a
14 preferred solution, we are stirring up trouble that we just don't need
15 right now.

16 MR. DeBUSK: I agree with David and Mary and some of the
17 others around the table. These people have the license, they have the
18 education, and they certainly have the experience, and today we are in
19 major need of these kinds of people in the medical setting. I don't
20 see how we can turn them down if we're going to let these other people
21 be paid.

22 DR. WOLTER: Just a clarification. The idea was that all

1 surgical fees for all surgical procedures, whether or not there was a
2 first assistant, there be a combined global fee created, or was it for
3 only those where there was a first assistant?

4 DR. MILLER: You could do it either way. I think the
5 presumption when we talked about this would be to identify the
6 procedures that most often use the first assistant, at least as a
7 starting point.

8 MR. MULLER: The issues we'll discuss tomorrow morning on
9 specialty hospitals now being every hospital in America, and the issues
10 of whether there is conflicts of interest and concerns about excessive,
11 inappropriate utilization would be exacerbated to every OR in America,
12 so I think it's just you have to look at the elegance of global fees
13 against the reality of how it affects economic incentives very
14 powerfully. So I could just as easily argue that this creates enormous
15 possibilities of changes in utilization in ways that we are not looking
16 to increase.

17 MR. HACKBARTH: I think the point made by Mary and Dave and
18 others about the practicality, if you will, of asking CMS to establish
19 criteria is a good one, which leads you to the conclusion, since they
20 do meet the licensure threshold, unlike some of the others that we have
21 looked at recently, saying let them in, but make it budget neutral. I
22 see some nods that that might be a way to go. Could I get just a

1 tentative show of hands? This isn't our official vote on this, but I
2 want to be able to give direction to the staff for the next meeting.
3 Who would like to see us move in that direction?

4 [Show of hands.]

5 MR. HACKBARTH: I know we have a couple who still like the
6 more complete, conceptually clean solution.

7 MR. DURENBERGER: I don't know that I've heard any solution
8 around here other than the one that we were asked to address and which
9 you've modified. I am more concerned about the report language than
10 anything else, because the best part of the preferred solution is the
11 global outcome, because that is the way beneficiaries are going to look
12 at this. If we care about the beneficiaries as much as we do the 1,700
13 CRNFAs than the most important thing is the global outcome from the
14 beneficiaries' standpoint. We're not there yet, but as an organization
15 that is what we ought to speak to.

16 Then we ought to speak to the example of the American College
17 of Surgeons and the pilots and so forth, and then work our way down to
18 whatever the recommendation would be. All I'm saying is I'm not
19 certain as I sit here today which way I'd vote on that.

20 I have a dear friend, high school classmate who swears his
21 life was saved by one of these people, because she not only was with
22 him in surgery, she stayed with him when the doctor wouldn't be with

1 him and things like that, while he was recovering and helped him with
2 his therapy and a bunch of things like that. So I am sure if he were
3 here he would want me to side with --

4 But I would just like to stress the conversation that went
5 around the table which is, this is not the donkey, this is not the
6 camel, but the global is the direction that the payment system should
7 be going if we are thinking about beneficiaries. So I am speaking
8 largely only to the report language that goes with whatever the
9 recommendation we come up with.

10 MR. SMITH: It might be possible to do both, to lay out the
11 argument that David just did, not join the issue that Alan correctly
12 says we're not ready to join, and still make the equity point about
13 reasonably similarly situated folks who ought to be able to get paid
14 for doing the thing that their colleagues can do, and we can do that in
15 a budget neutral way. It seems to me we can say, we wished you'd asked
16 us a different question. We wished times were different so that you
17 asked us different questions. You didn't. But here's what we would
18 have said if you had. In the meantime, here's an answer to the
19 question you did ask us.

20 MR. HACKBARTH: Again, let me just draw a distinction. I
21 wouldn't have any qualms in principle about responding to this question
22 with a comprehensive solution. It's not the narrowness of the question

1 that takes me away from that. What takes me in a different direction
2 is, I don't think, as appealing as this is, and I don't deny that, I
3 don't put it at the top of my list of priorities for people to invest
4 time and effort at CMS. Having been there I guess I have some sympathy
5 for what we ask of them, and we ask way more than they can reasonably
6 produce.

7 DR. MILSTEIN: Just to get a sense of, if we were to move in
8 the direction of the more innovative recommendation, in terms of
9 calibrating the degree to which it is an opportunity to learn versus a
10 complete overhaul of how Medicare pays for surgeries, maybe you said
11 this earlier but if so could you just remind me, what percentage of
12 total Medicare inpatient spending for surgery for the procedures for
13 which this is absorbed by the procedures to which this question of a
14 first assistant applies? Is first assistant at surgery 10 percent of
15 Medicare surgery or 90 percent?

16 MR. GLASS: I can't answer that directly because we don't
17 know -- if there isn't a separately payable person doing it, we don't
18 know if it happened. But for those procedures that the ACS said should
19 almost always have a first assistant, 36 percent had a separately
20 billable first assistant. We're assuming the other 64 percent had a
21 first assistant but they weren't separately billable because they're a
22 resident or they're a CRNFA or something else. The American College of

1 Surgeons says 1,700 different procedures should always require one, and
2 then there was some number that sometimes should and 1,700 or something
3 that should never have one. But I don't know how many that means in
4 terms of how many of those each happened a year. We could find that
5 out if you want.

6 DR. MILLER: In some of our conversations back and forth you
7 had said that at one point in time there was a proposal for a
8 demonstration of sorts on this. Can you just remind what that was?

9 MR. GLASS: This being pay CRNFA, in a Senate amendment which
10 actually later became our study, it was first a demonstration program.
11 It was to be in five states for three years and then an assessment made
12 of its cost-effectiveness and quality of CRNFA versus other people
13 doing first assisting. So that demonstration was in the Senate
14 amendment. It wasn't in the final version. It got changed into us
15 doing a study of it instead.

16 Now I think there is also a demonstration of this bundling of
17 surgeon and hospital fees is underway, though I'd have to check on that
18 to see if that's affecting payment or something else. But I think
19 there's something called the Virginia study. So there is a
20 demonstration on the bundled I think, but I'd have to check on the
21 details.

22 MR. HACKBARTH: It might be interesting to hear more about

1 that next time.

2 DR. CROSSON: Let me just ask with respect to this issue, if
3 we were to allow them to bill separately, what would budget neutral
4 mean in that context? I can't tell from this whether the expectation
5 is that they save money or they cost money, and how we would --

6 DR. MILLER: Part of the reason why it's hard to say that is
7 because although you see the physician first assistant expenditures
8 going down, it's hard to tell whether that's a secular trend of not, or
9 whether there's truly a substitution here. So part of judging the
10 budget neutral also requires making a judgment of whether that's a
11 trend or whether there's a substitution there. I think honestly we
12 don't know. It may be some of both. So that's one comment.

13 Another part of your question is, budget neutral, what does
14 that mean? There's really only two ways I think this can work, and I'm
15 thinking out loud here. But one way to make it budget neutral is you
16 make an estimate of what the expenditures would be under this and then
17 you take it out of the hospital payment, or you take it out of the
18 physician payment, although that's a little bit more difficult because
19 that's paid on a per-service type of basis.

20 MR. SMITH: Or you move 85 to 82.

21 MR. GLASS: Or I think we proposed in an earlier, the one
22 that had to do with the nurse midwives, that you adjust the conversion

1 factor to make it budget neutral. To the extent that they are
2 replacing residents, I guess you could argue take it out of GME.

3 MR. HACKBARTH: Any other thoughts on this?

4 We will revisit this again next time. Let us digest the
5 comments and try to come back with something that reasonably takes most
6 of them into account.

7 I think that's it for today except for the public comment.
8 So now we will have our brief public comment period.

9 * MS. CREIGHTON: Good afternoon, members of the Commission and
10 the staff. My name is Marlene Creighton. I'm from Buffalo, New York.
11 I'm a certified registered nurse first assistant. I had some comments
12 that I wanted to make to you in general, but in listening to your
13 conversation, would it be possible for me to take a few minutes and
14 help answer some of the questions that you asked that are relatively
15 easy to answer, but were apparent to me that maybe you had not had all
16 the information?

17 For example, when an assistant is working at a surgical
18 procedure, I do this about 10, 12 hours a day, whether or not an
19 assistant is billed for is determined already by the insurance
20 companies via a good coding system called current procedural
21 terminology. Only certain procedures are reimbursable.

22 So for example, if there's a total hip procedure taking

1 place, very large complicated procedure, the insurance company will
2 reimburse for an assistant at surgery. If I am there as a registered
3 nurse first assistant, the insurance company will not reimburse for my
4 services. However, if another non-physician, such as a physician
5 assistant is assisting on that total hip. the insurance company will
6 reimburse for his services. And of an M.D. is assisting. the insurance
7 company will reimburse that physician at a higher rate than they did
8 the non-M.D.

9 I am a hospital-employed registered nurse first assistant. I
10 do many cases in a string, and sometimes it's a total hip, followed by
11 a total knee, followed by an excision of a ganglion. If I remain in
12 the room with the surgeon who's during the excision of a ganglion to
13 help facilitate the case, make it go faster, help it be more safe,
14 insurance companies will pay no one as an assistant on a ganglion.

15 So if you're looking for the data as to how much money this
16 will cost to pay an assistant at surgery, Medicare has already
17 determined when and how much they will pay assistants at surgery.
18 Medicare is already paying for the service. The inequity is, if I
19 happen to be the assistant, Medicare will not reimburse for my
20 services.

21 So what we are trying to help you understand is that we as
22 nurses and RN first assistants are a cost-effective entity that is out

1 there that Medicare presently is not taking advantage of. Last night I
2 was at the hospital. My mother was hospitalized and I was there, and
3 at 8:00 o'clock a patient had to come back to have an evacuation of a
4 bleeding hematoma from their abdomen. The surgeon called and said, I'm
5 bringing this patient back. I need one of those RNFAs; are any of them
6 around? I was there. Had I not been there, he would have called
7 someone else to assist him. Medicare would have paid someone to be the
8 assistant.

9 Does that help?

10 MR. HACKBARTH: Actually, it may not have been evident from
11 our conversation but we really did understand that. So we appreciate
12 the reinforcement, but we do understand the nature of the problem.

13 MS. CREIGHTON: So that is basically our request. We are not
14 asking that a new payment be made. We are only asking that whatever
15 your decision is, whether you continue with the present methodology of
16 payment, or you decide to move to the payment in a global fee, we are
17 asking that your recommendation is that a registered nurse first
18 assistant should be included as an eligible receiver of first assistant
19 at surgery services. Not new payment; those that are already being
20 made.

21 Thank you.

22 MS. McELRATH: I'm Sharon McElrath. I didn't really want to

1 get up on this issue but I feel I have to. For those of you who
2 weren't here two years when this came up and the same proposal was
3 before the Commission and it was then turned down because the American
4 College of Surgeons and the American Medical Association circulated a
5 letter that was signed by virtually every medical specialty opposing
6 the approach of bundling these fees, I just would remind you that
7 you're stirring up a lot of consternation out there at a time when
8 people are already facing 30 percent in cuts from Medicare payments
9 over the next several years. So if you are going to take the payment
10 from somewhere, I don't think there's going to be a lot left in the
11 physician payment to get it from.

12 Just in terms of the budget neutrality, I would say that you
13 should keep in mind that we're under the SGR. So if new stuff is
14 moving over on the physician side, it's just going to lead to bigger
15 and bigger cuts. So in some sense there's a budget neutrality there
16 already.

17 I did also want to comment on the survey and just say that
18 one of the issues that came up this year was that you have to have an
19 even bigger response rate if you want to not combine data. In the past
20 we got around the response rate problem --

21 MR. HACKBARTH: This is the practice expense?

22 MS. McELRATH: This is the practice expense, the SMS.

1 In the past, CMS got around the size of the data by combining
2 a number of years of data. But since it will have been at least five
3 years between surveys, then whether you want to really be combining
4 practice expense data from 2005 with 1998, 1999, 2000 is a question.
5 CMS would like to be able to at least have the option of not combining
6 that data.

7 So it means that you need a much bigger response rate. It
8 means that you have to have a much more expensive survey. That became
9 the issue. We did have a lot of discussions with CMS. It might have
10 been possible to work things out if there had been more time in their
11 budget year. But what really became the problem was the issue of
12 whether in the current environment you can get a response rate with a
13 reasonable cost attached to it.

14 MR. HACKBARTH: Thank you.

15 We will reconvene at 9:00 a.m.

16 [Whereupon, at 4:29 p.m., the meeting was recessed, to
17 reconvene at 9:00 a.m., Friday, September 10, 2004.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 10, 2004

COMMISSIONERS PRESENT:

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

AGENDA

Mandated report on specialty hospital (Legal
overview, description of specialty hospitals, site
visits, markets, payer mix)
-- Ariel Winter, Carol Carter, Jeff Stensland

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Results of hospital charging practices survey
-- Chantal Worzala, Jack Ashby

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State lessons on the drug card
-- Jack Hoadley, NORC, Joan Sokolovsky

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Public comment

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P R O C E E D I N G S

1
2 MR. HACKBARTH: Good morning.

3 First on our agenda this morning is the mandated report on
4 the specialty hospitals.

5 * MR. WINTER: Good morning.

6 The Medicare Modernization Act requires us to study the issue
7 of physician-owned specialty hospitals. The report is due in March of
8 next year.

9 Specifically, we're required to compare costs of care of
10 physician-owned specialty hospitals to community full service
11 hospitals, compare the extent to which type of hospital treats patients
12 in specific DRGs, compare the mix of payers for each type of hospital,
13 analyze the financial impact of specialty hospitals on community
14 hospitals, and finally examine whether the inpatient prospective
15 payment system should be revised to better reflect the cost of care.

16 Today's presentation will include four topics. I will
17 provide an overview of the federal laws governing physician investment
18 in the hospitals and other facilities and also discuss strategies used
19 to align physician and hospital financial incentives. Carol will then
20 describe the characteristics of physician-owned specialty hospitals and
21 the markets in which they are located. Jeff will present preliminary
22 data from our analysis of payer mix. And finally, Carol will discuss

1 the findings from our site visits to three markets with specialty
2 hospitals.

3 Our discussion of the legal restrictions on physician
4 investment in health care facilities is based on research conducted by
5 Kevin McAnaney for MedPAC and I want to thank him for his excellent
6 work.

7 This topic is important because the context for our report is
8 the Medicare Modernization Act's moratorium on physician investment in
9 new specialty hospitals.

10 In addition, these laws relate to other services the
11 Commission has examined, such as outpatient imaging.

12 First, we'll look at the arguments put forth by critics and
13 supporters of physician ownership of health care providers. We will
14 then discuss the major federal laws in this area, the anti-kickback
15 statute and the Stark law. Finally, we'll review strategies used by
16 hospitals to align their financial incentives with those of physicians
17 and how these approaches are constrained by federal laws. Some of
18 these approaches are relevant to the specialty hospital issue.

19 Supporters of physician ownership contend that physicians are
20 a valuable source of capital for health care facilities. They also
21 argue that physician investments can improve quality, efficiency and
22 access to care. For example, physicians with a financial stake in an

1 ambulatory surgical center or hospital may have a greater incentive to
2 streamline operations.

3 On the other side, there are generally three rationales for
4 restricting physician investment in facilities to which they refer
5 patients. First, several studies by GAO, the OIG and other researchers
6 have found that physicians with a financial interest in ancillary
7 equipment and facilities have higher referral rates for those services
8 than other physicians.

9 Second, there is a concern that physician ownership could
10 improperly influence professional judgment. Ownership creates a
11 financial incentive to refer patients to the facility owned by the
12 physician which may or may not be best for the patient. There could
13 also be incentives to refer patients for too many services and to
14 economize on care in ways that reduce quality.

15 The third concern is that physician investment could create
16 an unlevel playing field between facilities. Physician-owned providers
17 could have a competitive advantage over other facilities because
18 physicians influence where patients receive care.

19 The anti-kickback statute was enacted in 1972 and has been
20 amended several times since. It prohibits offering or receiving
21 anything of value to induce the referral of patients for services
22 covered by federal health programs. Violators can be subject to

1 criminal penalties, civil monetary penalties, and exclusion from the
2 Medicare and Medicaid programs.

3 The statute applies to all types of services and entities but
4 it requires proof that there was knowing and willful intent to violate
5 the law. It is enforced on a case-by-case basis, which limits its
6 deterrent effect.

7 In the late 1980s, the OIG attempted to apply the statute to
8 physician investments and ancillary facilities to which they refer
9 patients. The OIG's position is that some of the companies organizing
10 these joint ventures are, in effect, buying physician referrals by
11 offering the physicians high returns on modest investments with little
12 financial risk.

13 However, the OIG has been largely unsuccessful at using the
14 statute to restrict physician joint ventures. Such cases are resource
15 intensive, time consuming and face a high burden of proof.

16 These limitations led to the Stark law, which is focused
17 exclusively on financial arrangements between physicians and facilities
18 to which they refer patients. The Stark law prohibits physicians from
19 referring Medicare and Medicaid patients for certain services to a
20 provider with which the physician has a financial relationship.
21 Violators can be subject to denial of claims, civil monetary penalties
22 and exclusion from the Medicare and Medicaid programs, but not criminal

1 penalties.

2 The Stark law goes beyond the anti-kickback statute by
3 prohibiting many types of financial arrangements between physicians and
4 entities to which they refer patients regardless of any intent to
5 influence referrals. Unlike anti-kickback, the Stark law applies to a
6 clearly defined set of services.

7 The original Stark law applied only to clinical labs but
8 amendments to the Stark law known as Stark II extended this prohibition
9 to several other services, which are all listed on the slide. The
10 Stark laws generally prohibit physician ownership of facilities that
11 provide these services. Compensation arrangements between physicians
12 and facilities are usually allowed if the physicians are paid fair
13 market value for their services.

14 The Stark law permits certain financial arrangements based on
15 the belief that they are unlikely to lead to overuse of services. Here
16 are some relevant examples. First, the law allows physicians to own
17 ASCs as long as the ASC does not provide ancillary services. There's a
18 perception that physician investment in ASCs where they perform
19 services involves less risk of overuse because the physician receives a
20 professional fee regardless of where he or she performs the service.

21 Physician who do procedures in ASCs that they own may also
22 receive profits from the facility fees. However, these profits are

1 probably only a small additional financial incentive.

2 In addition, the ASC could be viewed as an extension of the
3 physician's office practice and there's a principle that physicians
4 should have autonomy over their work place.

5 Second, the in-office ancillary exception permits physicians
6 to provide most ancillary services in their own offices. The logic is
7 that there is often a need for quick turnaround time on diagnostic
8 tests, although the exception also applies to other services such as
9 physical therapy.

10 Third, the law protects physician investment in hospitals as
11 long as the interest is in the whole hospital rather than a hospital
12 subdivision. Because hospitals generally provide a wide range of
13 services, the theory is that referrals by an individual physician would
14 be unlikely to have a significant effect on overall profits.

15 The growth of physician-owned single specialty hospitals
16 raises important questions. Because specialty hospitals derive their
17 revenue from a limited range of services, is there a greater
18 opportunity for individual physician investors to influence hospital
19 profits which could affect their referrals? Or is physician ownership
20 of a specialty hospital justified because the hospital may function as
21 an extension of the physician's practice?

22 The MMA prohibited the development of new physician-owned

1 specialty hospitals for a period of 18 months, ending in June 2005.

2 Finally, the Stark II final rule permits physician ownership
3 of entities that provide equipment and services to facilities covered
4 under Stark as long as the physicians don't own a facility that
5 actually bills Medicare. For example, a physician could own an MRI
6 machine and lease it to an imaging center for a fixed amount per use.
7 Every time the physician refers a patient to the imaging center for an
8 MRI, he or she receives a fee from the imaging center for the use of
9 the equipment. This creates the same financial incentives as direct
10 physician ownership of the imaging center.

11 So far we have focused on the physician perspective. Now
12 we're going to look at strategies used by hospitals to align their
13 financial incentives with those of physicians and the legal constraints
14 on those activities.

15 One approach we've already talked about is offering
16 physicians an ownership stake in the hospital. Aside from specialty
17 hospitals, there's broad protection under the Stark law for this type
18 of arrangement. Other strategies include medical practice support,
19 acquisition of physician practices, partnering with physicians and
20 economic credentialing.

21 Medical practice support can include help with recruiting
22 physicians, subsidized office space and low interest loans. These

1 activities carry legal risk under Stark and anti-kickback if the
2 support is provided for less than fair market value.

3 Another approach is to buy physician practices which provides
4 the hospital with a source of patients. In theory, this vertical
5 integration would also increase the hospital's bargaining power with
6 health plans. The Stark law allows hospitals to control referrals made
7 by employee physicians subject to the patient's own choice and
8 insurance coverage and the physician's professional judgment.

9 This strategy carries legal risk if the hospital
10 overcompensates employee physicians and there have been several
11 expensive legal settlements in such cases. Many hospitals have found
12 this model unprofitable and have divested their physician practices.

13 Another strategy is for hospitals to partner with physicians
14 by co-investing in joint ventures such as ASCs and imaging centers or
15 by creating gainsharing arrangements. In gainsharing, the hospital
16 shares cost savings with physicians who cooperate in efforts to reduce
17 costs. For example, the physicians may agree to use less expensive
18 equipment and supplies.

19 However, the OIG has ruled that gainsharing violates a legal
20 provision prohibiting hospitals from paying physicians to reduce
21 services to Medicare patients. This provision was meant to prevent
22 hospitals from providing financial incentives to physicians to

1 discharge patients quicker and sicker under the inpatient prospective
2 payment system. The OIG said that gainsharing has the potential to
3 improve care and reduce costs but that they need statutory authority to
4 regulate these arrangements.

5 Because of the potential to better align hospital and
6 physician financial incentives, gainsharing may be a productive area
7 for us to do further research.

8 Finally, economic credentialing is an approach in which
9 hospitals restrict staff privileges for physicians who invest in or are
10 employees of competitor facilities. This can take two forms. In some
11 cases, the hospital prohibits its medical staff from having financial
12 relationships with competitors. In others, the hospital requires its
13 staff to admit a certain percent of their patients to the hospital.
14 This strategy has recently attracted fierce opposition from physicians
15 and has been challenged in several state courts.

16 Now we'll move on to Carol's presentation.

17 MS. CARTER: To conduct our study of specialty hospitals, we
18 first had to define them. To meet our mandate, our first criteria is
19 that the hospital has to be physician-owned. The law also specifically
20 discussed hospitals primarily engaged in heart, orthopedic and surgical
21 cases.

22 We developed a criterion of concentration based on Medicare

1 data, since it is the only nationally available dataset. We defined a
2 specialty hospital as having 45 percent of its Medicare discharges in
3 the heart or orthopedic MDC or were surgical cases. Or a hospital
4 could have 66 percent of its cases in two of these categories. This is
5 very consistent with the definition that GAO used on two of its studies
6 last year. They used 66 percent of its cases in two MDCs.

7 To include the hospitals in our study and to make sure that
8 each hospital had enough cases to analyze, we included every hospital
9 that had at least 25 Medicare discharges in 2002. This is also
10 consistent with what GAO did. where they included 20 cases for every
11 hospital. The GAO study also included hospitals that were not
12 physician-owned and also included women's hospitals.

13 Using these criteria, we found 48 hospitals that met our
14 criteria: 12 of them were heart, 25 were orthopedic and 11 were
15 surgical. We know that there's been rapid growth in specialty
16 hospitals and there are an equal number of hospitals that have formed a
17 since 2002. But because we didn't have data on them, we could not
18 study them.

19 Our mandate also required that we compare specialty hospitals
20 to community hospitals. Our first comparison group was any community
21 hospital in the same market. Here we used the Dartmouth Hospital
22 referral regions as our definition of hospitals.

1 We also developed two other comparison groups. First, we
2 looked at hospitals that were identical to specialty hospitals in terms
3 of concentration but were not physician-owned. We called them peer
4 hospitals. Peer hospitals do not have to be in the same market as
5 specialty hospitals.

6 A second category included hospitals that were located in the
7 same market as specialty hospitals and provided similar services as
8 specialty hospitals, and we called these competitors.

9 We first looked at ownership characteristics. All specialty
10 hospitals were for-profit compared with 17 percent of PPS hospitals.
11 Twenty-three percent are partly owned by another hospital. A larger
12 proportion of surgical hospitals were owned by another hospital,
13 compared with heart and orthopedic hospitals.

14 Forty-three percent of specialty house are part of a chain
15 and this is comparable to the share in all PPS hospitals. A larger
16 proportion of heart hospitals are part of a chain than orthopedic and
17 surgical hospitals.

18 On average, 60 percent of the hospital is owned by its
19 physicians but this ranged from 18 percent to the entire hospital.
20 Surgical hospitals had the highest share owned by their physicians,
21 averaging 73 percent, compared with heart hospitals where only 35
22 percent of them were owned by their physicians.

1 The median share owned by a single physician is 4 percent.
2 There was a large range in the individual shares owned. At a third of
3 the hospitals, the largest share was 2 percent or less. And yet at 20
4 percent of the hospitals the largest share was 15 percent or more.

5 More heart hospitals had smaller shares owned by a single
6 physician.

7 Looking at location, we found that the specialty hospitals
8 are not evenly distributed across the country. Ninety-four percent are
9 located in states without certificate of need. Specialty hospitals are
10 concentrated in certain states. We found 59 percent were located in
11 just four states: Kansas, Oklahoma, South Dakota and Texas. Some of
12 these state have much larger shares of specialty hospitals than they do
13 of PPS hospitals. For example, South Dakota has less than 1 percent of
14 PPS hospitals but has 16 percent of specialty hospitals. Kansas has 2
15 percent of PPS hospitals but 12 percent of specialty hospitals.

16 We've noted that newly formed specialty hospitals that are
17 not part of this analysis also tend to be located in the same states
18 and often in the same markets.

19 Licensure laws may facilitate where hospitals locate. Some
20 states, such as Kansas and South Dakota, have two categories of
21 hospital licenses. There specialty hospitals do not have to offer a
22 full array of services to be licensed as a hospital. Other states

1 preclude their development, such as Florida. And not all states
2 require emergency rooms or emergency departments.

3 When we looked at the characteristics of the hospital
4 locations, we found that specialty hospitals tended to be located in
5 mid-sized MSAs that have larger population growth, a lower proportion
6 of elderly, lower managed care penetration, and similar poverty and per
7 capital incomes.

8 Their MSAs also tend to have fewer beds and fewer surgical
9 specialists per capita. And there was a little bit of variation by the
10 type of specialty hospital market. Heart hospital MSAs tend to locate
11 in high managed care penetration areas and do not have low surgical
12 specialists per capita.

13 The beneficiaries in MSAs with and without specialty
14 hospitals had comparable health status and service use.

15 Turning to hospital characteristics, the first thing to note
16 is that specialty hospitals are small. The average heart hospital has
17 52 beds. The average orthopedic and surgical hospital has about 15.

18 Two-thirds of Medicare cases are treated in specialty
19 hospitals that are heart hospitals. Once specialty hospital is a
20 teaching hospital and about six receive disproportionate share
21 payments.

22 About half the specialty hospitals have an emergency

1 department but there is considerable variation across the different
2 types of specialty hospitals. Two-thirds of heart hospitals have an
3 emergency department but only one of the surgical hospitals did.

4 Regarding their staffing, all of the heart hospitals staff
5 their emergency departments with physicians night and day, compared
6 with only one orthopedic hospital and no surgical hospital. At these
7 other specialty hospitals, they use a mix of physicians in the hospital
8 and on call.

9 When we looked at the mix of patients treated at specialty
10 hospitals, we see quite a bit of concentration. Heart hospitals are
11 more focused on heart care and within heart care the specialty
12 hospitals were more focused on surgeries and procedures.

13 At heart hospitals, 66 percent of their heart cases are
14 surgical compared with 40 percent at their competitors and 29 percent
15 at community hospitals. Thirty-three percent of specialty hospitals
16 are medical cases compared with 71 percent at community hospitals.
17 Over one-third of the cases at heart hospitals are coronary artery
18 bypass grafts and angioplasties compared with 19 percent at competitors
19 and 14 percent at community hospitals.

20 Looking at specialty hospital market shares, we found that
21 specialty hospitals account for a much larger share of the surgeries
22 and procedures done in their markets than their overall market share.

1 For example, heart hospitals treated 4.5 percent of the cases in their
2 markets but performed over a quarter of the local angioplasties and
3 CABGs.

4 Given their smaller size, orthopedic and surgical hospitals
5 play a smaller role in their markets. But even here, they treat a much
6 larger share of the orthopedic cases in their markets compared to their
7 overall market share. For example, they treated 1 percent of their
8 market cases but almost 5 percent of the orthopedic surgery cases.

9 DR. REISCHAUER: Excuse me, Carol. Are these Medicare-only
10 numbers?

11 MS. CARTER: Yes, they are.

12 Now, Jeff's going to talk about payer mix.

13 DR. STENSLAND: The Medicare Modernization Act requires that
14 MedPAC compare the payer mix of physician-owned specialty hospitals to
15 full-service community hospitals. We also compare physician-owned
16 specialty hospitals to the set of peer hospitals that Carol described
17 earlier.

18 First, we'll look at why would payer mix differ and then
19 we'll take a look at the data.

20 The payer mix of physician-owned specialty hospitals may
21 differ from the community hospitals for several reasons. First,
22 starting at the upper left-hand corner of this slide, we have patient

1 selection. Community hospitals frequently assert that physicians have
2 a financial incentive to send profitable patients to their hospital and
3 unprofitable patients to the community hospital.

4 Second, we have types of services offered. For example, if
5 the specialty hospital does not offer obstetric services, it may have a
6 lower than average share of Medicaid patients.

7 Third, emergency room services. If a hospital does not have
8 a staffed ER, it may receive fewer indigent patients.

9 Fourth, there's simply the geographic location of the
10 hospital.

11 And fifth, community hospitals may try to freeze out
12 physician-owned hospitals from private payer contracts. If a community
13 hospital is successful in obtaining an exclusive preferred provider
14 contract with a large insurer, the specialty hospital may have
15 difficulty attracting patients with that type of private insurance.

16 Now let's take a look at the data. First, we examine cost
17 report data on hospital discharges. The table shows that physician-
18 owned heart and orthopedic hospitals tend to have lower Medicaid shares
19 than community hospitals in the same markets. Heart hospitals tend to
20 have a high share of Medicare patients while orthopedic hospitals tend
21 to have an average share of Medicare patients.

22 There are couple of limitations in the cost report data.

1 First, Medicare cost reports don't have data on self-pay patients.
2 They are lumped together with privately insured patients in that all
3 other category of patients you see on the right-hand side of the slide.

4

5 Second, the differences we see in Medicaid shares may be
6 just due the types of services provided by the hospital. To address
7 these limitations, we conducted a survey of 134 hospitals that met our
8 criteria for being either a physician-owned specialty hospital or a
9 peer hospital. Using survey data, we compare physician-owned specialty
10 hospitals to peer hospitals that focus on a similar set of services.

11 This slide differs from the prior table in several ways.
12 First, we're using survey data. The hospitals are self-reporting their
13 fields of clinical specialization and self-reporting their payer mix.
14 Second, we are measuring payer mix by examining net patient revenue
15 rather than discharges. Third, we're focusing just on heart hospitals
16 on this slide.

17 We find that physician-owned heart hospitals tend to have
18 lower Medicaid shares than peer heart hospitals. This holds true for
19 physician-owned hospitals with an ER and those without an ER. We do
20 not see big differences in the revenue from self-pay patients.

21 Of course, hospitals may have a small share of net patient
22 revenue from self-pay patients either due to treating few self-pay

1 patients or due to collecting little from the self-pay patients they
2 treat.

3 Now, we'll turn to the orthopedic and surgical hospitals.

4 From this table, we see that physician-owned orthopedic and
5 surgical hospitals tend to have lower levels of Medicaid revenue than
6 their peers who describe themselves as orthopedic or surgical
7 hospitals. However, we should caution that there's a high level of
8 variance in the Medicaid shares for peer, orthopedic and surgical
9 hospitals. A few nonprofit orthopedic and surgical hospitals have very
10 high Medicaid shares but many peer hospitals have Medicaid shares of 3
11 percent or less. The 9 percent Medicaid share shown on the slide for
12 peer hospitals is the mean value for this highly variable group.

13 Orthopedic and surgical hospitals tend to receive a majority
14 of their revenue from patients with private insurance. Physician-owned
15 peer hospitals often have similar levels of net revenue from self-pay
16 patients.

17 To summarize our payer mix findings, first physician-owned
18 specialty hospitals tend to have lower Medicaid shares than both
19 community hospitals in their market and peer hospitals that provide
20 similar services. However, it should be noted that there's a wide
21 variance in the Medicaid shares among peer, orthopedic and surgical
22 hospitals. Heart hospitals tend to have high Medicare shares.

1 Orthopedic and surgical hospitals tend to have high shares of patients
2 with private insurance.

3 These findings are consistent with earlier work by the GAO
4 and consistent with what we found on site visits to communities with
5 physician-owned hospitals.

6 Carol will now talk about those site visits.

7 MS. CARTER: As part of our study, we conducted site visits
8 to three markets with specialty hospitals to hear from stakeholders
9 about the issues surrounding specialty hospitals and about the impact
10 specialty hospitals have had on community hospitals. We visited
11 Austin, Wichita and Manhattan, Kansas, and Sioux Falls, South Dakota.

12 We picked our sites to be geographically diverse, represent a
13 mix of types of specialty hospitals within a single site, and include
14 hospitals that had been around long enough to hear about the impacts on
15 community hospitals.

16 Each of our sites included a heart hospital because even
17 though they represent only one-quarter of specialty hospitals, they
18 treat two-thirds of the Medicare cases seen at specialty hospitals.

19 At each site we spoke with a mix of physicians, some
20 practiced at both types of facilities, some only at community
21 hospitals. We talked with hospital CEOs, CFOs, and in markets where
22 the specialty hospitals had emergency rooms, the city's director of

1 emergency medical services.

2 The hospitals were generous with their time in preparing
3 materials for us and in making people available to us during our
4 visits.

5 I'd like to emphasize here that what we're reporting here is
6 what physicians and the hospital personnel told us, much of which we
7 could not verify. There were large discrepancies in what we heard.
8 Some of the issues, such as case selection, will be examined in detail
9 later in other analysis and we'll present it later this fall.

10 The physicians we spoke with told us they set up specialty
11 hospitals for two reasons: governance and opportunities to increase
12 their income. The most frequently mentioned reason was governance.
13 Physicians wanted to control decisions made about the patient care
14 areas of the hospitals so they could improve their productivity,
15 improve the quality of care provided and make the hospital more
16 convenient to them and their patients.

17 At hospitals that had started at ASCs, the facilities worked
18 so well they wanted to expand their practices into patient care areas
19 that required overnight stays.

20 We repeatedly heard about the frustrations physicians had
21 with community hospitals. Many physicians said they tried to work with
22 the community hospitals but that decision making took too long and did

1 not support their practices. Some physicians acknowledged that
2 community hospitals had multiple priorities, which the appreciated but
3 did not want to compete with.

4 Many community hospital administrators acknowledged they had
5 been slow to react to the issues raised by their physicians. Less
6 frequently we heard about physicians wanting to generate more revenue
7 to counter perceived declines in their incomes.

8 Specialty hospitals created three kinds of opportunities for
9 physicians. The first is increased throughput. They can treat more
10 cases in a given amount of time. For investors, most older facilities
11 pay out annual dividends, frequently in excess of 20 percent. The
12 third is they can capture the facility portion of payments.

13 There was considerable variation in how important governance
14 versus ownership was to physician involvement. Several physician
15 investors we spoke with said that ownership had not been key to their
16 decision and they would have been content to have the community
17 hospitals address their concerns.

18 The first order of business in developing a specialty
19 hospital is to secure a core set of admitters. Usually, at the
20 hospitals we visited, the key admitters were owners. Physicians
21 typically sought financing for 70 to 80 percent of the cost of the
22 hospitals. Banks often wanted to see evidence of physician commitment

1 in the form of physician investment before loans were made. Rather
2 than find all of the equity themselves, physicians often turned to
3 outside investors. Particularly at the start of facilities, physicians
4 wanted to minimize their risk and outside investors -- often non-
5 physicians, sometimes a national chain and sometimes a local hospital
6 were sought. More often the investors were local business people.

7 In these cases, physicians made small investments, typically
8 on the order of \$25,000 to \$50,000. When owners sell their shares, for
9 example when they retire from practice, the shares are generally sold
10 to other physicians. A couple facilities noted they expected their
11 physician investors to bring at least some of their volume to the
12 specialty hospital.

13 The specialty hospitals we visited usually required their
14 physicians to have privileges at a community hospital. As a result,
15 physicians could admit certain types of cases to one hospital and other
16 cases to another. Physicians practicing at most specialty hospitals
17 accept restrictions on the range of supplies, stents, implant devices,
18 restrictions physicians told us they had resisted when they practiced
19 at the community hospital.

20 Many of the specialty hospitals we visited did not have
21 emergency rooms, which increases their control over admissions. But
22 even having an emergency room didn't mean the hospital was ready to

1 treat emergencies. At one hospital we visited, it had to turn on the
2 lights of its emergency room to show us the space.

3 However, at two of the four heart hospitals we visited had
4 emergency rooms and were fully staffed day and night. They accepted
5 cardiac and non-cardiac cases. Another heart hospital we visited is
6 planning to open an emergency room.

7 Many physicians practicing at orthopedic and surgical
8 specialty hospitals acknowledge that they selected patients who were
9 appropriate for their facility. Some couch selection in terms of
10 specialization and service offerings. The specialty hospital didn't
11 have certain services so the physician couldn't responsibly admit
12 patients who might need them.

13 Physicians practicing at heart hospitals more frequently
14 disagreed about patient selection. Some said they admitted medically
15 complex cases to community hospitals. Others said they didn't
16 selectively admit cases to one type of hospital or another.

17 Data from one heart hospital chain indicated that fewer of
18 its patients were classified into the highest severity patient groups
19 compared with community hospitals.

20 There was a lot of disagreement about transfers. Community
21 hospitals complained about two types of transfers: cases that were
22 stabilized and then transferred to the specialty hospital where

1 physicians had an ownership share for the procedure or surgery. And
2 the second type were cases where the course of care didn't go well and
3 the case was transferred to a community hospital. Data from one
4 community hospital showed that one-third of its transfers from
5 specialty hospitals died.

6 Specialty hospitals uniformly denied selecting cases based on
7 payer mix but the specialty hospitals we visited had much lower
8 Medicaid shares and provided less uncompensated care. One physician
9 told us the specialty hospital had used the lack of uninsured patients
10 as a marketing pitch to him.

11 Some selection may be a function of the referral base of the
12 physicians. The specialty hospital may take all comers, but their
13 referring physicians don't.

14 Service mix may be another explanation. For example,
15 hospitals that don't have obstetric services or an ER will have a
16 different mix of payers.

17 Turning to the impact of specialty hospitals on community
18 hospitals, many site visit community hospitals reported large initial
19 declines in volume associated with specific physicians who had moved
20 their practices to specialty hospitals but that overall volume declined
21 only slightly and mostly had recovered.

22 Surgical and orthopedic specialty hospitals had much more

1 varying impacts, depending on the size of the community and the number
2 of other hospitals in it. The replacement volume was reported to be
3 less profitable. Most of the hospitals remained profitable.

4 In rural markets, volume declines were much more difficult
5 for the community hospitals to rebuild. It was harder for them to
6 recruit physicians and it was unclear if the community hospitals would
7 fully recovered.

8 But community hospitals told us that rebuilding their volume
9 was costly. The costs associated with physicians included signing
10 bonuses, income guarantees and on-call pay, particularly we heard about
11 for neurosurgeons and less frequently orthopedists. The costs
12 associated with staff included retention bonuses for key staff members
13 and offering raises to staff working the less desirable shifts.

14 All hospitals we spoke with talked about the hiring away of
15 experienced staff, most often nurses but also pharmacists, radiation
16 technologists and nurse anesthetists who were attracted by the better
17 hours. Replacement nurses at community hospitals were typically recent
18 graduates with much less experience.

19 Some community hospitals also added new operating rooms or
20 new cath labs as inducements for their physicians.

21 Some community hospital administrators told us that the
22 development of a community hospital in their market was like getting a

1 wake-up call to make improvements. The community hospitals we visited
2 responded to the pressure of specialty hospitals by improving their own
3 performance. We heard numerous examples that included extending
4 service hours of the operating room, improving the operating room
5 scheduling and turnaround times, and upgrading their equipment. But
6 community hospitals told us there were limits to the improvements they
7 could make in their efficiency given the wider range and more complex
8 mix of patients that they treat.

9 Some community hospitals talked about the impact of specialty
10 hospitals on the market's health care resources. For example, in
11 Wichita, specialty hospitals had added 13 operating rooms and 130 beds.
12 In Austin specialty hospitals had added 13 operating rooms and 89
13 inpatient beds. It was unclear if the added capacity is meeting unmet
14 need or resulting in induced demand.

15 Some community hospital physicians raised concerns that
16 physician investors were making medical decisions based on economic
17 considerations, treating marginal cases where indications were less
18 clear and perhaps performing surgery instead of pursuing a medical
19 alternative.

20 Hospital relations with private payers varied widely across
21 the markets we visited. Some specialty hospitals had been excluded
22 from some private payer plans but this was unusual. Lower cost at some

1 specialty hospitals had resulted in lower private plan payment rates.
2 One payer noted that even though some of its per-service payments were
3 lower, its total hospital spending could be increasing due to higher
4 utilization.

5 We did not hear consistent differences between the quality of
6 care provided at community and specialty hospitals. Some thought that
7 because the same physicians practiced at both types of hospitals, often
8 using the same protocols, that the technical quality would be similar.
9 Some physicians practicing at specialty hospital thought the quality
10 was higher at specialty hospitals where the nursing ratios were higher.
11 Lower complication, infection and mortality rates at some specialty
12 hospitals could reflect measured and unmeasured differences in the mix
13 of patients they treat.

14 Physicians at community hospitals told us that the lack of
15 diversity in a medical specialties practicing at specialty hospitals
16 would weaken their peer review.

17 We heard about three types of retaliatory activities
18 community hospitals had engaged in. One community hospital had adopted
19 economic credentialing barring its physicians from investing in
20 specialty hospitals and others were considering it. One hospital had
21 included non-compete clauses in its contracts with its physician
22 employees. One community hospital had removed all investor physicians

1 from its ER rotation for unassigned cases, thereby taking away volume
2 from them.

3 In conclusion, though there were distinct differences across
4 specialty hospitals, there were common themes. Specialty hospitals
5 appear to increase physician productivity and present revenue
6 opportunities for physicians. They represent an attractive alternative
7 for patients and their families. And they often stimulated community
8 hospitals to make changes that would make their operations more
9 efficient.

10 But there were concerns raised. First, there was evidence of
11 patient selection, both in terms of the complexity and the payer mix of
12 the patients treated at specialty hospitals. Some of the transfers
13 raised concerns about the quality of care provided by some specialty
14 hospitals.

15 And finally, it was unclear if the expansion of capacity
16 would increase service provision and, if it did, whether this would
17 represent meeting unmet need or inducing demand.

18 MR. HACKBARTH: Thank you. Very well done.

19 This is the first of a series of presentations that we will
20 receive on this issue over the next couple of months. I thought it
21 would be helpful for the Commissioners just for Mark to outline what's
22 to come so you understand where we're going from here.

1 DR. MILLER: I may miss a couple, but we've been asked to
2 think about the payment system issues. And so we are doing work and
3 will be bringing work to you on trying to look at the profitability of
4 DRGs.

5 A way to think about this is many of the same issues that
6 were just implicated in the site visit we're going to be trying to look
7 empirically. So the profitability of DRGs, the selection issues
8 between specialty hospitals and community hospitals, and whether more
9 lesser severe patients. Trying to quantify more precisely the impacts
10 on community hospitals.

11 Also, ideally we would look at differences in the quality of
12 care but I want to be very tentative on that because our ability to do
13 that with these small ends is going to be relatively limited.

14 Did I miss any of the big ones?

15 DR. STENSLAND: Cost differences.

16 DR. MILLER: Right. I lumped that into the community
17 hospital impacts and looking across the two different facilities,
18 relative cost, that type of thing.

19 DR. STENSLAND: And utilization.

20 MS. DePARLE: Did you guys look at anything about readmission
21 from specialty hospitals to community hospitals? Are there impacts
22 that you would expect to see there?

1 MS. CARTER: We did not look at that but if it's an area, if
2 we were to do quality analysis, that would be one of the things we
3 would look at.

4 DR. NELSON: A question, I presume that they are all Joint
5 Commission accredited. Either that or else state certified, HCFA or
6 CMS. That might be one area where some quality data might be obtained,
7 from the Joint Commission.

8 I presume that you are, in terms of volume and utilization,
9 are you looking at the small area variations and correlating the
10 presence or absence of specialty hospitals with the volume of services
11 within those areas?

12 DR. STENSLAND: We're planning to look at larger areas
13 actually. One of the things we might look at is referral regions for
14 cardiac care and look at utilization before the introduction of the
15 heart hospitals and then after the introduction of the heart hospitals,
16 to look at that rate of change in utilization. And if that rate of
17 change differs from other referral regions that didn't have the
18 introduction of heart hospitals.

19 DR. WAKEFIELD: Your definition of rural hospitals, are you
20 using MSA/non-MSA? And I assume these are all PPS? Even though the
21 bed sizes are small, they're all PPS? We don't have any CAH hospitals
22 in this mix, do we? They're all PPS hospitals?

1 MS. CARTER: That's right.

2 DR. WAKEFIELD: Your comment about rural community hospital
3 volumes, the sense that they're more difficult and having greater
4 difficulty than their urban counterparts to rebuild volume, just a
5 question thinking about a little bit of the threat potentially to the
6 financial bottom line of some of the small smaller rural community
7 hospitals and how that might over time affect access to services.

8 I know we're talking about a really small end when we're
9 looking at the subcategory rural specialty hospitals, but can you tell
10 me whether or not those rural specialty hospitals that you're looking
11 at generally tend to have emergency rooms or don't? Do you know? The
12 ones you looked at, the rural category?

13 MS. CARTER: They tend not to, the specialty hospitals.

14 DR. WAKEFIELD: Specialty hospitals in rural community tend
15 not to?

16 MS. CARTER: Right.

17 DR. STENSLAND: In terms of ERs, almost all the staff ERs
18 were at heart hospitals and I think there was only one in our sample of
19 a non-heart hospital that had a fully staffed ER, where they would
20 staff it with a physician 24 hours a day. And heart hospitals are
21 usually in bigger markets because that's specialized. I mean, you
22 can't have a heart hospital in a real small town.

1 DR. CROSSON: As I've thought about this, it seems to me that
2 we have at least two compelling issues to look at. One of them is the
3 impact of specialty hospitals, whether they're physician-owned or not,
4 on the community hospitals. I think the issue there is that more or
5 less community hospitals are viewed as a public resource, at least in
6 some communities. And with respect to the needs of beneficiaries,
7 damaging those would create a problem of access and potentially a
8 problem of quality. I guess we're going to get into that issue later.

9 I think the second issue has to do with the potential for
10 conflict of interest for owning and referring physicians, so I'd like
11 to spend a second on that. It struck me that in reading the material
12 that the advent of physician-owned specialty hospitals, particularly
13 ones that are good deal smaller than community hospitals, seems to
14 violate the idea of the whole hospital exception in the sense that --
15 you know, I wasn't there at the time. But my sense of that is that the
16 whole hospital exception was placed there because it has something that
17 might be called a principal of dilution.

18 That is that because the whole hospital takes care of lots of
19 different kinds of patients and there's all different kinds of
20 physicians admitting patients there that the likelihood that any one
21 individual physician in a large general hospital is going to
22 significantly gain by referral patterns and the impact of those on the

1 profitability or lack thereof of the hospital is fairly small.

2 But that seems to have changed, at least based on the
3 analysis that we had, where we have hospitals that have a census of 10,
4 20 or 30 patients and physicians who own up to 15 percent of the
5 hospital. It seems like a different set of questions.

6 So when you think it through and say well, what might be a
7 solution to this if that's the direction we're going in, one might be
8 to try to return to some sort of balance that corresponds to the
9 thinking of the whole hospital exception. At least as I think that
10 through, it suggests something like limiting degree of ownership or
11 potential profit that any individual physician could receive from
12 ownership of one of these hospitals.

13 I would be interested in, as we get into this further, is to
14 see if we could rough that out. And that would be what percentage of
15 ownership of the average physician specialty hospital, based on what we
16 know about the profitability of those hospitals, would have what impact
17 on the annual income of the average physician? I realize that there's
18 a lot of modifiers there.

19 And yet, this is not an unknown dilemma in medicine, which is
20 how to balance the impact of finances on the professional judgment of
21 physicians and other professionals. I think it's a human fact that
22 judgment is more likely to be influenced by the potential to gain \$1

1 million than it is by the potential to gain \$5,000, at least for
2 someone who's already making a substantial amount of money.

3 And I just would offer that we might take a look at that.

4 MR. HACKBARTH: Let me just pick up on your initial framing
5 of the issue. I think of it coming in three basic parts. One is their
6 effectiveness on professional judgment of physicians.

7 A second, as you said, is the impact on community hospitals
8 and their ability to provide services to the public that may not be
9 completely funded, adequately funded through other means, means other
10 than cross-subsidies.

11 And then the third that I would include is the accuracy of
12 payment. Is the way that we're paying for patients creating
13 opportunities for selection of certain types of patients and then
14 exceptionally large profits on those patients?

15 Those are the three big issue categories that I see here.

16 DR. MILSTEIN: I think that our being able to make a strong
17 recommendation in this area is going to very much hinge on the quality
18 of the underlying analysis. And I'm also respectful of the fact that
19 we have limited time to complete that analysis. So my comments are
20 really directed at some of my thoughts on what the analysis might, at a
21 minimum, want to include if we're going to have maximum confidence in
22 our recommendation.

1 I think of there being three major categories of potential
2 impact of this new life form, one being impact on appropriateness. We
3 have bases in this country for judging appropriateness. It's not
4 particularly sensitive but the American Heart Association and American
5 College of Cardiology have given us a three-part classification system.
6 I don't know how feasible it's going to be to see if we can piggyback
7 on research already underway or otherwise be able to get a sense of
8 what the distribution is in specialty hospitals serving heart patients
9 versus community hospitals on the distribution of cases across the
10 three AHA ACC categories.

11 The second area of potential performance impact would be cost
12 efficiency. That is, assuming that the treatment made sense to begin
13 with, are these specialty hospitals more cost efficient, either using
14 charges per stay or charges per stay -- as Nancy was inferring -- to
15 some kind of downstream longitudinal notion analogous to what Jack
16 Wennberg has shown light on.

17 To the degree possible, it would be great if our cost
18 efficiency analysis, irrespective of what longitudinal time frame we
19 use to denominate it, could do everything we can to ensure that it
20 includes a trued up analysis for cost of teaching, research --
21 obviously both efficiently provided as we previously discussed --
22 indigent and underinsured care, truing up for that difference. And

1 also for what we believe to be the cost of the standby capacity
2 associated with having to accept transfers in when patients don't do
3 well and need to be handled by community hospitals.

4 And then last is this question of patient outcome. Are we
5 pursuing opportunities to partner with the American College of
6 Cardiology or the Society for Thoracic Surgeons, both of which maintain
7 the only really good quality risk adjusted outcomes database, at least
8 for heart care.

9 I know that at least some of the specialty hospitals that
10 I've interacted with do participate in those programs and they do the
11 best that science can now do for us in terms of a good risk adjusted
12 comparison of outcomes for two of the primary procedures being done at
13 least in heart hospitals, being bypass graft and various PCI
14 procedures.

15 So we have limited time, limited budget, but I think our
16 confidence we would have in our recommendation will very much hinge on
17 the quality of our analysis.

18 MR. MULLER: Let me also commend the three of you and the
19 rest behind you who did all this work. I think it's very well done and
20 I look forward to the work that Mark indicated is to come.

21 Some of my comments really have been anticipated by what Jay
22 and Glenn and Arnie had said.

1 But I think the thesis as to why is it in heart? Why is it
2 orthopedics needs to be tested a little bit more. Why don't we have a
3 lot of birthing hospitals? Why don't we have neurosurgical hospitals?
4 One can surmise that perhaps in neurosurgical cases there just aren't
5 enough to create a hospital.

6 Why don't we have breast cancer or prostate cancer hospitals?
7 My sense is some of it has to do with volume and some of it has to do
8 with the thesis of where the payment system may be skewed and therefore
9 we should look at that.

10 But if you look at societal need, if you did it on the basis
11 of need, one might think that there are other kinds of specialty
12 hospitals that come forth if we look at societal need and they may be
13 more linked to payment system than it is to need.

14 So I think we need to look at some other specialty areas and
15 see whether there's something in the payment system and so forth that
16 doesn't cause them to come forth.

17 I'm not going to repeat the necessity of getting the outcome
18 and margin data, which I think is very important in this, so I look
19 forward to that coming forth.

20 I do think we have to, and we've discussed at other times in
21 other settings how well the DRG recalibration goes on some kind of
22 basis. But since at least the number of these hospitals, more from

1 what your analysis indicates on the orthopedic side than on the heart
2 side, have a lot of private payers where the charge system -- which
3 we'll be talking about later -- may have some effect on the margins.

4 My sense is that if the charges are higher in certain areas
5 within a year or two, the DRGs should be recalibrated to take that into
6 account. But there seems to be something going on that over the years
7 -- I mean heart hospitals and heart services with general hospitals
8 have been more profitable than other services for probably 10 years or
9 20 years, since 1983 and so forth.

10 So there's something going on here where recalibration
11 doesn't work quite as well. I'm not quite sure what it is and whether,
12 Glenn and Mark, you want to do that inside this study or elsewhere. I
13 think it's something we have to keep looking at because there does seem
14 to be consistency over a period of years in certain services being more
15 profitable and other services being less so, even inside the Medicare
16 system let alone inside the private payment system.

17 So to sum it up, I think Jay's points about looking at the
18 effects on the community is something we should look at.

19 Certainly if there's any way of trying to capture those
20 standby costs that general hospitals or community hospitals have to
21 sustain that are not captured in hospitals that don't have ERs - I
22 mean, you don't want to judge off anecdotes but certainly if you have

1 to turn the lights on in an ER, then the marginal costs of running that
2 ER have to be pretty low.

3 Therefore, the staffing may not -- my guess is there weren't
4 staff standing there in the dark. So they probably didn't have a lot
5 of staffing costs in that ER.

6 So I think looking at those kind, whether there's some kind
7 of way of capturing what the general standby costs are of these
8 community hospitals vis-à-vis the specialty hospitals. The drive
9 toward specialization, not just in specialty hospitals but one can see
10 it in imaging centers and labs, et cetera, and so forth, is not going
11 away. And given that is by and large where our economy develops,
12 there's no reason to think that even if there's some changes along the
13 lines that may or may not come out of Jay's comments in terms of what
14 kind of limitations we put on these, the drive towards specialization
15 is going to continue.

16 So thinking about what the advantages are of specialization
17 vis-à-vis the general role of community or facilities and what they can
18 do in general for the needs of the public that Medicare serves, I think
19 is an important thing for us to keep looking at because, in fact --
20 once you undermine that general capacity it takes an awful long time to
21 bring it back.

22 So the whole sense of what we get out of specialization

1 versus the costs of it, whether this is the right time to take that on.
2 But I think that's a theme we have to keep going on, not just in
3 specialty hospitals. Because at this moment we don't have whole
4 imaging hospitals. They still tend to be imaging centers. But based
5 on the work we did a year two ago, we know that's one of the biggest
6 proliferating areas within Medicare. I think we had growth rates about
7 14 or 15 percent in imaging. So one could conceive that three or four
8 or five years down the road that we have whole imaging hospitals.
9 There's reasons to think they're not 12 months away but one could see
10 this happening, as well.

11 So again, looking at the community hospital costs, vis-à-vis
12 the specialty hospital costs, looking at the margin outcome data,
13 looking at, looking at the DRG recalibration system I think is very
14 important to see why after 20 years we still have some services
15 continuing to be making more margin.

16 And then any thinking we have about why there's some services
17 that are very much needed by communities. Around the country right
18 now, due to malpractice crises and other issues, the availability of OB
19 services is being restricted. If there's a community for OB services,
20 why don't we have birthing hospitals being created to meet that need?

21 MR. SMITH: Much of what I wanted to say has been said by
22 Ralph and Arnie and Jay. So let me just try to dig in on a couple of

1 those points.

2 Glenn, I thought your three-part distinction was right, the
3 professional judgment/community impact/payment accuracy. I want to
4 pick up on something Jay said, sort of linking the question of how this
5 economic arrangement works out to the question of community impact.
6 It's important to understand that the impact on community hospitals is
7 going to be the same whether or not the competing local heart hospital
8 is investor-owned or physician-owned or some mix. And I suspect that
9 the normal financial transaction here is investor initiated and who
10 recruit physicians rather than, as was adjusted in the slides, the
11 other way around.

12 So as we look at community impacts, I want to make sure that
13 we look at the impact of specialty hospitals, the kinds of broad
14 specialization questions that Ralph was raising, not simply the impact
15 on community hospitals, the ones where physicians are part of the
16 ownership mix. And concentrate on the physician side on the impacts on
17 professional judgment.

18 The standby capacity. we should remember, there are two
19 pieces of this. In the report from the site visits, Carol told us both
20 that community hospitals had become more efficient, had invested more
21 and had improved their general performance, and that they had also shut
22 down some services. We need to think about how those things interact.

1 And it's partly a function of just reduced income because
2 payment is flowing to new competitors. But it's also the question of
3 whether or not you can then any longer afford to maintain a services or
4 to keep it open. The community impact question is a complicated one.

5 And lastly Jay, I'd be a little concerned about thinking we
6 can capture how much is corrupting and decide that the dividing line is
7 15 percent or 13 percent and that at 16 percent you're hopelessly
8 underwater, for a couple of reasons. One, because I think it's very
9 hard to do that. But second, because these financial arrangements are
10 very complicated.

11 I could have as big a financial stake in my referral pattern
12 because I owned a real estate investment trust that invested in a lot
13 of hospital real estate without ever having an equity stake in the
14 actual operating hospital.

15 So I think it's awfully hard to say this much, both as a
16 matter of sort of ethical analysis, but also the financial transactions
17 I think bedevil this in ways that we ought to be careful not to think
18 that we know more than we do.

19 MR. DeBUSK: As you know, the hospitals right now are going
20 through a real increase in the number of uninsured patients that's
21 showing up at the doors. And going forward, I think if we can get at
22 some more recent data about the uninsured, that would be very important

1 to look at in this report.

2 MR. BERTKO: I'd just liked to add a thought about one of
3 Arnie's comments. Sometimes getting to quality and outcomes data can
4 be very difficult. I'll point to, I think, the transfer comment on
5 slide 30 to say maybe some of your analysis on the costs might be
6 patient-based as opposed to admission or episode based. If you could
7 link them together, that is if a patient starts in one facility and
8 transfers to another, what's the overall average cost in say some of
9 the site visits? I would hope that that might be a more practical
10 approach in some cases.

11 MS. RAPHAEL: I was very interested in the concentration of
12 specialty hospitals in four states, I think it is. I was wondering if
13 we could learn more about what's happening in the states?

14 For example, can you tell us what led to Florida prohibiting
15 specialty hospitals? And are there any studies that have been done at
16 the state levels that have kind of informed some of the decisions
17 whether to allow for licensing or to prohibit it?

18 MS. CARTER: I would have to get back to you on those. I
19 know that a number of hospital associations are conducting their own
20 studies of specialty hospitals, so I can look into that for you.

21 MR. DURENBERGER: First, I'd like to start, too, by
22 complimenting the staff and not just for the presentation that's in

1 front of us now, but the work at the retreat where everything was a
2 little bit more relaxed and getting your consultant in. That was
3 really, really helpful, Mark, in the way in which we were able to
4 prepare for the subject, for me and I think for everybody else, laying
5 the groundwork for this was really great.

6 Secondly, I want to acknowledge that every once in a while
7 somebody leaves the policymaking arena who makes a significant
8 contribution by doing something with looks negative, and that's John
9 Breaux. I think about all the people that are going to be missed
10 around that place, as the number of good folks dwindles. John is
11 probably -- for those of us who had experience with him -- going to be
12 missed the most.

13 He's the guy that contributed the moratorium, which I don't
14 think he necessarily believes is the ultimate solution to the problem.
15 But he made everybody stop in their tracks and say this is really an
16 important issue.

17 And I want to endorse the comments of all of my colleagues
18 about not just looking at this as fulfilling a mandate or something
19 like that. But I think as you pointed out, Mr. Chairman, this covers a
20 lot of the other work we're doing. And so I want to endorse your three
21 categories. I think that's the best way to say it.

22 In the issue of conflicts of interest and physician judgment

1 one of the most important judgments -- that's why I like Arnie's
2 suggestion to work with ATS, working with AAOS, those kinds of people -
3 - the connection between physician judgment, ownership and productivity
4 is really very important. And how we define it, whether you define it
5 as a Permanente, you define it as a Mayo, a Cleveland, whatever it is,
6 there's something very, very important to all of us in terms of
7 enhancing the quality of the work, the quality outcome, in having some
8 kind of an interest, if you will, measured financially, measured
9 profession and so forth, in that outcome.

10 So however we look at this so-called -- conflict of interest
11 sounds like a negative connotation. It would be nice to flip it over
12 and say there's a positive side to this, as well. And then, as we deal
13 with the positive side of it, how do we guard against conflict of
14 interest or something like that?

15 But there's a whole lot of issues that my colleagues have
16 commented on that belong in there. But the importance of the
17 connection between ownership and productivity, I think, is really
18 critically important.

19 And then the other two that we've already commented on, that
20 I simply want to endorse because of their importance, the whole issue
21 of the pricing distortions. We already know, from our work, that we're
22 overpaying hospital outpatient compared with ambulatory surgery

1 centers. We'd love to know why. A lot of other people would love to
2 know why.

3 But we're already doing that kind of work. So it seems like
4 some of that work is incorporated in here. I haven't read Joe's book
5 yet, but I'm looking forward to reading Joe Newhouse's book on this
6 whole issue of price distortion because I think we're not going to
7 solve it in this study but I think it's really critically important to
8 look at that in the light of the other things we're doing. And that
9 includes the efficiency analysis and stuff like that.

10 And the third one that's really hard to deal with but it
11 needs to be referred to is the issue of cross-subsidies because that's
12 the one that distinguishes one community from the other and it gets
13 really very difficult, from a public policy standpoint, to deal with
14 it.

15 And yet, if we're thinking about beneficiaries and we're
16 thinking about high-quality care and we're thinking about how to get
17 the best that medicine has to offer to everybody in every community, we
18 do need to deal with that issue of cross-subsidies, as you pointed out.
19 And in some way at least point policymakers to the failures in the
20 current system that deal more appropriately with issues like
21 uncompensated care and Medicaid payments and a variety of things like
22 that.

1 So I basically just want to endorse the comments of my
2 colleagues and the work of the staff so far.

3 MR. HACKBARTH: Just to pick up on your first point, it's
4 difficult not to feel ambivalent about some of these issues. On the
5 one hand, people are understandably concerned about compromising
6 professional judgment through inappropriate financial incentives. But
7 in many instances over the years, we've talked about the need or the
8 potential for aligning the incentives of physicians and hospitals to do
9 good things for patients and improve the efficiency of the system.

10 So there is little that's black or white. The trick here is
11 to find an appropriate blend and it's a very interesting problem, as
12 well as a difficult one.

13 DR. WOLTER: Just an observation and pick up a little bit on
14 something that Jay said earlier. I think one of the things that is
15 happening is there is this blurring on between ASC, specialty hospital,
16 and whole hospital. And as ASCs add overnight capacity, as ancillaries
17 of one kind or another are added, specialty hospitals are of one size
18 or another. Some do several service lines. Some are primarily one
19 service line. And that really complicates, I think, this issue.

20 Which is why I think the core issue around self-referral and
21 what Stark covers and what it doesn't cover really is one of the key
22 things that we need to address.

1 I like Dave's suggestion that maybe there's a way to flip
2 this and look at it positively. For example, in the Stark regulations
3 there are the group practice exceptions where physician ownership is
4 certainly allowed of some of these services but there are distinctions
5 about how salaries are created directly related to the referral to
6 certain service lines versus sort of how the organization as a whole
7 performs.

8 So I think there are some distinctions that we may be able to
9 get into that would help us as we move forward.

10 DR. SCANLON: I'd just like to make a short comment. I think
11 that the prior comments have really revealed some of the complexity of
12 what we're dealing with here. And I think, given our time frame, the
13 ability to deal with many of them is going to be constrained.

14 Unfortunately, I want to add another issue to the table which
15 is that the idea that we are talking about hospitals may be a misnomer
16 in terms of how we characterize this issue because our hospital, in
17 some respects, is a building concept. It's what goes on in a
18 particular building. The entities that we're talking about may be
19 something that's owned by a system, owned by a chain. And I think that
20 totally changes the economics that is underlying the issue here.

21 If a community hospital chooses to do its cardiac surgery in
22 another building that is independently certified, that's completely

1 different than if an independent entity opens up and takes patients
2 from that community hospital.

3 If we think about we're going to change rules with respect to
4 referrals under Stark, how are we going to think about all of the
5 permutations that may exist in terms of the kinds of arrangements that
6 might exist?

7 Jay's idea of a threshold in terms of ownership, that may be
8 an interesting avenue to pursue. But then again, when we're talking
9 about a chain, how the threshold rules would be adapted to deal with
10 that issue.

11 Given all of this, I think I come back, Glenn, to your
12 characterization and think that you really have hit on the three big
13 areas. And at a minimum we maybe should be very intent in focusing on
14 the question of the payment system and what is the payment system doing
15 here? Is it, as Ralph indicated, failing in terms of the recalibration
16 effort? And that we need to be worried about what the consequences of
17 that failure are in terms of creating incentives for the system to
18 operate in one way or another.

19 I think that may be, at a first step, the most important
20 piece of what we do.

21 MR. SMITH: Glenn, I was struck several times during this
22 discussion but particularly at Dave's last comment about how seamlessly

1 we have made a transition from a conversation we've often had about
2 impact on Medicare beneficiaries to impact on the entire health care
3 system at a community level. We've asked ourselves, and we are
4 entering in this one in a significant way, to what extent should we
5 think about Medicare's role in the health care system or simply
6 Medicare's ability to provide high-quality services to its
7 beneficiaries?

8 We haven't in this discussion, not a single one of us has
9 confined ourselves to beneficiary or access issues. we've talked about
10 much broader impacts. I think that's a step forward but it struck me
11 as an important transition.

12 DR. CROSSON: Just a couple of last comments on the physician
13 incentive issue, and I do agree with Dave that probably characterizing
14 it as incentives or the appropriate balance of incentives is a better
15 way to put it. Because that's really what it's about. It's really
16 about trying to get incentives or trying to influence incentives in
17 such a way that they're balanced, balanced between quality,
18 professional judgment and the finances, the complex finances.

19 It is messy. There's no question about it. You're mixing up
20 law, finance and human motivation. If we can only get rid of that last
21 part it would be a lot easier, because once you get that in it is
22 messy.

1 And I would say again that while that's true, yet other laws
2 that we have heard summarized earlier have attempted to do that. So
3 that as the Stark laws were put into place, people tried to wrestle
4 with these issues and accepted some things and allowed other things.
5 For example, the whole hospital exception. I believe that was done
6 because folks looked at the likelihood of extraordinary incentives and
7 decided that they were not present and therefore that should be
8 allowed.

9 So even though that is messy I think nevertheless, to be
10 responsible, those kinds of judgments need to be made when they can and
11 when they're appropriate.

12 The last note is, having said all that, I think we did get a
13 case presented by the staff that there were other reasons why
14 physicians involve themselves in creating these hospitals, some of
15 which were subsequently addressed by the community hospitals, others of
16 which were not.

17 I would just say that while the incentive issue is a real
18 one, there's a separate issue of physician governance. And as we work
19 our way through this I think we should, if we can, consider those
20 things differently because there may be a compelling reason in these
21 hospitals to have physicians involved in governance in a major way.
22 And yet, there may be reasons to separate that from ownership, if

1 that's possible.

2 DR. REISCHAUER: Just a footnote on that point, and that is
3 to go back to Ralph's question which has why haven't these specialty
4 hospitals sprung up in other specialties? Because certainly it isn't
5 only the cardiologists that are upset with the management of the
6 community hospital. And so I think we get, as you said, right back to
7 the getting the payments right issue first. And then see what the
8 ramifications of that are.

9 Just one comment on the community repercussions and how
10 complex this is really going to be for us. Everybody is concerned that
11 proliferation of specialty hospitals could reduce the social benefits
12 that come from having a community facility. But the question we get
13 into immediately is how much do you need of that?

14 We're often talking about communities with three full-service
15 hospitals and the fact that one of them is having a huge problem
16 because the heart and orthopedic business went somewhere else can be
17 true for that hospital, but in a sense may not be true for the
18 community as a whole because we don't know what that threshold level is
19 of this social benefit that we want to preserve. And we want to
20 preserve it for the community but also for the Medicare beneficiaries
21 in everything else that they might do.

22 MR. HACKBARTH: I was struck also, Dave, by that seamless

1 transition. And I think a complete analysis of this issue requires
2 careful consideration of the community impact of this development.

3 On the other hand, there are huge issues in terms of how you
4 finance those desirable public goods. At one extreme you finance them
5 through cross-subsidization. You basically protect from competition.
6 You allow the payment system to be inaccurate and people to reap large
7 profits here to cross-subsidize social goods there.

8 The other end of the continuum is that you promote
9 competition, especially competition that is quality enhancing and
10 efficiency improving and then say if we want those public goods we pay
11 for them directly.

12 I think one of the intriguing aspects of this issue is that
13 it forces that discussion out into the center stage.

14 DR. NELSON: I think we have to recognize also, though, that
15 the development of heart and orthopedic surgical techniques has come a
16 long way in the past 10 years. There are people walking around with
17 their knees done that we wouldn't have thought of that 10 years ago.

18 By the same token, the advancement in cardiovascular surgery,
19 because of new technology and transfer of that technology, there is
20 obviously an increased need for facilities to handle that.

21 You can't say the same thing about gastrectomy because that's
22 gone the other way. And endoscopic surgery has changed the face of a

1 lot of abdominal surgery.

2 So I have no doubt that payment policy is a factor but it's
3 certainly not the only factor.

4 MR. HACKBARTH: Any other comments or questions?

5 Okay, thank you very much. Good piece of work.

6 Next is results of a study done of hospital charging
7 practices that may have some relevance for the specialty hospital
8 study.

9 * DR. WORZALA: Good morning. I'm here to talk about a survey
10 that was recently conducted on hospitals' charge setting practices.

11 MR. HACKBARTH: Can I just interrupt for a second? For those
12 of you who are leaving, could you please do so quietly so as not to
13 disrupt this presentation?

14 Thank you.

15 DR. WORZALA: We recently had a survey completed by the Lewin
16 Group of hospitals about their practices in setting charges. Although
17 I'm giving the presentation, Jack is here with me because he was also
18 involved in the project.

19 The survey was motivated by a number things but primarily by
20 the center role that charges play in how CMS is setting payment rates
21 for hospital services under Medicare and also the lack of systematic
22 data and information on how hospitals set their charges.

1 As Glenn just mentioned, this study is relevant to our work
2 on specialty hospitals and it's also relevant to a mandated study that
3 we have due next July on how we are paying for pharmacy services under
4 the outpatient PPS.

5 Under the inpatient acute-care PPS, the relative weight for
6 DRGs are based on average adjusted charges. On the outpatient side,
7 once CMS sets payment rates it uses charges reduced to costs using
8 cost-to-charge ratios from the cost reports. So you can see that the
9 relationship of charges to payment rates is fairly direct.

10 On the inpatient side, if markups over costs vary across
11 services the relative weights could well be too high for some services
12 and too low for others.

13 More explicitly, where the markets are higher the relative
14 weights would be higher relative to costs and vice versa.

15 On the outpatient side, the connection is a little bit less
16 straightforward. However, given the methodology used, differences in
17 markups across services can still affect the relative weights. I'm not
18 going to go into detail about now but I'd be happy to talk about it
19 later if you're interested.

20 The survey consisted of 57 structured interviews and the
21 survey instrument is in your packet if you want to refer to it. Some
22 of the interviews covered a single hospital while others covered a

1 system where charges were set centrally for a collection of hospitals.
2 In all, the interviews represent the charge setting practices of 251
3 hospitals.

4 The Lewin Group interviewed charge master managers and/or
5 their supervisors in the finance department. The sample was non-
6 random, although the contractor did try to make it representative by
7 region, teaching status and ownership. Recruitment was quite difficult
8 for this study despite repeated assurances of anonymity.

9 The sample did have an equal representation by region, so
10 Northeast, South, Midwest and West. But it includes a greater share of
11 teaching hospitals than the national average and a smaller share of
12 rural hospitals.

13 In addition, we found very few for-profit hospitals willing
14 to participate and this may be due to the proprietary nature of the
15 topic. We also ended up with few government-owned facilities.

16 We were looking at a number of areas in this survey and we
17 included questions about the structure of the process hospitals follow
18 when they set their charges. We were looking at the factors they
19 consider, the relationship between costs and charges, and the
20 information used to set charges, the extent of variations in markups
21 across services and examples of where markups may vary.

22 We also focused on two areas that have received considerable

1 policy attention recently, one being cardiac services and the other
2 pharmaceuticals.

3 The rest of the slides will present the major themes emerging
4 from the survey. As a caveat, I want to note that this was a
5 qualitative study and we're sharing general impressions from the 57
6 structured interviews that were conducted.

7 Regarding the structure of the process, we found that
8 hospitals maintained a database of services and items that they supply
9 to patients and they attach charges to each item. This is called the
10 charge master.

11 Charge masters are large and complicated and they encompass
12 tens of thousands of items. As I'm sure you know, the Medicare program
13 requires participating hospitals to maintain one set of charges that
14 apply to all payers. That's what's in the charge master.

15 Hospitals set their charges for individual services and
16 items. This slide gives some examples, such as a daily room charge,
17 charge for an x-ray, the charge for a block of minutes of operating
18 room time, the charge for an individual supply, be that bandages of
19 some sort or a cardiac implant, and charges for a particular dose of a
20 drug.

21 Hospitals do not set their charges for the bundles of
22 services that Medicare pays for, that is the DRGs or the APCs, nor do

1 they generally set them for a different bundle such as admission or an
2 ambulatory surgery. Rather hospitals bill for an individual patient
3 the charges for each of the services or items that they have offered
4 during the stay or the encounter. These bills are then later
5 classified into a DRG or an APC.

6 So the charges that we are using when we set payment rates
7 for a DRG or an APC will vary both by the patient and by the hospital.

8 The process of setting charges is generally overseen by the
9 finance department but involves most hospital departments to some
10 degree as charges are set for each department's services.

11 Hospitals generally change their charge master for one of
12 three reasons. First, there is often an annual update or increase in
13 charges which accounts for cost increases or to satisfy other financial
14 goals. These increases are not necessarily uniform across departments.
15 Some departments may see a higher across-the-board increase than
16 others.

17 Second, on an ad hoc or periodic basis, hospitals will review
18 and revise some of their existing charges. Sometimes they will look at
19 all the charges for a whole department but more often they modify the
20 charge for a specific service or set of services that have been noted
21 to be problematic. An exhaustive review of all of the charges is very
22 rare due to the large number of charges in the charge master.

1 Finally, hospitals do modify their charge master to add new
2 services.

3 A major theme arising from the interviews was that setting
4 charges is a core business function. As such hospitals are responding
5 to many different pressures and balancing many different calls when
6 they set and modify their charges. Some of those factors include
7 accounting for changes in cost, both overall and for an individual
8 service or item. In addition, they think about the financial goals
9 that they have. They also think about other missions which may, as
10 previously discussed, include the need to cross-subsidize some services
11 with others.

12 Hospitals also face competitive pressures that they factor
13 into their charge setting, both from other hospitals as well as from
14 ambulatory settings such as ASCs.

15 Hospitals also have to consider their arrangements with
16 payers, which range from discounts off charges to per diems or fee
17 schedules or capitation. And depending on the relationship with
18 payers, charges may be more or less important to a hospital.

19 Hospitals also take community perceptions of the fairness of
20 their charges into account.

21 Another theme that emerged from the interviews involved the
22 relationship between costs and charges. When asked an open-ended

1 question about the information they used to revise existing charges
2 only half of the hospitals mentioned costs. Hospitals indicated that
3 they use many other sources of information as well, including public
4 data, market information, advice from consultants as well as
5 information from their payers which would include Medicare's payment
6 rates.

7 So you might get a little circular issue of using Medicare to
8 set charges and charges to set payment rates.

9 Hospitals reported that costs do play a greater role in
10 setting charges for supplies and pharmaceuticals as well as for new
11 services. And on supplies and pharmaceuticals we did find most
12 hospitals reporting using a formula or a table where they developed
13 their charges based on the costs of the items. These formulas generally
14 contain cost categories with the size of the markup over costs
15 depending on the cost of the item.

16 The survey had a set of questions on variations in markups by
17 service and hospitals reported that markups can vary by service for a
18 number of reasons such as payer mix, utilization and market forces.
19 One of the most cited examples of variation would be that low-cost
20 items have higher markups than high-cost items. Some of that has to do
21 with the notion of sticker shock. If something is very expensive and
22 you mark it up a lot, it becomes very, very expensive.

1 Other than that, responses concerning how markups vary were
2 not systematic across all the hospitals. But when asked to provide
3 examples of services with low markups, some hospitals mentioned room
4 and board and other visible services. Examples of services with high
5 markups included outpatient and diagnostic services.

6 Interestingly, some hospitals reported that they no longer
7 charge at all for very low-cost items such as aspirin.

8 The instrument contained a set of questions about charges for
9 cardiac services and we have heard anecdotally that these services are
10 more profitable than others under Medicare, as we were just discussing
11 under the specialty hospital study. One way that could be possible is
12 if the services that make up the cardiology DRGs had systematically
13 higher charges than other services. If that were true, then the
14 relative weights for cardiac DRGs under the inpatient PPS would be
15 higher in comparison to costs than the relative weights for other DRGs.

16
17 However, hospitals reported using the same process for
18 sitting their cardiac charges as for other services. One exception is
19 that some hospitals with a catheterization lab develop charges for an
20 entire procedure rather than billing for minutes of the operating time
21 and other inputs as they generally do when something is done in the
22 operating room.

1 Although hospitals report using the same processes to set
2 charges for cardiac services, responses to other questions do suggest
3 that the services may receive closer attention. First, many cardiac
4 services receive high dollar values which hospitals said they often
5 look at more closely. In addition, many of the cardiac procedures are
6 new.

7 The survey also focused on charges for pharmaceuticals for a
8 couple of reasons. First, setting payment rates for drugs has been
9 very problematic under the outpatient PPS. In addition, we have a
10 mandated study to consider whether or not there should be a payment
11 adjustment in the outpatient PPS to cover pharmacy services other than
12 the actual cost of the drug. That study is due in July 2005.

13 We found that hospitals reported charges for pharmaceuticals
14 as being handled separately and often with considerable involvement of
15 the pharmacy director. Almost unanimously the hospitals reported that
16 they have one charge that covers the cost of acquiring, preparing and
17 storing each drug. They do not have separate charges for their
18 pharmacy services.

19 About three fourths of the hospitals reported using a formula
20 based on acquisition costs or average wholesale prices where they
21 converted costs into charges. Some of the more sophisticated formulas
22 might also vary the markup by the type of drug or the route of

1 administration, is it oral or is it IV, or the form of preparation, are
2 they starting with a pattern or a liquid? In most of these formulas
3 hospitals reported that lower cost items have higher markups than
4 higher cost drugs.

5 So I've presented you with a number of findings from the
6 survey and this slide summarizes the major points. The charge master
7 is large and complex. Hospitals are weighing numerous factors when
8 they set their charges such as financial goals, other missions and
9 competitive pressures.

10 The survey results suggest that there is no systematic
11 relationship between costs and charges but that is more likely for
12 supplies, drugs and new services than for other existing services.

13 We also found that markups can vary by service. The most
14 common example was low-cost items having a higher markup than high
15 cost, as I've said. The other examples were not systematic across
16 hospitals.

17 The findings of the survey are relevant to several of our
18 studies. You just heard about the analyses being undertaken for our
19 mandated study on specialty hospitals. Another analysis that will be
20 done will compare the relative weights for DRGs that result from using
21 charges versus an approach of using charges reduced to costs.

22 In addition, questions on charges for the pharmaceuticals

1 will be appropriate for our mandated study in that area.

2 And finally, we also have a project to model CMS's approach
3 to setting payment rates under the outpatient PPS and we will try to
4 look at alternative approaches for setting payment rates that might,
5 for example, adjust in some way for this difference in markup between
6 high and low-cost items.

7 I'll take your questions.

8 DR. CROSSON: Chantal, do you have any information on how
9 other countries such as Canada or the U.K. or Switzerland would handle
10 payments to hospitals in relation to their costs? How they calculate
11 an appropriate payment?

12 DR. WORZALA: It's going to depend on the country, and I'm
13 going back to information I learned many years ago, but in Canada a lot
14 of it is I believe budgeting and negotiation. I actually am not sure
15 about what happens in England now with the GP fund holding, whether the
16 hospitals discharge. I honestly don't know.

17 DR. CROSSON: I wondered if they had anything analogous to a
18 cost report that formed the basis for beginning their negotiations and
19 whether indeed they based it, for example, on acquisition costs plus a
20 percentage rather than just sort of taking a stab, like we appear to
21 be.

22 DR. WORZALA: I can look into that but I can't answer right

1 at the moment.

2 MR. DURENBERGER: A question or two on the charge side and
3 then one question on the cost side.

4 On your slide, PowerPoint number seven, the hospitals balance
5 many factors when setting charges. One of them was arrangements with
6 payers. I wonder if you wouldn't just talk about that a little bit.

7 And then another question occurs to me, and that is would not
8 Richard Scruggs have a lot of information that might be valuable to us,
9 if you follow my question?

10 DR. WORZALA: On the arrangements with payers, the importance
11 of charges really depends on whether or not charges play into
12 reimbursement for the hospital. So if the hospital has a lot of
13 contracts where it discounts off of charges, they'll spend a lot more
14 time thinking about their charges than if they have a lot of capitated
15 arrangements or where they are responding to a payer's fee schedule or
16 a negotiated per diem rate.

17 MR. DURENBERGER: I know you're not an expert, nor am I, on
18 the lawsuit against nonprofit hospitals and so forth but is there not
19 something to be explored there that would be informative? I'm just
20 asking the question because I don't know the answer.

21 Obviously, they are digging into some of this same kind of an
22 area, I would assume.

1 DR. WORZALA: I think both have to do with how hospitals set
2 their charges but I think there's a pretty key distinction where what
3 we're really looking at it is pretty much relative markups across
4 services and how that plays into Medicare's process of setting payment
5 weights. We don't care so much about the absolute level of the charge
6 because when Medicare is setting its payment rates it all becomes a set
7 of relatives.

8 Whereas when you're thinking about what the uninsured pay,
9 for example you really care about the absolute level of the charges
10 much more than the relatives across services. So I think that would be
11 the key distinction.

12 MR. DURENBERGER: My other question relates, and again I
13 don't know the answer to it and I don't even know if it's relevant.
14 And that is the group purchasing organizations. Again, I don't know
15 exactly how they operate except that there has been some suggestions
16 over the last year or two that something is going on, and I don't know
17 what it is, between certain of the group purchasing organizations and
18 their members. And it varies from one to the other kind of a member.

19 Is there anything in there that is of value to us in
20 determining what is actual cost to the hospital?

21 DR. WORZALA: That's an interesting point. I can certainly
22 look into it. I'm not sure how hospitals would translate that into

1 their charges but certainly it could help us understand hospital's
2 costs.

3 MR. MULLER: While the chapter and your presentation showed
4 that a lot of these hospitals do in a very incremental way, we also
5 have seen evidence in the last few years, at least in the press, about
6 one chain at least that seemed to have doubled its charges routinely,
7 and so forth.

8 Remind me again, what's the relative advantage or
9 disadvantage of having charges of like 10 times cost versus just a
10 little bit above cost? So if somebody has charges that are like --
11 let's say your cost-to-charge ratio is 10 percent versus 90 percent.
12 Are there any, off the top of your head, advantages of a place that has
13 charges that are 10 times higher than costs?

14 I know there's that kind of short-term advantage for that
15 chain, in terms what are the systematic reasons one might want to have
16 charges being a big multiple of costs?

17 DR. WORZALA: Most of it pertains to non-Medicare.

18 MR. MULLER: I know about Medicare.

19 DR. WORZALA: Within Medicare, the only way -- and Jack can
20 correct me if I'm wrong -- but I think the only way that that's going
21 to play into how much you're paid is in the pace with which you
22 increase your costs and that will determine outlier payments.

1 So as we've discussed in the past, if you're increasing your
2 charges much faster than your costs and you have this time lag in the
3 cost-to-charge ratio that CMS is able to use to adjust your charges to
4 costs when calculating outlier payments, you will have an advantage
5 there.

6 I guess the other thing that I would say is hospitals with
7 higher --

8 MR. MULLER: Any sense of magnitude of that? I understand
9 that have a one year lag but how much is this worth to a hospital? And
10 if you double or triple your charges the day a new administration walks
11 in, is that worth 5 percent or 10 percent per year? Do you have any
12 sense of magnitude?

13 DR. WORZALA: I'll let Jack answer that.

14 MR. ASHBY: One thing I think that we have to make sure that
15 we understand is that outliers is really the only area where it makes
16 any difference. On all of the other allocations, the costs and the
17 charges are for the same period of time so it literally does not matter
18 how much the markup is because the cost-to-charge ratio adjusts for it
19 directly.

20 Within the outlier arena, I think that we should add that CMS
21 has made some substantial moves to reform the system so that they are
22 more closely aligning the time period of the charges and the costs also

1 to get to the point where it will also make very little, if any,
2 difference in the outliers that hospital gets.

3 So that's the goal, is to get to the point where they're
4 exactly the same and it won't make any difference.

5 MR. MULLER: At least that one chain seems to have had -- I'm
6 sure there's other reasons as well -- a considerable collapse of its
7 financial fortunes with the changes in the outlier policy. So if
8 you're basically saying that we're pretty close to not being able to
9 gain the system any more, is that the inference I should take from
10 that?

11 DR. MILLER: I don't think we're saying that. I guess what I
12 would answer in this situation is they have clearly tracked on the
13 example where it was an advantage and that, given that the cost reports
14 lag behind the charging practices, you could clearly game on that
15 front.

16 As Jack said, CMS has moved in to deal with that. I think
17 what I would like to do with this question is I would like to actually
18 think about it. It is correct that when you have the cost reports from
19 the same time periods, in theory when you track through you should, in
20 fact, be relatively close. And then for Medicare purposes -- and this
21 goes to Chantal's point about there may be other reasons to do that --
22 you should be relatively close.

1 But I also think this goes to the question you were asking in
2 the last session, which has to do with the issues around recalibration
3 and do we truly understand why some DRGs remain profitable and others
4 don't, if that's in fact what our empirical work turns out?

5 So I think there may be a couple of issues, even inside that
6 process, that we either need to think through to answer this question
7 or maybe we're not yet aware of in answering.

8 So I just don't want to end up with a flat statement of we've
9 basically eliminated the gaming possibility here.

10 DR. WORZALA: I wanted to get to that second part which is
11 just to say that hospitals with higher overall charges will have more
12 weight in setting the relative weights because you're taking averages.
13 So the bigger numbers have more weight. So in that way the relatives,
14 in their charges, will have some influence on the relatives across the
15 system. We need to think about and diagnose that but that would be the
16 logic.

17 MR. HACKBARTH: It's different from the outlier situation.
18 The outlier situation, especially pre-reform, you could immediately
19 directly benefit yourself as opposed to what it's all blended into the
20 relative weight process the benefit to your institution is vastly
21 diluted.

22 DR. REISCHAUER: Dave and Ralph brought up the two of the

1 three topics I wanted to talk about but you gave, Dave, a less specific
2 answer than I had hoped for. What I sort of want to know is for an
3 average hospital how much of the revenue is dependent on charges as
4 opposed to these other relationships? And I know it sort of varies
5 around.

6 But the way you described it it's really a very minor
7 fraction of the total. Because you have Medicare, you have Medicaid,
8 you have many big insurers are paying on a capitated basis, on a DRG
9 basis, or adjust DRG basis, something like that. I don't know whether
10 this is the tail on a very fat dog or it makes a difference. Why don't
11 we do issue one?

12 DR. WORZALA: I think that is going to vary a lot by
13 hospitals. I think some of the hospitals that we spoke with did
14 indicate that charges are becoming less important to them. But there
15 are still services and you may find that, for example, your services
16 weren't being paid discounted off charges or a specific set of
17 services. It's less likely to be the services the elderly provide, for
18 example, as the services that the uninsured and the people who are
19 insured by smaller insurance companies.

20 DR. REISCHAUER: But the uninsured, 60 percent of them aren't
21 paying their bill anyway. So what does it do, determine your bad debt?
22 What I'm wondering is is this 20 percent or 60 percent?

1 MR. MULLER: The APCs really haven't come to the private
2 outpatient side as fully yes. So for example, you're right, the
3 insurers by and large, after 20 years, have picked up the DRG system
4 for inpatient but they haven't really picked it up yet on the
5 outpatient side, by and large. So charges still make a difference on
6 privately insured outpatient, by and large. That's still the big open
7 field for charges.

8 DR. REISCHAUER: The second thing was with respect to
9 outliers and you answered a lot of the questions I had. But that
10 raised sort of the question about the sample that Lewin talked to. And
11 I wondered if anybody went through those hospitals and just checked --
12 if Lewin did because I know we aren't supposed to know who they are --
13 and checked where they were, in a sense, on their dependence on outlier
14 patients and whether you didn't get participation by that subgroup of
15 hospitals that, in fact, has shall we say gamed the outlier system and
16 so we really have a biased sample of the honest guys here.

17 The third issue was, if I read this right, this gets to
18 Mark's inquiry. A hospital spends a lot of time working out charges
19 for the little things that come in because they're relatively easy and
20 for new procedures. And if the costs of new things follows the pattern
21 that you see in most of the economy, they are relatively expensive when
22 you begin doing them. Then you learn how to do them and you specialize

1 and all of this, and the prices, the cost of it goes down.

2 And the hospital goes back and it reviews the things where
3 the costs are going up and there's sort of a problem. But it would
4 never review the things that costs are going down on unless there's
5 sort of competitive pressure or something like that. And that's where
6 we get into things like the cardiac area.

7 Is there any way we can look at two or three different areas
8 where there's been a lot of technological advance in the procedure that
9 we think will lead to lower cost? Laparoscopic surgery kinds of things
10 and things like that where maybe this is where the margins exist that
11 can cross-subsidize the other things.

12 MR. HACKBARTH: Was there anything in the survey results to
13 the question of whether charges for some services actually do decline
14 due to growing scale, experience and the like? Did anybody address
15 that?

16 DR. WORZALA: We didn't address that specific question but we
17 asked them why, what do they pick to change? And that certainly never
18 came up as an example.

19 MS. DePARLE: I was going to make a different point sort of
20 related to what Bob was asking. I think there's something circular
21 here, a lot of circular things.

22 I don't think I fully understand the extent to which charges

1 influence the DRG process at bottom because I think they do. I think
2 it's probably going to turn out that it's always in the hospital's
3 interest to have higher charges, even though we're kind of focusing on
4 this cost-to-charge ratio issue as it relates to outlier payments.

5 To the extent that other payers -- Bob, you were suggesting
6 that other payers have moved to these same sorts of systems. But many
7 of them are based on DRGs. So underlying all of this is some building
8 block that may or may not be quite influenced by how high you set your
9 charges.

10 DR. REISCHAUER: I think, as Chantal said, it's just that in
11 the great scheme of things you have a slightly higher weight in
12 figuring out what the DRGs' weights are then you would otherwise,
13 right?

14 DR. WORZALA: The logic of how the relative weights are set,
15 where you're taking the average adjusted mean charge so you're taking
16 out the wage index, you're taking out the teaching and the IME which,
17 if those are things are done correctly you're taking out those
18 influences in the charges. What you're really thinking about is the
19 relative between one DRG and another.

20 So what will really influence, if you want to think about the
21 profitability of one DRG versus another, is the relative markup over
22 costs of the services in one DRG versus the services in another.

1 Nobody sets charges for a DRG, so you can't talk about the charge for
2 the DRG but you talk about the bundle of services within that DRG. And
3 that's the most direct.

4 I think we do need to do some more thinking about the
5 influence of higher charges and escalating charges in that process.

6 MS. DePARLE: Maybe it goes so far back that it isn't
7 relevant but weren't the original DRGs partly based on historical
8 charges?

9 DR. WORZALA: My understanding is that when the weights were
10 set the first time it was charges reduced to costs. And then with the
11 first recalibration they went straight to a charge-based methodology.

12 DR. MILLER: At the time they felt that the correlation
13 between charge-based weights and cost-based weights were the same. One
14 of the issues that we're going to be taking apart when we think about
15 the profitability of DRGs is to begin to see if we can look into that.

16 To my point earlier on this line of questions, and to the
17 point where if you engaged in charging practices can it have a big
18 impact? Remember, all of this travels through a cost-to-charge ratio
19 which are based on different revenues which, as Chantal said, are not
20 directly aligned with the DRG.

21 So the impacts of raising your charges for certain services
22 is probably hard to track through and probably very specific to a

1 hospital. They may feel, and this survey says that hospitals are
2 engaged in a lot of different behaviors. They may feel that there's a
3 certain set of services that if they raise the charges on they'll see
4 the effects. And the effects could come through in the Medicare
5 payments but that's probably hard to see and judge and know in advance,
6 although you might establish it over time as a hospital.

7 Certainly the private side has been acknowledged by
8 everybody. We've acknowledged the outliers. Bad debt payments might
9 be influenced by this.

10 You made a statement if there at the margins --

11 MS. DePARLE: So would there ever be an incentive to ever do
12 anything other than have higher charges? And have you ever found an
13 example of charges that have been lowered? You asked the question of
14 over time if services diffuse or whatever.

15 I would suspect you're not going to find that.

16 I'm probably making this too complicated, but I just think
17 it's human behavior. This is all so complicated, so why would any
18 hospital ever assume it was in their interest not to increase charges?

19 If they aren't doing it for any untoward reasons.

20 DR. WORZALA: The conversations we've had leave me with the
21 impression that a charge is set and then it stays unless there's a
22 problem and it simply gets increased annually. I don't know of Ralph

1 or others have other...

2 DR. WOLTER: On the question of do hospitals ever reduce
3 charges, yes, on rare occasions. But they are rare and it would have
4 to do with recognition that out-of-pocket expenses have gotten very,
5 very high for a given procedure. That might be an altruistic reason to
6 do it.

7 And there are some cases also where ASCs or others come into
8 a market and to be competitive in your outpatient department you really
9 do go and try to make some adjustments downward. But that is certainly
10 not commonly done.

11 I was just going to give an example from our place for
12 whatever that's worth. We, on the inpatient side, are just over 50
13 percent Medicare, 50 or 55 percent. We probably have 25 or 30 percent
14 of our inpatient business that's commercial. Some of that's discounted
15 and some of it's discounted heavily. Some of it is actually based on
16 payment methodologies that's not related to our charges.

17 This is my observation of our finance department's behavior
18 on charge setting. They are looking at that 25 or 30 percent of
19 business more than they're looking at Medicare. Because when you raise
20 your charge, at least for the short run, your Medicare reimbursement is
21 not affected and people are not thinking about three year or so cycle
22 of re-weighting of DRGs as much as they are about how to get out of the

1 margin problem they're having in their given fiscal year.

2 So when those behaviors occur over 15 or 18 or 20 years,
3 which they now have since DRGs were originally put in place, their
4 actual relationship between your costs and your charges really does
5 start to change considerably.

6 And to the extent that the commercial payers pay you very
7 well in cardiology, orthopedics, neurosurgery, et cetera, you reinforce
8 in the Medicare system, through your behaviors of creating charges
9 aimed at the commercial market, weights that then drive payment that
10 are also a bit better in the Medicare system.

11 So my question has been, as we do this study, will we find
12 that that, in fact, tends to be the fact as we get more and more
13 information? It's sort of also my thesis.

14 I think the issues that raises are when we look at individual
15 DRG profitability, which we did to some degree in the transfer
16 conversation, we may not be looking at very good information on
17 individual margins anymore because those cost-to-charge ratios have
18 gotten so distorted over the years.

19 But more importantly, we just had a big conversation about
20 specialty hospitals and the focus on physician behavior. In the not-
21 for-profit world there are huge strategic decisions and capital
22 allocations being made around where the profitability is. And huge,

1 huge decisions about ortho and heart hospitals. And those behaviors
2 are very strong right now.

3 And yet, if you really want to look at how we might want to
4 apply resources into geriatrics or mental health or these non-surgical
5 areas, right now the payment system, I think, is driving us in a
6 direction that maybe doesn't balance how we might want those resources
7 to be allocated.

8 So this is very complex and it's very hard to get this data
9 but the importance, I think, is significant if we can get a sense of
10 how we might chart a new that direction.

11 MR. HACKBARTH: I think your observation, Nick, that this is
12 not just sort of a one-time problem but actually it accumulates
13 potentially the errors, the disconnect accumulates over time.

14 For example, one way it might would be a service that's
15 initially expensive when it's new. But as it expands in size and
16 experience the costs come down but the charges always stay up. And you
17 do that over a 20- year period and you're problem could be getting
18 dramatically worse over time, as opposed to the disconnect being
19 relatively constant.

20 MR. MULLER: Can I just make a narrow point on that among the
21 several very good points that Nick made. I'd like to at least follow
22 up on one in terms of what we can analyze, which is I agree with him

1 that the behavior of not-for-profit hospitals is especially much more
2 shaped by the opportunities on the private side than by Medicare
3 because of the administrative pricing in Medicare.

4 On the other hand, if you do have 20 years of higher charges
5 in neurosurgery and orthopedics and heart care and so forth, I'll go
6 back to the question that Jack took a crack at earlier. Does that have
7 an effect on the DRG weighting in a cumulative way? And perhaps doing
8 some arithmetic simulations of that might be worth it because it's not
9 hard to figure out that people with heart disease and prostate cancer
10 tend to be better insured than women who are 17-years-old and deliver
11 babies. They're just better insured and you have higher charges and so
12 on. And so after 10 or 20 years there are higher charges in heart care
13 than there are in delivering of children.

14 Does the cumulative effective 10 or 20 years of that have an
15 effect on the DRG rating? I think that is worth looking at. And
16 whether we want to do some arithmetic simulation of that, it may be
17 worth doing to see -- I grant Jack's point that it has more to do with
18 outlier policy but there may just be some skewing that we should look
19 at.

20 DR. MILSTEIN: My comments are somewhat overlapped with
21 Ralph's. Two comments.

22 Number one is, as Ralph was suggesting, the answer to this

1 question is modelable. That is both for Medicare and for non-Medicare
2 we can establish a quantitative sensitivity of the impact of a dollar
3 increase in charges on how much Medicare in the next year pays you and
4 how much non-Medicare payers pay you in the subsequent year.

5 There's a relationship there that relates to Bob's question
6 that relates to the size of the tail and the size of the dog. We don't
7 know that but I believe it is modelable.

8 Secondly, it would help me to get clear on the scope of the
9 question we're asking. We could have a narrow scope question, which is
10 post these adjustments that have just been made on gaming outlier
11 policy, what is the remaining sensitivity of how much Medicare pays to
12 every dollar increase in charges? That's a narrow question.

13 The bigger question is what are the indirect effects on the
14 Medicare program intermediate-term related to whatever sensitivity does
15 or does not exist with respect to charge increases that hospitals make
16 with respect to non-Medicare payers?

17 One could make the argument, I think Ralph referred to for
18 example the ambulatory non-Medicare areas -- this is not your exact
19 words -- but the last sort of arena of unconstrained hospital charge
20 setting or price setting that has some significance for revenue.

21 What does that do for the Medicare program intermediate-term
22 to have -- I'll call it from a purchaser perspective an unguarded

1 frontier, as it were, in terms of where there's a lot of remaining
2 price flexibility, a lot of payment systems based on charges minus X
3 percent?

4 That does have impacts intermediate on Medicare because to
5 the degree hospitals do not feel price constrained in any important
6 dimension in their revenue stream, their incentive to seek the kind of
7 efficiency capture that the IOM is talking about is reduced. And that
8 then has implications for the Medicare program.

9 So it would help me to understand whether or not we're trying
10 to, through our analytics and our modeling, answer the narrow question
11 or the broader question that would include indirect feedback loops on
12 the Medicare program from less charge flexibility on the part of
13 hospitals with respect to non-Medicare payers.

14 MR. HACKBARTH: Others can respond but my feeling is that
15 we've been talking primarily about the former. We're worried about the
16 direct impacts on the Medicare program and its mechanisms for setting
17 prices and therefore differential profitability and the like, as
18 opposed to the broader second issue.

19 This has been a helpful conversation for me. I think on the
20 one hand my impression is that the opportunities for individual
21 hospitals to game the charging system are primarily in the area of the
22 outlier payment and they have presumably been reduced, at least

1 somewhat, by the steps that CMS took.

2 On the other hand, I think it still may be true that Nick is
3 right that, although it's not conscious gaming activity, just normal
4 human behavior means that accumulating errors over 20 years could mean
5 that this important tool in the Medicare system is getting more and
6 more out of whack.

7 I don't think those are mutually exclusive possibilities.

8 Any other questions or comments?

9 Okay, thank you.

10 The last presentation is on state lessons in the drug card.

11 * DR. SOKOLOVSKY: As part of our continuing work of the
12 implementation of the Medicare drug benefit, you might remember last
13 spring we contracted with a team of researchers from Georgetown
14 University and NORC at the University of Chicago headed by Jack Hoadley
15 here from Georgetown, to look at what states were doing in terms of
16 enrollment and education, what their plans were for low-income
17 beneficiaries and dual eligibles.

18 What Jack found and what the team found was that states were
19 much more concerned with getting ready for the discount drug card. And
20 so we continued the project, looking at how the discount drug card was
21 implemented and particularly what lessons could be drawn from that that
22 would be relevant to the Medicare drug benefit.

1 Jack is going to present the results of that study.

2 MR. HACKBARTH: Welcome Jack. Good to see you again.

3 DR. HOADLEY: Thank you. I appreciate the chance to be here
4 and talk about this project.

5 Basically I want to go through several things, talk about
6 experiences that beneficiaries have had with the discount card program
7 seen through the filter of counselors and others who help beneficiaries
8 work through enrolling in a card and working with the cards.

9 Also comment a little bit about how the cards work a little
10 bit differently in the states with pharmacy assistance programs, what
11 the experience counselors are having with this process of doing this
12 counseling process, and then also we asked the same counselors a little
13 bit about what they were expecting looking forward to Medicare Part D.

14 This slide just basically runs through a few of the basics.
15 To refresh your memory, we haven't been in this discount card process
16 for very long. The card sponsors were selected back in March. Cards
17 first became effective in June. So we really, at most, have about
18 three months of experience with the cards actually being in place and
19 so I think that's an important caveat in thinking about what this
20 experience has been.

21 I also mention here the different aspects, enrollees select
22 one card with an enrollment fee of no more than \$30 and they have the

1 possibility of another card in the second year. Also the possibility
2 of signing up for transitional assistance of \$600, and we gave a lot of
3 attention to that particular aspect of the program for those low-income
4 beneficiaries eligible for transitional assistance.

5 Enrollment, the most recent numbers suggest that about 4
6 million beneficiaries have signed up for the cards, which is a bit
7 below what expectations were. Not clear whether these numbers will
8 continue to grow over the rest of the year and into next year or
9 whether we've sort of hit the plateau on this. There's no way to know
10 that. About 1 million beneficiaries have signed up for the
11 transitional assistance and there were actually expectations that as
12 many as 7 million beneficiaries could be eligible for transitional
13 assistance. So again this number is well below expectations.

14 It's also important to note that many of the people who did
15 enroll for these cards were auto-enrolled through one of two ways,
16 through their Medicare Advantage plans, those who are already in
17 Medicare Advantage plans could be auto-enrolled directly into a card.
18 And those that were already enrolled in state pharmacy assistance
19 programs in certain states, those states auto-enrolled people into the
20 cards. That actually accounts for a fair proportion, portion, probably
21 more than half of those that are enrolled in transitional assistance,
22 and perhaps quite a bit more than half although there are no hard

1 numbers out on that phenomenon.

2 Basically, our study consisted of interviewing about 20 to 25
3 people over the two months of July and August and a little bit into the
4 first of September. We talked to state health insurance assistance
5 programs, either state coordinators or some of the local or county
6 program folks for the different state SHIP programs. We talked to a
7 few pharmacists about their experience in counseling beneficiaries and
8 a few other sorts of beneficiary counselors who weren't directly
9 affiliated with the SHIP programs.

10 We had a general protocol that we followed and I should
11 emphasize this is obviously a qualitative study based on a relatively
12 small number of interviews but what is striking is that the
13 conversations we had across the different states were really quite
14 consistent. So that the things I'll talk about really were repeated
15 from across most of the interviews we had.

16 As the counselors report their enrollment experience, and I
17 will reemphasize that it is the reports of counselors that we're
18 dealing with, we didn't talk directly to beneficiaries for this study,
19 what is it that has worked about the discount card program?

20 One thing is that the counselors do report that real savings
21 seem to be available for at least some beneficiaries, especially those
22 eligible for transitional assistance and those with no other coverage.

1 When they sit down with the beneficiary and look at what their drugs
2 are and what their situation is, they often can find real savings for
3 these folks.

4 They also report that although the web site can be confusing,
5 especially for beneficiaries, it has improved. And from the
6 perspective of the counselors, the web site and the web tool has been a
7 very valuable resource to them in working with the beneficiaries.

8 Also, despite some of the speculation before the program
9 started, there has not been a lot of fluctuation in drug prices, at
10 least what the counselors have seen and this seems consistent with
11 other studies of this, that prices, after at least the first few weeks
12 that the discount cards were up, pretty much have stabilized. So
13 people are seeing the discounts that they're expecting when they
14 enroll.

15 The other thing, I think, that has worked is that counseling
16 has been available to folks. The SHIPs and others have really made it
17 possible for beneficiaries to get help in enrollment and working with
18 the cards.

19 So what do they report has not worked as well? One of the
20 consistent things we heard about was considerable confusion among the
21 beneficiaries. Beneficiaries are confused by the large number of
22 choices that they're facing, the fact that there may be something like

1 30 to 40 different cards to look at is really quite overwhelming to a
2 lot of the beneficiaries according to the counselors that we talked to.
3 In fact even, in some cases, overwhelming to the counselors.

4 That selecting a card is quite difficult for a beneficiary
5 without the help of a counselor walking through this process.

6 There is even confusion about trying to understand what the
7 discount card is versus what's in Medicare Part D. They're hearing a
8 lot of the publicity about Medicare Part D and some of them are having
9 trouble sorting out with the discount card does versus what Part D
10 does.

11 We also heard that beneficiaries didn't trust the program,
12 were just suspicious about this, what this was going to be. They were
13 concerned about the fact that prices would change and wouldn't be what
14 they were advertised even know, as I said before, that has tended not
15 to be the case at least so far in the program.

16 Part of what hasn't worked is that a lot of beneficiaries
17 have just decided not to choose a card. In being overwhelmed, their
18 response is to just say I can't deal with it, I'm not going to pick
19 one. And they can't seem to -- the counselors even have trouble
20 convincing them that this investment up front may actually pay off.
21 Some of them look at the up front enrollment fee and say well, I'm not
22 going to put down \$20 or \$30 for something that I don't even know

1 really has value to me, again having trouble getting past that notion
2 that there's this up front cost, even though there may be savings once
3 they really get enrolled and start to see things.

4 They just see it as a big hassle and especially because it's
5 a short-term program. They say this is going to come and go in 18
6 months. I'm just not going to bother. Obviously, this isn't everybody
7 but this is a surprising number of people, and again we heard this
8 repeatedly from the counselors we talked to.

9 Some others talk would talk about the fact that they already
10 have easier access to other discounts. Some talked about the cheaper
11 prices they get from Canada when we talked to states that are up along
12 the northern border. Others would talk about getting better discounts
13 from places like Costco or Target or wherever they tended to go.
14 Empirically, this may not prove to be true. They may actually be able
15 to get better discounts from the discount cards, but they're happy with
16 discounts they're getting and don't seem to want to look for others.

17 Of course, in some cases people have other coverage and
18 that's another factor. In those cases, the card isn't so relevant to
19 them.

20 The specific case of the states with pharmacy assistance
21 programs is a little bit different. Here we've got a situation where
22 the state can save money if the transitional assistance eligible

1 beneficiaries do enroll in the cards and do enroll for transitional
2 assistance. So what has happened is in all of the larger states with
3 the larger pharmacy assistance programs and some of the smaller ones as
4 well, were able working with CMS to set up auto-enrollment procedures
5 which have proved to be quite effective.

6 In those cases, they pretty much got everybody who was
7 eligible for transitional assistance enrolled in a discount card. In a
8 number of the cases the states share the savings with the beneficiaries
9 by reducing the copays that they otherwise would have had in the state
10 program in order to provide some incentive for the beneficiary to see
11 the value on this. In a few other state they just said well, it's
12 saving the state money and that will benefit you in the long run even
13 if it doesn't benefit you in the short run.

14 It's also true, however, that in most of these states people
15 enrolled in pharmacy assistance programs who are not transitional
16 assistance eligible are generally better off not getting a discount
17 card. Their state program is providing them a better deal than they
18 would get through the card. And so most of those did not enroll.

19 We did hear, though, that the Medicare discount card
20 publicity generated some new enrollment in the state programs, which is
21 a good thing. And also, in some cases, people would come in these
22 states and folks who had missed the threshold for enrollment in the

1 program people, the counselors could now tell these folks you can
2 enroll in this discount card and while it's not as good as the state
3 program at least it's something. In some cases, that was an effective
4 thing.

5 So what did counselors tell us that seniors did on their own
6 in the process of trying to confront this program and learn about it?
7 A very few number had tried the web site on their own, tried to work
8 through the tool that's there on the web site. We heard that most
9 seniors either don't know the Internet, don't have good connections,
10 and in particular don't have high-speed connections. And without a
11 high-speed connection, working with the web site tool is really pretty
12 difficult.

13 I do have to put the caveat that we're talking to counselors
14 who are seeing people who ended up talking to them, not to the people
15 who could do it on their own and never even talked to the counselors.
16 So it's hard to make a judgment of how many other seniors were
17 successful with the web site or the 800-number and never made it to the
18 counselors, although the number of people enrolled suggest that those
19 can't be too enormous in numbers.

20 More people had at least contacted 1-800-Medicare for
21 information but often found it was too complicated to work through
22 their situation, again with this bias that we're hearing the people who

1 made it through to the counselors and didn't stop after talking to 1-
2 800-Medicare.

3 Almost all of the seniors reported getting mailings from the
4 card sponsors. Many had talked to friends, family, pharmacists,
5 physicians and ended up getting referred to the state SHIPs for help
6 through many of these other sources.

7 So what is it that the SHIPs are really doing? They're
8 starting by doing substantial outreach efforts and I think I talked
9 about this a little bit in the spring when I spoke to you about our
10 previous project, that states were planning these kinds of outreach
11 efforts.

12 Some states did really quite massive outreach programs. We
13 talked to one county level counselor in one state and she personally
14 had been out, I think, and done 18 different programs all over about a
15 six week period, going around the county and talking to different
16 groups of seniors. So there were a lot of those. And everybody we
17 talked to talked about a systematic attempt to get out there and talk
18 to seniors in different kinds of venues.

19 We did hear, however, that the turnout for these often was
20 pretty substantial but wasn't always. In one case we were told about a
21 program that was scheduled at a retirement community where they were
22 accustomed to doing programs and getting quite high turnout, and ended

1 up canceling the session because the turnout was so minimal. People
2 already seemed to be convinced that this card wasn't something they
3 were interested in knowing more about, was the impression that they had
4 as to why that happened. Some states did fliers and letters and other
5 kinds of things. But mostly it was through these outreach
6 presentations.

7 The other piece of it is the one-on-one counseling, that's
8 really the bread and butter of the SHIP programs.

9 States definitely told us that their workload, their turnout
10 for one-on-one counseling had risen but that the numbers weren't
11 overwhelming. They had some concerns going into this that they might
12 just really be overwhelmed by this process and that wasn't the case.
13 People did seek one-on-one counseling in response to outreach or other
14 publicity, and so they did get a fair amount of this.

15 What's a typical counseling session like? What they try to
16 get people to do is bring with them a list of their drugs and their
17 income information, the same kind of thing that they're told if they're
18 calling 1-800-Medicare or going onto the web site that they need to do.
19 And then the counselor sits down in a session that can often take as
20 much as an hour and really works through, enters the drugs, puts in
21 their information, puts in their location and tries to narrow down the
22 choices. Many of the counselors, what they would try to do is identify

1 three or four programs that look like the best deals for the
2 beneficiaries involved.

3 Typically, they did not recommend a single program to the
4 beneficiaries. They asked the beneficiary to make the choice. They
5 offered, in some cases, to fill out forms. In other cases they would
6 send home the materials and the application form.

7 And then, in some cases a follow-up session was required. In
8 fact, one counselor said they often ended up meeting the people three
9 different times. The first time they would come in and talk and
10 discover they didn't really have with them complete information on the
11 drugs that they were taking so they'd come back a second time, maybe
12 with a bag of pill bottles so they could go through and be very
13 precise. And then sometimes come back a third time after they'd made a
14 decision for help filling out the application.

15 So this tended to be a pretty intensive process. One
16 counselor even said that she tended to call up the pharmacy where they
17 got their prescriptions done to try to find out exactly what they were
18 paying today for their drugs, so they could really get a fix on whether
19 there was a savings.

20 So some of these counselors went through a very elaborate
21 process to try to help people.

22 What do the counselors tell us that beneficiaries decide?

1 They said there were a fair number of people who ended up deciding, for
2 the reasons I suggested earlier, just simply not to enroll. In some
3 cases, a very logical decision that the cards weren't a better deal
4 than what they were getting today. In other cases, perhaps they still
5 has this feeling of being overwhelmed and just I don't want to deal
6 with that. I don't want to pay the up front fee. I'm not sure I'm
7 really going to get anything when it comes out.

8 But many did enroll. And those that do tended to pick one of
9 three strategies. They either looked for the best savings across all
10 the cards, even if it meant going to a new pharmacy to get a better
11 deal. This was especially easy when the counselors narrowed the number
12 of choices to sort of the best three or four cards.

13 Others tended to say I want to go to the pharmacy I'm
14 accustomed to going to, so they'd look for the best card that had that
15 particular pharmacy in the network.

16 Others seemed to really be bothered by the enrollment fee and
17 so looked to those cards with no enrollment fees and would pick one of
18 those, even if it was possibly not as good a deal overall but just
19 didn't like the idea of paying that up front fee.

20 So what did the counselors say in their reviews of this whole
21 process? They said overall these counseling sessions went smoothly.
22 They were good sessions. They felt really good working with the

1 beneficiaries. They were lengthy sessions, as I've said before.

2 They also were pretty consistent in saying that the web-based
3 decision tool for the counselors worked quite well. In fact, one
4 called it a godsend, that this really made it possible to work through
5 this process with the beneficiaries.

6 Most of them, as I said before, don't recommend a specific
7 choice for the beneficiaries. And as they reviewed the card program
8 itself, their reviews were more mixed. Some of them pointed to a lot
9 of flaws in the program, and I'll come back to that in a minute.

10 They also, though, told us some very positive spillover
11 effects. The fact that the publicity over this program got people to
12 come in and talk to them gave them the opportunity to discuss other
13 programs they might be eligible for and it generated new enrollment in
14 the state pharmacy assistance programs. It generated new enrollment in
15 Medicare Savings for people who were dually eligible for Medicaid.

16 It also gave them a chance to talk to them about other ways
17 to get help in buying their drugs, some of the drug manufacturer
18 assistance programs and the other things and other special programs
19 that might be eligible for their unique circumstances. And so, the
20 fact that they got in and talked to people really had a lot of positive
21 spillover effects.

22 We also noted, through the interviews, that there was a lot

1 of variation in the SHIPs. In some cases, their resources vary quite a
2 bit, the resources for outreach and counseling. You have to remember
3 that these SHIPs, while they have a few permanent staff, the bulk of
4 the work that is done is by volunteers. One-on-one counseling, in many
5 cases, is done by volunteers. So they're spending a lot of time
6 training volunteers and depending on the availability of volunteers to
7 do these things.

8 Some of the programs are quite well prepared and quite well
9 funded. They're building from a good base. They've had a lot of
10 success in past years. They integrate this new program with their
11 other counseling. They try to make it just seamless as part of their
12 normal operations. As some of them said, we just built this in to one
13 more thing we talk to seniors about.

14 It was also, as I said before, a chance to educate clients
15 about other resources available.

16 In other states, the programs would really struggle with some
17 of the basics. They had an absence of outreach sites or volunteers.
18 And they had problems with computers. In one state they talked about
19 trying to set up programs around some of the really remote rural areas
20 of that particular state and they'd get out to the state and discover
21 there was no computer available to use. Or if they had one there was
22 no Internet connection available with the computer. Or if it had an

1 Internet collection it was a dial-up. And trying to do this, again,
2 over a dial-up just was not very effective, especially trying to get
3 through these things quickly.

4 I think the programs vary based on just the resources they
5 have, the state funding as well as the federal funding that they have.
6 But it's also a lot about the history and the partnerships they
7 develop. Some of the best programs have really extensive histories and
8 partnerships and go at it with a lot of enthusiasm.

9 We also, as I said, talked to a few pharmacists. Pharmacists
10 generally reported a lot less activity on the counseling side. They
11 did get a spike of inquiries when the program was new and all the
12 publicity was initially out initially out but that quickly tapered off,
13 we were told.

14 Some of them put signs in their windows and did other things
15 to solicit inquiries. Some pharmacists really seemed to take a
16 personal interest in trying to talk to some of their longtime clients
17 who maybe had trouble paying for their drugs to try to get them
18 involved in these cards.

19 There were other pharmacists, it seems, not ones we talked to
20 directly but ones we were told about, that seemed unwilling to take the
21 time to help. They were busy with their business and didn't really
22 want to take the time to talk to customers in what they knew would be a

1 longer process.

2 There were also some concerns from the counselors we talked
3 to that pharmacists had a tendency to recommend only the cards that
4 their drugstores were cosponsors of or their chain or whatever was a
5 cosponsor of and that was somewhat of a concern that we heard about as
6 well.

7 What about the experience actually using the cards for those
8 that signed up? The counselors did report -- first of all, we've only
9 had this going on for a couple of months and a lot of the enrollment
10 didn't even happen as early as the first of June. But they have not
11 heard much about problems. They say our folks, when they talked us for
12 this kind of counseling, if they have problems they're going to call us
13 up again and they're not. We're not hearing back that oh, we went to
14 the drug store and the card wasn't being accepted. Cards to seem to be
15 accepted. The discounts people expected seem to be getting there. Or
16 at least there is no evidence to the contrary, based on complaints back
17 to the counselors.

18 We also heard more consistently or least from more different
19 people that where the states had the pharmacy assistance programs and
20 they were try to interact between their card for the PACE or the EPIC
21 program and the new discount card that that interface had worked quite
22 well, and there were really very few problems with that.

1 So to wrap up, what were the sort of assessments and
2 recommendations that counselors told us about the discount card? They
3 consistently told us they would prefer to see fewer choices. This idea
4 of having as many as 40 choices was just too much.

5 They also felt that there were a number of people not being
6 reached. And they have a real frustration and concern that they do not
7 know how to get at some of these hard to reach populations.

8 One explicit comment we heard a couple of times was the need
9 to make materials available in more languages, that while there are
10 more than just English available, that there's a lot of languages in
11 these communities where there aren't materials available.

12 But they are equally frustrated how to reach some of the
13 sicker populations, the poorer populations, the ones who don't tend to
14 come in, who don't know that these SHIPs exist.

15 They also said we needed more time at the beginning. They
16 understood that was a program that was rolling out quickly. But they
17 needed more time to learn about the program to be able to be good
18 counselors. And that's something that they felt was a concern.

19 They also did say that the discount cards were a hard sell to
20 the beneficiaries they talked to for the various reasons that we've
21 talked about.

22 When we asked them about Medicare Part D mostly they told as

1 well, it's still far away. We're not sure what that's going to look
2 like. But some of the concerns they did raise was that they were
3 concerned that the program would be more complex and that that would
4 make the counseling process pretty complicated.

5 They were also concern that the consequences of mistakes are
6 greater, particularly because of the late enrollment penalty, which is
7 something that they're very aware of.

8 From their perspective, they're concerned that more people
9 will be affected. Now this isn't saying that that's a bad thing about
10 the program, that it's simply something that they're going to have to
11 deal with as counselors, not only the relatively few people for whom
12 the discount card was a potential good deal but Medicaid beneficiaries,
13 state program enrollees that could mostly not pay attention to the
14 discount card will have to pay attention to Part D. So they know this
15 is just a bigger process. They also know that it's a more complex
16 program. There are a lot of complexities of benefit design,
17 formularies, interactions with existing coverage and they know they've
18 got a lot of work ahead of them.

19 Finally, one of their recommendations about Medicare Part D,
20 they think it's really very important that messages about the program
21 be clear and simple. I mentioned before the confusion about the
22 discount card versus Part D. They felt that some that was because a

1 lot of the early publicity said here's this discount card rolling out
2 and then there's going to be Part D coming after that.

3 They said what would be much better is talk about the thing
4 that's there now. Don't also talk about immunizations, physicals and
5 other kinds of things. Talk about the thing that they need to know
6 today.

7 They also said that more choices is something that's going to
8 complicate the education process. And if there are a lot of choices
9 that that is a concern to these counselors.

10 They also say you need to allow plenty of lead time to
11 prepare the counselors. They need to know about what's available in
12 their community enough in advance to get on top of it before the
13 onslaught of open season occurs.

14 They also would like to see more focus on educating
15 pharmacists. They think they are an important part of the contact that
16 people have and that they need to understand the programs.

17 They also point out consistently that seniors are not
18 Internet savvy and that programs need to be wary of overemphasis of web
19 use, even though web use can be very important to them as counselors.

20 And finally, they point to the need for more and better ideas
21 for finding, educating and enrolling the hard-to-reach beneficiaries.

22 Thank you.

1 MR. HACKBARTH: Thank you, Jack.

2 DR. MILSTEIN: A few questions.

3 First, have any of these programs attempted to calculate what
4 their costs are in getting somebody onto the program? And what
5 relationships those costs bear to the likely incremental savings
6 resulting from the card?

7 DR. HOADLEY: I don't think we ever asked a question that
8 specific. We did talk to them some about the resources involved but
9 nothing that was that focused, so I can't answer that.

10 DR. MILSTEIN: Another question is are any of these programs
11 attempting to either expand the benefit of the counseling by moving
12 into scope questions like obvious things like opportunities for generic
13 substitution that a senior may not have appreciated? And/or already
14 making efforts to improve the quality of the counseling, such as some
15 Medicaid agencies who now have these handheld sort of Hertz check-in
16 type things to help the Medicaid enrollment process go faster and be
17 more accurate? I can imagine something similar for these programs so
18 that your quality control on the counseling process goes up and the
19 efficiency of the process goes up. Many programs making headway in
20 I'll call it the performance of their services?

21 DR. HOADLEY: On the first question, I think there were very
22 few states that do try to get their counseling very broad, so that they

1 might sometimes talk about generics just like they would talk about
2 well, you have this Pfizer drug and Pfizer has this special program. Or
3 we're looking at your drugs and there are some generic alternatives.
4 Some of them do, I think, take an active role in trying to do that.

5 To the second question, I certainly didn't hear anything
6 about that. And I think what we would probably hear, just to
7 speculate, is the resources to do it in the front end. They are
8 working on real shoestring budgets, in most cases, and I think they're
9 struggling just to do what they're doing and would need up front
10 investments, I think, to move in those new directions.

11 MR. HACKBARTH: Jack, could you just say a little bit more
12 about the funding of the SHIPs, how much, sources.

13 DR. HOADLEY: I don't have numbers, at least not in my head.
14 The sources, some of the money is federal and there were some
15 additional grants available to the SHIPs through the MMA to help. And
16 states certainly recognize that, the program folks recognize that.
17 Although one complaint I did hear was that why do all of these new
18 streams of funding always have to be a grant that we have to sit down
19 and fill out a proposal for? And so they waste time, they feel, in
20 having to go through an application process to get new funding instead
21 of just getting the funding.

22 They get state funding in, I think, most cases. They're

1 generally based at area agencies on aging or other places within the
2 state government, departments of aging. And so certainly some of their
3 funding comes from the state. And then they have partnerships with
4 private organizations. So some of them very actively work with,
5 whether it be AARP chapters or other local senior organizations, to try
6 to build partnerships. And then they use volunteers, as I said before.

7

8 But I think the bulk of their funding is a mix of state and
9 federal, but the numbers I don't have with me.

10 MS. DePARLE: We also gave them -- I think at the time of the
11 BBA they were mostly state funding and we gave them -- I mean, it's
12 still pennies, but a substantial increase as part of the BBA because we
13 were trying to build up their capacity.

14 But as you say, Jack, they're still tremendously under-
15 resourced and that could be certainly one way to use some of the
16 additional funds that Congress gave CMS to implement this benefit, even
17 though they are disappearing funds, in a sense. But one would hope
18 that Congress will recognize the need for this.

19 DR. WOLTER: This reminded me a little bit of the
20 conversation yesterday on benefit design and copays and caps and the
21 whole tension between innovation and flexibility and choice and options
22 versus the complexity of the choice making.

1 I do think, as we have a chance to address those issues, how
2 you would cast the balance of that I'm not certain. But I do think
3 it's an issue. And right now it does seem like we're much more on the
4 side of complexity than we are on clarity. And we may want to try to
5 guide things in that direction.

6 MR. HACKBARTH: And by coincidence, there was a piece in the
7 Post this morning, a column on the business page, about research on
8 choice and how people process choices and whether they do well with
9 open choice versus these types of constrained choice.

10 I don't know how much research exists on that question and
11 what its utility might be, but it is a very interesting, and I think
12 increasingly important, question for the Medicare program.

13 MR. MULLER: There's a lot of research at NORC on that.

14 MR. HACKBARTH: Anything else?

15 Thank you, Jack. Well done

16 We'll now have a brief public comment period.

17 * MR. FENIGER: You always preface it with brief, after lengthy
18 and interesting discussions.

19 MR. HACKBARTH: And when you get up I say really brief.

20 MR. FENIGER: Because you've heard this before.

21 Randy Feniger with the American Surgical Hospital Association
22 and, of course, I would like to comment on the beginning discussion of

1 the work so far on the MMA assignment.

2 Congratulations to the staff for what I thought was a very
3 well done presentation about a very complex issue. And I was also very
4 impressed by the depth of the discussion of the members of the
5 Commission. You obviously have given a lot of thought to this and
6 recognize that this is not a slam dunk one way or the other. There are
7 many complex issues. And I think certainly as an industry we
8 appreciate that.

9 We had very positive feedback from our own members who were
10 visited in the site visits, in terms of their interaction with the
11 staff. So I think that simply reflects upon the quality of your staff,
12 the way they handled themselves out in their site visits. And they
13 would be welcome back, which is not always what we say about government
14 officials.

15 Some points I would like to have you keep in mind as you go
16 forward in your consideration. A good bit of discussion about self-
17 referral and the potential for conflict. I would only say what about
18 the conflicts created when a hospital employees physicians or owns
19 medical practices? There are silly pressures there to make referrals,
20 to make judgments. I think we have to be extremely careful in if we're
21 going to look at one, we look at all of them to try to sort that out.

22 The issue that was raised in a number of comments, trying to

1 analyze in a community the impact of a hospital, especially the
2 hospital opening, and change in procedure level or capacity. What
3 benchmark do you use to evaluate that change as either positive or
4 negative?

5 I think that's going to be very, very important because an
6 individual community may not be providing adequate amounts of heart
7 care or orthopedic care. The specialty hospital adds to that. I'm not
8 saying that's true in every case. But I think that the benchmark you
9 use for the basis of your judgment will be important.

10 Most of this focused on investors. I would encourage you and
11 encourage the staff to take a look at those physicians -- and perhaps
12 they have and it was just not discussed as much. There are on average
13 three times as many physicians with attending privileges at these
14 hospitals as there are investors.

15 So obviously, there's something attractive about this model
16 for other physicians who haven't put a nickel into the system. I think
17 it's important that you understand that as a Commission, that the staff
18 develop that to the extent that they are able to, because I think it
19 goes right to the heart of whether this is driven simply by a financial
20 issue or it's driven by other more complex issues related to physician
21 efficiency, patient quality, et cetera, et cetera.

22 The point was made that heart hospitals are the dominant

1 Medicare provider in terms of a number of patients but they are not the
2 dominant model in the industry. We have 71 member hospitals. Only
3 five are cardiovascular hospitals. All of the others are mixed
4 surgical hospitals. They provide, on average, six surgical specialties
5 in their service mix.

6 So I would be concerned, and hope you would be cautious,
7 about making decisions that affect everybody based on the heart model
8 alone. It is a different kind of hospital and I don't mean this in any
9 way critically. It is simply not the style of hospital that we see
10 across the country that most physicians are involved in.

11 Also, the stories behind these, the point was made -- I'm
12 not sure which commissioner made it -- that these companies come and
13 hunt for investors in sort of build it and they will come theory. Most
14 of these hospitals arise out of conflict between medical staff and
15 hospitals. And then physicians, because they can't resolve it, rightly
16 or wrongly, then may turn to an investment group or corporation to
17 develop an alternative solution.

18 I think those stories may be important, perhaps a good lesson
19 for hospital management graduate programs.

20 Financial impacts on community hospitals, as was discussed,
21 are multifaceted. Isolating the specialty hospital is the cause of
22 financial change in an individual institution or group of institutions,

1 I think is going to be very, very tricky. I think it's very easy, if
2 your money isn't doing quite what you want it to as a hospital, to say
3 well, it's that specialty hospital across town. I was fine until then.
4 But we heard that about for-profit hospitals 20 years ago. We heard
5 that about ASCs 20 years ago. We still have hospitals in business. So
6 I'd be a little careful on that.

7 The rural issue is an important one. There are not a lot of
8 hospitals. I have been told, and this is anecdotal, by people in rural
9 communities, the presence of the specialty hospital is often a tool to
10 recruit additional specialists who would not otherwise be willing to
11 come to that community. And that may be something that, to the extent
12 the staff is able to look at the rural issues at all, they might want
13 to get behind that and see has it actually improved the quality of
14 care.

15 And finally, I think you really hit on the debate towards the
16 end and then the second discussion after that really got into it. This
17 is an issue about the correctness or the accuracy of the payment
18 system. Hospitals use subsidies to pay for things.

19 To the extent that we, as a society, agree community
20 hospitals provide social goods that we want, we should be prepared to
21 pay for them. If we are not paying for them accurately, I would think
22 that should be the focus of the ultimate analysis. I realize you have

1 to make a report on specialty hospitals.

2 But I think the issues as you got into them in both your
3 discussions are much broader and I think we would very much welcome a
4 debate over the quality and accuracy of the reimbursement system, as
5 opposed to whether competition should be allowed to develop in any
6 given community under state or federal law.

7 Thank you.

8 MR. HACKBARTH: Okay.

9 Thank you, very much.

10 We're adjourned.

11 [Whereupon, at 11:49 a.m., the meeting was adjourned.]

12

13

14