

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
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COMMISSIONERS PRESENT:

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DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

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

2 MR. HACKBARTH: Welcome to our guests in the
3 audience and I apologize for the temperature in here. It
4 actually feels like it is getting a little bit warmer. It's
5 been quite cold.

6 Our first item for today is a presentation on what
7 is basically our context chapter and each of our March
8 reports. Rachel?

9 DR. SCHMIDT: Good morning. Today I'm going to
10 walk you through some information that, with your input, we
11 will turn into the introductory chapter of the March report
12 to Congress. Since that report will include your
13 recommendations for payment updates we tried to use that
14 first chapter to put those recommendations within the
15 broader economic context as you begin to consider -- in
16 which the Medicare program operates. By describing the
17 overall spending context as you begin to consider update
18 recommendations, we're also trying to be responsive to a
19 mandate within the MMA for MedPAC to consider the budget
20 consequences of its recommendations.

21 when MedPAC reviews payment rates for each sector
22 of providers we try to keep in mind what would be adequate

1 payment for efficient and effective providers that are
2 providing appropriate care. We do that because part of the
3 Commission's role is to get the best value for Medicare's
4 resources, which are really the resources of taxpayers and
5 beneficiaries.

6 We aim to walk a line between ensuring good access
7 to quality care for Medicare's enrollees while using the
8 program's resources efficiently and effectively. In recent
9 years you have taken a particular interest in exploring how
10 Medicare might link payment to quality.

11 Part of the reason for doing this is to better
12 serve the clinical needs of beneficiaries. But another
13 reason may be that in some cases paying more for better
14 outcomes or higher quality could improve the efficiency of
15 how care is provided. This is not always the case but it
16 may be at times. This draft chapter tries to describe the
17 economic landscape for Medicare and some of the trade-offs
18 and goals for the program.

19 Now let's take a look at some of the forces
20 affecting health care spending in general and the Medicare
21 program in particular.

22 This slide summarizes the most important trend to

1 focus on, the fact that health care spending has been a
2 growing part of our economy, and all indications suggest
3 that it will continue to grow faster than national income
4 for the foreseeable future. The United States spent about
5 \$1.4 trillion on personal health care in 2003 or about 13
6 percent of our gross domestic product. This includes health
7 care services funded by all payers. So private health
8 insurance, public programs like Medicare, and out-of-pocket
9 spending. The Medicare program spent about \$281 billion
10 that same year, or about 2.6 percent of GDP.

11 This chart shows you that over the longer term
12 there's been a steady upward trend in the share of our
13 nation's resources devoted to health care. Notice that
14 there was a period in the 1990s when these lines were fairly
15 flat, a time when managed care was introduced and plans were
16 able to bargain successfully with providers over payment
17 rates and, to some extent, to control the uses of services.
18 Also, the Balanced Budget Act of 1997 put constraints in
19 place on the growth in Medicare spending.

20 However, the lines have begun rising again and
21 many analysts believe that the flat period of the 1990s was
22 an anomaly. There was a subsequent backlash against managed

1 care. Consumers demanded broader networks of providers, and
2 providers exerted more bargaining power in negotiations over
3 payment rates.

4 So now spending is on its upward trajectory again.
5 There are some important effects that result from this. On
6 the one hand, health care industries are a growing part of
7 our economy, creating jobs and providing new technologies
8 that can improve our lives. On the other hand, health care
9 costs have grown to the point that some businesses say it is
10 affecting their ability to compete in the global marketplace
11 and some workers are deciding that they cannot afford health
12 insurance premiums.

13 The relative market power of plans versus
14 providers is an example of a short-term factor that affects
15 growth in health care spending. So let's talk about the
16 factors that affect growth over the longer term.

17 Most economists have concluded that innovation is
18 the biggest driver of spending. Some new health
19 technologies spend money, for example by helping to avoid
20 hospitalizations or reducing lengths of stay. However, in
21 some cases, innovations may not be worth their costs, and
22 even in a few cases might have been harmful in unexpected

1 ways.

2 Many innovations lead to higher spending because
3 they increase the demand for health care. Providers and
4 their patients become aware of how to use those technologies
5 more broadly. And since many innovations reduce the
6 invasiveness or pain of treatments, more people want the
7 therapy.

8 Other characteristics of the U.S. health care
9 system interact with new technologies to increase the demand
10 for health care. For example, while insurance is good for
11 limiting the potential out-of-pocket liability of
12 beneficiaries, it can also lead people to use more care than
13 they would otherwise if they paid for it all themselves
14 directly at the point of service.

15 Likewise, providers may not be sensitive to the
16 cost of care when deciding among treatment options. Many
17 people's expectations about how long they will live and what
18 the quality of their lives should be is changing. And as
19 our standard of living increases, so does our demand for
20 health care services.

21 Of course, the Medicare program is affected by
22 demographics, specifically the coming retirement of the baby

1 boom population. Our country's lifestyle has become more
2 sedentary than before. That fact, in combination with our
3 high fat diets, has led to a higher prevalence of obesity
4 and more of the chronic conditions that are associated with
5 it.

6 And last but not least, some analysts point to
7 Medicare's payment systems as providing little incentive to
8 control spending since, in many cases, providers are paid
9 more for doing more.

10 So there are a lot of upward pressures on health
11 care spending in general and on the Medicare program in
12 particular. It's also important to bear in mind for the
13 context of Medicare that the federal government is facing a
14 sizable budget deficit. This chart shows the latest
15 baselines from the Office of Management and Budget and the
16 Congressional Budget Office. Both organizations estimated
17 that for fiscal year 2004 the deficit was about \$415 billion
18 or 3.6 percent of GDP, about where the vertical line is on
19 this chart. That's the largest it's been since the early to
20 mid-1990s when Congress passed the Budget Enforcement Act
21 which included pay-as-you-go rules for constraining growth
22 in spending associated with entitlements and tax changes.

1 The Congress has been considering readopting pay-
2 go rules but has not yet done so formally. In any event,
3 there may be considerable pressure to limit Medicare's
4 program spending in order to reduce the deficit, but at the
5 same time there are a lots of upward pressures on program
6 spending.

7 I just want to remind you briefly about the
8 sources and uses of the Medicare program's resources. We
9 tend to focus on things like trust fund balances when we
10 talk about Medicare's financing. This chart combines all
11 types of funding and benefit spending together without
12 making distinctions between Parts A and B.

13 The pie chart on the left-hand side shows you that
14 in 2003 just over half of Medicare's total financing came
15 from payroll taxes that active workers and their employers
16 pay into the Part A Trust Fund. Another 30% came from
17 general tax revenues. That's the taxes we all pay that
18 aren't dedicated to a specific use like the payroll taxes.
19 Beneficiary premiums, mostly for premiums on Part B, made up
20 just 10 percent while interest on trust fund balances and
21 other small sources made up the rest.

22 The pie chart on the right-hand side shows how

1 Medicare used its resources on 2003. The majority, 45
2 percent, were paid for hospital care with 17 percent going
3 for services on the physician fee schedule. 13 percent went
4 to managed care plans, 5 percent went to skilled nursing
5 facilities, 3 percent for home health, 2 percent for CMS's
6 administrative expenses and 14 percent for other services
7 that include hospice, clinical lab, DME and other things.

8 I'm showing you a chart that was put together by
9 CMS's Office of the Actuary for the 2004 Trustees Report.
10 This shows you their long-term projections of Medicare
11 program spending, which is the height of the top line of
12 these stacked layers, along with the expected sources of
13 funding which are the layers themselves except for interest.

14 We're sitting at the point shown by the vertical
15 line, with Medicare making up just under 3 percent of GDP.
16 Note the bump-up in 2006, when the new prescription drug
17 benefit begins, which will bring Medicare up to about 3.4
18 percent of GDP. Over time, the trustees expect that share
19 to grow to about 8 percent of GDP by 2036 and about 14
20 percent by 2078. That growth is driven by the things we
21 talked about, medical innovation, the retirement of the baby
22 boomers, and so on.

1 The scare part of this chart is the layers. First
2 off, note the yellow layer at the bottom, payroll taxes on
3 active workers. That makes up about half of the financing
4 today but look how it's flat and becomes a smaller share of
5 the total picture over time. That's because the payroll tax
6 is a fixed percentage of earnings and there will be fewer
7 workers supporting each beneficiary in the years to come.
8 Today there are about four workers paying taxes for each
9 enrollee in Part A. But that ratio will fall to about 2.4
10 workers per beneficiary in 2030 and 2.0 in 2078.

11 Note that premiums from beneficiaries are expected
12 to grow over time, both for Part B and the new Part D.
13 However, most of the funding will come from general tax
14 revenues, the dark blue area. Today, general tax revenues
15 make up about 30 percent of all funding, but that share is
16 growing.

17 The MMA put in place a trip wire to make
18 policymakers consider changes in Medicare program financing,
19 when general revenues are projected to reach 45 percent of
20 program outlays. This wire could be tripped in just a few
21 years from now. That means that the president would have to
22 propose and the Congress would have to consider legislative

1 changes to reduce the share of financing from general
2 revenues.

3 Also note the red area at the top. I'm sure you
4 know that this year the Trustees projected that the Part A
5 Trust Fund will be exhausted in 2019. The red area shows
6 you how much revenue the Medicare program will need to make
7 up to keep Part A benefits as they are today. Under the
8 law, the Medicare program cannot pay for benefits once the
9 trust fund is exhausted, so policymakers will need to make
10 changes to address this shortfall.

11 So clearly, there's a lot to be concerned about in
12 terms of Medicare's long-term financing, not to mention the
13 overall health care spending in our economy. Which raises
14 the issue of how much do we value health care services and
15 how much do we want to spend on it?

16 It seems that our society values health care a
17 lot. Our health care spending has led to improvements in
18 public health and medical innovations that have lengthened
19 our lives and kept us healthier than before. But that's not
20 to say that all new technologies have been worth their
21 expense. Some have not. And it's not always clear that
22 every use of a new technology is worth its cost.

1 The body of research by Elliott Fisher and the
2 Wennbergs has shown that a lot of our health care resources
3 aren't used very efficiently or effectively. They found
4 that higher spending areas of the country do not necessarily
5 have better outcomes or higher quality or satisfaction, and
6 often it's lower.

7 This is a famous body of research that suggests
8 that the Medicare program could save as much as 30 percent
9 if higher spending areas adopted the practice patterns of
10 lower spending ones.

11 So we're in a situation where we value health care
12 a lot but we don't necessarily use the resources we have
13 very well and we're beginning to face some very real pain in
14 terms of financing that health care. Some analysts have
15 begun to say that the upward trend in the share of our
16 national income that we devote to health care is too much.
17 Others disagree. So it may be useful to start talking about
18 how much we, as a society, want to spend on health care.

19 Basically that involves looking at trade-offs,
20 spending resources on health care just up to the point where
21 the value that we get out of that spending is just worth the
22 value of what we're giving up in terms of the other ways

1 could use those resources.

2 This isn't just a theoretical discussion. The
3 budget deficit situation may mean that we are reaching a
4 crossroads where society will need to consider more
5 explicitly some of the trade-offs and what it values and
6 what it wants to do with its scarce resources, for example
7 trade-offs between health care, education, homeland
8 security, defense, that sort of thing.

9 Even within Medicare program spending by itself
10 policymakers will have to make trade-offs. Some analysts
11 believe that initiatives such as effective use of
12 information technology, adopting pay-for-performance
13 strategies and limiting growth and supply induced demand
14 will help Medicare make the most of its resources. It seems
15 pretty important to move Medicare towards value-based
16 purchasing.

17 The final part of the draft chapter reviews the
18 various categories and policy options that decisionmakers
19 have been considering and they are listed on this slide.
20 Given the magnitude of Medicare's long-term financing
21 problems, it's likely that policymakers will need to use a
22 combination of approaches. All of the options are pretty

1 difficult but in general it seems that if policymakers wait
2 longer to realign Medicare spending and financing the
3 changes that they would need to make would be more drastic.

4 The list of categories here is intended primarily
5 to motivate discussion about what sorts of changes the
6 Medicare program could face and the chapter discusses some
7 of the available literature on their likely affects on
8 quality of care, access and Medicare spending.

9 This concludes my presentation. I welcome your
10 comments on the content and tone of the chapter and any
11 further research that you think is necessary.

12 MR. HACKBARTH: Good job, Rachel.

13 Let me start with a comment and question. The
14 title is At a Crossroads in Medicare Financing: Assessing
15 Payment Adequacy and Moving Toward Value-Based Purchasing.
16 I wonder if we should be even a little stronger than the
17 draft in terms of saying that it's our view -- and I think
18 this is our collective view -- that faced with the sort of
19 financial trouble that you describe in the chapter and is
20 captured in that one graph, number six, that trying to deal
21 with the problem through across-the-board spending
22 constraint, treating all providers equally as though they

1 are the same, is a dangerous approach. That has been
2 Medicare's traditional approach to trying to achieve budget
3 savings. We just squeeze everybody equally.

4 But under these circumstances we need to change
5 our game. And as difficult as it may be across the whole
6 range of providers, Medicare needs to be more careful and
7 discriminating, if you will, among providers on various
8 types of care. We need to send clearer signals that this is
9 good and we want to reward it, and this is bad and we want
10 to discourage it.

11 That's a major change in direction for Medicare
12 but I think it's a theme that consistently is emerging out
13 of our work and I would like to see it more prominent in the
14 chapter. There's a question mark at the end of that. Do
15 other commissioners to agree with that? Does that make
16 sense?

17 DR. CROSSON: Yes, I think I do. And I think I
18 had a similar comment. I really like the paper. I think
19 the breakdown of the last five methodologies to try to
20 resolve the problem is a good one.

21 When I looked at the space of that each one of
22 them occupies, I think I would have wished for perhaps more

1 discussion around the payment rate issue and then the
2 management and use of services, only because I think -- and
3 I think other discussions have suggested this, that we have
4 had here -- is that these may very well be the two areas
5 where most change is possible and the most leverage exists.

6 So for example, I think some of the issues around
7 how services are paid for, physician services and hospitals
8 are paid for, what potential changes could or would not be
9 wise to change would be useful just in general.

10 And then secondly, in terms of the management and
11 use of services, maybe expanding that section a little bit
12 to indicate some potential areas that might be fruitful,
13 realizing that they are going to be discussed in later
14 chapters, might strengthen the paper.

15 DR. SCHMIDT: I certainly take that point but
16 let's reiterate that there will be another chapter that is
17 evolving as we speak, one or maybe more, that goes into
18 particularly the management of use of services in greater
19 detail.

20 DR. CROSSON: Thank you.

21 DR. SCANLON: I thought this was an excellent
22 piece of work and really does lay out the issues, as grim as

1 they are, extremely well and comprehensively. I think we
2 are probably at a point where we need to think about
3 fundamental changes in order to try and deal with this for
4 the future.

5 The idea that Medicare is going to be a value
6 purchaser is the one that I think we really need to
7 emphasize. And emphasizing that, which to me means that
8 Medicare is trying to efficiently purchase access to quality
9 services for its beneficiaries. The use of the term
10 efficiency in that sentence is, I think, the appropriate
11 place for efficiency because one of the things that has been
12 a premise behind much of the payment policy that we have
13 had, at least in the minds of many, is that the prospective
14 payment system is recognize efficiency and reward
15 efficiency. The reality is that they recognize low cost.
16 The two don't necessarily equate.

17 I think we need to consider how to move away from
18 the idea of always rewarding the low cost and perhaps
19 inordinately rewarding low cost. We need to think about
20 what is it we're buying, have a greater variation in the
21 rates in terms of what we pay for a particular service based
22 upon quality, maybe also based on market factors.

1 This may end up being an incredibly important
2 aspect of trying to maintain access throughout the country
3 while trying to be an efficient purchaser. So I think we
4 want to make sure that we emphasize efficiency in the right
5 place, and that's from the program's perspective as a
6 purchaser. We're really relatively ignorant of exactly how
7 efficient providers are but we need the program to be
8 efficient.

9 MR. HACKBARTH: I agree and I would add the point
10 that right now we don't even necessarily reward low cost.
11 We do it for relatively small bundles of services, but
12 sometimes rewarding low cost for a narrow range of service
13 may lead to higher cost in overall management of the patient
14 looked at on a grander scale.

15 MR. DURENBERGER: Obviously, I agree with
16 everything that's been said, particularly the title. It's
17 so challenging. And then there's so much material after it
18 that what I did is reorganize your material, just as an
19 outline form. And I'll send it back to you because the
20 content is absolutely terrific and you got it all on
21 PowerPoint, which is like a miracle.

22 But I wanted to suggest one addition, and I don't

1 know exactly whether this is our purview. One of the ways
2 in which this could start is by a comment that says that the
3 histories of this commission is really the history of the
4 policy changes and financing access to health care service
5 over the last 20 years. This morning we've already talked a
6 little bit about was that the right direction to go. I
7 think pointing out to the reader -- and my tendency is
8 always to think about who's going to read this. And I would
9 like to target somebody other than Bill Thomas and the staff
10 of the Finance Committee, and try to get more people who are
11 in the Congress to get interested in the challenges that
12 they face in supplementing the work of leadership.

13 So reminding people that the history of these
14 commissions or commission traces the history of efforts to
15 try to change the financing, I thought, was a great way to
16 start.

17 But at the end of it, and maybe this is coming in
18 the future, is the Medicare Modernization Act as the future.
19 It just feels to me as though it would be important for
20 MedPAC to point out and to stress the importance of the
21 effort to privatize the Medicare program using the
22 experiences of the past, including the predecessors to

1 Medicare+Choice, now Medicare Advantage, and perhaps a
2 little more emphasis on "health insurance" side of the
3 paper.

4 Like many of you, I was probably taken by the
5 current issue of Health Affairs and the lead articles on
6 health insurance which they haven't updated for five years.
7 But there's a lot of really good information, some of which
8 you already touch on.

9 The commitment to consumer driven health care and
10 what does that actually mean in the context of integrating
11 and care coordination versus something else? Again, to the
12 extent that we can ground that in the realities of what
13 research tells us, the commitment or lack thereof to
14 universal coverage. What does that actually mean in the
15 context of the issues that were discussed earlier regarding
16 hospital margins and is it our obligation versus somebody
17 else's obligation? Certainly, this commission would have a
18 concern about commitments in the MMA policy and the related
19 things that came into it towards universal coverage.

20 And then finally, on perhaps -- at least from my
21 standpoint -- a more positive context, the issues around
22 regionalization and all of the quality demos and the care

1 coordination demos and those kinds of what are very positive
2 in the context of what we're looking at, parts of the
3 Medicare Modernization Act.

4 But again, particular emphasis on regionalization
5 because regionalization they weren't quite sure -- it feels
6 like they weren't quite sure of it. First it's going to be
7 prescription drugs, then it's going to be PPOs. And then
8 there was this battle over what happens in 2010. I, for
9 one, given the conversation we had earlier on, feel fairly
10 strongly to say something positively about regionalization
11 in the Medicare program, in the same way that I feel that
12 perhaps the work that we all engaged in over the last 20
13 years of treating all doctors alike, all hospitals alike may
14 not have been the wisest course of action in some parts of
15 the country.

16 So bottom line, adding to Medicare at a crossroads
17 should be the reality that besides that big budget deficit
18 graph, we need some kind of a narrative graph about the
19 potential impact, insofar as health service research can
20 help us understand it, of the current policy track that the
21 majority in the Congress is on right now.

22 MS. BURKE: To start with, it's a terrific piece.

1 I just have a couple of comments, one or two small technical
2 things and then one is just a broader context.

3 The two small technical things, on page 29 of the
4 document you very effectively talk about the extraordinary
5 impact that the decline in a number of workers per retiree
6 will have. In the first instance you cite what the
7 alternatives will be to an increase in the payroll tax of
8 2.9 percent to 6.2 percent. And then alternatively, you
9 could cut HI expenditures by 48 percent.

10 In the second instance, you talk about the delay
11 until 2019, the message being if we don't start dealing with
12 this now, the impact will be far greater. And you've chosen
13 to show what the increase in the payroll tax would be to 7.1
14 percent but you don't talk about what the cuts would be in
15 the program.

16 So I would again, in both instances, use those
17 examples because I think they are a positive message.

18 The second relatively small thing is there's no
19 reference, and I kind of understand it, but there's no
20 reference in the entire document to Medicaid. Particularly
21 in the context of page 32 and page 33, where you talk about
22 cost-sharing and changes that might be paid with respect to

1 the beneficiary's participation, there's no reference to the
2 potential impact that would have on the Medicaid program and
3 the number of people who are duals.

4 So I would, again, at some point reference
5 essentially the impact would not only be here but it might
6 well be on not only their tendency to buy wraparound but
7 also the impact on the state Medicaid programs in terms of
8 the duals.

9 The final thing is really an overall question. An
10 extraordinary job of talking about the context of Medicare
11 and the structural issues around financing and alternatives.
12 What is here, but only briefly and only at the very end, is
13 who the Medicare beneficiary is. There is a brief reference
14 in the course of the discussion around cost-sharing that
15 references Marilyn Moon's work and some others about who
16 this population is.

17 I think we might benefit from reminding people
18 once again early on who is this person? This sense that it
19 is a 68-year-old living in Palm Beach that has the capacity
20 to bear all of these changes is a false impression. And I
21 think an up front clear indication of who these people are,
22 essentially the female dominance over time, particularly in

1 the old-old, the fact that there are a large percent of them
2 who are relatively low income, many of them with
3 comorbidities. They're not all playing golf full-time.

4 I think that helps create the context as well, not
5 only about the structure of the program, but as we alter the
6 program what the impact would be on this, in many cases,
7 very fragile population. And I think it would benefit us to
8 remind people because, as Dave suggests, I'm not worried
9 about Bill Thomas. But I am worried about the large number
10 of people who have this false impression of what the
11 Medicare program is today, as compared to what it was in
12 1965. Because it is a different program, not only because
13 of the way we pay for services and deliver them, because the
14 population is different than it was.

15 And I think we need to remind people of that
16 because how we design it going forward will have a huge
17 impact in terms of who these people are. Many of them are
18 in Palm Beach playing golf, reading Fortunate Magazine. But
19 there's a whole heck of them that are not, and I think we
20 need to make sure that they understand that.

21 So I'd put that in the context, as well, up front.

22 DR. BERTKO: I also want to commend Rachel for

1 doing an excellent job of stressing many of these things. I
2 guess I would only suggest perhaps considering a tone of
3 even greater urgency for two reasons.

4 I'll point out that the assumptions used in the
5 chart shown are from the intermediate assumptions of the
6 trustees under current law. The 2004 reporting facts cites
7 the SGR, in particular, as being one of the things that
8 might be, in fact, something that needs to be considered as
9 how it changes with the probable reaction that it would
10 accelerate the trigger for that 45 percent rule.

11 The second reason for urgency, which is apparent
12 from the graph of course, that the HI Trust Fund revenue
13 from payroll taxes will now be exceeded by outgoes within
14 the next year or so. And so while the trust fund itself
15 isn't technically exhausted until 2019, this outgo over
16 income is going to have an effect on budgets very, very
17 soon.

18 MR. SMITH: Rachel, this is terrific work, as many
19 of the other commissioners have said.

20 I had thought as I read the last part of the
21 chapter along the lines that Jay and Glenn talked about
22 earlier. It seems to me we ought to reverse the order in

1 part because more leverage, more capacity on the last two
2 points, both the payment rate point and the management of
3 services point. That is also more our area of competence,
4 rather than talking about taxes or even eligibility.

5 I do think it's important to leaven the
6 eligibility discussion a little bit with -- we are living
7 longer. We are gradually ratcheting up the Social Security
8 retirement age. But folks who fall into that pre-Medicare
9 eligible hole are very vulnerable. You say that but I think
10 it needs a bit more emphasis.

11 So I think about reordering the five. I think the
12 five are fine. But I would say more about chapter three in
13 the management of service provision. That that's the
14 thematic, as Glenn said, that I think we want to drive
15 everywhere we can here.

16 Just one point, building on Sheila's point about
17 the material on page 29, it's all true. But it's also true
18 that the fewer workers supporting each beneficiary are going
19 to be much richer than their predecessors were. And so
20 increasing the payroll tax, not an option that it seems to
21 me we want to jump up and down and say we are for, but
22 increasing the payroll tax is still going to leave the

1 supporters of tomorrow's beneficiaries with higher real
2 incomes than their predecessors had.

3 This is scary stuff. I don't want to try to
4 minimize how scary it is. But it's important not to be
5 scarier than we have to be.

6 MR. HACKBARTH: Any others? Okay, thank you,
7 Rachel.

8 Next is the mandated report on eliminating
9 physician referrals for physical therapy

10 MS. CARTER: Last month you reviewed and provided
11 comments on a draft of this report. We've tried to reflect
12 your comments in this draft and would like to get your last
13 thoughts on it.

14 Briefly, this report was included in Section 647
15 of the MMA and is due January 1. It requires MedPAC to
16 study the feasibility and advisability of allowing Medicare
17 fee-for-service beneficiaries to have direct access to
18 outpatient physical therapy services.

19 Under current Medicare coverage rules, a
20 beneficiary must be referred by and under the care of a
21 physician for outpatient physical therapy services to be
22 covered. These requirements are listed in the next slide.

1 First, a patient must be referred by a physician.
2 A written plan of care must be reviewed every 30 days by a
3 physician. And for longer-term treatment the patient must
4 be reevaluated by a physician. Direct access refers to
5 eliminating these requirements.

6 Medicare's coverage is limited to services that
7 match a patient's condition and are provided with reasonable
8 frequency. Note that services must be restorative. Local
9 carriers and fiscal intermediaries are key to how these
10 coverage policies are implemented and to the determination
11 of whether services provided were medically necessary.

12 The Office of the Inspector General has concluded
13 that some of the services provided that are medically
14 unnecessary are due to a poor understanding of these
15 coverage guidelines.

16 At the last meeting, you concluded that there was
17 no reason to change the current physician requirements but
18 you raised several specific concerns that we've tried to
19 address.

20 The first argument for retaining requirements is
21 that many beneficiaries have multiple and chronic health
22 care conditions. In 1999 about 78 percent of beneficiaries

1 had at least one chronic condition and 63 percent had two
2 ore more. The physician requirements are in place so that
3 beneficiaries' often complex health care needs are correctly
4 diagnosed and considered in treatment decisions. You noted
5 that many beneficiaries seeking physician referrals are also
6 having their other health care needs addressed during the
7 same visit.

8 The second argument is that the current
9 requirements do not appear to impair access for most
10 beneficiaries. In 2003, 85 percent of beneficiaries report
11 no problem in getting therapy services.

12 Third, lifting the referral requirements for
13 physical therapy services would set a precedent for other
14 services with similar coverage requirements.

15 And last, the program uses the requirements as a
16 way to curb unnecessary utilization. The private sector
17 uses a combination of strategies. When physician referrals
18 are not required, service limits are commonly used to
19 control service provision.

20 Your discussion last month noted that while
21 Medicare's physician requirements are necessary, they are
22 not as effective as they might be and that additional steps

1 need to be taken. These next steps might include increasing
2 provider education about coverage rules for physicians
3 making the referrals and for physical therapists furnishing
4 the services.

5 The Office of the Inspector General has repeatedly
6 recommended that Medicare's claims contractors, the
7 facilities where physical therapists practice, and the
8 professional associations step up their efforts at
9 increasing provider knowledge about Medicare's coverage
10 rules.

11 At the last meeting you noted that research is
12 needed to develop a body of evidence indicating when and how
13 much therapy services benefit older patients. This evidence
14 could then be used to establish practice guidelines that
15 could be used to educate physical therapists and physicians
16 about physical therapy service provision that is likely to
17 be effective for beneficiaries.

18 At this point, I would like to gather your last
19 comments on this draft and if you have specific edits you
20 can give them to either me or Sarah.

21 MR. HACKBARTH: Comments?

22 I think you did a very good job of capturing the

1 comments at the last meeting.

2 Okay. We are racing ahead of schedule, which is
3 actually a good thing because I think we've got some topics
4 in the afternoon that may run a little bit long. And so
5 what we're going to do is move up our scheduled lunch and
6 shoot for 11:45 on that, and maybe even a few minutes
7 earlier.

8 We will now have a public comment period. Let me
9 reiterate, as I always do, the rules, which are brief
10 comments, very brief comments. And if somebody before you
11 in line has made your comment, please don't feel the need to
12 repeat it in its entirety.

13 Goodness gracious, we are setting new records for
14 speed here.

15 Hearing none, we will reconvene at 12:30. So
16 12:30 is when we'll reconvene. Thank you.

17 [Whereupon, at 11:23 a.m., the meeting was
18 recessed, to reconvene at 12:30 p.m. this same day.]

19

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22

1 To assist us in this analysis we spoke with and
2 collected sets of measures from accreditors and
3 certification bodies, CMS, purchasers, plans, specialty
4 societies, including the AMA's consortium, and others. This
5 analysis is based on staff research on the measures and
6 discussions with those experts.

7 Again, the purpose of the analysis is to really
8 answer the key question of whether it's feasible to base a
9 small portion of physician payment on quality.

10 There are a couple of different considerations when
11 we're looking at this question. One is, as we looked about
12 in the other settings, the criteria that the Commission
13 developed back in the first discussions on moving towards
14 pay for performance. And the second is, as you've stated in
15 past meetings, the cost of not moving forward, which may be
16 particularly important in the physician setting because of
17 the central role that physicians play in the health care
18 system pay for performance may be less effective without
19 their participation.

20 In addition, there's increasing awareness of the
21 need for incentives for physicians to adopt and use
22 information technology in their practices, and using

1 information technology as one measure in pay for performance
2 may in fact strengthen the business case for physicians to
3 adopt IT.

4 I am not going to go through each of these
5 criteria. We have talked about them several times in the
6 past few months, but these are the criteria the Commission
7 developed for determining whether in fact the measurement
8 activities were sufficient in different settings to apply
9 pay for performance.

10 We looked at four types of measures, just as we
11 did in the hospital and home health setting. That would be
12 process measures, outcomes measures, structural measures,
13 and then patient experience of care.

14 Process measures are used in the physician setting
15 to really try to answer the question of whether physicians
16 are providing care that is known to improve outcomes. The
17 strength of these measures are a couple. One is they both
18 measure the quality of care and at the same time identify
19 specific steps that physicians can take to improve quality.
20 They are also well-trusted by clinicians because they're
21 often based on research that shows that these processes are
22 associated with good results for the patient.

1 Examples of process measures in the physician
2 setting include, for diabetic patients, whether eye exams or
3 HgbA1c tests are given at appropriate intervals; for
4 patients with coronary artery disease whether lipid profiles
5 are done again at appropriate intervals; whether
6 immunizations are done for patients, either pneumococcal
7 immunizations or influenza immunizations.

8 Then the last one is a slightly different type
9 that we're going to be talking about in this setting, and
10 that is looking at physician care within a setting of care.
11 A lot of measures look at physician care only in their
12 office, and we have included in the analysis some ability to
13 look at physician care within its setting. So for example,
14 you could look at a process measure in a hospital, such as
15 for patients who had acute myocardial infarction or a heart
16 attack, whether they received aspirin on arrival and
17 discharge and then hold the physician at least partly
18 responsible for that.

19 So who uses process measures and how are they
20 used? The National Committee for Quality Assurance uses
21 process measures in their accreditation process for health
22 plans, so that's not at an individual physician level. They

1 also have two recognition programs which rely heavily on
2 process measures, one targeted at diabetes and the other at
3 heart/stroke where in fact the physician can voluntarily
4 come forward and give their own data to the NCQA on
5 particular measures and if they meet a certain level then be
6 recognized as a high quality provider of diabetes care.

7 CMS uses process measures in the QIO program.
8 Specialty societies and the AMA's consortium also have
9 developed and used process measures for confidential
10 feedback for individual physicians. And health plans and
11 purchasers use these in a variety of different ways. You
12 can see that RAND, for example, uses them for research and
13 then MedPAC uses them for monitoring purposes. So we've
14 used some of these process measures ourselves.

15 The measures on a few conditions such as heart or
16 diabetes are used very often and those are the examples that
17 you will often see. But there are also measures available
18 in many other conditions.

19 So are there process measures that meet our
20 criteria? Many process measures are well-accepted and
21 evidence-based. The burden of data collection really
22 depends upon the measure. If we were just to use measures

1 that were based on claims, were derived from claims there
2 would be less burden. The physician would not have to
3 collect information. However, the set would be a smaller
4 set and possibly not as accurate as if we had more
5 information in addition to claims.

6 If the information came from direct reporting from
7 the physician, such as from flow sheets where information
8 could be collected right at the time the patient is seen or
9 through medical record abstraction it would be more
10 burdensome for the physician but probably more accurate and
11 would have a larger set of measures to use. Of course, the
12 use of electronic health records would greatly decrease this
13 burden of collecting information on process measures.

14 In general, risk adjustment is not necessary on
15 most process measures. And clearly physicians do have it
16 within their control to improve on these measures. Many of
17 these measures do need improvement. The one issue that we
18 may have on process measures is it is unclear if there are
19 measures available for all types of physicians. That would
20 take a little bit further analysis.

21 Outcomes measures try to answer the question of
22 how the physician care actually affected the patient, and it

1 can capture information on both clinical effectiveness and
2 an important concern, safety, which some of the measures
3 don't look at quite as directly.

4 Here we looked at three types of outcomes measures
5 for physicians, and they are actually fairly different so I
6 want to take each of them in turn to try to define and give
7 an example of them. First we looked at intermediate
8 outcomes, which is something that goes between being a
9 process measure and outcome measure. There's no need to be
10 too pure about the definitions but we've called it an
11 intermediate outcomes.

12 An example here is where a process measures would
13 be whether the HgbA1c test was performed. The intermediate
14 outcome is considered, what was the level of control that
15 was actually achieved for the patient. Were levels within
16 the normal range or the healthy range for patients?

17 Potentially avoidable admissions are a longer-term
18 outcome and perhaps one that you are really trying to avoid
19 an admission, an acute event in a person's life. These are
20 admissions that have been associated with what are termed
21 ambulatory care sensitive conditions, where it's been shown
22 through research that in fact high quality ambulatory care

1 will prevent some of these admissions. So one example here
2 would be the percent of patients who are admitted to a
3 hospital with complications of diabetes.

4 The other type of outcome that we looked at was to
5 look at physician outcomes within a setting of care. For
6 example, you could look at the percentage of patients who
7 died, such as CABG mortality, those who develop infections
8 or experience complications in a hospital. You could also
9 look at other types of settings where you would not be
10 looking necessarily at adverse events, which are what all
11 these are on your slide here, such as in the home health
12 setting you could look at functional improvements, for
13 example, as one outcome, or in dialysis you could look at
14 the adequacy of hemodialysis.

15 So who uses outcome measures and how are they
16 used? The intermediate outcomes are really used fairly
17 similarly to process measures so I won't go into detail
18 there on how they're used. It is really the same way in
19 which many process measures are used. They are used both at
20 the individual physician level but also at the group level
21 or the health plan level.

22 Potentially avoidable admissions are generally not

1 used at the individual physician level. AHRQ has used them,
2 MedPAC, as well as disease management organizations to look
3 broadly at the quality and access to ambulatory care for an
4 overall population. Then outcomes and settings are used by
5 specialty societies and by some feedback initiatives.
6 They're usually used in a confidential manner for quality
7 improvement purposes with physicians. However, there are a
8 couple example where there's some reporting on individual
9 surgeons; the most famous is probably the New York CABG
10 mortality which is done at an individual surgeon level.

11 So are there outcomes measures that meet our
12 criteria? Some are well-accepted. For example,
13 intermediate outcomes are quite well used. Potentially
14 avoidable admissions are accepted at the population level so
15 they could be useful if the unit of analysis were groups.
16 Then setting-specific measures are used primarily for
17 confidential feedback at this point, so those we would need
18 to look at a little further to use them for accountability
19 purposes.

20 There is some increased burden for data collection
21 but there are strategies to lessen this burden. The
22 intermediate outcomes pretty much you would need to require

1 some level of records abstraction or flow sheets. Again,
2 the EHR would make that a little bit less. Potentially
3 avoidable admissions you could look at through claims, so
4 that would be a low burden on the physicians. Setting-
5 specific measures you could actually look at the facility
6 reports and then assign them to physicians, so perhaps the
7 physician wouldn't have to actually do the data collection.

8 Risk adjustment is available for intermediate
9 outcomes but we would need to look in more detail to
10 evaluate whether outcomes are appropriately risk-adjusted
11 for the in-setting types of measures. Improvement is
12 definitely something that people have called for in this
13 type of measure. For example, it could help address safety
14 issues in hospitals as well as some of the management of
15 chronic conditions with the potentially avoidable
16 admissions. However, because they are outcomes there are a
17 lot of different factors that affect the scores on these so
18 it would be important to do a further evaluation of how much
19 effect, for example, beneficiaries might play on the
20 outcomes measures.

21 Structural measures help to ensure that physicians
22 are capable of delivering quality care. Some examples here

1 include certification and education. Board certification
2 might by one thing you could look at, but there might be
3 other types of certification programs. You could look at
4 continuing medical education that would be particularly
5 targeted at quality improvement, for example, as one
6 structural measure. There is also an increasing interest in
7 looking at physician's care management and patient education
8 functions in their offices.

9 But probably the most central to this discussion
10 and the most well-used at this point is physician use of
11 clinical information technology. There are really three
12 different ways that this is looked at. One is just the
13 simple adoption. We could look at simply, do you have an
14 electronic health record? But that doesn't get you
15 necessarily into knowing whether the physician actually used
16 the electronic health record for quality improvement. So
17 another step would be to say, does the electronic health
18 record have the functions that you need? For example, you
19 could say, do you have a patient registry and do you
20 actually keep track of your patients within that registry?

21 But then an even further step to make sure that
22 the EHR would be used for quality improvement would be to

1 look at the results of that use. So you say you have a
2 patient registry. Do you actually track patients with
3 certain chronic conditions, and then do you follow up on
4 that information? So then also give them reminders, for
5 example, to come to the office for a particular preventive
6 service or diagnostic test.

7 Increasing awareness of the importance of
8 electronic health records in physicians' offices and the
9 need for incentives to encourage physician adoption make
10 this a central piece of any structural measures that you
11 would want to apply.

12 So who uses structural measures and how are they
13 used? NCQA also has a recognition program called Physician
14 Practice Connections similar to their other recognition
15 programs that are specific to conditions. These could be
16 applied to all types of physician offices. There they ask
17 physicians to basically document on three different types of
18 measures. They have measures in clinical information
19 technology, a set that is geared toward care management, and
20 the other set is geared toward patient education, all within
21 one recognition program. It's designed so that basically
22 it's easier to actually meet the care management and patient

1 education standards if in fact you use a clinical
2 information technology system. So the way it's designed is
3 actually as an incentive to, over time, encourage physicians
4 to about information technology.

5 CMS is considering using these types of measures
6 in a demonstration project called the Docket Project. And
7 large purchasers, Bridges to Excellence being the one group
8 that is most well known for this, does rely on the NCQA
9 recognition program as one piece in their pay for
10 performance initiative. Plans and consumers also have been
11 known to use board certification as one measure of whether
12 physicians are delivering good care.

13 So are there structural measures that meet our
14 criteria? Certification and education are well-accepted as
15 measures of quality. Information technology, while strongly
16 supported by many, is not as well-accepted simply because
17 the measures are newer, but it is clearly an area that is
18 growing in importance.

19 The burden is really pretty low for data
20 collection for certification and education. I would really
21 be just informing, yes, no, I am certified, I have a certain
22 level of education. The measures would need to be developed

1 but the data reporting would be fairly straightforward.
2 There is some burden for reporting on the use of IT.
3 Simply, there would have to be some type of survey or some
4 data reporting form created for that. Risk adjustment isn't
5 necessary. They apply to all physicians, which is nice
6 because you know you have measures that will apply broadly.
7 And there is a growing recognition that physician use of
8 information technology is critical for significant
9 improvements in quality.

10 Patient experience is the last type of measure we
11 looked at. Here the question is really whether the care met
12 the goals of the patient. These types of measures can
13 ensure that patients are involved in their care and that
14 they also understand their role. These also apply broadly
15 to all patients and types of physicians.

16 I'm not going to go through each of these examples
17 but these come from the Consumer Assessment of Health Plan
18 Survey which has been used by CMS to look at health plan
19 quality and access. But many of these questions are the
20 same types of questions you would want to look at individual
21 physicians as well.

22 These are used really to look at broad populations

1 generally, and because there is no particular tool now, no
2 standard tool, but AHRQ is developing a tool -- in the
3 United Kingdom where they also do not have a standardized
4 tool they simply ask whether the physician is using a survey
5 and don't look at the levels or the response.

6 Are there patient experiences measures that meet
7 our criteria? Clearly, the concept is well-accepted. There
8 is no standardized tool, but again, the burden would be low
9 if simply the question was whether the physician used a
10 survey. Risk adjustment may not be necessary but this is
11 something that AHRQ should really research as they develop
12 one. As I said, it does apply broadly and improvement is
13 possible.

14 So even though our analysis thus far focuses on
15 quality measures, pay for performance raises other issues as
16 well. I think we talked about a couple of these even in our
17 discussion this morning. The first is how you would
18 actually assign responsibility for an individual patient to
19 a physician. Medicare beneficiaries often see more than one
20 physician, so there's some question about who would actually
21 be responsible.

22 Two methods that we found in the private sector

1 were, one, simply evaluating claims to look at whether there
2 was a certain minimum threshold, either dollar-wise or
3 utilization of visits, that could be assigned to a
4 particular physician and then you would consider that
5 physician, or perhaps several physicians that take care of
6 the patient would be responsible for their care.

7 Another way to do it is to let physicians self-
8 identify or identify the patients who have particular
9 conditions. Clearly this would need to be audited to make
10 sure that they were not choosing just their healthier
11 patients, but that's the method that NCQA uses in their
12 recognition programs.

13 Another issue as I've mentioned going through the
14 presentation, is whether there are process and/or outcomes
15 measures that are available for all types of physicians. It
16 is unclear so further analysis would be needed on that.
17 Using IT or patient experience would apply broadly so that
18 wouldn't be an issue for those types of measures.

19 Another issue is the unit of analysis, whether it
20 would be individual physicians or groups of physicians. We
21 would particularly like some Commission feedback on this
22 one. Many issues can be addressed by groups. For example,

1 sample size would be larger if you looked at groups rather
2 than individual physicians. It may be easier to attribute
3 patient care to a group rather than to an individual
4 physician. In addition, groups often will have better
5 feedback loops so it might be more useful for quality
6 improvement purposes. And there may be economies of scale
7 in reporting at the group level rather than individual
8 physicians having to collect data. Of course, not all
9 physicians practice in groups so that's an issue that would
10 need to be dealt with.

11 This last slide tries to be a picture summary of
12 what we found in our analysis. It is really a potential
13 strategy to help us prioritize options. The initiative
14 could really be phased in in several different ways. What
15 we present here is a left-to-right look at where we think it
16 might be possible to start. For example, you might start
17 with structures and have a few process and then move on out
18 as we became more comfortable with measures, or as it was
19 determined really what the important priorities in the
20 physician setting were.

21 The other way to do it is also to think about ways
22 to use the information differently. So some of the

1 information might be used in the beginning for confidential
2 feedback. For example, that's often how information about
3 physician care in a setting is used currently. That might
4 be a place to start with that type of information rather
5 than actually paying on the basis of it right away.

6 Thirdly, you could weight measures differently
7 based on their importance or your level of trust in the
8 measures. For example, in the U.K. example on patient
9 experience they have very few points assigned to patient
10 experience but many more points to the areas where they feel
11 more comfortable with the measurement, for example, clinical
12 indicators.

13 Just to summarize quickly. Information technology
14 clearly has a central role in making it possible for
15 physicians to assess and report on the quality of their
16 care. IT use also applies broadly to all types of
17 physicians and has the potential to improve quality of
18 health care. Therefore, this type of structural measure
19 could be very useful initially, along with certification and
20 education.

21 Process measures, either claims-based or those
22 derived from flow sheets or records abstraction could also

1 be used initially on physicians where those measures exist.
2 The same would be true of outcomes measures. Patient
3 experience of care is clearly an important dimension but
4 until there's a standardized tool we wouldn't suggest that
5 you would want to do anything other than ask the physician
6 if in fact they did survey their patient.

7 That concludes my presentation. I would be
8 interested in your comments on the direction of the analysis
9 and again whether there are important concepts or measure
10 sets that we may have missed in our evaluation.

11 DR. MILSTEIN: That was a wonderful summary. One
12 of the facets of performance that we have not yet looked at
13 but I think is something we may want to look at is what the
14 Institute of Medicine in categorizing dimensions of quality
15 referred to as efficiency. Right now in California I am on
16 the steering committee of what I think is today the largest
17 of the pay for performance programs at the physician level
18 in the U.S. It's a program operated by the Integrated
19 Healthcare Association California-wide across many managed
20 care plans that will in 2004 pay out approximately \$100
21 million in bonus pay to California physician groups. We are
22 now about three years into it and we're looking back and

1 saying, what changes do we want to make. Having gotten our
2 toe in the water maybe I can just briefly tell you what the
3 pioneers are thinking anyway.

4 First, I think we're tilting in the direction of
5 more measures even if less perfect. We started out focusing
6 on a very narrow list of very methodologically pristine
7 measures and now our self-criticism is, we measured what
8 could be measured with great precision but we maybe missed
9 what was clinically important. And we now are tilting in
10 the direction of the U.K. which has literally hundreds of
11 performance measures, something maybe in between those two
12 extremes. But our feeling is that 10 or 15 were not enough.

13 Secondly, we are in the interim tilting a little
14 bit more of the reward on actual uptake and use of robust
15 clinical IT systems since that eventually creates very low
16 measurement burden if the measurement is being fed by
17 electronic health records. We're adding efficiency measures
18 because we feel that was an important dimension of quality
19 that we missed the first time around. We are also moving
20 measurement from measuring only physician groups to
21 measuring groups and individual physicians, as challenging
22 as that might be.

1 Lastly, I think taking a cue both from the U.K.
2 and from Mark McClellan's recent comments, we feel that the
3 percentage of total physician pay that needs to be on the
4 table for physicians to very heavily prioritize performance
5 improvement needs to be a lot more than the 5 percent to 10
6 percent we currently have on the table. We believe it needs
7 to be considerably north of 10 percent if performance
8 improvement is going to be a very high priority among
9 physicians. So those are just some lessons or learnings
10 from some early adopters.

11 MR. HACKBARTH: A couple of questions about that,
12 Arnie. What percentage currently is on the table for the
13 program that you're describing?

14 DR. MILSTEIN: It varies somewhat by health plan
15 but it is 5 percent to 10 percent. There's some variation
16 across the plans.

17 MR. HACKBARTH: You've emphasized including
18 efficiency as one of the measures. Can you say for what you
19 mean by that. What kind of the efficiency measures are you
20 talking about?

21 DR. MILSTEIN: I think something that would be
22 more analogous to what economists call total cost of

1 ownership. That is average cost per patient of all health
2 care resources utilized in taking care of either an episode
3 of acute illness or a year's worth of chronic illness and
4 preventive care. So it's total health care cost associated
5 with a particular physician or a physician group being
6 primarily, or as Karen was describing, substantially
7 responsible for the care of that condition or that patient
8 over that time period. So it would take into account things
9 like propensity of a physician to use a brand drug rather
10 than a generic drug. It would take into account propensity
11 of that physician's asthma patients to end up in the
12 emergency room. It would take into account propensity of a
13 physician to order a lot of follow-up visits by specialists
14 for a chronic condition. All that would be wrapped up into
15 a total cost of ownership rating.

16 There are seven or eight brands of commercial
17 software on the market that many health plans and capitated
18 delivery systems use in order to quantify or attach a rating
19 to a physician with respect to total cost of ownership or
20 what the folks at Dartmouth would call longitudinal cost
21 efficiency.

22 MR. MULLER: Let me add my compliments to you on

1 this chapter. It both builds on previous work and does it
2 very powerfully.

3 In terms of things to emphasize, I think the fact
4 that we are starting to use a common language here of
5 structure, process, outcomes, patient experience, I urge us
6 to keep going in that direction. One of the things we
7 discussed last month is over the last three or four years
8 there's been some kind of coming together across the various
9 groupings for measuring quality. And the more that we move
10 in that direction so that we are speaking in a common
11 language with common categories and common terms I think is
12 of critical importance. Obviously the extent to which both
13 MedPAC and CMS go in that direction I think that helps the
14 general cause.

15 Secondly, I want to speak to the unit of
16 accountability. We have come to that before and Arnie just
17 touched on it too. Having larger group practices and
18 integrated groups -- we had some estimates this morning as
19 to what proportion of the nation's physicians fall into
20 those categories. But one of the collective setting that is
21 well-established is the hospital medical staff. Not always
22 organized to operate as one, but the Joint Commission

1 evaluates it, state health departments review it. So as you
2 think about collectivity - and I think we all are moving
3 towards that -- it has to be bigger than one doctor here and
4 three doctors there. So when we think about what collective
5 institutions do we already have within the American health
6 care system, the fact that the national regulators and the
7 state regulators use the hospital medical staff I think is
8 something we should keep thinking about, whether that can be
9 one of the collective units that take some kind of
10 accountability.

11 So I think the issues both raised in the paper,
12 and of the issues that Arnie and others have brought up
13 indicate how distributed care -- all the Wennberg stuff --
14 is just one more bit of evidence about the enormous
15 diffusion of the way in which practice proceeds in the
16 American health care system. So the more we can start
17 thinking about accountable units -- we had some discussion
18 this morning whether that can happen on a national
19 geographic basis. My guess is that is a little bit too hard
20 to figure out exactly how to implement. But states are a
21 big part of the health care structure of the country so
22 thinking about accountable units and local regions I think

1 makes a lot of sense.

2 I also agree that we should put more of the
3 payment at risk. Last year when we encouraged CMS to put
4 some of the update at risk, so roughly we put more than 10
5 percent of the update at risk last year, went with 0.4
6 against 3.5 or whatever. So I think that's the right
7 direction to be going into. I know 1 percent, 2 percent, 3
8 percent I agree is just too small a number. You cannot jump
9 up to an extreme number that quickly, but having some sense
10 that in a multi-year period, maybe three, four, five years,
11 we're going to move that up every year for the payment risk
12 and whether you go to 10 percent, 20 percent, 30 percent.
13 But we have now seen 30 years of evidence that the payment
14 system drives behavior more powerfully than almost
15 everything else. So if you want quality to be as big a part
16 of the agenda as we are suggesting that it should be than
17 more and more of the payment system has to be tied to
18 quality.

19 Fourth, I would just suggest that I do think that
20 we have to be able to work off existing information and
21 systems, and therefore with all the defects and limits of
22 going off claims systems I would still urge us to go off

1 systems that are already being created for other purposes.
2 I think to have to go back and do chart abstractions and so
3 forth, to really add more cost to implementing a system of
4 quality I think is going to put a big burden on it.

5 So again, there's a lot of movement towards
6 putting more emphasis on the EMR and more computerization of
7 the health record. The extent to which we can use existing
8 systems as they more and more get put into the American
9 health care scene, not just payment systems, as opposed to
10 coming up with separate systems for the purpose of
11 evaluating quality, I think we should err on the side of
12 using existing systems rather than trying to implement any
13 new systems.

14 That obviously then puts pressure on your payment
15 system, your EMR and so forth, to be developed in such a way
16 that it can be used for quality measurement purposes. I
17 think we want to keep some incentive out there for both the
18 vendors and the other people who are creating these systems
19 to have quality measurement built into the basic system,
20 rather than thinking about creating a whole new set of tools
21 just to measure quality.

22 But again, I thought it was a superb chapter.

1 DR. NELSON: Obviously I support the notions that
2 are in this, and I found particularly helpful the
3 description of the U.K.'s efforts in this area. I am really
4 glad you included that.

5 I just want to make the point that we have to be
6 aware as we proceed with this of unintended consequences
7 that could end up in worse patient care rather than better
8 patient care. I don't think that that is the dominant theme
9 running through this, but I will give you two examples where
10 it could in actual fact happen.

11 One would be in the potentially avoidable
12 admissions, understanding that oftentimes the decision
13 whether or not to hospitalize the patient is the toughest
14 decision the clinician makes. The patient with congestive
15 heart failure that you probably can take care of at home but
16 you are not exactly sure, the patient with asthma, or --
17 oftentimes that was the toughest decision I had to make as a
18 clinician. Once I made the decision to put the patient in
19 the hospital then it was very clear-cut what to do. It was
20 how far I could go in managing them successfully at home,
21 whether they are diabetic in mild acidosis and I decided to
22 talk to them on the phone every six hours and adjust their

1 insulin and try and bail them out without putting them in
2 hospital. Oftentimes that is what I did.

3 If we get brownie points for potentially avoidable
4 hospitalizations according to certain categories and err on
5 the side of not putting the patient in the hospital and
6 impose a greater risk on the patient as a consequence, that
7 obviously would be a bad thing. I don't know exactly how
8 you build safeguards into that but one way to protect
9 against that is on the iffy kinds of factors, let's not put
10 them in right away. Let's do some more research and work
11 before they are included with either rewards or penalties.

12 Another example is the possibility of physicians
13 avoiding certain patients because they might make their
14 profile look bad. The patient who won't quit smoking. They
15 still need medical care even if they can't quit smoking.
16 If, for example, a physician's performance was paid
17 differently according to some factors that relate to patient
18 compliance that they can't control and it resulted in harm
19 to the patient, that would be a bad thing.

20 DR. CROSSON: On the issue of the unit of
21 measurement, group versus individual, whatever group means
22 in this context, and I think Karen laid out nicely there are

1 a lot of attractive aspects to doing it at the group level.
2 The issue of sample size, for example, would expand the
3 number of measures you could use because you would have
4 enough experiences and a greater number of diagnoses in that
5 regard. There are economies of scale. Certainly measuring
6 at the group level begins to address the issue of
7 attribution. It also begins to address the issue of care
8 coordination or integration that in the absence of it being
9 provided by a group tends to fall to the patient, sometimes
10 to a vulnerable, sick individual to do, which is an
11 important issue.

12 I think also measuring at the group level, at
13 least in some context, is helpful to the extent that it
14 drives peer pressure, peer support and pressure which in our
15 setting and others is a useful tool, which would not be
16 present measuring at the individual physician level.
17 Certainly I was interested in Ralph's suggestion about
18 expanding the idea if there is a value here, expanding the
19 idea of what a group would be. Perhaps this could be
20 something that in some settings a medical staff could do, I
21 would agree with that.

22 Another value of measuring at the group level is

1 that in fact, at least at the moment, this is where the IT
2 systems are being used and put in place, and therefore from
3 the perspective of a vanguard you would be getting the
4 better information for a while anyway from those groups.
5 There are two big problems with doing this. The first is
6 that most physicians aren't in groups. That's a small
7 problem. But as Ralph said, there are other ways to think
8 about this and to address this. On another issue this
9 morning we talked a little bit about that. Certainly the
10 medical staff, county medical societies, there are ideas,
11 some of which are difficult to imagine but yet possible.

12 The second problem I think is that even in the
13 group setting you are going to have outliers. I think one
14 of the objections that is raised to measuring a group level,
15 are you saying you don't have anybody in your group who's
16 not performing in the way he or she should be performing,
17 and that's problematic. My sense of that is that that can
18 be addressed and probably should be addressed as part of an
19 overall evaluation by making sure that if the measurement
20 takes place at the group level that there is a process in
21 place to deal with that problem. Of course, many groups
22 have that and I would probably suggest that many don't and

1 depending on the definition of groups you might not have
2 such a mechanism.

3 As opposed to moving towards a measurement process
4 which focuses only on the individual and therefore rolls
5 back all those advantages to measuring at the group level.
6 A couple thoughts.

7 MR. HACKBARTH: If I understand this correctly,
8 it's not clear to me that it needs to be all individual or
9 all group. There are instances of existing well-defined
10 groups that have the internal controls and processes in
11 place, even bill Medicare as a group as opposed to
12 individual clinicians, and they could be accountable at the
13 group. But for the individual physician who wishes to be
14 independent of that, then you would have individual
15 accountability. You could have a blend of the two.

16 Just by virtue of my experience, I guess I'm where
17 you are, Jay, in terms of seeing some advantages in terms of
18 the group process and improving quality. If there is truly
19 accountability at the group for the overall result I think
20 clinicians working with other clinicians can often
21 accomplish things that a distant government, even with more
22 refined tools cannot, because physicians respond to their

1 peers. So I'd be uneasy about ruling out systematically
2 group influence in improving performance.

3 DR. WOLTER: I was somewhat responding to a little
4 bit of a theme in here about how important it might be to
5 find measures for all physicians. Is that the tack we want
6 to take or would it be important to identify the high use,
7 high dollar, high likelihood of areas for improvement in
8 quality and focused an initial wave of pay for performance
9 with a bit of a focus rather than trying to just find
10 something for everybody? I don't know, Arnie, how you have
11 addressed that but I would think you probably asked those
12 questions in one way or another. So that is a question more
13 than anything.

14 Then on the structures of care, in my experience
15 as we have tackled quality it really has involved -- really
16 a lot of nursing has been our success, finding clinical
17 nurse specialist in quality who support teams led by
18 physicians to take on diabetics, congestive heart failure,
19 et cetera. There's a fair amount of expense to that when
20 you do that which really is not reimbursed. The It tools,
21 as important as they are going to be, are tools around which
22 teams like I've just described have to organize the care.

1 So I don't know how we would include that in our thinking
2 but that is a structural issue.

3 I was interested in the U.K. list also. I noticed
4 they had something about organization of care as one of
5 their pay for performance criteria. I don't know what that
6 is but I'm wondering if they're trying to incent something
7 along those lines.

8 You have heard me say this before, if you look at
9 the areas where there seems to be great opportunity to
10 improve quality and possibly at the same time deal with
11 efficiency, they are congestive heart failure, diabetes,
12 some of these big chronic disease areas. If we were to be
13 patient-centered in our thinking we would follow the
14 patient's quality experience and cost over the course of a
15 year and longer. That really does mean we'd been looking at
16 inpatient and outpatient care, and ultimately we are.

17 So how do we chart a course where we are really
18 trying to look at the patient's experience through the
19 system and how the Part A and Part B systems really have to
20 be looked at in a coordinated so that the incentives for
21 physicians and hospitals to work together across the
22 settings start to come into play? I think that is, from my

1 standpoint, certainly an important theme.

2 MS. BURKE: Just following on that for a second
3 and reflecting back on our discussion early this morning, I
4 wonder, Karen, as you identify the four questions at the
5 outset that we're trying to look, I wonder if we ought not
6 add to those questions in the vein that we were just
7 discussing which is whether or not in the course of looking
8 at each of these issues whether their application ought to
9 vary. The whole question of whether you do it by specialty,
10 by geographic location.

11 It is not only a question of confirming whether
12 the evidence is well-based, whether or not it can be
13 collected in a standardized way, whether they have risk
14 adjustments. The other question it seems to me is an
15 application issue. As we challenge ourselves to figure out
16 what can be applied generally there is also the question
17 that we have asked, which is whether or not that ought to
18 be, at the outset, the first place we go. So one might ask
19 whether an application issue, that is how one might begin to
20 do this, ought not in and of itself be a question as well as
21 the factors that would make up the decision as to which of
22 these we would apply, how relevant they are, how accurate

1 they are.

2 MS. MILGATE: Are you referring to the unit of
3 accountability, because of the examples you gave --

4 MS. BURKE: No, I'm talking about to whom they
5 should be applied. For example, we might decide that our
6 primary concern as we move towards pay for performance is
7 around certain kinds of behaviors among certain physicians
8 and it might be related to certain practices, certain
9 specialties, certain services. While I am not arguing
10 against a broad application when we moved towards a pay for
11 performance system, one of the questions we have to struggle
12 with is, will we be ready to do everybody all at once in all
13 cases? Or are we more likely to be focused on the areas
14 where there seems to be the highest need?

15 MS. MILGATE: Which is somewhat what Nick was
16 saying.

17 MS. BURKE: I'm saying, following up on Nick's
18 point. The questions that you've identified at the outset
19 are presumptive of a broad application. When I think in
20 fact there is a question to be asked as to narrowing that
21 application and phasing it in over time, narrowing it for a
22 variety of reasons. I don't know that I would know which of

1 those categories to choose, but following Nick's point maybe
2 a question ought to be asked. Maybe that's one of the
3 things that we continue to pursue as we go forward.

4 DR. MILSTEIN: Just following up on Sheila's
5 question. In order to target, we need some reasonable
6 baseline information on which we might target. I think
7 probably our best and most precisely calculated inventory of
8 the epidemiology of quality of care problems in the U.S. was
9 the study that RAND finished a year and-a-half ago and
10 published in the New England Journal of Medicine. Thought
11 they didn't break it down across an infinite number of
12 frames, I think RAND's conclusion was that in terms of using
13 compliance rates with evidence-based medicine, excluding any
14 contraindications, that the opportunity for performance lift
15 in American health care was very widely distributed across
16 multiple specialties and settings.

17 Unfortunately, if one were to say, weren't there
18 some sterling examples of either settings or physician
19 specialties where performance is so good that we really can
20 say that is a lower priority, I think if the RAND folks were
21 here they would say no. Unfortunately, though there were
22 some specialties and settings where the rate of compliance

1 with evidence-based guidelines was higher rather than lower,
2 but in general I don't think there was any setting or
3 specialty group that they examined in which there wasn't at
4 least a 30 percentage point opportunity for gap closure.

5 MR. HACKBARTH: I'd like to go back to some of the
6 issues that have been raised and try to generate some
7 specific discussion just so we have a better understanding
8 of where commissioners are. One issue that Arnie has raised
9 is the notion of longitudinal efficiency and not just
10 looking at short periods of time, but the bigger package,
11 longer periods of time and the full range of services. Now
12 I assume that's being done in your project in the context of
13 still fee-for-service payment system. So this is an overlay
14 on top of fee-for-service payment; is that right?

15 DR. MILSTEIN: Yes, the California project is
16 focused on managed care plans, and the managed care plans
17 vary in how they pay the doctors. I think probably because
18 there's been a rollback in capitation, probably most of the
19 medical groups that are participating are currently being
20 paid fee-for-service, but there are some capitated groups.

21 MR. HACKBARTH: So the flow of dollars out of this
22 quality pool, so to speak, are to the plan and then it's up

1 to the plan to distribute them among the individual
2 providers?

3 DR. MILSTEIN: The flow of dollars is from the
4 plans to the medical groups. The medical groups are in some
5 cases of IPAs, very loosely organized, and in some cases
6 they're very well organized multi-specialty groups analogous
7 to Permanente. There's a blend.

8 MR. HACKBARTH: So what I'm struggling with is,
9 although I certainly agree with the concept of we ought to
10 be rewarding high quality with some consideration of the
11 efficiency, what I'm struggling with is how you graft that
12 onto what is still basically a fee-for-service payment
13 system in Medicare, and how that would actually play out.

14 DR. MILSTEIN: Let me illustrate. Irrespective of
15 whether the physician payment system were capitated/risk-
16 based or fee-for-service based, it would still be possible
17 to take that payment and increase it or decrease it based on
18 some weighted combination of quality of care measurement and
19 longitudinal cost efficiency measurement.

20 MR. MULLER: That whole discussion about
21 accountability comes right back and hits you in the fact
22 because you're just miniaturizing the SGR argument, which is

1 when you have -- as soon as you start having three, four,
2 five physicians or settings, dialysis, ambulatory surgery,
3 hospital, et cetera, involved in the care, how do you make
4 the allocation among them? In some ways if you just had one
5 doctor and one setting for a course of a year then you could
6 deal with this issue. But that is not the way the care is
7 delivered. Therefore the unit of accountability needs to be
8 decided upon before one can -- Arnie, I don't know how you
9 do it except if you just allocate the issue to medical
10 groups, that is not 100 percent of your population, so I'm
11 not quite sure how you do it.

12 DR. MILSTEIN: The folks who have been working on
13 it would say that at this point it's an art form based on
14 scientific methods in which you -- there is, for example,
15 kind of a consensus exercise occurring in the private sector
16 now being administratively managed by a combination of the
17 Leapfrog Group and Bridges to Excellence which includes
18 participation by provider organizations, health plans, and
19 consumer organizations. Essentially saying, how do we deal
20 with issues of either quality or cost efficiency attribution
21 in situations where there is more than one physician or more
22 than one medical groups, or a medical group and a hospital's

1 performance are both at play?

2 I think the good news is multiple stakeholders in
3 thinking through the challenges are saying the answer is not
4 to back away from the challenge but rather to come up with
5 something that multiple parties agree is reasonable. So
6 there is a variety of so-called attribution methods that are
7 currently likely to be deemed equally reasonable as long as
8 at least one of them is used.

9 MR. HACKBARTH: Let me move on to the issue of
10 what is the data used for the adjustment, claims versus new
11 data collection. I'd like to hear some more thoughts on
12 that issue.

13 MR. BERTKO: I am always one for being on the
14 practical side without increasing expense and I believe
15 Ralph was one to say -- chart pulls in my own experience are
16 very expensive. I do know that the RAND people have taken
17 their chart methodology, summarized it down to fewer
18 indicators, and then are trying to roll that out in terms of
19 piloting it. That would seem to be a very practical way to
20 run it across the Medicare Part A, Part B data. Ideally,
21 there are a number of them that I know on the commercial
22 side work with what will become Part D in prescription

1 drugs.

2 So going in that direction strikes me as possible
3 for some subset today and even better starting in 2006 when
4 we have that data stream flowing through, and avoids perhaps
5 -- I clearly agree with Karen's comment that the individual
6 stuff where you go to charts is more robust, but this might
7 be something that is good enough to get us started and
8 eminently practicable.

9 MR. HACKBARTH: As I understand it, there are
10 people trying to develop another option, not go to raw
11 charts and pull out data anew, but rather have concurrent
12 collection of data through flow sheets and other mechanisms
13 so that maybe the costs on lessened and you still get a more
14 robust set of data.

15 MS. MILGATE: Alan could maybe talk about it more
16 than I can. In fact the AMA's consortium for performance
17 improvement has really been the leader in this and they have
18 developed for each condition that they've looked at both
19 measures and then a data collection tool which they call a
20 flow sheet where it basically has different -- it has a
21 history. It is one page which is unique to look at it --
22 history of patient visits over time and you can check off

1 preventive test, diagnostic test, blood pressure, so that
2 the physician is managing the patient's care at the same
3 time as being able to check what happened over time and it's
4 also the data collection tool.

5 And actually having talked to several different
6 medical groups, their comment is it really isn't that
7 helpful for quality improvement often to be going back into
8 records. But if you are doing this at that point in time --
9 Alan probably should comment on whether it's an increased
10 burden or not. It would seem to me it would replace some
11 note-taking now, but it may be an additional step.

12 MR. HACKBARTH: So the concept -- and I'd like to
13 hear from clinicians about whether this might be realizable,
14 but the concept is that you do it concurrently and
15 potentially there is the benefit of not just collecting data
16 but also saying, here is what we're looking for. You're
17 telling the clinician, this is what you're being measured
18 on.

19 MS. MILGATE: Right, and becomes a checklist for
20 them for their own care management as well.

21 MR. MULLER: The early evidence on putting the
22 computerized provider order entry when it's physician order

1 entry that came out of the Brigham is there's about a 15
2 percent to 20 percent decline in efficiency in the first
3 period. That period can be three to six months. So if
4 you're asking in a difficult environment to have a decline
5 in efficiency of 15 percent, 20 percent to put CPOE in, and
6 then you think of this as an extra form of CPOE, I think you
7 can think of it that way, you're really putting on more.
8 It's hard enough to get -- a lot of us have been urging for
9 years that we move more towards the physician order entry.
10 It's still I think less than 15 percent of the order entry
11 is done through that. If you have the sense it's a real
12 slowdown in efficiency I just think you're putting too many
13 strikes in the way of getting this done.

14 MS. MILGATE: This wouldn't necessarily be
15 electronic. It could be.

16 MR. MULLER: If it's not electronic it makes it
17 even worse.

18 MS. MILGATE: It could be built into an EHR but it
19 would basically just be a replacement for whatever the
20 physician would use not to record. But maybe it might slow
21 down, it's true.

22 DR. NELSON: I agree with avoiding the unfunded

1 mandates on data collection if we can possibly do it. If we
2 can get it from administrative data while we're starting,
3 that's fine. And checklists would be better than nothing
4 but I don't think that they would be greeted with open arms
5 by a clinician who is also facing the possibility of reduced
6 fees anyway.

7 So I think a lot of it depends on whether or not
8 there is some consideration of the administrative burden in
9 terms of paying for it. If you can calculate how much
10 additional time is taken in patient care through the use of
11 checklists and submitting these quality data and build that
12 into the reimbursement formula in some fashion then I think
13 that would be acceptable because most clinicians want to do
14 a good job. They want to improve if they can.

15 But I think to tell the clinicians that from now
16 on you will use this checklist and you will turn it in with
17 some regularity, and don't worry we will make it as easy as
18 possible on you, if they've got their choice between two
19 patients, one Medicare and one not Medicare and they only
20 have one appointment open, you know which one they're going
21 to take.

22 MR. HACKBARTH: Yes, the burden is a very real,

1 very important issue. On the other hand, we don't want to,
2 in keeping with your earlier theme of unintended
3 consequences, we wouldn't want to pay people to do things in
4 an inefficient way, pay for collection. Ultimately what we
5 want them to do is move into the 21st century and use
6 computers for these things. If you pay them for the old
7 way, the incentive for them to move towards better systems
8 is diluted. So it's a tough balance to strike.

9 DR. CROSSON: Perhaps the same point. I just want
10 to make the obvious point that the value of the clinical
11 system approach is that you are actually having the
12 clinician record the information that is necessary for
13 patient care, and then electronically it extracts the
14 information that's needed for quality and other things. So
15 you are not actually having extra work.

16 That is not to say that taking physicians from
17 paper to a computerized medical record is easy. It is not.
18 We are in the middle of it. We just had a rollout in
19 Colorado of 500 physicians in the last couple of weeks. It
20 does have a short-term impact on productivity, but in all of
21 the settings where we have put it in place, including
22 Portland, Oregon and Colorado and Hawaii, we have really not

1 experienced a sustained reduction in productivity. In some
2 specialties, in internal medicine which is the most complex
3 administratively and clinically, it has added some. But in
4 most specialties it has not, and the recovery time of
5 productivity is measured in weeks.

6 DR. MILSTEIN: I certainly support Glenn's notion
7 that we build a better information base sooner rather than
8 later than issues of how imperfect are the performance we'll
9 drop off quickly. Karen and I actually attended a meeting
10 sponsored by RWJ and Commonwealth Foundation about three
11 weeks ago in which Shelley Greenfield reported on fresh
12 research that asked the question, if you rank physicians
13 with respect to quality of care performance using claims
14 data, which is obviously the least perfect, and compare it
15 to how physicians rank using medical record abstracted data
16 he reported that the correlations now are running quite
17 favorable. Not perfect, but quite favorable. Adam Dudley
18 has done research on hospital inpatient performance for AHRQ
19 reporting a very similar results. That is the correlation
20 in rankings either way is quite good.

21 I think at the end of the day what we're talking
22 about here is what kind of physician or hospital

1 misclassification error are we prepared to tolerate as we
2 move forward in pay for performance? And as Karen was
3 saying, what's the opportunity cost of not proceeding, given
4 what we know about current quality levels? Dana Saffron in
5 Boston has actually looked very carefully at this question
6 of physician misclassification error. That is, giving a
7 physician a B rating when actually his or her performance
8 might be an A- or a C+. Her point is that if you do a
9 statistical analysis, as long as you're not trying to very
10 carefully separate by deciles and instead are separating by
11 above and below average or top or bottom tertile, that
12 claims data has relatively low risk of misclassification
13 error.

14 MR. HACKBARTH: It would be helpful, Karen, if we
15 could learn more about that research, because I think that
16 goes right to the heart of the issue. You are trying to
17 optimize and if you use claims data you have a lower cost of
18 collection. Potentially I gather also a broader set of
19 measures that you can do quickly, but the risk is accuracy,
20 and if in fact there is research showing that that cost in
21 terms of accuracy is not very large, that's potentially very
22 important information.

1 DR. MILLER: Before we move on to other issues
2 here, the other thing I want to say about -- something just
3 to put in your minds. If we think that we are going to go
4 down a claims approach, either alone or in conjunction with
5 something else, another thing we might want to think about
6 is enriching the claims process. So having test reports
7 reported on the claims, so that over time if that's the
8 path, the data set becomes richer. I just wanted to put
9 that thought, and I think people have said that in other
10 settings.

11 Can I ask one thing? So is it that you do get a
12 richer set of measures out of a claims stream than from --

13 DR. MILSTEIN: It's not a richer set of measures.
14 It's a richer set of affordable measures. You could get
15 that same richness of measures out of medical record review
16 but it would cost a lot of money or a lot of physician time
17 in collecting.

18 MR. BERTKO: I would only add that the set of
19 measures for RAND is quite substantial. It is over 100
20 measures. It's much less than the 450 or so in the New
21 England Journal article and it covers a broad range of
22 specialties, which I think is another important part.

1 MR. HACKBARTH: So perhaps a better way to put the
2 point I was making, Mark -- I think I did misstate it -- is
3 for any given level of investment you can have a broader set
4 of measures if you use claims because of the lower cost of
5 collection than you could if you tried to extract clinical
6 data from records or flow sheets or something else.

7 DR. NELSON: Karen, you may have referenced this
8 and I didn't see it. One of the considerations that we
9 haven't touched on is whether we pay for performance that
10 meets a certain standard level, for whatever condition, or
11 whether we pay for improvement even though it may start at a
12 lower level and show substantial improvement. Whether or
13 not those who have been in this business and are performing
14 at a 95-percent level and can only go up 1 percent are
15 disadvantaged with respect to those who go from 30 to 50, or
16 some combination thereof. I think the article in Health
17 Affairs goes into this in some detail in terms of what the
18 private sector is doing on this.

19 MS. MILGATE: We didn't talk about it in great
20 detail in the paper. I think it's is referenced, but we did
21 discuss that when we were talking about whether to apply
22 these pay for performance for health plans in Medicare as

1 well as dialysis facilities and physicians, and the
2 Commission at that time said that it should be a mix. So we
3 have kept that in mind. I think that is probably
4 referenced, but it isn't developed in the paper, which it
5 could be a little bit more if you think that is an important
6 point to make a little stronger.

7 DR. MILLER: I would just say a little bit
8 stronger than that. We're operating under the assumption
9 that that is one of the principles the Commission has agreed
10 to and as we crank through these differences that we are
11 assuming, until we hear differently, that is a principle
12 we're going to carry forward.

13 MR. HACKBARTH: Karen, I'm sorry, I cut you off a
14 minute ago and then didn't come back to you.

15 MS. MILGATE: There was just one point on the RAND
16 data. One of the reasons they had so many is that they had
17 prescription drug data. So it would be really important in
18 the Medicare program to be able to use the prescription data
19 if we are going to rely on claims, along with Mark's point
20 on making the claims as useful as possible. I don't know if
21 they also included lab values in the claims. I don't think
22 they did, but that is another improvement that would be very

1 useful, because then you could get not just whether an
2 HgbA1c test was done, which is currently all Medicare can
3 get out of claims data, but look at the actual levels that a
4 patient achieves, which in and of itself is more useful.
5 But as you said, there may be a broader set you could do
6 initially with just claims.

7 MR. HACKBARTH: The last issue I wanted to go back
8 over is the amount, how much the potential quality payment
9 is. What we've been saying is take an amount equal to 1
10 percent or 2 percent and then redistribute that based on
11 quality performance. Ralph and Arnie and maybe some other
12 commissioners as well have said, that seems awful small
13 relative to what we want to accomplish. I just wanted to go
14 through that a little bit further.

15 First of all, my understanding of what we've been
16 saying is that the 1 percent or 2 percent is a starting
17 point not necessarily an end point. I think the spirit of
18 the conversation there has been we need to be wary of
19 unintended consequences, and by initially attaching a lower
20 level of payment perhaps we diminish the risk of having
21 unintended consequences while we're ramping up and learning
22 in the early stages of the effort.

1 I think the circumstance in Medicare is perhaps a
2 bit different, Arnie, than the circumstance in a private
3 project in a couple ways. One, obviously, is the political
4 process that one needs to go through to get approval. But
5 beyond that, Medicare is much larger than even usually a
6 band of major private purchasers in terms of dollar volume
7 and the potential impact. So 1 percent or 2 percent on
8 Medicare may be in dollar value equal to or greatly larger
9 than 15 percent or 20 percent from a local purchaser
10 consortium.

11 I think given the magnitudes and given the policy
12 process I guess I still feel comfortable that we ought to
13 start small as we are learning but keep the door open to a
14 progressively larger amount as we become more confident.
15 That is just my take and I wanted to get other people to
16 react to it.

17 MR. SMITH: You are right about the potential size
18 of a 1 percent or 2 percent pot. But of course the universe
19 across which you would distribute it is correspondingly
20 large. So I think if we are concerned, and I share Arnie's
21 concern that 1 percent or 2 percent is very unlikely to have
22 the kind of impact that we are looking for here, that we

1 ought not to think about just total dollars. Medicare is
2 the biggest payer in the game but it also pays more doctors
3 than anybody else. So it's both sides of that equation.

4 MR. HACKBARTH: But let me just push on that for a
5 second. My point is that Medicare has a larger average
6 share of the typical physician practice than any individual
7 private payer, and even in most cases, aggregations of
8 private payers. So the influence, the power of Medicare is
9 potentially greater both for good and for ill. I am just
10 saying that as we ramp up and are learning that the power of
11 that statement warrants some caution that maybe others
12 wouldn't be required to exert.

13 MR. SMITH: Caution is appropriate and I do agree,
14 Glenn, that this ought to ramp up. Whatever the departure
15 point is we ought to be headed on an upward slope. I think
16 we have learned not to try to do arithmetic in your head,
17 but 1 percent of 20 percent of my practice is a very small
18 number. And if that is both the up and downside of doing
19 something which otherwise I would not do, it is hard for me
20 to imagine at least that that gets the powerful -- we have
21 got a lot riding on making the pay for performance stuff
22 work, as we talked about this morning and last month. We

1 ought to use not a risky big stick but a big enough stick to
2 think it has got some capacity to change behavior.

3 DR. SCANLON: I think that the numbers are
4 magnified some by the amount of redistribution that we think
5 we're going to accomplish. If we set the bar so low that
6 everybody succeeds then there's not going to be any
7 redistribution. But if the bar is high enough than the 2
8 percent maybe becomes 4 percent for some and only a half-
9 percent for others, so that does reinforce it.

10 One of the issues related to this that I feel we
11 need to talk about is, what's the pool going to be that
12 we're going to be taking this 2 percent out of? Because it
13 became clear as I went through the paper that all physicians
14 in some respects don't have the same opportunity to perform,
15 given current measures. So it is not necessarily 2 percent
16 of physician payments. But then once we've said that, where
17 do we draw the boundaries in terms of identifying what the
18 appropriate pool is and how it is going to be redistributed
19 among the people that are eligible for that tool.

20 DR. MILLER: I think it is a question and to date
21 the way we have dealt with it is we have said 1 percent or 2
22 percent from existing payment. So you go through the

1 process of setting whatever payments are going to occur. So
2 you go through an update process. You say, these are the
3 dollars that are available and you take a percentage or so
4 off of that and you redistribute on the two bases that
5 you've talked about, attainment and improvement.

6 Part of the reason that we have thought and tried
7 to work so hard about thinking about how comprehensive you
8 can be here is because of this very issue. Nick's point is
9 well taken. You could zero in and take a set of conditions,
10 providers or however you wanted to do it, but then you would
11 have to get into the idea of drawing the boundaries of the
12 dollars that are associated for them.

13 One of the things that was unsaid but implicit in
14 the strategy moving from left to right on that picture is
15 that the first set of measures are in fact trying to pertain
16 to all physicians. Then you go to the second set of
17 measures, and then probably the process measures don't reach
18 across the entire spectrum. There the do-no-harm issues
19 does become an issue when you probably do want to stay
20 small. But I can also say that if you begin to say this is
21 a direction that Medicare is going to move in, the necessity
22 of specialties and providers to bring process measures

1 forward and say, here is my set to be measured on, you begin
2 to get some kind of pressure to do that. But I don't need
3 to minimize this point. This is a judgment.

4 DR. MILSTEIN: I think this is a great moment for
5 what some would term evidence-based policymaking. If you
6 look at Meredith Rosenthal's summary in Health Affairs last
7 spring of pay for performance programs where she summarizes
8 about 50 of them, many of them at the physician level, she
9 makes the observation which has been reinforced by AHRQ and
10 other health service researchers is that we actually have
11 yet to have a single pay-for-performance program in the
12 United States, whether it's at the physician or hospital
13 level in which the dosage level was adequate to pull forth a
14 significant detectable performance improvement.

15 So I like this line of reasoning of saying, we
16 know what Medicare is as an average percentage of physician
17 income. We multiply that times whatever percent pool we
18 have in mind. It seems to me we at least ought to make sure
19 that the dosage that we apply is above the dosage at which
20 we know, based on others who have gone before us, has not
21 been effective. So we have an evidence base of 30 or 40
22 physician pay for performance where we know when you

1 multiple the amount of the size of the pool times the amount
2 that that payer represented to a physician we have yet to
3 get a therapeutic effect.

4 So I would hope as we go forward we would use
5 evidence to make sure we don't start out at a dose we
6 already know to be sub-therapeutic based on others who have
7 gone before us. I think it's probably not insignificant
8 that the U.K. looking at the evidence said, start out with
9 18 percent of total comp and go to 30. That was their
10 intuition.

11 They obviously had to struggle with the issue of
12 unintended consequences as well. I think into their logic -
13 - I had a chance to talk to the folks who put it together.
14 Underneath their logic was, one has to be careful about
15 unintended consequences partly in proportion to how good
16 your baseline is. If you have a great baseline of
17 performance then be very cautious about messing with it.
18 But when you start out with a baseline of 55 percent
19 compliance with evidence-based medicine, it does tend to
20 encourage putting a little bit more money on the table
21 because it isn't like our current baseline is that precious
22 and worth preserving necessarily.

1 MR. MULLER: Using different metaphors but along
2 the same line of argument, is basically that the powerful
3 incentive drive powerful innovation, and that's is core to
4 economic theory. We have seen in all our work that we'd
5 done last year or so there's powerful incentives out there
6 for imaging, there's powerful incentives out there for
7 diffusion of technology. And there's not powerful
8 incentives out there for diffusion of quality. So what
9 don't we understand here? The overarching incentives inside
10 the system right now take us in a different direction.

11 So if we want there to be a powerful incentive
12 towards quality then have one, rather than keep tweaking
13 around at the margin with it. Again, everybody will get
14 upset about how one gets from here to there, but I do in the
15 paper saw the average G.P. in the U.K. has income of under
16 \$100,000 a year, and you're saying they can make up to
17 \$77,000 in incentives for quality. That is beyond 18
18 percent to 30 percent. That is not what the expected value
19 is likely to be, but still it gives you a sense of how much
20 they are putting the economic incentive behind the quality
21 initiative.

22 So I think one has to think in those kind of

1 powerful terms. Again one can think in a phase-in basis.
2 You can't just -- we don't have a political system like the
3 U.K. where you can just put it in in one year, so you need a
4 segue into it. But unless we think in those terms -- and
5 then what we learn in the rest of the economy, having
6 incentives -- this is not just a static model. The
7 incentives then drive the innovation that you want. So a
8 lot of the questions that we're trying to answer today
9 really have to be answered down the road as a result of the
10 innovation that goes forth. This is something where having
11 the 50 states try to figure it out in different ways or the
12 regions figure it out in different ways is not a bad idea.
13 So I think let's think about, whether you use Arnie's
14 metaphor or this one, moving in a more powerful direction.

15 MS. MILGATE: Just one comment on that. One of
16 the reasons in the beginning we had thought it would be
17 small that is unique from the U.K. example is just the
18 consideration would be that it would be budget neutral, so
19 it would be money taken out of a base and then
20 redistributed. The U.K. example, they actually had an
21 analysis done that showed that their system was underfunded
22 and uniquely said, we're going to put some more money in to

1 make sure that we are adequately funding this system, and
2 then decided this was probably the best bang for their buck
3 to spend those dollars.

4 That doesn't mean that we still might want that
5 level to be higher, but I think that the comparison is not
6 quite apples to apples, just for that reason.

7 DR. CROSSON: I just want to recognize that Bob is
8 not here so some of us have the responsibility for the
9 runaway metaphor. I just want to make sure that we know
10 whether we're talking about the biopsy or the pill, the dose
11 that gets administered. Because it seems to me that we're
12 talking about a 2 percent biopsy from the Medicare payment
13 corpus. But then that doesn't necessarily mean that the
14 dose that gets administered is only 2 percent, because that
15 is a function of the design of the incentive system. So the
16 dose that gets administered could be a good deal larger than
17 that. Make it too large and then you don't have enough
18 people winners. I understand that.

19 But I just think that it strikes me that maybe the
20 size of the biopsy really is the political problem more than
21 the size of the dose that gets administered. And depending
22 on some clever design we might be able to get more impact

1 than with other designs.

2 MR. HACKBARTH: We may put you permanently in
3 charge of metaphors.

4 We are going to have to move ahead in a second.

5 DR. WOLTER: I was thinking about the return on
6 investment piece and the budget neutrality piece. You might
7 imagine over time that fewer avoidable admissions and
8 improvements in quality in chronic disease might save some
9 money, but you would almost certainly decide that might not
10 show up in 12 months. Or you might imagine that connecting
11 this effort to profiling over time, as people are
12 participating in data streams, might allow other decisions
13 to be made that would get patients in the hands of more
14 value-oriented providers. But that's also not going to
15 happen probably in 12 months.

16 So I think the question is, at what point do we
17 try to look at something that is a little bolder, but it's
18 going to have a longer time frame? I don't know what the
19 appetite for that is, probably not very high in this next 12
20 months. But really that is what would be a bolder approach,
21 would be to think over three, four, and five years, try to
22 put some things in place that really could create the

1 ability to profile, could create the ability to measure
2 improvements in quality, and some reduction in cost in some
3 areas. I think it's almost impossible to do it in a 12-
4 month budget neutrality set of principles.

5 MR. HACKBARTH: Thank you very much, Karen. Well
6 done as always.

7 MR. HACKBARTH: Next is the mandated report on
8 physician volume.

9 DR. HAYES: Good afternoon. Dana, Ariel and I are
10 here to review a draft report on growth in the volume of
11 physician services. Congress asked for this report in the
12 Medicare Modernization Act.

13 Recall that we presented parts of this report at
14 the October meeting. We're here today to present the rest
15 of the report. Based on your discussion, we will revise the
16 report and prepare it for submission. It is due on December
17 8th.

18 Let me take just a few minutes to review the
19 requirements for the study and give you a progress report on
20 where we are and what we'll cover today. The specific
21 requirements are shown on this slide. They begin with a
22 request that we address the extent to which the volume of

1 physician services results in improvements in beneficiary
2 health and well-being.

3 The MMA then goes on to list five factors that are
4 believed to help explain volume growth. They are listed
5 here. The first one is really three topics in one. It's
6 growth in the components of spending that are included in
7 CMS's definition of physician services. They include the
8 physician fee schedule, outpatient laboratory services and
9 Part B drugs. These are drugs that are usually administered
10 in physician offices.

11 The other factors listed here are a little bit
12 easier to explain, but a lot harder to address it turns out.
13 We were asked to look at the extent to which changes in the
14 demographic characteristics of the beneficiary population
15 affect volume growth. Also to contrast the volume growth
16 for Medicare beneficiaries and other populations, the
17 effects of coverage decisions and new technology on volume
18 growth, and finally shifts in the site of care.

19 Just as an added bonus, so to speak, we were asked
20 also to look at the impacts of law and regulation on the
21 sustainable growth rate. Recall that the sustainable growth
22 rate is part of the formula that's used to update payments

1 for physician services and control spending for those
2 services.

3 At the October meeting we presented results on the
4 first two factors listed here. We will today cover the
5 remaining topics in the report. They are shown in bold on
6 this slide.

7 Dana will begin with a brief recap of what we
8 covered at last month's meeting and then she will begin our
9 presentation of new material for this meeting.

10 MS. KELLY: I will quickly review the findings
11 from last time. We found that Medicare expenditures for
12 physician and lab services and Part B drugs combined have
13 increased on average 8.4 percent since 1999. Per fee-for-
14 service beneficiary spending for Part B drugs has grown
15 disproportionately over the period, averaging almost 23
16 percent per year. So as a result, Part B drugs now account
17 for almost 12 percent of the total expenditures considered
18 by the SGR, up from about 7 percent in 1999. Nevertheless,
19 physician expenditures remain the most important driver of
20 growth in spending for SGR services.

21 You saw this chart last time. It demonstrates the
22 importance of physician spending to overall growth. The

1 bars represent the annual increase in per fee-for-service
2 spending for the three components, physician, lab services
3 and Part B drugs. The first bar, for example, represents an
4 increase of 10.7 percent between 1999 and 2000. Growth in
5 spending for physician services, shown in green, accounted
6 for 82 percent of the total increase in that year.

7 Since 1999 the only point at which growth in
8 physician expenditures did not account for the lion's share
9 of spending growth for the SGR components is between 2001
10 and 2002. During that period, of course, we had the
11 negative update for physician services, combined with a jump
12 in drug spending.

13 The bar at the far right represents the change in
14 spending between 2003 and projected spending for 2004. As
15 you can see, CMS expects changes to Medicare's payment for
16 Part B drugs to significantly slow drug spending. No such
17 slow down is projected for physician spending growth.

18 As the mandate asked us to, we also talked about
19 factors that might explain growth in expenditures last time.
20 We first looked at the aging of the Medicare population.
21 This is important, as you know, because older beneficiaries
22 are more costly to the program. But we found that the

1 proportion of beneficiaries aged 75 to 84 and those 85 and
2 older increased just slightly.

3 We also found an increase in the proportion of
4 disabled beneficiaries, a very slight increase in the
5 proportion of male beneficiaries, and a small decrease in
6 the proportion of fee-for-service beneficiaries who died.
7 Since beneficiaries in the last year of their life tend to
8 be more expensive than other beneficiaries, a decline in the
9 death rate would tend to decrease expenditures in that given
10 year.

11 Taken together, our analysis found that changes in
12 beneficiary age, disability status, sex and rate of death
13 cannot explain the growth in physician volume in spending.
14 The net effect on spending per beneficiary during the time
15 period was actually negative, minus 1.1 percent per year.

16 In addition to demographics, we also considered
17 shifts in the geographic distribution of fee-for-service
18 beneficiaries because some states have been shown to have
19 higher utilization patterns than others. We looked at each
20 state's proportion of total fee-for-service enrollment in
21 1999 and in 2002. We found that states that gained in their
22 fee-for-service enrollment shares had higher use relative to

1 those with reductions in their fee-for-service enrollment
2 shares but the effect was very small. Because of these
3 shifts, we would expect per beneficiary spending to go up
4 about 0.2 percent per year.

5 We've shown that the physician component is the
6 important driver of growth in services covered by the SGR
7 and that the growth is not due to demographic changes or
8 shifts in the geographic distribution of beneficiaries. We
9 attempted to isolate the effects of price and volume and
10 found that volume and intensity increases accounted for more
11 than 80 percent of the growth in physician expenditures
12 between 1999 and 2002.

13 As you know, previous analyses that the Commission
14 has done looking at the growth in physician services found a
15 particularly high rate of increase in use of imaging
16 services and diagnostic tests. These types of tests also
17 vary widely across geographic areas, raising questions about
18 whether they are value added services. It's of concern not
19 only because of its effect on Medicare spending but also
20 because greater use of services is not associated with
21 improved outcomes.

22 Now I'll turn to our analysis of a factor that

1 many believe explains the growth that we've seen in service
2 volume and intensity, new technology. As you know, some new
3 technologies have been extremely expensive, involving
4 hospital stays that cost tens of thousands or even hundreds
5 of thousands of dollars. In many cases, new technologies
6 have indirect effects, creating new demands for physician
7 office visits and other physician services and costly
8 pharmaceuticals. Even where medical advances reduced per-
9 service spending, they may raise total spending by making it
10 possible to treat more beneficiaries, including those who
11 were previously too frail or ill to be suitable candidates.

12 Many new technologies enter the Medicare system
13 informally, through the back door so speak. Technological
14 change can occur within an existing code without increasing
15 a physician's work, and therefore the relative value of the
16 code. This type of change may increase volume, for example
17 by expanding the number of beneficiaries who can safely and
18 appropriately receive certain types of services.

19 New technologies also can enter the Medicare
20 system formally, sometimes through CMS's national coverage
21 determinations, but far more frequently via decisions made
22 by local carriers and intermediaries.

1 Congress asked us to examine the impact of new
2 technology on recent growth in physician volume and
3 expenditures. It's very difficult to sort out the impact of
4 new technology. The purest way is to look at new codes.
5 Our contractor, the Urban Institute, found that 372 new
6 codes were introduced in 1999 through 2002. Overall, almost
7 a third of the volume associated with these codes was for
8 oncology-related radiation therapy while about 8 percent was
9 for imaging services. But newly introduced codes had only a
10 small effect on overall volume growth, on average 0.33
11 percent of total expenditures for physician services
12 furnished each year was associated with the new codes.

13 The mandate also asked us to consider technology
14 introduced through national coverage determinations or NCDs.
15 Between January 1, 1999 and December 31, 2002 CMS issued 18
16 NCDs related to coverage for physician and lab services and
17 Part B drugs. The vast majority of coverage determinations,
18 as I said, are made by local carriers.

19 It's difficult to determine the impact of these
20 coverage determinations and of the national coverage
21 determinations. NCDs generally do not introduce new
22 technologies to the Medicare system. Instead, they

1 formalize or clarify decisions that have already been made
2 by local carriers.

3 In addition, NCDs don't always expand coverage.
4 Sometimes they restrict coverage by nullifying local carrier
5 decisions or by specifying that certain technologies will be
6 covered only if provided to patients meeting specific
7 criteria.

8 This estimate of new technology is obviously very
9 conservative, the effect of new technology. It does not
10 account for technology change with existing codes or
11 diffusion of technologies to new populations. It also does
12 not account for the indirect effects of technological
13 advances. These types of effects generally increase costs
14 but quantifying them is quite difficult.

15 Technological advances, of course, can also reduce
16 costs by improving productivity. The work of Susan Foote,
17 et al, demonstrates that simply identifying what constitutes
18 new technology can be difficult. They asked two physician
19 consultants to review local carrier coverage policies and
20 identify which ones related to new technologies. One
21 consultant thought that 8.5 percent were related to new
22 technology. The other thought almost twice as many were

1 related to new technology.

2 So that concludes our presentation on
3 technological change and Ariel will talk about shifts in
4 site of service.

5 MR. WINTER: Thank you. I'll be talking about our
6 analysis of the impact of shifts in setting on the growth of
7 physician fee schedule services and will be addressing two
8 questions as part of that, which are in the slide.

9 The first one is have services shifted between
10 facility and non-facility settings? Facilities include
11 hospitals, skilled nursing facilities and ambulatory
12 surgical centers. Non-facilities are primarily physician
13 offices, but also include dialysis centers, clinical labs
14 and patient homes. We will be using physician offices as a
15 shorthand for all non-facility settings during the
16 presentation.

17 The second question is whether shifts in setting
18 have affected growth in the volume and intensity of
19 physician services. We measure volume and intensity using
20 relative value units or RVUs. Each service is assigned an
21 RVU that determines how much it is paid. We consider non-
22 imaging and imaging services separately because there are

1 differences in how the equipment, supply and overhead costs
2 are billed for each type of service. We will be discussing
3 this more further on.

4 Our contractor, the Urban Institute, examined the
5 share of non-imaging fee schedule services provided in
6 physician offices in 1999 and 2002. The setting for each
7 service is derived from the place of service variable on the
8 physician claim. This table shows the share of services
9 provided in physician offices in each year. The services
10 are weighted by their RVUs.

11 Let me draw your attention to the top right cell
12 on the table. This shows that the share of non-imaging
13 services provided in physician offices declined by 1.4
14 percentage points between 1999 and 2002. This is somewhat
15 surprising, given changes in technology that have made it
16 easier to offer procedures in physician offices.

17 You'll notice that the portion of major procedures
18 done in offices declined steeply from almost 8 percent to
19 4.5 percent. This category includes cardiovascular,
20 orthopedic and surgical procedures that are generally not
21 performed outside of hospitals. We were surprised to see a
22 number as high as 8 percent in 1999. We don't have a

1 definitive explanation for why the number is so high but it
2 could be due to errors in how the place of service on the
3 claims was coded.

4 I'd like to mention one caveat. We were looking
5 at a relatively short time frame and there could have been a
6 migration of services to physician offices that occurred in
7 earlier years. We started with 1999 because in that year
8 Medicare began to pay different practice expense rates based
9 on the site of service which we thought would lead to more
10 accurate coding of the place of service on the claim.

11 Next, we will examine whether the shifts in
12 setting that we observed had an impact of growth in RVUs.
13 We will first review the structure of the physician fee
14 schedule so that you can better understand our analysis.

15 Fee schedule rates have three parts. The first is
16 the work component, which covers the physician's time and
17 expertise. There is the practice expense part, which covers
18 the equipment, supply and administrative overhead costs.
19 And finally, is the part that reimburses for professional
20 liability insurance.

21 As I just mentioned, CMS pays higher practice
22 expense rates for some services when they are provided in a

1 physician office rather than a facility. This is because
2 when a service is delivered in a facility Medicare pays the
3 facility a fee to cover its equipment and overhead costs.
4 Thus, the practice expense payment for the physician should
5 be lower than if the service was provided in a physician
6 office.

7 If services were to migrate from facilities to
8 physician offices, practice expense RVUs would increase for
9 those services with higher practice expense rates in the
10 office. Although we found that there was no overall shift
11 of services to offices, it is possible that some discrete
12 procedures with high practice expense rates for the office
13 may have moved to the office setting. The migration of such
14 services could have caused an increase in overall RVUs.

15 Here are the results. We found that total RVUs
16 and practice expense RVUs for non-imaging services grew by
17 19 percent between 1999 and 2002. This is a conservative
18 number because we controlled for changes in RVU values
19 between these years and we excluded new codes that were
20 introduced after 1999. But we do not adjust for enrollment
21 growth. Movement of services to the office setting do not
22 appear to account for any of the RVU growth, which is what

1 we had expected, given that there was a slight decline in
2 the share of services provided in physician offices.

3 There are a couple things I'd like to note here.
4 One is to repeat the caveat I mentioned earlier, which is
5 that we measured a fairly short time frame. And second,
6 there were some procedures that moved from facilities to
7 offices and other procedures moved in the reverse direction,
8 but there was no net effect on RVU growth. For example,
9 there were two urological procedures that shifted
10 dramatically from facilities to offices. On the other hand,
11 there were several endoscopic procedures that moved from
12 offices to facilities. By the way, those could include
13 ambulatory surgical centers.

14 I'll move on now to a discussion of our
15 methodology for imaging services. There are three types of
16 imaging claims. Professional component claims cover the
17 time of the physician to interpret test results and write
18 the reports. These are paid regardless of whether the study
19 is performed in an office or facility.

20 The technical component claims, those cover the
21 cost of performing the study, such as the equipment, supply
22 and technician time. These are only paid if the study is

1 done in a physician office. If the study is done at a
2 facility, Medicare pays the facility a fee that covers these
3 costs.

4 The third type of claim is when one physician does
5 both of these components, they submit a global claim. If
6 two physicians provide each component separately, they bill
7 separately for each. This is in contrast to non-imaging
8 services in which the same physician bills for both the
9 professional and nonprofessional cost.

10 If imaging services are performed more frequently
11 in physician offices, there will be an increase in the share
12 of imaging claims that are either technical components or
13 global. So we looked at whether the share changed over
14 time, which is the next slide.

15 Here is what we found. The proportion of imaging
16 services that were billed as technical components or global
17 claims, indicating that they were performed in physician
18 offices, increased from about 63 percent in 1999 to 66
19 percent in 2002. The services are weighted by RVUs.

20 Among different imaging categories, nuclear
21 medicine grew the most, from 75 to 81 percent. This shift
22 toward physician offices reinforces our rationale for

1 exploring ways to manage the growth and quality of the
2 imaging services provided in physician offices.

3 Now we will examine the impact of this shift in
4 setting for imaging services on growth of total imaging
5 RVUs. If more imaging services are performed in the office
6 setting, this leads to more technical component or global
7 claims, which in turn leads to additional practice expense
8 payments. We found that total imaging RVUs grew by 39
9 percent between 1999 and 2002. As with our estimate of the
10 growth of non-imaging services, this is a relatively
11 conservative number.

12 Practice expense RVUs increased by 47 percent.
13 Movement of imaging procedures to physician offices led to
14 additional practice expense payments that accounted for 18
15 percent of total RVU growth. To estimate this number we
16 simulated RVUs in 2002 based on the 1999 distribution of
17 types of imaging claims.

18 What if we were to combine the impact of shifts in
19 setting for imaging services with non-imaging services? The
20 net effect is that 3 percent of the growth in total RVUs is
21 related to shifts in setting. So even when we factor in
22 imaging there is a very small net impact on all services.

1 Now we will move on to Kevin.

2 DR. HAYES: Our next and final factor that we were
3 asked to look at concerning growth in volume has to do with
4 comparing Medicare beneficiaries and other populations. For
5 several reasons, we would expect that volume growth would be
6 higher for Medicare beneficiaries than for others. The
7 first has to do with a disparity in coverage. Medicare
8 beneficiaries, of course, by definition, have health
9 insurance coverage while many of those under the age of 65
10 and in the non-disabled population do not.

11 Second, Medicare beneficiaries have greater
12 protection from cost-sharing because in a lot of cases they
13 have supplemental coverage. By contrast, those with private
14 insurance are often paying cost-sharing out-of-pocket.

15 Third is the matter of technological innovation.
16 Because of the greater burden of illness experienced by
17 Medicare beneficiaries, it's quite possible that more
18 technological innovation is directed toward them.

19 We found however, in looking at a variety of
20 different data with the help of Chris Hogan, our contractor,
21 that we were just unable to reach a definitive conclusion
22 about whether there is a difference in volume growth between

1 Medicare beneficiaries and others.

2 Let me just make several points about this.

3 First, we did find some data that -- and research by others
4 -- which showed that looking service by service that there
5 is some evidence of higher volume growth for Medicare
6 beneficiaries than for others.

7 A problem with this kind of work, however, is that
8 it doesn't allow us to aggregate up and to reach conclusions
9 overall about volume growth for Medicare beneficiaries
10 compared to others. What I would ask you to recall is work
11 that we have done for the payment adequacy chapter in the
12 March report, where we recall that we've looked at volume
13 growth for Medicare beneficiaries over time and tried to
14 reach some conclusions about payment adequacy based on that.

15 So we have come up with figures like on a per
16 beneficiary basis volume growth has gone up by -- going back
17 to 1999 -- it's been in a range of 4 to 5 percent per year.
18 So what we were striving for in this kind of a comparison
19 was a number like that that we could compare with the
20 Medicare population. And clearly, looking service by
21 service, we were unable to do that.

22 That prompted us then to try and look at some

1 alternative data sources. The first one that we turned to
2 was the database of private insurer claims that we've been
3 working with for the past few years. As you know, we've
4 used that database previously to compare Medicare's payment
5 rate for physician services with private insurer's rates.
6 The thought was that we could tap that database and use it
7 also to look at volume growth. But it turned out to be an
8 exercise really in frustration. One of our data sources
9 changed the data reporting methods midstream, which had a
10 big impact on how subscriber enrollment was reported. So
11 that made it difficult for us to adjust the volume growth
12 numbers for growth in the number of enrollees.

13 The other problem that we encountered from our
14 other data source is that coverages, benefit packages,
15 benefit designs that were used for enrollees were all
16 changing over time, even within year. So there again, it
17 became difficult to try and adjust the volume numbers that
18 we were getting with the private insurer claims for growth
19 in the number of enrollees.

20 So that was kind of, if you will, a bottom-up way
21 of trying to assess volume growth by looking at use of
22 specific services in the privately insured population. So

1 we then tried a different, more top-down approach, and
2 looked at data on aggregate spending for physician services
3 spending on the part of private insurers. We encountered
4 some difficulties there, as well.

5 Part of it just had to do with the need to adjust
6 for inconsistencies in the benefit packages between the
7 privately insured and Medicare beneficiaries coverage. The
8 other just had to do with cost-sharing differences between
9 the two types of populations. So we ended up abandoning
10 that effort, as well. And as I say, reached the conclusion
11 that we were just unable to come up with stable measures of
12 volume growth for Medicare beneficiaries and others.

13 We turn now to the last topic for the report,
14 having to do with the estimates of the effects of law and
15 regulation that are in the sustainable growth rate.

16 With this part of the report we did not feel that
17 we were capable of looking at the effects of specific
18 changes in law and regulation in trying to assess whether
19 CMS had evaluated those adequately. Instead, we focused on
20 a process that CMS is using to come up with these estimates.
21 At the end of the section in the report, we have some
22 suggestions for how they might improve that process.

1 Let me first talk about some of the issues that
2 CMS confronts in trying to do this work. The first just has
3 to do with the limited data that are available. Really, by
4 definition, we're talking here about limited experience with
5 changes in spending due to law and regulation. In a lot of
6 cases we're talking about new benefits that Medicare
7 beneficiaries have not had previously, the effects of
8 regulations and how they affect the operation of the program
9 and so on.

10 CMS attempts to address these data limitations by
11 consultation with a variety of entities. The work for this
12 is done by the Office of the actuary in CMS. Staff there
13 consult with staff in other parts of the agency, physicians
14 working in the agency, physician organizations outside CMS,
15 previous research that's been done that might be relevant to
16 the topic, whatever it is.

17 The other thing that they try to do in this kind
18 of an environment is to consider not just the primary
19 effects of a change in law and regulation, say in the case
20 of a new benefit the use of that benefit itself, but also
21 the secondary effects of a change in law and regulation.
22 Any sort of associated services that might be used in

1 addition to the new benefit itself.

2 The other issue that's important in considering
3 changes in spending due to law and regulation just has to do
4 with the need to revise the estimates as better data become
5 available. By law CMS is allowed to revise a sustainable
6 growth rate for a particular year twice over the course of
7 subsequent two years. So there is a potential here for
8 changes in these estimates to occur as better data become
9 available.

10 Let me just come back to the issue of how CMS
11 estimates the secondary effects of law and regulation. Two
12 examples illustrate this. If we start with a new screening
13 benefit, that's a relatively straightforward case where
14 we're talking about use of the screening benefit itself as
15 well as associated tests and procedures. The latter would
16 be the secondary effects.

17 Things get a bit more complicated when we're
18 talking about a preventative benefit, however. There is, of
19 course, the primary effect of the benefit itself. But
20 there's also secondary effects, which could be positive or
21 they could be negative. In other words, the benefit could
22 result in greater use of some services but less use of

1 others. And so where the Office of the Actuary often ends
2 up from a secondary effect standpoint, the net effect is
3 zero.

4 Of course, as better data become available over
5 time, there is the potential for such an estimate to change.

6 We concluded the section of the report on this
7 with some thoughts about transparency. Clearly, we're
8 operating here in an environment, CMS is, in an environment
9 of limited information. And so it would certainly be
10 prudent for the agency to look for opportunities to lay out
11 the assumptions that have to be made in making these
12 estimates.

13 In addition, this is a case where what qualifies
14 as a change in law and regulation and what does not is
15 important. Are local coverage decisions included in the
16 definition? What about administrative actions such as new
17 billing codes? Here again, it would be useful for greater
18 transparency to occur, for there to be perhaps a onetime
19 explanation of what's included in the definition and what is
20 not.

21 That concludes our presentation on the report and
22 we look forward to your comments.

1 MR. HACKBARTH: Let me begin with a question and a
2 comment about how we frame the report. The statutory
3 mandate has as the basic question to what extent do
4 increases in volume result in care that improves the health
5 and well-being of Medicare beneficiaries? That's sort of
6 the mega question. And then it asks us to respond to a
7 specific series of factors that you've just gone through in
8 the presentation, change in site of service and so on.

9 As I read the report, we sort of jump over the
10 mega question, to what extent are changes in volume
11 improving the health and well-being of Medicare
12 beneficiaries? And obviously that is not a question that
13 lends itself to simple response. But it does seem to me to
14 be an opportunity to make what is one of our basic points
15 recently, some of the increase in volume is good. Some of
16 the increase in is not so good. In fact, the same can be
17 said about what's in the base. Forget the growth. The base
18 is a mixture of good and bad.

19 It's a very basic point but I think a critical
20 point. It leads to our policy recommendations that we need
21 to start being more discriminating in the tools that we
22 apply, not just in Part B but in the whole program in

1 general. So I think this is one more opportunity to toot
2 that horn and we ought not to pass it up.

3 I also had just one narrow question about the
4 process of revision of estimates for new benefits and the
5 like. In the paper it says that the estimates are subject
6 to revision for one year. But I thought I heard you say
7 that they have two chances to revise. Could you reconcile
8 that?

9 DR. HAYES: The draft is incorrect on that point.
10 It is for two years.

11 MR. HACKBARTH: We were telling Hill staff
12 yesterday that it was one, so we need to go back.

13 DR. MILLER: So we need to change the law and make
14 it one. I think that's what Glenn is saying.

15 [Laughter.]

16 MR. HACKBARTH: Right, that's what I'm saying.

17 Other comments or questions about the report?

18 MS. BURKE: I guess just to underscore your
19 comment, Glenn. I thought the report was useful in helping
20 us understand what we did and didn't know about increases in
21 volume. But I could not find the answer to the central
22 question, which is the question of whether it contributed or

1 not. So I felt that I was better informed as to what we
2 knew about, why, and what we didn't know. But I've really
3 didn't ever come to understand the answer to the central
4 question.

5 DR. HAYES: And it is a very difficult thing to
6 try and pin down. What we probably need to do in the intro
7 to the report is to make that point clearly.

8 MS. BURKE: Yes, or not. If we don't know the
9 answer, then we ought to just say we don't know. Because it
10 wasn't a question of hard to pin down. There was no answer
11 to that question, that I found. And if, in fact, answer is
12 that there is no answer, that we cannot determine that, then
13 we ought to just say that outright.

14 I think one of the challenges that I think we
15 always find in the course of these reports, which are
16 enormously helpful, is sometimes we ought to just state the
17 obvious at the outset and then spend the next 25 pages
18 getting to where we started. But I think we ought not wait
19 for someone to try and figure that out, 20 pages in, that we
20 couldn't answer that question. If we can't answer it, then
21 we ought to just outright state that and then explain what
22 the challenges were in trying to derive that.

1 So I think we ought to just say that.

2 DR. MILLER: Based on comments in discussion with
3 Glenn, the way we were thinking about going at it was at the
4 beginning of the report to review sort of the Cutler and
5 Fisher arguments as a way to frame this question, reach the
6 conclusion that Glenn was making, and then say now we'll
7 proceed with the other parts of the mandate and kind of
8 march through the rest of the report.

9 DR. MILSTEIN: It may not be feasible, but in view
10 of some of the insights that all of us have gained over the
11 last five years based on the research continuously flowing
12 out of the Dartmouth Group, it would be for me useful in
13 interpreting these growth numbers to understand whether
14 there are any differences in these growth numbers in what
15 I'll call the North Central geographies where care has
16 historically, as a matter of who knows what, been much more
17 conservative versus areas where that conservatism -- at
18 least in service volume -- has been lacking.

19 For example, if we were able to do some kind of a
20 geographic segregation along that line and we were to see,
21 for example, that service growth rates are quite modest in
22 the geographies that are known to be conservative in their

1 service use and getting equal or better outcomes and doing
2 well on quality measures, and that the bulk of the growth
3 rate was in areas in which historically there has been and
4 continues to be a lot of high-volume service use without
5 associated evidence of either quality numbers going up or
6 health benefit, at least for me that might be useful in
7 offering a judgment about what this means.

8 MR. HACKBARTH: I vaguely recall that in our
9 initial cuts at why volume is going that we did some
10 geographic looks at it. Kevin, do you want to summarize
11 that?

12 DR. HAYES: Yes. Yes, we looked at volume growth
13 for the 50 largest metropolitan statistical areas. We were
14 not in a position of looking at the specific areas and
15 identifying what the areas were, so much as we were focusing
16 on this matter of growth in use of more versus less
17 discretionary services.

18 What we found was that in the areas with the
19 highest volume growth, the highest -- hold on a second.

20 That the greatest variation in volume growth among
21 geographic areas was in the most discretionary services,
22 imaging services and tests and least variation with respect

1 to major surgical procedures.

2 MR. HACKBARTH: The same is true of the growth
3 rates as is true of the base, that the variation is in the
4 discretionary and not in the less discretionary. And there
5 is variation in the growth rates.

6 DR. MILSTEIN: Resources permitting, it would be
7 useful to see the analysis in which we would, for example,
8 of the 50 geographies for which we've already cut the data,
9 maybe apportion them by the Dartmouth quintiles and then see
10 what growth rate analysis shows in areas that are relatively
11 conservative versus relatively less conservative in their
12 volume of service use.

13 MR. HACKBARTH: This particular report, as I
14 recall, is due very soon, like December 8 or something like
15 that. So maybe what we can do is look at some of that
16 previous analysis and see what we can import into this very
17 quickly. Then, if we so desire, we can do some more in-
18 depth analysis in the future.

19 Anybody? I have one more.

20 In Rachel's paper this morning, she included a
21 table that was done by Ken Thorpe and others. This is not
22 Medicare-specific analysis but it analyzes the rate of

1 growth for specific conditions and breaks it into component
2 parts, how much is due to price increase, how much is due to
3 increased intensity of service, and how much as due to
4 population growth.

5 When I first looked at that table I found it very
6 striking how much variability there is among conditions. In
7 some cases, it's the treated prevalence of the disease that
8 is driving the growth. For example, in the case of
9 diabetes, I think was one where we've had a rapid growth in
10 the number of diabetics. Other conditions, the treated
11 prevalence is not growing much at all and it's just that
12 we're treating each existing case much more intensively than
13 we did in the past.

14 That slice at the growth is really not in the
15 report as written. I know Thorpe's data are not Medicare-
16 specific and I'm not suggesting that we go back and try to
17 look at the Medicare data, but I think that's an observation
18 worth including, that some of the volume growth is not
19 really attributable to physicians or the health care system,
20 but maybe to how we live our lives and our behavior. It's
21 just an important point for completeness, I think, to be
22 included.

1 Any other questions, comments? Okay, thank you
2 very much.

3 Next on our agenda is a report on a survey that we
4 did on retiree health benefits. Jon Gabel, one of the
5 presenters, is not yet here. So we're going to shift the
6 order and move ahead to the home health update and outlier
7 policy. Then after that, we'll come back to the survey
8 results.

9 MS. CHENG: I have two topics to discuss with the
10 group this afternoon. One, you need to put your payment
11 adequacy hats back on. A lot of our sectors began their
12 payment adequacy review in our last meeting and I'm the
13 oddball out here. So just put that on real briefly.

14 The other topic that I'd like to discuss with you
15 is some research that I've done on the home health outlier
16 provision, and I'll give you a little bit of background and
17 get you started on some research that we have there.

18 First, to payment adequacy. I've got four of the
19 factors from our framework that I've got some information on
20 for you today. The first is going to be beneficiaries
21 access to care. The second is quality of care in home
22 health. I've also got some information on the entry of new

1 home health agencies and access to capital for this sector.

2 MedPAC has acknowledged several times in the past
3 that this benefit itself has always had some ambiguities. A
4 lack of definition of the benefit makes it difficult to
5 determine whether the appropriate beneficiaries are getting
6 the appropriate care. Also, how does the spell of illness
7 concept apply to this benefit, that covers both skilled and
8 custodial care for patients whose conditions are not
9 expected to improve?

10 These ambiguities have complicated our analysis of
11 this particular prospective payment system really since
12 we've begun our analysis of it. MedPAC has, in the past,
13 recommended that definitive eligibility and coverage
14 guidelines be developed and that research be done to develop
15 clinical guidelines to enhance our understanding of who
16 ought to be getting what in this benefit. Until those
17 changes are made, however, any analysis of this benefit is
18 going to face some limitations.

19 This is a quick review of home health. I've got a
20 picture here of the spending for this benefit. In the first
21 half of the 1990s spending and use of home health grew quite
22 rapidly. The care was increasingly resembling long-term

1 care and not so much the medical services of other post-
2 acute benefits. Nearly half of the visits in the early '90s
3 were the non-medical home health aide visits. And one third
4 of all visits were delivered to patients who, on average,
5 received at least one visit nearly every day for the entire
6 year.

7 These growth trends and other trends led to
8 changes in the enforcement of program integrity, eligibility
9 and changes very basically to the payment system itself.
10 The payment system was changed from a cost-based system to a
11 cost-based system with limits in 1997. Spending fell by
12 about half from 1997 to 1999.

13 In October of 2000, CMS implemented the current
14 prospective payment system. Payments began to grow again.
15 The Office of the Actuary predicts 8 percent growth in
16 spending in 2005 and 4.7 percent growth annually over the
17 next 10 years.

18 For our payment framework factors, the first one
19 is beneficiaries access to care. I've taken this down into
20 three different questions, the first one being do
21 beneficiaries have providers in their community? Can
22 beneficiaries obtain care from those providers? And when

1 they do, are they obtaining appropriate care?

2 In examining answers to our first question we
3 found that 99 percent of all beneficiaries live in an area
4 that was served by at least one agency in 2004, according to
5 our research and CMS's Home Health Compare database of
6 service areas for home health agencies. 97 percent of
7 Medicare beneficiaries live in an area that was served by
8 two or more agencies. Many of the unserved areas on this
9 map are also unpopulated. If we look at the state that has
10 some of the lightest shading, such as Montana, we find a
11 coverage rate of 93 percent.

12 Now this estimate may overstate coverage because
13 willingness to serve one portion of a ZIP code that is
14 either very large or not homogenous may not be a true
15 indication of the willingness to serve the entire area that
16 we are describing. However, it may also understate the
17 coverage because of two elements in this analysis. We have
18 P.O. boxes for a number of beneficiaries, so we can't
19 accurately put them in the place where they reside. So
20 those beneficiaries actually show up, in our analysis, as
21 unserved.

22 Also, because this service area is driven by the

1 actual presence of a served beneficiary, if there was a
2 number of beneficiaries in an area and they did not ask for
3 service in the time period, it may mean that there's an
4 agency willing to serve that area, there just was no call
5 for service in our time frame.

6 Looking at our second access question of whether
7 or not then beneficiaries can access the providers that are
8 in their community, we found that nearly 90 percent of
9 beneficiaries who responded to the CAHPS survey about their
10 home health experiences in 2003 reported that they had no
11 problem or a small problem in accessing the home health
12 services when they sought them. The percentage of
13 beneficiaries who did not have a problem was slightly but
14 statistically significantly higher in 2003 than in 2002 and
15 the percentage of beneficiaries who had a small problem was
16 significantly lower in 2003 than in 2002, again slightly but
17 statistically significantly. The number of beneficiaries
18 who reported a big problem is statistically unchanged
19 between these two periods.

20 For our third access question of whether once the
21 beneficiaries get in the door do they get the services that
22 they need, we turned to quality and outcome measurements. I

1 haven't put each of the 11 national outcomes on this slide.
2 A more complete set of these measures is available in your
3 mailing materials on page seven.

4 This evidence suggests that beneficiaries access
5 to appropriate care has not decreased because the measures
6 of quality recently rose. The share of patients who achieve
7 a positive outcome has increased in the most recent time
8 period over the previous period. This could be the result
9 of more home health patients receiving appropriate care and
10 thus enabling good outcomes. However, this evidence does
11 not allow us to conclude that all care that patients receive
12 is appropriate care. If inappropriate care doesn't have an
13 impact on this measure, then we can't pick that up.

14 It also focuses on functional improvement and
15 these functional improvement measures may not reflect the
16 goals of patients with chronic condition whose care is more
17 oriented towards stabilization than improvement.

18 These quality indicators are risk-adjusted, so
19 they account for diagnoses, comorbidities and other patient
20 characteristics from time period one to time period two. So
21 to the extent that we are able to adequately risk-adjusted
22 this, we are looking at differences in quality rather than

1 differences in the patient mix from the first period to the
2 second period.

3 DR. NELSON: Sharon, are these data reported by
4 the agencies?

5 MS. CHENG: This data is driven from the OASIS
6 assessment that every agency has to do on each patient when
7 they are admitted to care and then again when they're
8 discharged.

9 On another one of our framework factors, we are
10 looking at the supply of home health agencies and we note
11 that it has recently increased. Over 500 home health
12 agencies began to participate in Medicare over the last 12
13 months. Over the same time period about 100 agencies exited
14 the program, making the net gain about 400 agencies, which
15 is a 9 percent increase in one year in the number of
16 agencies participating in the program.

17 All the newly participating agencies that we're
18 picking up in this analysis, however, are not necessarily
19 brand-new. CMS is continuing its efforts to assign ID
20 numbers to entities that formerly conducted business as
21 branches of other agencies. So some of these new
22 participants might have been branches of existing agencies

1 before they received their own Medicare ID.

2 The final indicator that I will discuss from our
3 payment adequacy framework is access to capital. As I've
4 noted a couple of times before, access to capital is not a
5 particularly strong indicator in this sector. It seems to
6 be determined more by the size of the industry compared to
7 other health care industries. And also, it is influenced by
8 perceptions of risk on the part of the investors but not
9 necessarily going to be reflective of the adequacy of
10 Medicare's payments in any given year.

11 We also note that most home health agencies don't
12 use the kinds of access that we can measure. They are not
13 publicly traded and they don't access bonds or other forms
14 of capital that we could get some measurements on.

15 That said, the market analysts that do look at the
16 publicly traded companies in this sector are generally
17 positive about the companies in this sector. One company
18 that specializes in buying and selling home health agencies
19 predicts that the upcoming year will be "breakout" and that
20 access to debt appears to be improving. They note that the
21 value of invested capital at one fairly large publicly
22 traded home health agency grew 355 percent over the last 12

1 months. In most of the analyses that we have, Medicare is
2 still noted as the highest margin payer in the sector.

3 The second topic I'd like to discuss this
4 afternoon, moving out of our payment adequacy framework, is
5 the outlier provision of the home health PPS. The outlier
6 provision was an optional feature when CMS designed this PPS
7 in 2000 and it was implemented in 2000 and has been a part
8 of the system since it was implemented.

9 Through the outlier provision, Medicare shares the
10 losses on particularly high cost patients with the agencies.
11 It covers 80 percent of the losses incurred on patient
12 services. Not all high cost episodes will qualify for
13 outliers. The costs have to exceed the payment by a
14 threshold amount, which would be about \$2,600 in calendar
15 year 2005.

16 CMS anticipated that the outlier payments would be
17 about 5 percent of total spending on home health. The base
18 payment when they designed this system was lowered to
19 accommodate the outlier payments and still remain budget
20 neutral. In 2002 2.6 percent of episodes qualified for
21 outlier payments and those outlier payments were about 2.7
22 percent of total payments. In their most recent rule, CMS

1 has proposed a reduction of the fixed loss amount and this
2 change is designed to increase the number of outlier
3 episodes and outlier payments.

4 Again to say, we have not reached a decision point
5 on our analysis of the outlier. Today's information is
6 really provided to you as an early step in a project to
7 answer your questions about whether this PPS is working in a
8 broader sense. So we hope as you look at some of these
9 results you can point the staff in a direction about how we
10 can best proceed with questions on the outlier specifically
11 but also if they raise questions in your mind about things
12 to look at in the PPS more broadly.

13 In looking at this provision, the conclusion that
14 we come to is that the initial results are mixed. The
15 payment system does meet the criteria that we suggested for
16 an outlier provision that we proposed in this analysis.
17 However, we also note that there other provisions in this
18 payment system that fulfill many of the outlier functions.
19 There is an adjustment called the LUPA, the low utilization
20 payment adjustment. And what that does is provide an
21 outlier for especially low cost episodes.

22 There's also a provision in this payment system

1 that's called the significant change in condition or SCIC
2 adjustment which if, during the course of a 60-day episode,
3 a patient's health deteriorates to the point where they
4 would qualify for a different payment group, then they can
5 be switched to that payment group and then the balance of
6 days will be paid at the additional payment group. So
7 though that might cause a patient to be a high cost compared
8 to their original payment group, then they can adjust the
9 payment group for the balance of the days.

10 The other provision in the system that works
11 somewhat like an outlier is also the fact that our episodes
12 are 60 days long. So if you have a patient with a
13 particularly long stay, there's a new episode payment every
14 60 days. So that source of cost variation is also cared for
15 in another way in this payment system.

16 We also note that the way that the outlier
17 provision is formulated can be manipulated. And we note
18 that the issues that we identified in our analysis, you
19 could try to address them with refinements to the outlier
20 provision or you could look elsewhere in the PPS for
21 refinements to address some of the issues.

22 So as we thought about the role that an outlier

1 payment could pay, we came up with this list of criteria.
2 An outlier payment could be appropriate if there's a
3 particularly wide variability in the cost per episode within
4 the payment groups that we've designed. In a prospective
5 payment system, payment will rarely be exactly the same as
6 the cost per unit of service. But the system is designed to
7 pay appropriately on average. However, if especially costly
8 episodes are not particularly rare events, it may be
9 necessary to offset the losses incurred by the providers who
10 care for those particularly expensive patients.

11 An outlier provision might also be appropriate if
12 some providers treat a greater proportion of high cost
13 patients than others. This outlier payment could then
14 provide some equity among providers by increasing payments
15 for those who care for especially costly patients.

16 A third criteria that we proposed would be that an
17 outlier policy would be appropriate if beneficiaries who are
18 likely to be high cost could be identified in advance. An
19 outlier payment could then maintain access for those
20 patients who can be identified as high cost by mitigating
21 the losses that the provider is likely to incur if they
22 decide to admit them. Similarly, an outlier payment could

1 reduce the incentive to limit care after a high cost patient
2 has been admitted.

3 To look at our first criteria, we estimated
4 variation in costs by measuring the variation in the number
5 of minutes of service that are delivered in an episode. And
6 we used the coefficient of variation to describe this
7 variation. The coefficient of variation is a statistic that
8 measures the standard deviation in the number of minutes and
9 divides by the average number of minutes for that case-mix
10 group. It thus produces an index that allows us to compare
11 the variability in case-mix group with the sense of the
12 meaningfulness of the variation.

13 Let me take you through a quick example using this
14 picture. On this graph you see the 80 case-mix groups that
15 are used in the home health PPS. I've drawn a heavy line at
16 the value cv of one. So in the case-mix group that's the
17 first to hit that line at one, the average number of minutes
18 of care is 1,300. The cv of one for that case-mix group
19 tells you that the dispersion around that average is, in
20 fact, quite large as measured by standard deviation. In
21 fact, it's also 1,300 minutes. So for most of the episodes
22 in that case-mix group the average number of minutes is

1 1,300, give or take 1,300 minutes.

2 Out of 80 case-mix groups, 42 had coefficients of
3 variation equal to one or greater than one. Those 42 widely
4 variable case mix group account for 58 percent of all
5 payments in the system in 2002. Even below that heavy line
6 that I've drawn at one, a cv of 0.9, 0.8 or 0.7 indicates
7 fairly wide dispersion compared to the average number of
8 minutes in those case-mix groups. Some of the cv's above
9 that line at one indicate very wide dispersion.

10 So from this we know there's plenty of variation
11 in minutes within almost all of the case-mix groups. We do
12 not know from this analysis exactly how variation in minutes
13 relates to variation in cost, but it does suggest that costs
14 probably vary a great deal as well.

15 The presence of this wide variation suggest that
16 there is work for an outlier policy to do. However, it
17 might also suggest a more fundamental approach, namely an
18 examination of the case-mix system. The red bars that I've
19 included on this picture are the five case-mix groups with
20 the highest amount of outlier payments. Together, the
21 outlier payments in those five case-mix groups represent 60
22 percent of all outlier payments made in 2002. As you can

1 see, four out of the five do cluster at the right-hand side
2 of this graph, which does suggest that most of our outlier
3 payments are going to case-mix groups where there is a
4 fairly large amount of variability.

5 Considering our second criteria, we did find
6 evidence that high cost outlier episodes are not distributed
7 randomly among agencies. We found differences by type of
8 control of the agency -- voluntary, proprietary or
9 government -- as shown on this slide. We also found
10 differences between freestanding and hospital-based
11 agencies. We also found a wide variation among agencies
12 generally.

13 In considering our third criteria, because home
14 health is delivered in patient's homes, the availability of
15 informal care that's unpaid or is perhaps paid separately by
16 the patient but is not provided by the home health agency is
17 going to affect the amount of care that the home health
18 agency has to provide to that patient.

19 Payments however, do not vary based on the
20 availability of these other sources of informal care. Not
21 surprisingly, the availability of caregivers in addition to
22 those provided by the home health agency does appear to be

1 related to a significant difference between outlier and non-
2 outlier cases. This pattern suggests that an agency may be
3 able to identify patients with high cost relative to
4 payments if the agency can ascertain the ability of
5 caregivers in advance of admitting a patient. Patients with
6 very frequent care from caregivers, the ones at the top
7 whose caregivers are available multiple times during the day
8 or night or multiple times during the day have a
9 statistically significantly lower average frequency of
10 outlier episodes. Conversely, patients with infrequent care
11 or no caregiver have a higher than average frequency of
12 outliers.

13 In your mailing materials, there was also an
14 additional table of 16 other patient characteristics such as
15 obesity, ventilator use or heavy smoking that are also
16 significantly related to the frequency of outliers. These
17 patterns suggest that patients who are likely to be high
18 cost outliers could be ascertained in advance by a fairly
19 simple screen and potentially avoided by home health
20 agencies. Such behavior would lead to an access problem for
21 beneficiaries with these characteristics. An outlier policy
22 can mitigate the impact of these high cost cases and could

1 play a role in maintaining access for those beneficiaries.
2 However, this information, too, could point to the need for
3 re-examination of the case-mix system.

4 We then compared the average minutes per outlier
5 episode to average minutes in non-outlier episodes to get a
6 sense of where the cost of high cost episodes were coming
7 from. We found the greatest difference between the amount
8 of skilled nursing minutes in outlier episodes and those of
9 non-outlier episodes.

10 Again, because we do not have standards of care,
11 we cannot determine whether these additional services are
12 medically necessary to meet the needs of the patients who
13 receive them. However, this does suggest that there is a
14 substantial opportunity to limit services or differentiate
15 between high cost and low-cost patients once they are
16 admitted.

17 This amount of nursing service also points to the
18 possibility that the outlier provision could be manipulated
19 by some agencies. A back of the envelope calculation
20 suggests that the average skilled nursing minutes of 2,400
21 are equivalent to a skilled nursing visit every weekday for
22 the entire 60 day episode. The fact that agencies max out

1 the number of visits in an outlier episode could suggest
2 that there is an incentive to maximize the number of visits.
3 If an agency's marginal cost of additional skilled nursing
4 visits is below the per visit payment that they receive,
5 then agencies could have an incentive to provide the maximum
6 number of visits once they've qualified for an outlier
7 episode.

8 Our experience under the cost-based payment system
9 pre-1997 suggests that this can be a powerful incentive to
10 provide additional visits.

11 In summary, this is again very preliminary
12 research but we think it has a couple of suggestions that
13 appear to tell us several things. There does appear to be
14 wide variability in the minutes and perhaps the costs of
15 care within payment groups. The proportion of outlier
16 episodes does vary between agencies. And beneficiaries
17 likely to be high cost do seem to be able to be identified
18 in advance based on patient characteristics.

19 We also note that many agencies in this sector are
20 small, so a handful of expensive outliers could have an
21 impact on their financial stability.

22 We also note that other provisions in this payment

1 system do much of the work of outliers, so perhaps outliers
2 are somewhat of a belt and suspenders approach to payment
3 system. Outliers might not correlate with high variability
4 in costs if our estimate in the minutes doesn't correlate
5 very well with the true cost of episodes. And there seems
6 to be a question of whether outliers can be manipulated, and
7 that question should probably be examined.

8 MR. HACKBARTH: Could you put up the graph again
9 with the yellow bars? I think we need to just reflect for a
10 minute what this means, with the acknowledgment that this is
11 based on minutes as opposed to costs. But to me that's a
12 very striking picture, I think with ramifications beyond
13 outlier policy. It goes to the heart of the case-mix
14 system.

15 Last year we included in our report some language
16 expressing concern that the current case-mix system may not
17 be appropriately capturing all of the variation and
18 therefore there was some risk that we were mispaying for
19 certain types of patients. This graph and the amount of
20 variation documented augments that concern, at least in my
21 mind.

22 I want to think for a second about other possible

1 explanations of this. Part of it is that the case-mix
2 poorly defines homogeneous classes of patients. But I can
3 think of at least one other possible explanation, and that
4 is that the product is so poorly defined, so flexibly
5 defined, that we are really not talking about a fixed
6 product, let alone fixed category of patients.

7 I don't know if there other possible explanations
8 of what that means, as well.

9 MS. BURKE: Glenn, what would you have expected?

10 MR. HACKBARTH: That's a good question. I wonder
11 if we had a comparable graph for the hospital DRG system.
12 I'm not sure that the coefficient of variation is on this
13 scale. I may be wrong, but it's much smaller.

14 MS. CHENG: I'd love to be able to do apples to
15 apples and I did sit down with our hospital team and asked
16 them if they've look at something similar.

17 The hospital measurement has the advantage of
18 really being able to look at cost variation within DRGs.
19 This is minutes, which is not going to be one-for-one for
20 cost. But the DRG system has cost variations with cv's
21 around 0.6. And that's the starting point for the variation
22 of minutes that you see here.

1 MR. HACKBARTH: We're going up from there.

2 DR. SCANLON: I expected this. Partly it goes
3 back to when we were paying on the basis of cost and we saw
4 the variation that existed in agencies across the country in
5 terms of the amount of services that were being provided.

6 At that point, no one was complaining about
7 underservice. The issue would be then in a world where we
8 create an incentive to reduce services, people are not going
9 to complain about underservice because they don't recognize
10 what services they should be getting. I think the hospital
11 comparison is totally different because there was an
12 expectation about the services you were going to receive.
13 Physicians are there to ensure that you receive those kinds
14 of services. And in this area it's completely different.
15 The problem starts at the very beginning of the paper where
16 it says we have no coverage guidelines, we have no clinical
17 guidelines as to what this service involves.

18 The solution is never going to be -- until we get
19 those, which I think may be impossible -- the solution is
20 not going to be in fixing the case-mix measures. We're not
21 going to define groups that are going to be so well-defined
22 that we know what services the people within that group are

1 going to need to receive.

2 That's what's critical to protecting patients. So
3 I think it's a more fundamental issue. We talk about an
4 outlier policy that if we designed one that was well enough
5 to protect the patients, we suddenly would discover the
6 outlier policy was the payment policy.

7 MS. RAPHAEL: The only thing I would say to that
8 is, first of all, I think there actually is progress in
9 clinical guidelines. I think one of the reasons we have
10 some improvement in outcomes is because we now do have
11 guidelines for how we deal with diabetics and congestive
12 heart failure and wound care patients. And while I'm not
13 saying if any way there's a systematic approach here, I
14 think that this has crept into practice.

15 Secondarily, there is an assertion throughout
16 this, starting with page one, that there are no clinical
17 guidelines. And home health care isn't meant to cure
18 illness. It's meant to treat illness. And how do we know
19 when a spell of illnesses over?

20 But then, for many chronic conditions, if someone
21 enters a nursing home, if they see a physician, do we have
22 clinical guidelines in those cases? Do we know when the

1 spell of illness is over? I think we face the same thing in
2 dealing with chronic illness in a number of settings.

3 So why single out home health care? Because no
4 matter how you slice it, even when you look at the
5 improvements, this is still a chronically ill population.
6 We're hoping now 36 percent of the people can improve
7 walking. Basically that's our improvement level for this
8 group, are those who are confused less often. We've gone to
9 42 percent are now confused less often. So it's still
10 basically a very chronically ill population, even though
11 we've narrowed the benefit to much more skilled and post-
12 acute kinds of services.

13 DR. SCANLON: That is, in part, why I wouldn't
14 propose that we move completely to having clinical
15 guidelines to govern whether or not we bought the right
16 services. I think we have a chronically ill population and
17 we have very great difficulty in defining what we want in
18 terms of the maintenance of that chronically ill population.

19 There are some that would react to the word
20 maintenance and say that's not going to be a Medicare-
21 covered service at all. And I think that's not where we are
22 today. We've moved beyond the point where we say you have

1 to be able to demonstrate that you're going to improve or
2 we're not going to cover you. I think we are now into
3 caring for the chronically ill. We don't have a good
4 outcome for what that care should produce. So therefore, I
5 wouldn't want to hold it against home health agencies
6 because they didn't achieve the kinds of outcomes that are
7 associated with people that do improve because, as you said,
8 you've got 60 percent of people who are not improving on
9 that kind of a measure. And that may be appropriate for the
10 vast majority of them.

11 The probably we have now is we're paying and those
12 people are not necessarily being served. That graph, if you
13 had a hypothesis that the number of minutes was zero, you
14 can't reject it on the basis of that graph. The confidence
15 intervals overlap zero in every case. That's believable.

16 So I think we have a fundamental problem with the
17 structure of the payment system that goes to taking
18 something that is totally undefined, an episode of care, and
19 making a very large payment for it.

20 I'm somewhat concerned about the fact that even
21 though Wall Street's not that involved, that Wall Street
22 seems to have said that there may be a breakout year coming.

1 would invest, too, on the basis of this graph.

2 It's too bad that the CMS data do not allow us to
3 know exactly what's happening with respect to the number of
4 agencies. But there is this issue of what we saw before was
5 when we identified that there was considerable profits in
6 home health services, we had an explosion in terms of the
7 number of agencies. And they tended to be proprietary. And
8 they tended to have very different patterns of services than
9 did the traditional non-profits that were providing these
10 kinds of services, almost double the members of visits as
11 the traditional agencies.

12 I keep asking myself why haven't we've seen that
13 yet, given the system?

14 MS. RAPHAEL: I don't want to make this a dialogue
15 here, but I do think this is a very segmented industry. You
16 have some sort of pure Medicare players who are almost 90
17 percent dependent on Medicare. And whither Medicare goest,
18 they will go. And you have other organizations where they
19 are very Medicaid dependent, where they do a lot of
20 charitable care, they are working with managed-care plans.

21 And I think you have an industry that is really
22 very bifurcated. Yet, we are trying to have a unitary

1 payment policy. That is something that really, I think, is
2 very, very difficult to do.

3 And you're right, the outlier policy, when you
4 look at it, the proprietaries had a 3.3 percent outlier rate
5 which is much higher. I think it's fascinating, 60 percent
6 of home care agencies provide 1,000 or less episodes a year.
7 This is an industry with a lot of very, very small entities.
8 And then you have this cluster of really large entities who
9 could manipulate. I think a lot of the small agencies
10 wouldn't even know how to manipulate. They're having a hard
11 enough time just surviving.

12 So for me the larger question is how do you make a
13 payment policy that preserves access for those who really
14 are smaller and more fragile and vital in their communities,
15 at the same time that there is equity here?

16 MR. HACKBARTH: Other comments?

17 We have danced around this issue of how well the
18 product is defined, and then last year how good the case-mix
19 adjustment is. And now we're looking at the outlier and
20 whether it's needed and how accurate it is.

21 I guess I have a growing feeling that we are not
22 going to the real issue. We're not even particularly close

1 with this payment system. And it's not just a matter of
2 refining it around the edges. I think we are missing the
3 mark by a substantial amount, although don't ask me what
4 exactly the alternative is that we put in place tomorrow. I
5 think that requires some thought. But we may want to change
6 the tenor of our recommendations and make it clearer how far
7 off the mark we think this system is.

8 DR. MILSTEIN: Do we know very much about
9 performance variation among home health care agencies in the
10 same geography on these or any other measures of change in
11 patient functional status? Is this an industry where all
12 the home health agencies are pretty much getting the same
13 results? Or is there a lot of performance variation within
14 the industry in say holding geography constant?

15 MS. RAPHAEL: My impression, and Sharon can
16 probably modify it, this is impressionistic, is there's not
17 much difference in the outcomes between the agencies.

18 MR. HACKBARTH: As you will recall, we're just now
19 at the point of trying to say what's our basically quality
20 measure set that is sufficiently robust that we can make
21 meaningful comparisons of performance?

22 MS. RAPHAEL: But Sharon, do you see much

1 variation? I don't.

2 DR. WAKEFIELD: Has anyone looked at that data set
3 for variation?

4 MS. RAPHAEL: Yes. And if you look at Home Health
5 Compare in any geographic area, if I were a consumer I would
6 find it hard based on that data right now to differentiate.

7 DR. MILSTEIN: Addressing my own ignorance, what
8 do we know about the impact on these or any other measures
9 of patient functional status of home health agency
10 intervention versus no intervention?

11 MS. CHENG: Versus no intervention? We really
12 have a pretty different dataset. Because we have such good
13 measurement of people who are under the care of a home
14 health agency, we know a whole lot more about them. We
15 could get very different measurements, though, and compare
16 perhaps folks that were discharged from a hospital to
17 different post-acute care settings or no post acute-care
18 setting. But then you don't get information on their
19 functional improvement 60 days later because they sort of
20 drop off our measurements.

21 DR. NELSON: When I was checking the publicly
22 reported data on the Web for Utah for home care and for

1 SNFs, I certainly wouldn't have a clue of which were the
2 better ones or the less good ones as a consumer. I didn't
3 have a clue as a practitioner from which ones were how I
4 would choose.

5 MS. RAPHAEL: I think a lot of what causes
6 variation in costs have to do with informal caregivers
7 because unlike other parts of health care we know there are
8 54 million informal caregivers in our nation. On average,
9 they spend 18 hours a week. And they really bear a lot of
10 the brunt of this care. There's no doubt about it. If you
11 have someone 89 with no informal caregiver, that's a whole
12 different situation than someone 66 with a spouse.

13 Also, we find that dually eligibles, if you think
14 of Medicaid, if in anyway that's a proxy for social and
15 economic problems, they cost us a lot more in resource
16 consumption than a Medicare-only case.

17 So there are other things that enter into this
18 variation that are very hard to capture when you try to move
19 toward clinical guidelines.

20 DR. NELSON: Can I make another point? There are
21 there some lessons in this discussion we've just had with
22 respect also to other publicly reported data, for example

1 hospital quality data as that's becoming gathered to the
2 point that you can look at it and try and draw some
3 conclusions.

4 I saw some data on use of aspirin, prescribing
5 aspirin for patients who had a myocardial infarction. There
6 were a number of the hospitals that I was looking at in this
7 cohort that were reporting 100 percent compliance. Well,
8 let's see, a good hospital shouldn't have 100 percent
9 compliance with that. You've got some patients for whom
10 aspirin are contraindicated.

11 The point that I'm making is that we are having
12 self-reported data. And whether it's collected on OASIS or
13 whatever, there isn't any external validation or
14 verification at this point.

15 So I don't know how useful it's going to be.

16 DR. MILLER: Sharon, I'm going to need some help
17 here. Of the measurement and quality issue for just a
18 second and back to the structure of the program, I think we
19 recognized coming into the room that this wasn't a narrow
20 conversation about outliers. And I think some of the
21 references throughout this that there are other parts of the
22 system that might be addressing this and there are other

1 issues to look at.

2 A couple of things to keep in mind. We have a
3 mandated report that talks about case-mix and profitability
4 coming online at some point, which I can't remember right at
5 the moment.

6 And also we have discussed -- and Sharon this is
7 where I want to be clear -- a longer-term agenda of looking
8 at the elements of the payment system more broadly.

9 And then also, the notion of if you were going to
10 step back from the payment system and think about it what
11 are some of the issues or what are some of the other ways to
12 think about this? That's all fair, Sharon? That's on our
13 agenda for the June cycle? I can't remember; is that right?

14 MS. CHENG: The mandated report on whether or not
15 there is a relationship between case-mix at an agency and
16 that agency's financial performance is due to the Congress
17 in November of 2005.

18 DR. MILLER: And then for June we had talked about
19 looking at some of the other elements of the payment system?

20 MS. CHENG: That's right.

21 DR. MILLER: So in a sense, I think some of these
22 other issues and potential broader problems with the payment

1 systems can be implicated and discussed. But it is this
2 issue that we do kind of return to time and time again, what
3 is the benefit? And what do we think this benefit should be
4 for Medicare? And that's a little harder to analyze, but I
5 just want the commissioners to know that we will go through
6 the pieces of the system and talk about are there ways to
7 improve it? But I do believe we will always either back in
8 or run into, whichever way you want to think about this,
9 issue at some level or another.

10 Carol, I just want you to know, we have not
11 forgotten the point about the informal caregiving and the
12 dual eligibles that you brought up. Part of our cranking
13 through some of this is to see whether those issues do
14 apply.

15 MR. HACKBARTH: Any other comments on home health?
16 Thank you, Sharon.

17 Now we'll go back to the survey results. Welcome,
18 Jon.

19 MR. GABEL: Thank you.

20 MR. HACKBARTH: Jill, you will do the formal
21 introduction?

22 DR. BERNSTEIN: Earlier this year, MedPAC

1 sponsored a supplement to the Kaiser Family Foundation/HRET
2 survey of employer health benefits. We designed a
3 supplement to look at some questions about retiree coverage
4 now and where it's going in the future.

5 Jon Gabel, who is a vice president at HRET, is
6 going to walk you through the main findings from that
7 survey.

8 MR. GABEL: Thank you for allowing me to present
9 the results of the survey about post-retirement benefits.
10 Just a little bit of background to begin with, let me back
11 up a second.

12 Please, as I give the presentation, if you have
13 any presentations please ask the questions as we go along.

14 Just a little background about retiree health
15 benefits. Slightly more than one-third of all Medicare
16 elderly beneficiaries rely on retiree health benefits for
17 their supplemental coverage. This coverage is generally
18 recognized as the most complete coverage for the Medicare
19 population. It is historically a continuation of the same
20 benefit package that retirees had as active workers.

21 Research shows that these beneficiaries tend to be
22 younger and wealthier, and other factors held constant they

1 use about 25 percent more services than other beneficiaries.

2 MedPAC commissioned a special supplement of the
3 2004 Kaiser Family Foundation/HRET survey to study retiree
4 health benefits. MedPAC, in commissioning the study, wished
5 to collect data not available from other surveys.

6 Specifically, MedPAC wanted to examine the
7 employee share for retiree health benefits, the status of
8 active workers with regard to their future retiree health
9 benefits, and also look at an early indication about how
10 MMA, the Medicare Modernization Act, was likely to affect
11 retiree health benefits.

12 Just a little background. I think most people
13 here are familiar with the Kaiser Family Foundation survey.
14 It is a national survey, a random sample of American
15 employers, public and private, three or more workers. In
16 the 2004 survey we completed interviews with 1,925 employee
17 benefit managers. Of those firms, 634 offered retiree
18 benefits and 509 offered retiree benefits to the Medicare-
19 eligible population.

20 Let's look at some results. This first graphic
21 shows since approximately 1993, when FASB went into effect,
22 that there have been relatively little change in the

1 percentage of firms offering retiree health benefits. But
2 this is misleading because, in fact, what happened in the
3 1990s was when the economy was expanding, when employer-
4 based health coverage was expanding in the latter half of
5 the decade, there was an erosion in retiree health benefits.
6 This erosion took the form of restricted eligibility and
7 increased cost-sharing on the part of retirees.

8 The vast majority of Medicare-aged retirees are
9 retirees who formerly worked for a firm with 5,000 or more
10 workers. In other words, it is 81 percent of the retirees.

11 We note that these same firms constitute just one-
12 tenth of 1 percent of the nation's firms and cover
13 approximately 40 percent of the active workers who are
14 covered by job-based health insurance.

15 In fact, during this period of time, again in the
16 1990s, and since 1999, there has been relatively little
17 change in the percentage of firms offering health benefits
18 to early retirees and to the Medicare-eligible retirees.
19 About 95 percent of all firms that offered retiree health
20 benefits will offer them to early retirees. The figure for
21 the Medicare-eligible population is lower at about 75
22 percent. Again, we see no discernible trends over the last

1 couple of years. Again, this is misleading, as we'll show
2 in subsequent graphics.

3 MS. BURKE: Can I confirm what I assume I know to
4 be the case, that these numbers do not include the federal
5 or state government as an employer?

6 MR. GABEL: They do include state government.
7 They do not include the federal government. They include
8 local.

9 MS. BURKE: Military?

10 MR. GABEL: No, they would not include military.

11 Among the firms that offer retiree health benefits
12 to the Medicare-eligible population, the so-called jumbo
13 firms are far more likely to offer retiree health benefits
14 if they offer retiree health benefits at all.

15 Some firms have already terminated coverage. Let
16 me back up. Some firms that currently offer health retiree
17 health benefits have already terminated coverage to some of
18 their active workers. Based on our survey, we find that
19 about two-thirds of the workers from firms offering coverage
20 will be eligible for retiree benefits when they retire.
21 Restated, about 25 percent of the current workers will be
22 offered -- some of the workers will be offered benefits.

1 And then we have about another 8 percent of the workers who
2 work for a firm that will not offer retiree health benefits
3 to any one of these active workers when they retire.

4 State and local governments are far more likely to
5 offer coverage in the future.

6 MS. BURKE: I'm trying to equate what you just
7 said to the chart. Do I read this chart to suggest that 91
8 percent --

9 MR. GABEL: That's state and local government.

10 MS. BURKE: That's state and local, and 67 percent
11 of large firms will offer?

12 MR. GABEL: Are currently planning to offer, yes.
13 This is weighted by workers. So we're talking about workers
14 who work for firms who currently offer retiree health
15 benefits.

16 MS. BURKE: I'm trying to understand your passing
17 comment about 25 percent. 25 percent will not?

18 MR. GABEL: It's going down to the second group of
19 bars. It's about 25 percent of the active workers that work
20 for firms that currently offer retiree health benefits work
21 at a firm where some of the workers will be covered.

22 MS. BURKE: I'm slow. I'm trying to understand

1 that with the first case.

2 DR. BERTKO: Sheila, let me try. I used to work
3 in this area.

4 The some worker bar says out of a group of current
5 active employees there may be a newly hired group who have
6 none and people with five or more years of coverage -- and I
7 think you have some of these -- after a certain date won't
8 have coverage. And that's that 25 percent.

9 MS. BURKE: The second set isn't a subset of the
10 first set?

11 DR. BERTKO: No.

12 MS. BURKE: So the first set suggests that of
13 workers in firms of 200 or more, 67 percent will be offered
14 coverage.

15 MR. GABEL: Yes, all workers.

16 MS. BURKE: Now who are the some workers?

17 MR. GABEL: I think if we go to the next graphic,
18 it will explain it.

19 So for those firms which will be terminating
20 eligibility for future retirees, what is the criteria they
21 are using? The most common criteria is the date of hire,
22 affecting about 60 percent of the active workers. The

1 second most common -- and more than one criteria can apply -
2 - will be a collective bargaining agreement. Other firms
3 will use the date of retirement as a criteria or criterion
4 for determining who will receive retiree health benefits and
5 who will not receive retiree health benefits.

6 State and local governments, again, are more
7 likely than those in the private sector to offer coverage.

8 Here is a glimpse into the future. For those
9 firms currently offering coverage to retiree and active
10 workers, about 27 percent of those active workers are
11 working at a firm that plans to eliminate Medicare-age
12 retiree health benefits for new hires in the next two years.

13 Now 17 percent very likely, 10 percent somewhat likely.

14 And about 13 percent of the active workers in
15 these firms work for a firm that plans to eliminate
16 Medicare-age health benefits for active workers who have not
17 yet retired.

18 MR. SMITH: So that 13 percent is a subset of the
19 60 percent?

20 MR. GABEL: Yes, of the 67 percent.

21 MR. SMITH: So today 67 percent of folks in firms
22 with over 200 employees will be offered or are in a firm

1 where 100 percent of employees will be offered retiree
2 health insurance? And of that number, 13 percent is likely.

3 MR. GABEL: Yes. For the new hires the figures
4 are larger, 27 percent.

5 Retiree health benefits are highly valued by
6 retirees. Compared to active workers, retirees are much
7 more likely to take up coverage. For the retirees, of those
8 who are eligible for retiree health benefits, 93 percent
9 will take up coverage. Compare that to 83 percent or so for
10 active workers. In all, about 77 percent of the retirees
11 will be covered by the retiree health plan.

12 Medicare retirees have higher enrollee premiums
13 than active workers. This is true for early retirees, as
14 well as the Medicare-eligible retirees. On average, they
15 contribute about \$68 a month. They pay about one-fourth of
16 the cost for single coverage. The average cost for a
17 Medicare retiree is \$276. About half of the claims expenses
18 not seen here are for prescription drug expenses. Premiums
19 for retirees who work for smaller firms are higher and
20 retirees pay a higher percentage of those premiums.

21 DR. MILLER: Jon, when we reviewed this one of the
22 questions was what the percentage was relative to active

1 workers. And the answer to that was 15; as I recall?

2 MR. GABEL: That's correct.

3 DR. MILLER: And then there was another question
4 of for other retirees, non-Medicare age, and you were going
5 to look into that.

6 MR. GABEL: I confess, I wasn't able to access
7 that. We have not asked that question in recent years.
8 John, maybe you can help me. Is it higher or lower than --
9 I think it's lower for the Medicare eligibles.

10 DR. BERTKO: Can you rephrase the question, Mark?

11 DR. MILLER: The reference points that I think we
12 need to keep in mind as we go through this are we're talking
13 about what's happening to Medicare-aged retirees. But
14 there's also a phenomenon that's happening to the work force
15 and other retirees.

16 So the question I'm just trying to draw a bead on
17 is when we see these things can we put them in the context
18 of relative to other groups? The question I was asking
19 specifically, I know for the active worker population -- in
20 fact, we were talking about it a little bit at lunch, 15
21 percent.

22 When we went through the review, you were going to

1 look at what it was for non-Medicare-aged retirees to see
2 how this figure compares the other retirees.

3 MR. GABEL: Mark, let me get back. I will send it
4 to you. I apologize. I will send you that figure.

5 The last graphic looked at central tendency. This
6 one looks at the distribution. You'll note that still about
7 one-third of all Medicare-eligible retirees receive their
8 retiree coverage free, about one-third. And of 5 percent
9 have to pay 100 percent of the bill. Retirees from firms
10 with 1,000 to 4,999 workers, you will note, are more likely
11 to have to pay the full fare than for other sized firms.
12 You will also note that union workers are slightly likely to
13 receive full premium payment

14 Medicare-age retirees are less likely than active
15 workers, slightly less likely than active workers, to face
16 incentives not quite as strong to purchase the preferred
17 drug, whether generic or brand-name drug. You'll note from
18 this graphic that about 65 percent among firms with 200 or
19 more workers work for a firm with either a three-tier or a
20 four-tier cost-sharing. That figure is 52 percent for the
21 retirees. Also, please note that the numbers for two-tier
22 are relatively the same.

1 In the next two years we have some more bad news.
2 It's true for both active workers and it is true for
3 retirees. When we asked employers were they planning to
4 increase the share of the health benefit premium in the next
5 two years, you can see overall for large firms about 65
6 percent of large firms said yes, they were very likely to do
7 so, 8 percent somewhat likely to do so. In fact, these
8 numbers are even slightly higher for active workers than
9 they are for the retirees.

10 Just an aside, having asked these kinds of
11 questions about active workers for many years in the survey,
12 employee benefit managers tend to underestimate what they
13 actually do. The answer is why is this? Because we ask
14 them the question in January and February. And then in
15 September and October they receive a 20 percent increase.
16 At that point, they start buying down in different forms or
17 other.

18 DR. BERTKO: Jon, can I interrupt here because I
19 think this is mostly an answer but there are really two
20 things that are hidden in here, I think, and I'll ask you to
21 confirm it. The first, I think, is what you alluded to most
22 directly which is as premiums rise not only is the

1 percentage going to lead to bigger absolute dollars but
2 perhaps the percentage will be changed bigger.

3 MR. GABEL: Yes.

4 DR. BERTKO: But for retirees in particular, I'm
5 at least aware of a number of large jumbo employees who have
6 firm lids or caps on the contribution. I was wondering if
7 that is also probably embedded in those 48, 63, and 67
8 percent numbers?

9 MR. GABEL: We didn't specifically ask that this
10 year. We have asked that in the past and, of course, we
11 have observed that many employers are putting some types of
12 caps on contributions and lifetime benefits and other such
13 measures.

14 DR. MILLER: Can I get one other clarification?
15 You said it was slightly higher for active workers? But 72
16 percent are someone and very likely. And if you add up the
17 numbers for the active, it's 90 percent.

18 MR. GABEL: Correct.

19 the survey was fielded only a few months after the
20 passage of the MMA. Over the last two months I have given a
21 number of seminars to employers in about 15 different cities
22 in the United States. So let me just relate what I've

1 learned on firsthand exchange.

2 When I've asked at these seminars, which say
3 typically have 50 employers at them, I ask them what are you
4 planning to do with regard to the MMA? Most of them say I
5 don't know. We asked the question last spring. I think,
6 therefore, you should put a great deal of uncertainty about
7 the results that I'm about to show you. That's your caveat.
8 Now let's go to the results.

9 We asked them how they were going to respond to
10 the MMA. About 1 percent said they were going to totally
11 drop coverage. Less than 10 percent said that they would
12 buy into a Medicare Part B, either in full or partially. We
13 have about 14 percent who said they don't know. And now of
14 the remaining firms, by about two to one, the firms say that
15 they will offer a Medicare qualified plan. The other group
16 says that they will wrap around the Medicare Part D benefit.
17 They will offer a wraparound type package.

18 So the conclusion therefore is that very few will
19 drop coverage. There's a great deal of uncertainty.
20 Perhaps not as many, but it's very uncertain will offer any
21 Medicare Part D coverage as had been originally envisioned.
22 Again, a great deal of uncertainty.

1 At this point, let me try to summarize what I see
2 as the conclusions from the survey. I believe we are
3 witnessing an acceleration of past trends. The erosion of
4 retiree health benefits which took place during a period of
5 a strong economy in the late 1990s is accelerating during
6 the period when the economy is not nearly as strong. We're
7 not witnessing wholesale dropping of health plans.
8 Instead, what we're seeing is restrictions on eligibility,
9 so current and new hires, for those firms currently offering
10 retiree health benefits are less likely to have retiree
11 health benefits when they retire.

12 If you're going to ask me what is the principal
13 reason why we are seeing this erosion? I would say it is
14 simply the fact that the cost of retiree health insurance
15 has increased 56 percent since the year 2000.

16 Let me also add the burden of retiree health
17 benefits. We don't have any graphics here, but when we
18 looked at those firms offering retiree health benefits one-
19 third of these retirees received their health benefits from
20 a firm which has more retirees than active workers. 27
21 percent of the Medicare-eligible retirees receive their
22 retiree health benefits from a firm which has more Medicare-

1 eligible retirees than active workers.

2 MR. SMITH: A 56 percent increase in costs in four
3 years. Is that because of drugs? And what will be the
4 impact of -- if it is, that's totally off the charts with
5 respect to other health care cost increases --

6 MR. GABEL: No, it's not. It's very comparable.

7 MR. SMITH: Really?

8 MR. GABEL: Yes.

9 MR. SMITH: How much of it is drugs?

10 MR. GABEL: Well, 50 percent of the claims
11 expenses in any given year. I would say that the underlying
12 claims expenses -- I'm doing this from memory. Up to about
13 2001, retiree health benefits on private insurance, not just
14 for retiree, for active workers and retirees, prescription
15 drugs were the fastest increasing component of claims
16 expenses.

17 Claims for inpatient health expenses have gone up.
18 They are still less. Right now the fastest increasing
19 component on the private side is for outpatient hospital
20 services. That includes the way the data are calculated.
21 It includes ambulatory surgery centers. And it also
22 includes emergency rooms. That's in double digits. It

1 continues to be in double digits. I think that's driven
2 heavily by the volume of services.

3 Lastly, if you were going to ask me what has been
4 the impact of the MMA on retire health benefits? I would
5 say it's really too early to say. I think most employers at
6 this time have not made a decision. Again, talking to my
7 employer groups I note that their big hesitancy is the
8 thought of having to qualify each year to be a Medicare
9 plan. That certainly is a constraining factor.

10 I thank you again, very much.

11 DR. BERTKO: Let me only add a slight update. Jon
12 talked to people earlier in the year. We had an informal
13 meeting with employer representatives, consultants from a
14 variety of things. This was only a month ago and they said
15 basically the same thing. Wait and see. We'll do whatever
16 makes most sense. We're keeping everything in place, which
17 somewhat implies that they will accept the 28 percent
18 subsidy, provided that they qualify for it, with some
19 indication that in a couple of years they might go to the
20 wraparound option.

21 Again, I think that's almost along the lines of
22 what you said.

1 MR. GABEL: Yes.

2 MR. DURENBERGER: I guess this is out of curiosity
3 more than anything else. It seemed to me, watching from
4 afar, that one of the most difficult provisions to put
5 together in the Medicare Modernization Act was the
6 application of employee retiree benefits. I don't know what
7 the difficulties were.

8 Secondly, when you look at the amounts of money
9 that were budgeted over 10 years for this particular
10 provision, they seem quite large.

11 Which gets me to the third question, which is at
12 what point do we understand what kind of recommendation, if
13 any, we should be making to the Congress if we don't get any
14 reaction or feedback from a lot of employers because they're
15 waiting for something else? Or maybe I'm missing something
16 here but can I ask John that?

17 DR. BERTKO: I would ask Bill to chime in. Bill
18 and I have, as part of the Trustees Technical Advisory
19 Panel, sat through six weeks or eight weeks of which this
20 was one of the key questions. Among the things we think
21 about very seriously is as no one knows. It's unknowable
22 today. And that we need to really wait, not only until

1 2006, when these are out there, but more likely to 2007 or
2 2008 before the employers actually have their time. They
3 have a very long lead time, in terms of making changes.

4 So the 1/1/06 benefit cycle begins in January for
5 most of these jumbo employers. And they won't know what to
6 do because the bids won't be in until June 2005 for those.
7 So they may not do much of anything in year one, other than
8 play along, which would be to see if they qualify for the 28
9 percent subsidy.

10 I guess my personal advice to the Commission at
11 the moment is let's wait and gather data before we say much
12 about it because I'm not sure what else we can say today.

13 DR. SCANLON: I would agree with John. I think
14 one of the things that came out of that session was the
15 unfortunate situation the Actuary is in in having to make an
16 estimate of how the employers are going to respond. And
17 really, that there are no data that can guide this.

18 The Congress has created incentive that is
19 intended to try and maintain some of that coverage, to
20 preserve or to reduce somewhat federal spending. But the
21 question is going to be whether it works out to be that way.
22 And we won't know for maybe two or three years.

1 People really need to get some feel as to how this
2 is going to work out over time and then they will be making
3 their decisions. A lot probably will depend on where the
4 economy is at the given points in time. We may not see the
5 reaction immediately if the economy is doing well. But if
6 we are in the period of somewhat higher unemployment, more
7 may tend to react sooner.

8 MR. DURENBERGER: Then a related question because
9 there are other programs out there that supplement the
10 Medicare benefit package, Medicaid being a very large one.
11 We did a whole section on this in our June report some time
12 ago. Does the same thing apply to all of these other areas
13 of financial supplementation? Do we really need to wait
14 until somewhere after 1/1/06 to see what is happening,
15 particularly to prescription drug, in order to get a
16 reaction back from others?

17 MR. HACKBARTH: I think the other circumstances
18 are little bit different.

19 DR. MILLER: Some of what I would say about what
20 was said here, and I'll come back over to you here, is I
21 think part of what you and John and Bill were just saying is
22 part of the reason to return to the caveats here. We're

1 talking about people speculating what they're going to do
2 about in a couple of years. There's a very small number of
3 firms that drive these numbers and they're working in an
4 environment that they don't understand at this point. So I
5 think you have to take this with several grains of salt.

6 I think it's absolutely true on the employer
7 piece, we really are going to have to wait to see what's
8 going on. The reason that we did this is there's two
9 agendas that this could potentially link up to. One is our
10 direction on monitoring the impact of the drug benefit and
11 seeing how that is going. And that could pull in some of
12 these other payer issues. That's a little bit different
13 issue than the employer piece, which I think will play out
14 over a longer period.

15 And then the general agenda of looking at out-of-
16 pocket costs and supplemental coverage and how the
17 beneficiary is carrying that. And some of what we were
18 trying to do with this was to see whether there was places
19 that we needed to be looking on that agenda. So I see this
20 hooking up to those two agendas, but I think your point on
21 the employer piece specifically is probably a little bit
22 further out.

1 DR. NELSON: And volume. It works into volume.

2 MR. HACKBARTH: With regard to Medigap, as I
3 understand the process, they're now going to be redesigning
4 the standard plans to accommodate the Medicare drug benefit;
5 are they not, John?

6 DR. BERTKO: Even more complex than that. First
7 of all, they have 10 major options, three of which have the
8 drug benefit. As of 1/1/06 those are frozen. You can stay
9 in or you can leave. The new ones will not have a drug
10 benefit and you would pick that up from a stand-alone drug
11 plan. PDPs is our shorthand for that.

12 MS. RAPHAEL: I had an accounting question. Are
13 there issues about this liability that employers are facing
14 comparable to the pension liability and being underfunded
15 that could affect future patterns here?

16 MR. GABEL: I would say the immediate dark cloud
17 on the crisis is with state and local governments. They did
18 not have to comply -- FASB didn't apply to them. Now
19 there's a new one, GASB, is that what it's called?

20 Now that will be applying to state and local
21 governments. So they will have to go on an accrual basis
22 for their future retiree benefits. They have many, many

1 retirees relative to the number of active workers. So I
2 would think if I were to come back and talk to you in two
3 years I would see we've seen a real change among state and
4 local governments in their offering of future retiree health
5 benefits.

6 DR. BERTKO: For Carol, and let me just offer that
7 unlike defined-benefit pension plans, there is no PBGC
8 organization. Some folks, like United Airlines, just
9 through bankruptcy terminated their plans, at which point
10 nothing is there. The last point is for a whole variety of
11 reasons, some of which are linked to FAS 106, there is very
12 little prefunding on this. Most of it is on a pay-as-you-go
13 basis. As John said, there are companies that have 120,000
14 retirees and now 30,000 active supporting that kind of a
15 benefit.

16 DR. WAKEFIELD: PBGC is there.

17 DR. BERTKO: There is no PBGC for retiree health
18 benefits.

19 DR. WAKEFIELD: For the rest of their income
20 plans.

21 DR. BERTKO: For their income pension plans, yes.
22 Except of course, you read in today's paper about their own

1 separate problems.

2 MR. SMITH: Folks have a property value in their
3 pension but there is no property value associated with the
4 promise of --

5 MR. HACKBARTH: Anybody else?

6 Thank you, Jon. Thanks, Jill.

7 We are now to the last item of the day, which is
8 actually two separate items, the mandated reports on cardiac
9 surgeons practice expense and then the first assistant
10 study.

11 MR. GLASS: Thank you. We're talking about two
12 studies, as Glenn said. The Commission has draft letter
13 reports, and you, as a Commission, have discussed each of
14 these once and given us your comments. We've put these in
15 the draft reports on we're hoping that we'll get your last
16 thoughts today and wrap these up.

17 The first is the certified registered nurse first
18 assistant study, again mandated in the MMA. We discussed
19 this in September. What we were asked to do is study the
20 feasibility and advisability of paying certified registered
21 nurse first assistants directly from Part B. Currently some
22 groups are paid for first assisting under Part B, physician

1 assistants, clinical nurse specialists and nurse
2 practitioners. Others are not, including the certified
3 registered nurse, first assistants and surgical
4 technologists.

5 The scope of this issue is that the total payments
6 for first assistants have been going down. The physician
7 part has been going down. The non-physician practitioner
8 part has been going up.

9 It was \$54 million for non-physician practitioners
10 in 2002 and \$104 million for physicians. So that's the
11 scope of this. Of 74 million surgeries, 5 million of those
12 use first assistants.

13 There also about 1,700 certified registered nurse
14 first assistants. If they replace physicians or others who
15 are currently being paid for these services, paying them as
16 a total effect on Medicare payment wouldn't be very large.
17 We went into that somewhat in the paper, what might happen
18 in the future.

19 This is due January 1.

20 Now we've attempted to incorporate September's
21 discussion and subsequent comments from the commissioners in
22 the letter report. To start off with, there are no Medicare

1 criteria for paying non-physician practitioners separately.
2 So there's no clear criteria that you could say this group
3 should be paid and this group should not be paid. So you
4 have to either imply it or otherwise figure it out.

5 From what we found, CRNFAs are not automatically
6 disqualified by licensure, as were some other groups that
7 the Commission has looked at in the past. And they are
8 similar in education and training to some of the groups.
9 But because duplicate payments are still a concern, we feel
10 if Congress chooses to pay CRNFAs separately the whole
11 payment issue should be budget issue.

12 In the paper we also mention the conceptual appeal
13 of combining payments and how that would support the
14 Commission's goals of quality and care coordination and
15 relieve the Congress of having to revisit who's eligible to
16 separately bill repeatedly and leave the decision of should
17 assist to the clinical experts. We believe this reflects
18 your comments on the paper.

19 The second study we discussed last month, again
20 mandated in the MMA, on cardiothoracic surgeon practice
21 expenses for bringing clinical staff to the hospital. Here
22 we were to determine if the practice expense relative value

1 units for thoracic and cardiac surgeons adequately take into
2 account the cost of surgeons providing clinical staff in the
3 hospital. Also due January 1.

4 We also may want to remember the broader practice
5 expense study Nancy briefed last month. That was on phasing
6 in resource-based relative value units.

7 To review, the IG report found that surgeons bring
8 staff with them, cardiothoracic surgeons bring staff with
9 them, about 75 percent of the time to the hospital. The
10 other 25 percent of the time hospital staff members would be
11 doing the things the clinical staff does. So the clinical
12 staff may assist in the operating room, they can provide
13 pre- and postoperative care, and they could be physician's
14 assistants, surgical technologists, CRNFAs and others. Some
15 of those people can bill separately and some of them can't.
16 And according to CMS, the Society of Thoracic Surgeons
17 reported that about half the time that the clinical staff
18 are brought they can bill separately. The IG also pointed
19 out that about 19 percent of the time hospitals reimburse
20 the surgeons for bringing clinical staff.

21 So in total, about 30 percent of the cases where
22 staff are brought there is no direct reimbursing. The other

1 70 percent of the time there are.

2 In our new draft of the letter report we've
3 incorporated your comments and the views you expressed last
4 month or attempted to. We conclude that the current
5 practice expense relative value units exclude the cost of
6 clinical staff brought to the hospital. So if you took a
7 narrow perspective and said where the definition as adequate
8 and includes everything, then clearly it does not. This is
9 true for all specialties, not just cardiothoracic surgeons.

10 However, there other factors that need to be taken
11 into account. Note that revenues may offset the cost in
12 some cases, for example, separately payable clinical staff.
13 Beyond the separately payable and other offsetting revenues,
14 the issue of payment duplicating some hospital PPS payments
15 or perhaps physician work payments and GME payments still
16 remains. Improperly accounting for all the offsetting
17 revenues and duplicate payments would be quite complex and
18 touch payment systems.

19 As you recognized last month in our practice
20 expense report, a lot of data and other issues is going to
21 be addressed in CMS's five-year review of practice expense
22 RVUs and our work plan for that study mentions several

1 issues. Basically we're saying that this should probably be
2 part of that larger effort of practice expense review, not
3 its own project. So that's what we're saying we should
4 address as part of the larger practice expense review.

5 Again, we mention the conceptual appeal of
6 combined payments.

7 In the case of cardiothoracic, it's interesting
8 because there was the heart bypass demonstration where
9 payments were combined for the Part A and Part B. People in
10 those demonstrations felt it improve quality and it did seem
11 to save money. So the appeal may be greater here. It also
12 gets to the government out of the decision of what clinical
13 staff to use when and that sort of thing.

14 That's about it. We want to know if we properly
15 reflected your comments in the draft report and if there's
16 anything else you want us to touch on?

17 MR. HACKBARTH: Any questions, comments?

18 Okay, everybody's read their materials. We're
19 ready to go. Thank you.

20 Now I need to get credit for the next time I'm
21 running late. I've got an hour plus in the bank. Just so
22 everybody knows.

1 We'll have a public comment period.

2 MR. MEYER: Good afternoon. My name is John
3 Meyer. I'm a cardiothoracic surgeon from the Children's
4 Hospital in Boston. That's my day job. My other job is to
5 be the Chair of the Health Policy Council for the Society of
6 Thoracic Surgeons, which is a profession association that
7 represents essentially all of the cardiothoracic surgeons in
8 the United States.

9 I appreciate the opportunity to address the
10 Commission on this issue of Medicare reimbursement for
11 practice expenses of cardiothoracic surgeons, particularly
12 around the clinical staff issue.

13 I have to admit, this is a pretty arcane technical
14 issue and I have to confess that I didn't really figure this
15 out until I read the GAO report that Mr. Scanlon prepared in
16 1999, which includes this two-page diagram with boxes and
17 arrows all over the place. Then I finally understood it.

18 The basic problem is that the practice expense
19 methodology that CMS has adopted, including their edits,
20 results in a phenomenon that they term euphemistically pool
21 leakage. This pool leakage basically amounts to a transfer
22 of funds from the cardiothoracic surgery practice expense

1 pool to all of the rest of medicine. The consequences,
2 which we fervently hope are unintended but are real, are the
3 following: the Congressional intent that CMS recognize all
4 staff, equipment, supplies and expenses -- not just those
5 which can be tied to specific procedures -- is not being
6 fulfilled. Cardiothoracic surgery practices our incurring
7 these costs. The data come from the AMA/SMS survey of all
8 practicing physicians which is the basis for the whole
9 practice expense reimbursement.

10 When these costs are not recognized because of
11 administrative and, we believe, methodologic errors, the law
12 is not being followed. The policy of recognizing and
13 reimbursing physicians based on the typical situation is not
14 being followed.

15 The HHS OIG study independently found and verified
16 results that were almost identical of what we did from an
17 internal survey from our own members, that 74 percent of
18 cardiothoracic surgeons bring clinical staff that are
19 employed by the practice to the hospital as part of their
20 team of caregivers. Over 80 percent of the hospitals where
21 cardiac surgery is performed indicated in the same OIG study
22 that they do not reimburse the cardiothoracic surgeons for

1 any of the costs of the clinical staff that they bring with
2 them to the hospital setting. This is the equity issue
3 which the staff have appropriately outlined in their draft
4 report.

5 We understand that there are some concerns among
6 the commissioners and the staff about Medicare paying twice
7 for the same service. We contend that the large majority of
8 these costs are not even been paid once. With the current
9 CMS methodology, the same total amounts of money are being
10 spent by Medicare for physician services. This is budget
11 neutral.

12 We estimate that this pool leakage phenomenon
13 amounts to \$50 million to \$60 million a year. This may not
14 seem like a lot of money in the grand scheme of Medicare
15 physician spending, but when you realize that there are only
16 2,000 practicing heart surgeons in the United States the net
17 result is a \$25,000 to \$30,000 hit per year per surgeon.
18 This has been going on since 1999.

19 We estimate, conversely, that the increase in E&M
20 payments, which is where all of the practice expenses get
21 loaded using the current CMS methodology, we estimate that
22 the increase in E&M payments due to this pool leakage

1 phenomenon is less than 25 cents on \$100 E&M service.

2 How could this problem be fixed? There are at
3 least three different solutions to this problem, and all
4 three are relatively simple and, I repeat, all are budget
5 neutral.

6 One way is to simply mandate specialty specific
7 evaluation and management codes for office visits and
8 consultations. This eliminates much of the pool leakage
9 problem and at least keeps the practice expense pool of
10 money within each specialty.

11 A second option is to require hospitals to
12 reimburse cardiothoracic surgeons for the cost of the
13 clinical staff that are employed by the practices and are
14 brought to the hospital as part of their surgical team. The
15 HHS OIG study, I remind you again, found that over 80
16 percent of the hospitals where heart surgery is performed do
17 not reimburse surgeons for these costs.

18 The third and perhaps the simplest option is to
19 have CMS restore the direct input data that they had and
20 used in the first year of paying under a resource-based
21 practice expense system, just restore that data. If that
22 occurs, then that solves the problem because the basic

1 problem with this pool leakage thing is that there is a
2 misallocation of the practice expense dollars from the
3 cardiothoracic surgery pool into the E&M services.

4 All we're asking is that they be reallocated what
5 we believe is more correctly. And by the way, by doing so
6 you don't have the occurrence of what is happening now,
7 which is that an office visit for a cardiothoracic surgeon -
8 - according to CMS's own data -- is six times the practice
9 expense of what it is for an internist. That's sort of a
10 patently absurd result.

11 We believe that this problem, combined with a
12 whole series of other reimbursement changes, is having an
13 effect. For the last four years there been fewer American
14 medical school graduates applying for training in
15 cardiothoracic surgery than there are available positions.
16 This year there were only 92 American medical school
17 graduates applying for the 138 available positions.

18 We have read the draft report of the staff and,
19 with all due respect, we request that the Commission adopt
20 any one of the three alternatives that I have outlined. We
21 respectfully request that you not meet the Congressional
22 intent by recommending another study three years from now,

1 perpetuating the current inequities.

2 There are copies of our more detailed comments on
3 the table behind Mr. Hackbarth. I appreciate your attention
4 and willingness to consider this issue. I'm happy to answer
5 any questions. Thank you.

6 MR. HACKBARTH: We don't normally engage, in fact,
7 never engage in exchange during these. So we appreciate
8 your comments.

9 Any other public comments on this or any subject
10 that we've covered today?

11 MS. McILRATH: I just wanted to make a couple of
12 comments about the pay-for-performance and to just say that
13 I hope you would talk about the environment in which you
14 think it would be possible to do this. You're talking about
15 a 2 percent withhold. Out of what? A negative 5 percent
16 update? Or a freeze or those who do adopt whatever kind of
17 pay-for-performance measures that you think are possible,
18 they get negative 4.5 instead of negative 5 percent?

19 The other thing is that I think you should think
20 about can you do pay for performance and quality measures in
21 a system like the SGR because depending upon which measures
22 you choose, you may very well be increasing physician care,

1 at least in the early years with the savings occurring over
2 on the hospital side.

3 So long as you have the SGR, you may be making
4 that problem worse when you have quality improvement. I
5 think it would be a good thing to address.

6 I also wanted to say on the volume report that I
7 hope you would put some caveats in there about the new
8 technology. If you only look at new codes, and I
9 acknowledge that it's very difficult to look at -- it's
10 probably impossible to look at the whole realm of what is
11 happening. But to just give you an example: for
12 photodynamic therapy for macular degeneration, the treatment
13 is \$311. The drug that they use as part of the treatment,
14 which is also in the SGR, is \$1,322. You also normally have
15 three visits and three -- I don't know if I can even
16 pronounce this -- fluorescein angiograms and three fundus
17 photographs that are done before and after the treatment.
18 The costs of the visits comes out to \$229. The cost of the
19 scans is \$543. The scans are required as part of the
20 coverage decision. So basically, if you were looking for
21 new code, you would have picked up \$311 out of a \$2,406
22 bill.

1 So I'm just saying, there are a lot of other
2 things that go along with a new procedure or a new code
3 sometimes.

4 MR. HACKBARTH: Any others?

5 MR. HOGAN: Hi, my name is Mike Hogan and I just
6 have two quick corrections hopefully to again the issue, the
7 pesky issue of cardiothoracic practice expense.

8 The staff said that these PAs and other staff can
9 bill separately half the time. The data showed that it's
10 about a third of the time that they can bill separately.
11 And that amount is easily known and excludable from what you
12 pay in practice expenses. So it's easy to calculate.

13 And he said that 30 percent of the time physicians
14 receive no payment for this. The data show that it's over
15 60 percent of the time physicians receive no payment for
16 this from any source.

17 MR. HACKBARTH: Any other comments?

18 Thank you. We reconvene at 9:00 a.m. tomorrow.

19 [Whereupon, at 4:17 p.m., the meeting was
20 recessed, to reconvene at 9:00 a.m. on Wednesday, November
21 17, 2004.]

22

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Wednesday, November 17, 2004
9:05 a.m.

COMMISSIONERS PRESENT:

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

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

2 MR. HACKBARTH: Good morning. We have two items
3 on the agenda for this morning. First is another
4 installment in the analysis of specialty hospitals, and then
5 we will have a session on variation in hospital financial
6 performance.

7 MR. PETTENGILL: Good morning. As you know, the
8 Medicare Modernization Act requires MedPAC to study
9 physician-owned specialty hospitals and report to the
10 Congress in March of next year. Under this mandate we have
11 been asked to compare the cost of care in physician-owned
12 specialty hospitals and full-service community hospitals,
13 the extent to which each type of hospital treats patients in
14 specific DRGs, and the mix of payers in each type of
15 hospital. We have also been asked to analyze the financial
16 impact of specialty hospitals on community hospitals, and
17 how the DRG payment system should be updated to better
18 reflect the cost of care in an inpatient setting.

19 At the last two meetings this fall we have
20 presented preliminary information on many of these topics,
21 including those listed on the slide, and we have covered the
22 applicable federal laws governing physician ownership or

1 investment in hospitals or other health care facilities,
2 characteristics of physician-owned specialty hospitals in
3 the markets in which they are located. We have provided
4 preliminary findings on our analysis of payer mix, and
5 findings from our site visits to three markets that have
6 specialty hospitals. We also provided preliminary evidence
7 on differences in relative profitability across and within
8 DRGs, and on patient selection in specialty hospitals.

9 This morning we are going to turn to four
10 additional questions. Carol will lead off with preliminary
11 evidence on whether physician-owned specialty hospitals
12 patient transfers are different than those in other
13 hospitals. I will follow with preliminary findings on
14 whether Medicare inpatient cost per discharge differ between
15 physician-owned specialty and comparison hospitals. And
16 then Jeff will give his preliminary results on two issues.
17 The first of these is whether physician-owned heart
18 hospitals affect Medicare per capita use of heart procedures
19 for beneficiaries living in their local markets. The second
20 is whether these specialty hospitals affect the financial
21 performance of local community hospitals.

22 With that brief introduction, Carol take over on

1 transfers.

2 MS. CARTER: Many hospitals transfer a small
3 number of cases to other acute care hospitals. In some
4 cases, hospitals that lack certain equipment or lack of
5 staff expertise transfers patients who need services that
6 they do not offer. Such transfers are likely to improve the
7 quality of care the patients might otherwise receive at the
8 transferring facility. In other cases hospitals respond to
9 the incentives of the prospective payment system to lower
10 their own cost by discharging patients to other hospitals or
11 post-acute settings. A disproportionate share of transfers
12 raises concerns that the hospitals are inappropriately
13 transferring patients for financial gain or that their
14 quality of care may be in jeopardy.

15 In September we reported on our site visits to
16 specialty hospital markets. During those visits we heard a
17 range of opinions about transfers. Specialty hospitals told
18 us that they transferred out cases that they did not have
19 the services to treat appropriately. Community hospitals
20 told us that they thought that some of the transfers might
21 be financially motivated.

22 Last month we presented information about the

1 relative profitability of different types of cases. We
2 presented evidence that in general lower severity and
3 surgical cases were relatively more profitable than high
4 severity cases and medical cases.

5 Our analysis of the patterns of transferring cases
6 out of specialty hospitals focused on two questions. Do
7 specialty hospitals transfer cases more frequently than
8 other hospitals? And second, do specialty hospitals
9 transfer their costly and severely ill patients more
10 frequently than other hospitals? To study this issue we
11 analyzed Medicare discharge data for 2002 using the same
12 comparison groups we've used for other analyses. Because
13 physician-owned orthopedic and surgical hospitals transfer
14 very few cases we did not analyze their transfer patterns.

15 We first compared the transfer rates of physician-
16 owned heart hospitals to those of their peers and
17 competitors. I will remind you that peer hospitals meet all
18 the specialty hospital criteria but they are not physician-
19 owned. Competitors are located in the same market and
20 provide similar services but are not nearly as concentrated.

21 We found that physician-owned specialty heart
22 hospitals transferred 2 percent of their cases. This was a

1 higher share of the cases than the percent transferred from
2 peers, which you can see is 0.9 percent and competitor
3 hospitals at 1.3 percent of their cases. Looking at the
4 type of cases transferred, specialty heart hospitals
5 transferred 1.6 percent of their heart cases compared with
6 0.7 percent of the heart cases at peer hospitals. This
7 difference was statistically significant.

8 The difference in the percent of cases transferred
9 was larger for non-heart cases. Specialty heart hospitals
10 transferred 3.7 percent of their non-heart cases while peer
11 hospitals transferred 1.1 percent. For the non-heart cases,
12 the differences between specialty heart hospitals and their
13 peers and competitors was also statistically significant.

14 Looking at the transfers from specialty heart
15 hospitals for different types of cases we found that non-
16 heart cases were transferred more than twice as often as
17 cardiac cases. That is the 3.7 percent compared with 1.6
18 percent. This reflects their specialization. Yet because
19 specialty hospitals have much higher volume of heart cases,
20 in terms of the number of cases the typical heart specialty
21 hospitals transferred 27 heart cases and 16 non-cardiac
22 cases a year.

1 We also wanted to know what kinds of cases
2 physician-owned specialty hospitals transferred. Are the
3 transfer cases more complex and would be expected to have
4 high cost? Are they low or high-severity patients? To
5 evaluate the complexity of their transfer cases we
6 calculated the national average relative costliness of
7 Medicare cases in each of the severity classes of the all-
8 patient refined, APRDRGs. Then we used these national
9 averages to compare the mix of cases transferred and those
10 retained by physician-owned specialty hospitals and
11 comparison hospitals.

12 If the hospitals had the national average relative
13 costliness for each APRDRG severity class the index would
14 tell us whether the cases they transferred were expected to
15 be relatively more or less costly than the cases that they
16 retained. The expected relative costliness of heart cases
17 transferred from specialty hospitals was higher than the
18 index of the heart cases transferred from peer and
19 competitor hospitals. This is the 2.2 percent compared to
20 the 1.8 percent for peers and 1.1 percent for competitors.
21 The difference between specialty hospitals and competitors
22 was statistically significant. The difference between

1 specialty and peer hospitals was not.

2 Heart cases that were not transferred from
3 specialty and peer hospitals had similar indexes. You can
4 see this is 1.5, 1.4 up there. Both of these indexes of
5 costliness were higher than the index of the cases that
6 remained at competitor hospitals, and those differences were
7 statistically significant.

8 Looking just at the heart specialty row you can
9 see the expected relative costliness of the heart cases that
10 specialty heart hospitals transferred was considerably
11 higher than the index of the cases that they kept. That is
12 the 2.2 percent compared to the 1.5 percent. We know that a
13 hospital's expected relative costliness captures two
14 factors. One is the severity of the patients within a given
15 illness or condition. The other is the relative costliness
16 of the patients across the illnesses or conditions.

17 For example, one hospital may treat low severity
18 cases from case mix groups with higher relative costs, while
19 another may treat higher severity cases from less costly
20 groups. These two hospitals would have the same index.
21 Therefore, we also compared the share of cases in the
22 highest severity class. This is class 4 of the APRDRG

1 classification system. We looked at the cases that were
2 transferred compared to those that were not. Nationwide, I
3 should just say that 7 percent of Medicare discharges are
4 assigned to this highest severity class.

5 We found that 8 percent of the APRDRG class four
6 severity cases were transferred from specialty hospitals
7 compared with 2 percent transferred from peer hospitals and
8 3 percent transferred from competitors. The differences
9 between hospital groups were larger for non-heart cases, 13
10 percent of the class four non-heart cases were transferred
11 from specialty hospitals compared with 2 percent from peer
12 and competitor hospitals.

13 In conclusion, specialty hospitals appear to
14 transfer cases more frequently than peer and competitor
15 hospitals. Compared to peer and competitor hospitals
16 specialty hospitals appear to transfer cases with higher
17 expected relative costs, and they transferred a higher share
18 of severely ill patients. We do not know if the transfers
19 were done to provide more appropriate medical care, or
20 financially motivated, or both.

21 Now Julian is going to talk about the analysis of
22 the cost differences.

1 MR. PETTENGILL: Now we come to the question of
2 whether the costs differ between physician-owned specialty
3 hospitals and traditional hospitals. Ideally, if costs are
4 different we'd like to be able to identify at least some of
5 the major sources of those differences.

6 Hospitals' Medicare inpatient cost per discharge
7 might differ for three reasons. First, hospitals' costs
8 reflect what they do. This includes differences in the
9 kinds of patients they treat. Physician-owned specialty
10 hospitals' costs might differ simply because they treat
11 patients that have higher resource requirements. In
12 addition, hospitals' costs reflect the other activities that
13 they engage in. These include the extent to which they
14 operate medical education programs or serve disproportionate
15 share of poor patients. Generally, physician-owned
16 specialty hospitals don't train residents, nor do they
17 generally serve a disproportionate share of low income
18 patients. But many of the hospitals that we're comparing
19 them to do engage in those activities.

20 Second, market conditions, particularly input
21 prices for labor and other inputs, differ across markets.
22 So physician-owned specialty hospitals' costs might differ

1 because of where they are located. They are not everywhere
2 in the country.

3 Third, hospitals may perform with different levels
4 of efficiencies as indicated by differences in length of
5 stay, differences in size as reflected in opportunities or
6 the lack thereof for economies of scale and scope,
7 differences in staffing patterns or compensation for
8 employees.

9 To examine the cost differences we compared
10 Medicare inpatient costs per discharge in physician-owned
11 specialty hospitals and our comparison groups. We used much
12 the same comparison groups we've been using, in particular
13 the peer specialty hospitals, competitors within the same
14 markets, and all community hospitals. We used data from
15 hospitals' fiscal year 2002 Medicare cost reports. But to
16 make the comparisons fair we standardized the cost per case
17 to control for differences in factors that affect cost but
18 are largely outside of hospitals' control, at least in the
19 short run. These include case mix, input prices, and the
20 extent to which hospitals train residents or serve poor
21 patients.

22 We also examined length of stay. We did that

1 because length of stay might be one controllable factor that
2 accounts for differences in costs. Here we compared each
3 hospitals' actual length of stay with it's expected length
4 of stay, taking into account its mix of Medicare cases. The
5 expected length of stay for each hospital is based on its
6 mix of cases by APRDRG and severity class and the regional
7 average length of stay in each of those categories in its
8 region. That is, given a hospitals' mix of cases this
9 measure tells us what it's length of stay would look like if
10 it had the same length of stay as the region in which it's
11 located for each of the APRDRG severity classes. The ratio
12 of actual to expected length of stay then tells us whether
13 their stays are longer, shorter, or about the same as what
14 you would expect. Other things being equal, shorter than
15 expected lengths of stay are normally associated with lower
16 cost per discharge.

17 Now let's look at the results. This table shows
18 the standardized Medicare inpatient cost per discharge for
19 physician-owned specialty hospitals and selected comparison
20 groups. Standardized costs here are expressed as relatives.
21 That is, we divided the value for any hospital group by the
22 overall national value. The bottom row for community

1 hospitals is 100 percent and anything else is relative to
2 that.

3 The amounts compared are expressed as percentages
4 of the national amount, and the last two columns show the
5 means and medians for each group. For example, in the
6 middle column you can see that the average cost for
7 physician-owned heart hospitals are 8 percent higher than
8 they are for peer heart hospitals or for all community
9 hospitals. Average costs in orthopedic and surgical
10 hospitals are still higher at 117 percent and 133 percent of
11 the national average. The averages for peer orthopedic and
12 surgical hospitals lie in between. They are higher than
13 those of all community hospitals but they are not as high as
14 those for physician-owned specialty hospitals.

15 You might think that these large differences would
16 be statistically significant, but in fact they are not. The
17 explanation for that is that these are very small groups of
18 hospitals we're comparing here, at least the physician-owned
19 and the peer hospitals, and the cost per discharge vary a
20 lot across the hospitals within these groups. So it's hard
21 under these circumstances to achieve statistical
22 significance. In our preliminary data the physician-owned

1 specialty hospitals appear to have somewhat higher costs
2 than the comparison hospitals but the differences are not
3 statistically significant.

4 The length of stay data show a different story.
5 The middle column of this table shows the ratio of actual to
6 expected length of stay where the expected length of stay
7 accounts for the hospitals' mix of cases and is based on the
8 regional average length of stay in each APRDRG severity
9 class. Physician-owned specialty hospitals appear to have
10 shorter than expected lengths of stay and these differences
11 are generally statistically significant.

12 For example, heart specialty hospitals have
13 significantly shorter length of stay relative to the
14 expected value than peer heart hospitals. That is the 83
15 percent at the top of the middle column. Physician-owned
16 orthopedic hospitals have shorter than expected lengths of
17 stay and these are significantly shorter both than either
18 the peer orthopedic hospitals or all community hospitals.
19 Surgical specialty hospitals, the 69 percent in the middle
20 column also have shorter than expected lengths of stay and
21 these are significantly shorter than those for all community
22 hospitals. They are not shorter than those for the peer

1 hospitals, although the difference has to be close to being
2 significant.

3 So our tentative findings are, physician-owned
4 specialty hospitals appear to have higher costs than other
5 hospitals but the differences are not statistically
6 significant. They also appear to have shorter than expected
7 stays, given their case mix and regional length of stay
8 patterns. Something else must be going on here to explain
9 this difference, but at the moment we do not know what it
10 is.

11 Now Jeff will talk about findings from his
12 studies.

13 DR. STENSLAND: Today I'm going to address two
14 questions. First, is a Medicare beneficiary more likely to
15 receive cardiac surgery if a physician-owned heart hospital
16 operates in that beneficiary's market? Second, did the
17 relative profitability of community hospitals decline when
18 heart hospitals entered their markets?

19 We investigate the impact of physician-owned
20 specialty hospitals on utilization and hospital profits by
21 focusing on physician-owned heart hospitals. We focus on
22 heart hospitals because they are larger, 52 beds on average,

1 than orthopedic or surgical hospitals which have 15 beds on
2 average. If physician-owned specialty hospitals cause an
3 increase in utilization or a strain on the financial
4 performance of community hospitals it will be easier to
5 detect the impact of physician-owned specialty hospitals by
6 examining the case of heart hospitals rather than smaller
7 orthopedic and surgical hospitals.

8 We compare the rate of change in cardiac surgeries
9 in 10 markets that gained a physician-owned heart hospital
10 to the rate of change in cardiac surgeries in markets
11 without physician-owned heart hospitals. This is known as a
12 difference in differences approach. The year 1996
13 represents a year before any of the heart hospitals opened.
14 By 2002, our heart hospital had been operating in each of
15 these 10 markets for more than one full year.

16 By comparing the rate of change in cardiac
17 surgeries in these 10 markets that gained a heart hospital
18 to the rate of change in 295 markets without a heart
19 hospital we can control for national trends in cardiac
20 surgery utilization. To define market areas for cardiac
21 surgery we used the Dartmouth atlas of health care hospital
22 referral regions. These markets were created in part by

1 examining travel patterns for Medicare patients receiving
2 cardiac surgery.

3 Second, we will examine the financial impact of
4 physician-owned heart hospitals on local, full-service
5 community hospitals. We use the same difference in
6 differences approach, but financial data was only readily
7 available for 1997 through 2002. Due to the loss of 1996
8 data we're limited to examining the impact of physician-
9 owned heart hospitals in eight markets.

10 Before we get into the data let's spend a minute
11 thinking about the financial incentives facing physician
12 investors in heart hospitals. Physicians who invest in
13 heart hospitals share in their hospitals' profits. Once the
14 physician-owned heart hospital opens these physicians have
15 an incentive to recommend patients for cardiac surgery; an
16 increased incentive. As we told you last month, low
17 severity cases tend to have higher profits than high
18 severity cases. Therefore, cardiologists and cardiac
19 surgeons who own heart hospitals have a financial incentive
20 to increase the ratio of low severity admissions to high
21 severity admissions.

22 In addition, certain types of DRGs are expected to

1 have higher marginal profits. For example, CABG surgeries
2 may have had a higher marginal profit in 2002 due to having
3 a fairly high DRG payment and relatively low supply and
4 device costs. In contrast, defibrillator implantation is
5 believed to have had a relatively low marginal profit in
6 2002 due to high device cost and relatively low DRG payment
7 in that year. Hence, heart hospital investors may have had
8 a stronger incentive to increase CABG surgeries at their
9 heart hospital in 2002 than they had to increase
10 defibrillator implantation in 2002. It should be noted in
11 2003 CMS significantly increased the average payment for
12 defibrillator implantation.

13 While the financial incentives to increase the
14 number of cardiac surgeries are there, it is not clear that
15 all physicians alter their clinical decisions due to these
16 incentives. Some cardiologists could change their practice
17 patterns. Others may not change their practice patterns at
18 all. We do not attempt to evaluate whether specific
19 individual physicians are changing their practice patterns.
20 This study is limited to examining whether the introduction
21 of a heart hospital is followed by either a shift upward in
22 the total number of cardiac surgeries or a shift toward

1 higher profit cardiac surgeries.

2 Now let's look at the data. From this slide we
3 see that both types of markets experienced an increase in
4 the volume of cardiac surgeries, which include
5 angioplasties, from 1996 to 2002. While the rate of
6 increase is higher for markets with heart hospitals, the
7 difference is not statistically significant. In our site
8 visits we found that some community hospitals responded to
9 the loss of cardiac surgery volume by recruiting
10 cardiologists and cardiac surgeons into their community.
11 These would be new cardiologists and new cardiac surgeons to
12 replace those that are primarily practicing at the
13 physician-owned heart hospital. It may be too soon to
14 evaluate whether this recruitment will have an effect on the
15 volume of cardiac surgeries in these markets.

16 Next we want to examine whether physician-owned
17 heart hospitals see unusual rates of increase in the more
18 profitable categories of cardiac surgery. From 1996 to
19 2002, the number of coronary artery bypass surgeries
20 declined resulting in 0.5 fewer bypass surgeries for every
21 1,000 beneficiaries in heart hospital markets, and by
22 approximately 0.9 fewer CABG surgeries for every 1,000

1 beneficiaries in other markets. The literature attributes
2 this nationwide decline to be the substitution of
3 angioplasties for CABG. However, the decline was smaller in
4 markets with physician-owned heart hospitals, which is
5 consist with the financial incentives we discussed earlier.

6 Angioplasties increased in all markets. The
7 growth rate in markets with physician-owned heart hospitals
8 is not statistically differently from the growth rate in
9 markets without physician-owned heart hospitals.
10 Defibrillator implantation increased in all markets. The
11 differences in rates of increase was not statistically
12 significant. This is consistent with our assumption that
13 marginal profits on defibrillator implantation were small in
14 2002 and did not create a significant incentive to increase
15 admissions.

16 Most interestingly, the ratio of low severity
17 surgeries to high severity surgeries is increasing in all
18 markets. Low severity cases are defined as those with
19 APRDRG severity level one or two. High severity cases are
20 defined with an APRDRG severity level of three or four. The
21 ratio of low severity cases to high severity cases in
22 markets with physician-owned heart hospitals is not

1 statistically different from the growth rate in other
2 markets. The difference is not statistically significant.

3 We can summarize by saying, if the opening of
4 physician-owned heart hospital did introduce an increase in
5 cardiac surgeries through 2002, the magnitude of that
6 increase is too small to be detected with most of our tests
7 for statistical significance. In September we told you that
8 physician-owned heart hospitals conduct over 25 percent of
9 the Medicare cardiovascular surgeries in their markets.
10 Because the impact of physician-owned heart hospitals on
11 utilization is very small relative to these hospitals 25
12 percent market share, we know that physician-owned heart
13 hospitals are primarily obtaining patients by taking market
14 share from community hospitals. This raises the question of
15 whether community hospitals' profit margins fall
16 significantly when they lose these patients.

17 In this slide we compare community hospitals in
18 markets with heart hospitals to community hospitals in
19 markets without heart hospitals. First of all, we notice
20 that heart hospitals form in areas where hospitals are
21 receiving more Medicare revenue per bed. This could be due
22 to heart hospitals choosing to locate in markets with less

1 excess capacity and in markets where the patients are
2 disproportionately elderly. The 11.3 percent change in
3 Medicare revenue per bed at community hospitals in heart
4 hospital markets was slightly lower than the 13.7 percent
5 change in other markets.

6 Our preliminary results from a multivariate model
7 indicate that there is a statistically significant reduction
8 in Medicare inpatient revenue at community hospitals that
9 compete with physician-owned hospitals. In other words, we
10 found that the difference between the 11.3 percent and the
11 13.7 percent growth rates shown in this slide is probably
12 not purely due to chance.

13 While heart hospitals appear to take Medicare
14 patients from competitor community hospitals, these
15 competitor community hospitals do not appear to have below
16 average levels of overall profitability. This implies that
17 most community hospitals were able to compensate for the
18 revenue they lost to heart hospitals. On our site visits we
19 found that community hospitals responded to competition from
20 physician-owned heart hospitals with measures such as cost
21 reductions, expansions in other surgeries, rehabilitation,
22 pain management, neurosurgery, and aggressive price

1 negotiations with private payers, and in some cases
2 recruiting new surgeons into the community.

3 In summary, our findings are first that it appears
4 that heart hospitals are capturing market share from
5 community hospitals. Second, despite competition from heart
6 hospitals, full-service community hospitals that competed
7 with heart hospitals continued to have profits that were in
8 line with national averages through 2002. During the
9 timeframe of our study, 1997 to 2002 we do not have any
10 evidence suggesting that the introduction of physician-owned
11 heart hospitals has caused a significant reduction in
12 community hospitals all-payer margins.

13 We are available for questions.

14 MR. MULLER: If I understand the summary of the
15 information correctly, the model here of the specialty
16 hospital was that, whether one uses the words a focused
17 factory, but the sense that the care would be better, the
18 costs would be better, it would be more efficient. What
19 we're saying here is the costs are no better, they may be
20 higher. There's not evidence of more efficiency.

21 There is evidence that we are avoiding case
22 selection in the payment system that pays on averages

1 because there's an incentive to do the less severe cases,
2 even though the payment is based on an average payment, so
3 therefore basically there's the advantage of -- and you
4 showed that last month -- shows a great reward for case
5 selection, which is one of our concerns always is we don't
6 want to pay -- we want the payment system to reward
7 providing better care rather than selectivity in taking care
8 of less ill people in an average payment system. And by the
9 fact that they transfer more cases, that is probably a proxy
10 or a marker that they have less medical capacity because
11 they have to transfer more cases out.

12 So it seems to me that the case that this is a
13 more efficient way of practice is not only not made but it's
14 counter-proved. So they are more costly, less efficient,
15 and they don't have the medical capacity of other hospitals.

16 MR. HACKBARTH: To totally judge efficiency we
17 would also need to be able to control for quality
18 differences, and that is a big missing piece of the puzzle.
19 So it could be that the increased costs are associated with
20 increases in quality. We do not know that and I'm not -- is
21 there any way we can address that question?

22 MR. MULLER: That would be an interesting finding

1 in the program in general.

2 DR. MILLER: I would just say, as you went through
3 the results I think you summarized everything pretty well.
4 The one thing that I would have put just a few degrees
5 differently, I think our evidence on efficiency, to the
6 extent that we can measure it, which we can't because
7 quality is not present, is mixed. We have the cost per
8 case, there's no difference, but the length of stay was
9 statistically shorter.

10 MR. MULLER: But in some ways if you have a lower
11 severity with a higher cost, that should be a proxy for
12 efficiency.

13 DR. MILLER: I admit that your point is taken on
14 that. On the quality stuff, I just want to remind people,
15 we aren't going to be able to grind through that in any
16 detail. We have tried a couple of things. The transfer was
17 one was to very indirectly look at it. We have tried some
18 other methods to look at quality data but we're not going to
19 be able to get any deeper on that point.

20 MR. MULLER: In terms of measuring the effect when
21 the heart hospital is there and its effect on the costs or
22 the margins at the other hospitals, there is a question of

1 scale. Obviously, if there's a lot of hospitals in a
2 community, one hospital by itself is not going to
3 dramatically change the average of 10 or 20 hospitals in a
4 community. If there's one heart hospital and one community
5 hospital, you could see a big effect on that. So the fact
6 that they may not be as big an effect, that could also be
7 the result of the number of hospitals in the community,
8 there's enough of them that even one very successful
9 competitor, successful in the sense of moving cases over,
10 may not have a big effect.

11 So do we have a sense of what's roughly the number
12 of hospitals that were in the sample of the communities that
13 we took? Are we talking about comparing one community
14 hospital, five community hospitals, 10 community hospitals?

15 DR. STENSLAND: The sample of community hospitals
16 is 35, and there's 10 markets, so it's an average of 3.5
17 community hospitals that are doing cardiac surgery in each
18 one of those markets.

19 In terms of being able to detect the influence of
20 these hospitals, that's why we focused on the heart
21 hospitals and not these little surgical and orthopedic
22 hospitals. Then we did it in stages first saying, what

1 these heart hospitals do primarily is inpatient Medicare
2 surgeries, so most of their patients are Medicare and most
3 of their revenue comes from the inpatient side. So we
4 decided to look at, are these community hospitals losing
5 Medicare inpatient revenue, because that's probably where
6 they get hit the most when these heart hospitals come into
7 the community. And we were able to detect a significant
8 drop-off in Medicare inpatient revenue.

9 But then when we get to the larger picture of
10 saying the overall profit margin, which is much harder to
11 detect because now we're looking at the influence of these
12 heart hospitals on a much bigger pool of revenue and
13 expenses and we weren't able to detect any statistical
14 significance difference there.

15 MR. MULLER: You would expect these hospitals, if
16 they are struggling to reshape their programs, to take
17 adaptive steps to accommodate over a five, six-year period.
18 Obviously, if they didn't change their conduct at all you'd
19 wonder about what they were doing. So the fact that they
20 were able to accommodate in part is useful information to
21 have.

22 My concern in part is if we look at the set of

1 patients that we are concerned about here who are treated
2 for heart care, the findings of they're taking patients of
3 lower severity without getting lower cost, without evidence
4 of -- as you say, we're silent on quality but I take lower
5 severity and at best equal cost, perhaps higher cost, as a
6 sign that the quality may not be there either. So one of my
7 concerns is in the group of patients that we're looking at,
8 to have the payment system be advantaged so that there is a
9 clear signal to take care of less ill patients and then have
10 the community hospital be there as a backup by showing the
11 rate of higher transfer. That doesn't strike me as good
12 social policy for Medicare to be engaged in.

13 MR. HACKBARTH: I am with you on a lot of that,
14 Ralph, in particular what we discussed last time, we don't
15 want people to profit from taking advantage of errors, if
16 you will, in the pricing system. But going to the issue of
17 the competitive effect, I would hope that if a new entrant
18 comes into market, whether it is a specialty hospital or a
19 general hospital, that it tends to reduce the profitability
20 of the other competitors in the market. That is the way
21 markets work. That is the impetus to change.

22 To the extent that we find that that doesn't

1 happen, that is a cause for concern on my part. You can
2 just add new entrants into markets and the system produces
3 more money so everybody is held harmless. That is a bad
4 thing. That is not a good thing.

5 MR. MULLER: That goes back to the discussion we
6 had yesterday. Those were all-payer margins or were those
7 Medicare margins? Those were all-payer margins, right?

8 DR. STENSLAND: Yes, all payer.

9 MR. MULLER: So obviously what else is going on in
10 the health care economy in the last four or five years, we
11 went through some of those numbers yesterday in terms of the
12 payment rates from private payers going up in this last four
13 or five-year period. So that's probably more a function of
14 what wasn't happening in terms of cost control in the
15 private payer market in the last five years compared to
16 other parts of the cycle. But the way we discussed that in
17 the past, it is hard for us to use Medicare policy to try to
18 shape the private payer market.

19 MR. HACKBARTH: But my basic point, you would hope
20 that competition has some effect on the margins of the other
21 participants, otherwise the system is even more broken. So
22 if you find an effect of specialty hospital entry on

1 community hospitals, I'm not sure that that is a sign of
2 something bad going on. I think that might be a sign of a
3 small ray of hope that in fact there's some market dynamic
4 left in the system.

5 MR. SMITH: It would depend in part on what the
6 adaptive strategies were. If the community hospital cut
7 capacity, that would raise a different set of concerns than
8 if they be increased efficiency.

9 Jeff, you talked a little bit about, as I
10 understood the written material and last month's
11 presentation, no clear pattern. In some cases they became
12 more aggressive competitors, in some cases they did cut
13 capacity. Do we have enough information, either
14 statistically or from your site visits, to think about what
15 the modal adaptation was? Because I think trying to
16 understand that tells us whether or not this is a good or a
17 bad thing. If people in response to a shift in volume to
18 the specialty competitor simply squeezed everything and
19 became less available to play the backup role that the
20 community hospital is still responsible for, that would be a
21 cause of concern regardless of what happened in the relative
22 margins. I am wondering what we know about that.

1 Julian, a question for you and then I'll stop.
2 What is on your suspect list to explain the anomaly of
3 shorter length of stay and increased cost? Where are you
4 headed to try to --

5 MR. PETTENGILL: I think that is a time and
6 resources question. As Mark pointed out the other day, we
7 are really cranking a lot of things, particularly the policy
8 options for next month, and that doesn't leave much in the
9 way of resources to follow up on this immediately. Time and
10 resources permitting, we will try to take advantage of some
11 of the other work that others on the staff have been doing
12 with the cost report data to look at components of
13 hospitals' costs and see if we can't pick up what's
14 accounting for the difference. But again, that needs some
15 time and effort to focus on it.

16 MR. SMITH: Would that include a look at the
17 impact of both ownership structure and capital structure on
18 costs?

19 MR. PETTENGILL: Part of it would have to do with
20 capital for sure. I don't know that we had in mind just
21 looking at ownership structure in particular, but that is a
22 possibility.

1 DR. MILLER: Let me set some expectations here a
2 little bit. We have a very tight timeline to put this
3 together. Our next step in December is to bring sets of
4 recommendations on what we have. This has been a very
5 resource-intensive project, both in staff time and in
6 computing time.

7 I also want, just as a broader caveat as we talk
8 about what conclusions we are reaching here, we are sampling
9 in a sense on a number of hospitals and a time period. The
10 staff were very careful in caveating their results, but we
11 are saying we are not discerning statistically significant
12 effects so far in the time period and the sample of
13 hospitals that we have. I get a little nervous if we start
14 to drill down into smaller and smaller units, do you see
15 effect on these types of hospitals or this type of a cost
16 structure? I think we're going to continue to encounter
17 insignificant results.

18 So I don't want to build up a lot of pressure
19 behind that because I don't know that we will have the
20 resources to slog through it. Plus I just think given our
21 sample size, I think that is going to be hard to reach down
22 into. If you don't agree you should say so, but I just see

1 us coming back with results saying, didn't see an effect as
2 we drilled down.

3 DR. STENSLAND: The question on how do they
4 respond, what's the modal behavior, I think in most cases in
5 the site visits we saw their reaction was more, we've lost a
6 profit center. Let's find a new profit center. I thought
7 one of the most interesting things is we asked them what you
8 do. In one case a hospital was willing to actually outline,
9 we lost X amount of money. We got this much from here,
10 here, here, here and we ended up at the same spot in the
11 end.

12 So we asked them, where did they get that money
13 from? What were these new profit centers? It was these
14 things like rehabilitation, pain management, expanding the
15 cardiac lab, certain price increases. But the interesting
16 thing is that in the survey we asked specialty hospitals,
17 what are you specializing in. In some cases they would say,
18 we also do pain management and we also do rehabilitation.
19 So there's this one playbook and they're both playing off
20 the same playbook of what profit centers are there for you
21 to expand and make the money off of.

22 DR. SCANLON: This is in some respects is a very

1 similar to what David was saying. I will qualify it with
2 time and resources conditional, that what is happening on
3 the cost side I think is important. Maybe this will assuage
4 your concern about the lack of the competitive effect. I
5 think for the hospitals to remain in the market they need to
6 keep those margins at some level. Some of the good response
7 to competition can be a change in cost structure. If we can
8 learn a little bit more about that, that would actually be
9 helpful. But I recognize that we have learned a lot about
10 specialty hospitals from this whole process and that we've
11 got many other things to do at the same time.

12 DR. MILSTEIN: As others have already commented,
13 it is distressing to have to make a recommendation here
14 without any information on the numerator of the value
15 equation that is quality. I think the staff has done a
16 terrific job of trying to ferret out available quality
17 comparisons. I also respect the fact that we are in the
18 eighth inning and we have limited resources.

19 I wanted to say that as I've thought it through I
20 think there's probably one other avenue of approach that
21 might allow us to make this decision with the benefit of
22 some quality information that is credible in the scientific

1 community. And that is, as staff is previously aware of and
2 has pursued, roughly two-thirds of the hospitals doing
3 bypass graft surgery in the United States do participate in
4 a gold standard risk-adjusted outcomes reporting system
5 operated by the Society for Thoracic Surgeons.

6 Staff, at my suggestion, went to the STS and said,
7 would you be willing to run an aggregate profile of these
8 hospitals as a group versus hospitals in their communities
9 so we can see how they are doing on risk-adjusted outcomes.
10 And as I understand it, the Society for Thoracic Surgery
11 said, maybe but this is a policy and we can't deliver it
12 within your timeframe.

13 I want to suggest a second avenue of approach that
14 would be not time-consuming or resource-consuming, and that
15 is, every hospital that participates in the STS system gets
16 a report every quarter that tells the hospital, relative to
17 risk-adjusted national norms, how they are doing on risk-
18 adjusted mortality. Could we not go to these same hospitals
19 who have cooperative with us in these markets, both the
20 specialty heart hospitals and the hospitals that have given
21 us information who are their competitors and say, would you
22 voluntarily be willing to give us your risk-adjusted

1 mortality score as reported to you by the STS, which is an
2 actual to expected ratio, we might combine it into a market-
3 specific, de-identified comparison so we can get at least a
4 clue using a gold standards outcomes system, how these
5 hospitals are doing on the numerator of the value equation?

6 MS. CARTER: I just wanted to note, when I did
7 talk about the specific requirements that we were asking
8 about for, about half of our specialty hospitals were in the
9 STS database. So that is going to limit the markets that we
10 can look into.

11 MR. HACKBARTH: But it's something.

12 MS. DePARLE: Arnie and I were talking about, one,
13 how much we have learned, but also that the case that the
14 specialty hospitals had been making that has given me at
15 least pause is that they have data showing that the outcomes
16 are better. We all care about that. So if that data exists
17 I would like to see it. I understand the limitations we
18 have on getting it, but this is a place where I think these
19 hospitals could help us get that data. So if we can get it
20 in a reasonable timeframe it would help me at least in
21 thinking about this.

22 DR. STENSLAND: We may not have made this clear

1 but when they are allocating duties in the MMA of who's
2 doing what with regard to specialty hospitals, we can look
3 at quality. But CMS was specifically given the
4 responsibility of comparing community hospital quality
5 versus specialty hospital quality in their report that's due
6 in March.

7 DR. MILLER: Which was one point that I was going
8 to make. But to also say, we can try to go follow up on
9 this. I think what you want here, if I understand the
10 suggestion, we want to get for a given marketplace the
11 specialty hospitals that would voluntarily give us these
12 reports, and also I assume we need some community hospitals.
13 We will pursue this idea but there is always the issue of,
14 in a situation like that who's willing to provide it may in
15 some ways bias what you actually get.

16 DR. MILSTEIN: I agree with that comment. That
17 said, what's nice about the STS reports is that it tells you
18 for any given hospital how they're doing on a risk-adjusted
19 basis of a national comparison. So I think it would shed
20 some light on our decision if all specialty hospitals that
21 are participating in STS were to voluntarily give us their
22 reports and they were to show us that compared to national

1 risk-adjusted norms they were either no different,
2 favorable, or unfavorable. That would, at least for me, be
3 a partial light in an otherwise dark room.

4 DR. SCANLON: For me I think Mark's comment is
5 very important, the issue of self-selection into this would
6 need to be examined. If only half the hospitals are
7 participating we need to know are they different than the
8 other half, because we don't want to have an impression that
9 is misleading on the basis of this self-selection process.
10 And then you used a very important word, if all of them are
11 willing to provide the information, because if there's a
12 further selection in terms of the ones that are willing to
13 provide, the information becomes more suspect.

14 DR. MILLER: We will pursue this.

15 DR. CROSSON: Looking forward to the
16 recommendations in December, throughout the analysis there
17 have been two issues here, two elements that have been
18 interwoven all throughout it. One is the phenomenon of the
19 specialty hospitals itself, and the other one is the issue
20 of physician ownership. Most of the analysis that we've had
21 have had those two elements in there.

22 Each one of those two elements has a political

1 issue attached to it. In the case of the phenomenon of the
2 hospitals themselves there's the moratorium. Then with
3 respect to physician ownership there is the question that
4 may evolve around closing or not closing the whole hospital
5 exception to Stark.

6 I realize that we have specific questions that
7 we've been asked but what I'm basically asking is, as we
8 moved towards recommendations it seems like there are three
9 possible areas they could be in. One would be some
10 recommendations about having some direct change to the
11 market dynamics. The moratorium is an example of that.

12 Another one would be a recommendation to deal with
13 this perhaps indirectly by fixing the problem that appears
14 to exist in the distortions in the pricing, and
15 parenthetically I would favor that. I think that probably
16 is the most sensible.

17 But the third issue has to do with the element of
18 physician ownership per se, and particularly I think the
19 issue of the percentage or the degree of physician
20 ownership, and the potential impact based on that, on the
21 perception of conflict or of concerns in that area, which
22 has been a traditional issue in the profession to at least

1 look at and examine. There's plenty of difference of
2 opinion about where that exists and what might or might not
3 be done.

4 So the question is, on that third issue, are we
5 going to try to take a look at that?

6 MR. HACKBARTH: Yes. What we have been doing here
7 now over the course of several months is addressing
8 component parts of this, trying to build some analytic
9 foundation. Next month, December, as I understand it, is
10 now when we will begin to go back and look at these issues
11 in terms of recommendations for policy. Certainly that is
12 one of the component parts that we will address as well as
13 the pricing and so on. So the fact that we haven't talked
14 about it for a couple months doesn't mean that we've
15 forgotten about it.

16 DR. NELSON: You reported last month about the
17 previous growth of these hospitals. Of course there is a
18 moratorium now so the growth is flat now. But is there any
19 information from the business plans of Medpath and national
20 surgical hospitals, or from CON, or are there ways to infer
21 what the projected growth might be, given the similar
22 circumstances to what we've had in the previous few years,

1 which of course might change? What I wanted to get a feel
2 for is whether we're just at the beginning of a real steep
3 curve in development of these facilities, or whether it is a
4 more shallow curve, or whether perhaps it's flattening. Any
5 way to infer that?

6 DR. STENSLAND: I think what we mentioned before
7 is they have approximately doubled in number from 2002 to
8 2004. So when we have our sample, which is things that were
9 active in 2002, and then there's the other sample out that
10 we get from industry and other sources saying, this has been
11 formed or this is under construction, so that difference is
12 approximately a doubling from 2002 to 2004. A lot of where
13 they're going is in a lot of the same states where they
14 already are. So it's not so much that a lot more
15 communities will have one specialty hospital. It's that the
16 community that already has one is now going to have two.
17 That is the direction things are going from what we've seen.

18 MR. HACKBARTH: I think it's important to keep
19 reminding ourselves that we and the Congress have a
20 difficult task here. We are trying to evaluate a phenomenon
21 in the relatively early stages of it, and because we need
22 data to do analysis we have to reach even further back and

1 we end up with small samples that compromise our ability to
2 reach definitive judgments. This whole phenomenon, if it
3 were left to run, might look very different five years from
4 now, maybe for better or for ill, I don't know which. But
5 trying to do it at this point in time is very challenging.

6 DR. WOLTER: This is a question on the competitive
7 response. Jeff, you said that some of the community
8 hospitals responded with price increases as one of their
9 strategies. I was just wondering if it would be possible
10 for us to look at charges, cost-to-charge ratios? Is there
11 any difference in what has happened in these communities
12 from other communities, and would there be a possibility we
13 might see a trend toward higher charges? I don't know --
14 the sample size is small but that might not be too difficult
15 to look at.

16 DR. STENSLAND: That's a good idea. We can do
17 that without too much difficulty.

18 MR. HACKBARTH: I had just a couple things that I
19 didn't quite understand. On number 21, the bottom row, the
20 growth in low severity surgeries divided by growth in high
21 severity surgeries, it suggests that for both the heart
22 hospital markets and the other markets that there is more

1 rapid growth in the low severity than the high, and the
2 difference between the two I think you said was not
3 statistically significant. That runs counter -- I thought
4 the way these things worked is that as we got experience
5 with them, we started applying them to more and more
6 difficult patients. That was the pattern of diffusion, they
7 started to go and be applied to older patients. It just
8 struck me that there was such rapid growth in the low
9 severity cases in both types of markets. What am I missing
10 here?

11 DR. STENSLAND: I guess there are a couple things
12 that it could be. One is, this is absolute changes. So if
13 there were 10 more low severity cases and five more high
14 severity cases, we would say the ratio was two. But I could
15 rerun this and look at what is the percentage growth in low
16 severity growth versus the percentage growth in high
17 severity cases. So it might be that there is a bigger base
18 of low severity cases to start with.

19 MR. HACKBARTH: That is probably why it looks like
20 this.

21 DR. STENSLAND: There is related literature on
22 this in that when they looked at what happened in New York

1 and Pennsylvania after they started having report cards and
2 they asked, what's happening to the high severity cases in
3 those states, they found out the high severity cases did
4 decline after they started offering report cards, which
5 would be a similar incentive there. You don't want a high
6 severity case because you have a worse report. And this
7 would be, if you have high severity case, there's less
8 profit.

9 MR. HACKBARTH: Then on number seven, the right-
10 hand column, the heart cases not transferred. You are
11 saying the average expected relative costliness of the not
12 transferred cases is higher in the specialty hospitals than
13 in the peer and competitor. How is this consistent with the
14 selection hypothesis that they are taking the lower-cost
15 cases, the cases you would expect to have lower cost?

16 MR. MULLER: It makes the case. They transfer -

17 MR. HACKBARTH: No, the not transferred column I'm
18 looking at. So the ones they're not transferring have a
19 higher average expected cost if I'm reading this correctly,
20 but I can't square that with what we were told.

21 MS. CARTER: I think that is because it measures
22 both the costliness of the DRG and the complexity, so that

1 this measure captures both of those. So for example, peer
2 and competitor hospitals have higher weighted DRGs, if you
3 will, but they could still be taking the low severity cases.
4 Like the specialty heart hospitals are mostly, something
5 like two-thirds of their cases are heart cases and two-
6 thirds of those are surgical cases, and those are higher-
7 weighted cases. That's how I would interpret that.

8 MR. HACKBARTH: So this doesn't control for the
9 fact that they are taking --

10 MS. CARTER: The measure reflects both of those,
11 which is why I went to the next slide and looked at just the
12 severity measure.

13 MR. HACKBARTH: Any other questions or comments?

14 MS. DePARLE: Is it possible to look at
15 readmissions? Would that tell us anything about quality?

16 MS. CARTER: It's possible, but I don't know,
17 given the time constraints on our programmers whether it is.

18 MR. HACKBARTH: Thank you.

19 Next is a variation in hospital financial
20 performance.

21 MR. LISK: Good morning. Today Jack and I will be
22 reviewing results of an analysis we conducted that examines

1 the performance of hospitals with consistently negative and
2 consistently positive overall Medicare margins. In this
3 analysis we are trying to understand the role different cost
4 factors might have in explaining variation in hospitals'
5 financial performance. We hope that this analysis will help
6 inform our discussion of payment adequacy for hospitals that
7 will take place in December.

8 As you may recall, the Commission included an
9 analysis in our June 2003 report that examined factors that
10 help explain variation in hospitals' financial performance.
11 The study, which is 1998 data on hospital performance under
12 the acute care inpatient perspective payment system, found
13 that a quarter of the total variation in inpatient margins
14 was attributable to components of the payment formula,
15 particularly the IME and DSH adjustments and rural hospital
16 specific rates paid to sole committee hospitals and Medicare
17 dependent hospitals.

18 Some of the in financial performance was also
19 attributable to the area wage index and case-mix adjustments
20 but the individual influences of these factors was smaller
21 than that of the policy adjustments I just mentioned.

22 About a fifth of the variation was found to be

1 attributable to hospital operating characteristics thought
2 to be at least partially under hospitals' management and
3 control, such as occupancy rates and length of stay.

4 Market characteristics such as population
5 demographics, provider supply and local competition were not
6 found to be important sources of variation. About half the
7 variation in financial performance remained unexplained.

8 Now the analysis I just reviewed examined one year
9 of data from 1998 for Medicare inpatient margins. The
10 Commission though, in its payment adequacy framework when
11 we've looked at hospital financial performance, has focused
12 on the overall Medicare margins which incorporates payments
13 and costs for most patient care services provided to
14 Medicare patients by hospitals, including inpatient,
15 outpatient, skilled nursing, home health, rehabilitation
16 care and psychiatric services for fee-for-service Medicare
17 beneficiaries.

18 The overall Medicare margin, however, varies
19 substantially from one year to the next. For half of all
20 hospitals it differs by 4 percentage points or more from one
21 year to the next. And for a quarter it differs by 8
22 percentage points or more.

1 There are a variety of reasons why the margin can
2 vary from year-to-year but it may also mean that a single
3 year margin may not provide the best representation of
4 providers' performance. So to avoid the pitfalls of single
5 year data, we decided to examine performance of hospitals
6 with consistently good or poor financial performance over a
7 four-year period.

8 We might expect to see different results in this
9 analysis compared to the earlier results also, because we
10 are looking at different Medicare margin measures for one,
11 the overall Medicare margin instead of the inpatient margin.
12 And we are looking at performance over four years rather
13 than one year. Just keep that in mind.

14 I want to briefly review the methods. Our
15 analysis examined overall Medicare margin data for 1999
16 through 2002. We required that hospitals have overall
17 Medicare margin data and total all-payer margin data in all
18 four years of the analysis. Consistent performers had to
19 have negative overall margins or positive overall margins in
20 all four years of the analysis.

21 Our final analysis included more than 80 percent
22 of hospitals covered by the Medicare acute care inpatient

1 PPS. The analysis excluded critical access hospitals.

2 Our final analysis included almost 3,000 hospitals
3 and what we find is that about 29 percent had consistently
4 negative overall Medicare margins. But over two-thirds had
5 either consistent positive margins or margins that were
6 intermittently positive and negative over the period. The
7 largest fraction of hospitals, 37 percent, consistently had
8 positive overall Medicare margins over the period.

9 Of note is the small share of hospitals, less than
10 2 percent, that had both negative Medicare and negative
11 total all-payer margins.

12 Our presentation today will focus on the
13 costliness measures. I did want to mention, however, that
14 we also looked at some basic provider payment system
15 characteristics that were like in the previous analysis and
16 found the results to be consistent with our earlier study.
17 So we will not be presenting those findings today.

18 So let's move on to some of our findings and look
19 at factors influencing costs. The first set of cost-
20 influencing factors we examined are annual changes in length
21 of stay. Here we go back to 1994 to help capture some of
22 the shift in care that occurred to post acute care in the

1 '90s. As a reminder, length of stay dropped substantially
2 during the '90s as hospitals began discharging patients
3 earlier, at earlier points in their stays, to various forms
4 of post-acute care.

5 The drop in length of stay was larger for Medicare
6 patients than for privately insured. At least this is in
7 part possibly due to the financial incentives of the
8 inpatient PPS, in terms of the per-discharge payment system.

9 It does not appear the negative margin group had
10 any difference in length of stay compared to that of all
11 hospitals. But hospitals with consistently positive
12 Medicare margins had a median decline in Medicare length of
13 stay of three-tenths of a percentage point larger than the
14 national median. That translates to about 3 percentage
15 points over this period, which could translate into savings
16 in variable cost for these providers.

17 The positive margin group also had slightly larger
18 drop in length of stay across all payers and the negative
19 margin group had a slightly smaller drop.

20 Next we can look at occupancy rates where we see
21 the median value for the positive Medicare margin group is
22 higher than for the negative margin group. Higher occupancy

1 should translate into lower unit costs as fixed costs are
2 spread over unit output. We can see that there's
3 differences in Medicare share of patient days, some small
4 differences in Medicare patient days.

5 Another factor to consider is also the average age
6 of plant. We often hear that dealing with an aging plant
7 potentially reduces provider profitability. However, we see
8 here very small differences in average age with the positive
9 margin group having slightly older plant and equipment and
10 the negative group having slightly younger plant and
11 equipment.

12 MS. BURKE: Craig, can I ask a clarification? On
13 the occupancy rate, is that of all patients or just
14 Medicare?

15 MR. LISK: That's of all outpatients.

16 Moving on to Jack now.

17 MR. ASHBY: Moving on to the next slide, in
18 addition to looking at specific factors that affect
19 costliness, we also compared the negative and positive
20 margin hospitals directly using a measure that standardizes
21 for differences in case-mix using the Medicare DRGs and
22 input prices using the Medicare wage index. As we can see

1 on this chart, the negative margin group has above-average
2 costs in the absolute and the positive margin group has
3 below average costs. More specifically, the negative
4 group's median cost per discharge is about 12 percent above
5 the national median and about 24 percent above the median
6 for the positive margin group.

7 What's more, the positive margin hospitals have
8 continued to have their costs increase more slowly over the
9 last four years so that it does appear that the gap between
10 the two groups is continuing to grow.

11 Next, we compared the negative and positive margin
12 groups to their competitors, which we defined as a hospital
13 covered by the inpatient PPS that's located within 15 miles
14 of the subject hospital. Both groups do have competitors
15 but the median positive margin hospital has three
16 competitors, the closest of which is about four miles away,
17 while the median negative margin hospital has one competitor
18 about 12 miles away. The negative margin group does tend
19 to, on average, be located in more sparsely populated areas.
20 And in some of the cases, there is also a critical access
21 hospital within that 15 mile radius.

22 Looking at the results of this analysis, first let

1 me say that we brought in a third comparison group for this
2 part of the analysis, the small group that Craig referenced
3 earlier that has negative Medicare and negative total margin
4 hospitals.

5 DR. WAKEFIELD: Jack, on your previously slide,
6 distance to areas -- I'm sorry, I just answered my own
7 question. Never mind.

8 We were looking at the statistical period and
9 wondering if the distance was to any hospital, CAH or PPS?

10 MR. ASHBY: No, it's only to a PPS hospital. We
11 just defined CAHs as outside this analysis. But I did want
12 to make note of the fact that there are some CAHs in these
13 communities. So in some sense, the distance is a little bit
14 less than would appear here.

15 At any rate, we brought in a third group into this
16 comparison, those with negative Medicare and negative total
17 margins. You'll notice first, looking left to right here,
18 that this new group has even lower occupancy, 42 percent
19 versus 46 percent for all of the hospitals with negative
20 Medicare margins, and even higher costs, about \$6,000 per
21 case compared to \$5,900 for all of the negative margin
22 hospitals.

1 Second, looking up and down in this chart, both
2 the negative margin groups have considerably lower occupancy
3 and higher costs than their competitors. And those with
4 negative Medicare and negative total margins are the
5 furthest behind their competitors on these measures. The
6 positive margin hospitals, on the other hand, have close to
7 the same occupancy as their competitors and they have lower
8 costs than those competitors.

9 We conclude from this analysis first, that higher
10 costs and higher cost growth play a major role in explaining
11 differences in financial performance under Medicare. Of
12 course, the payment system also plays a role but the
13 implication of this particular analysis is that hospitals do
14 indeed have substantial influence over their own performance
15 under Medicare.

16 Second, we would conclude that hospitals with
17 consistently negative Medicare margins have generally a poor
18 competitive stance in their markets. They are not doing as
19 good a job in attracting patients, which then contributes to
20 higher unit costs and ultimately to lower Medicare margins.

21 But a negative Medicare margin usually does not
22 mean a negative total margin. As we've talked about several

1 times in previous sessions, there's very little relationship
2 between Medicare and total margins. But for the small
3 subset of hospitals that does have both a negative Medicare
4 margin and a negative total margin consistently over our
5 several years, this group has the same problems as the
6 larger group with negative Medicare alone but to the even a
7 greater proportion. So in the end, they are even less
8 competitive in their own market areas.

9 Any questions?

10 MS. BURKE: Jack, tell me what we know about the
11 payer mix in these hospitals?

12 MR. ASHBY: We did look at Medicaid and found that
13 there was just virtually no difference on average between
14 the groups. So the leftover group, kind of an all other,
15 mostly private, is essentially about the same.

16 MS. BURKE: So the presence of either
17 uncompensated care or Medicaid as a payer doesn't have any
18 influence on the margin?

19 MR. LISK: Actually, Medicaid in the positive
20 group was 12 percent of the cases, compared to 10 percent
21 for the negative margin group and the all hospital group.
22 So there is a small difference there.

1 MS. BURKE: It contributes positively, not
2 negatively?

3 MR. LISK: Right.

4 MS. BURKE: And uncompensated care?

5 MR. ASHBY: Uncompensated care, unfortunately we
6 don't have a measure available at the moment to look at that
7 directly.

8 MS. BURKE: In the mix among size of hospital or
9 the nature of the hospital, for example teaching hospitals
10 as compared to community hospitals, privately owned as
11 compared to community owned?

12 MR. LISK: Teaching hospitals tend to be in the
13 positive group. Rural hospitals tend to be in the negative
14 group.

15 MR. ASHBY: But perhaps a qualifier on that latter
16 one. This is data through 2002 in this analysis so it does
17 not reflect the benefit of the MMA provisions that will
18 markedly raise the bar for rural hospitals.

19 MR. LISK: Ownership really, on the negative
20 Medicare, it was really the positive Medicare was more
21 likely to be proprietary, for instance. In the negative, it
22 really wasn't anything to say who was more likely to be

1 there in terms of hospital characteristics.

2 MS. BURKE: So if you were to try to put into a
3 sentence or two the characteristics of hospitals who have a
4 tendency to be negative in terms of Medicare margins, what
5 would be the quick summary? Like low occupancy, high cost,
6 rural -

7 MR. LISK: A little more likely to be rural. A
8 little more likely to not receive IME or DSH payment
9 adjustments.

10 MS. BURKE: Relatively small.

11 MR. LISK: Smaller than average.

12 MR. SMITH: And likely not to have as much
13 competition.

14 MS. BURKE: And more likely to be relatively
15 isolated.

16 MR. ASHBY: Relatively, but again on average, you
17 do have a hospital within a 15 mile radius, which means that
18 by any real standard they're not isolated.

19 DR. MILLER: Did you say that relative to their
20 competitors they tend to also -- when you were going through
21 yours. They tend to have lower occupancy.

22 MR. LISK: And considerably lower occupancy rates

1 than their competitors.

2 MR. MULLER: Along those lines, in the work
3 earlier this morning we were pointing out that surgical DRGs
4 tend to be more profitable than the medical. Can you
5 comment as to whether there's any, as far as we know, any
6 big difference between the proportion of medical DRGs versus
7 surgical DRGs in the profitable versus the unprofitable?

8 MR. LISK: Don't know that. We know that there's
9 some slight -- the negative hospitals have slightly lower
10 CMI on average than the consistently positive group in terms
11 of CMI, which is consistent with the earlier analysis that
12 was done. A small CMI effect, not a huge. The differences
13 aren't big. I don't know about the medical/surgical split.

14 MR. MULLER: It's probably not enough to explain
15 all the variation that Jack and Craig have come up with but
16 since one of the things we've noticed over the years is both
17 a difference in payment but also the likelihood of the costs
18 going up in these kind of complex medical cases. Now
19 whether you have those complex medical cases in small
20 hospital that tend to be more rural is probably not as much
21 the case. But I think to the extent to which our payment
22 system and some of its weaknesses has some affect on this,

1 if we could just look at that as well without an inordinate
2 amount of extra work.

3 MS. RAPHAEL: I thought this was very useful, kind
4 of not looking at one year and really trying to get a sense
5 of some of the trends. Could you review what's been
6 happening in terms of the trends in the Medicare share of
7 patient days for hospitals overall? Because clearly for
8 these less profitable hospitals, they have a higher share of
9 Medicare patient days. But what's been the trends in that
10 area?

11 MR. ASHBY: I don't know that we have data on the
12 tip of our tongues to look at that. My sense is that it's
13 been relatively stable. We have not noticed that being a
14 major dynamic in the industry. But it's something we would
15 really have to go back and measure to be certain.

16 DR. MILLER: You have it in this dataset; right?

17 MR. ASHBY: Yes.

18 DR. MILLER: I think the answer is we'll look at.

19 MR. ASHBY: We can certainly get that. It's easy
20 to do.

21 DR. CROSSON: Just a question. As Sheila was
22 painting the picture of the hospitals that are negative

1 Medicare margin hospitals, thinking about it it sounds to me
2 like a failure of governance, actually. You can say failure
3 of management or failure of governance.

4 In other words, the question for me would be what
5 are the people who run those hospitals doing? Or actually,
6 what are the boards of those hospitals doing or not doing?
7 I just wonder whether there has been any thought given to
8 looking at the characteristics of or the effectiveness of
9 governance between those two groups of hospitals.

10 MR. LISK: I think that's what we're trying to do.
11 I guess the governance, you're talking about in terms of
12 some of the ownership and some of those types of structures.

13 DR. CROSSON: I'm talking about the role of the
14 hospital or the management but ultimately the role of the
15 hospital board to have a hospital that year after year, at
16 least in Medicare, is losing money. When you look at the
17 cost structure differences there, they're pretty
18 significant. And those things generally are different
19 because of management activities. But often those
20 management activities are directed by the governance of the
21 hospital.

22 And I just wonder whether we actually have

1 evolving differences in hospital governance that is, in some
2 ways, accountable for some of those differences. That's the
3 question.

4 MR. HACKBARTH: I think the governance variable is
5 very difficult to get a grip on and measure in this sort of
6 analytic way. What we're trying to do here is get a grip on
7 the management variables, the things that you think
8 management might be able to influence. And the general
9 pattern is consistent in the sense that the costs are
10 higher, occupancy lower in the losing hospitals. So I think
11 it's consistent --

12 MR. ASHBY: It certainly implies a lot about the
13 management.

14 MR. HACKBARTH: -- about the management. It's
15 consistent with that hypothesis. It's probably too limited
16 data to say it proves that the problem is management.

17 But are there other variables that we could look
18 at that would go to the management hypothesis? Wage
19 increases. If we could spend 15 minutes we might be able to
20 think of a number of other variables that could be explored.

21 MR. LISK: That's right.

22 In terms of the total facility though, what's

1 surprising is you see these low occupancy rates for this
2 group of consistently negative Medicare margin hospitals.
3 But as Jack said at the end, if you look at the total
4 margin, it's very similar to the other hospitals in terms of
5 other hospitals on average.

6 So something else is happening there, as well, in
7 terms of management. They are able to manage the bottom
8 line. And it may be that they're in less competitive
9 markets and so the cost pressures from the private sector
10 aren't there and the private sector payments are increasing
11 but the pressures aren't there to control Medicare costs. I
12 think that may be one of the things that's happening here.

13 MR. ASHBY: Just to elaborate one point on that
14 and that is, as we've said, the cost increases in recent
15 years continued to be higher despite the fact they had
16 higher underlying costs.

17 But if you focus more specifically on the group
18 that had negative total margins as well as negative Medicare
19 margins, then you see that the cost growth was beginning to
20 come down in recent years. There was extreme pressure to do
21 so and some evidence that they had acted. But in the
22 absence of that bottom line pressure there didn't seem to be

1 any indication that management was making moves to do
2 anything about this situation.

3 DR. NELSON: Know anything about the bad debt
4 factor between these groups? It seems to me that a hospital
5 is struggling because it's in an urban area that has a large
6 amount of uncompensated care and has to write off a lot of
7 bad debt.

8 If its bad debt amount was similar to what a more
9 affluent community hospital's bad debt was, then one could
10 infer that there were management factors rather than
11 catchment, demographic factors that were reflected in their
12 performance. But you're saying no, you don't know anything
13 about bad debt?

14 MR. ASHBY: We don't have a measure at the moment
15 to put into this analysis.

16 MR. HACKBARTH: That would have a more limited
17 affect on the Medicare financial performance because you
18 don't have uninsured patients. People could be failing to
19 pay their deductible if they don't have supplemental
20 coverage.

21 MR. ASHBY: But Medicare is covering 70 percent of
22 that by policy anyway, so we wouldn't expect great

1 differences there.

2 MR. HACKBARTH: Other questions?

3 MS. BURKE: I think it would be enormously useful
4 to tease out the urban/rural mix of these three groups,
5 particularly the group with the negative margins. I would
6 guess, based on just instinct and probably a little in the
7 way of fact, that we would see a pattern of rural.

8 I mean, the question of governance is a good
9 question but it wouldn't surprise me in the least if these
10 weren't community hospitals, relatively small, low-volume.
11 I think of the state of Kansas that at one point had more
12 than 50 percent of the hospitals had fewer than 50 beds.
13 And I suspect that's higher now. I can see those hospitals
14 and I wouldn't be in the least bit surprised if they
15 weren't, in fact, these hospitals that are struggling along
16 in these communities.

17 It would be interesting to know how many of them
18 are urban because I think that is a different nature of
19 question. But I think understanding the rural versus urban,
20 urban even sort of community within 15 or 20 miles of a
21 large metropolitan area, would be helpful in understanding
22 or at least appreciating what some of the issues might be

1 with some of these hospitals.

2 Not to suggest that it's good or bad but I think
3 that would help our understanding to understand where they
4 were.

5 MR. HACKBARTH: Although the smallest have, in
6 very large numbers opted for CAH status.

7 MS. BURKE: That's why I'm asking whether or not
8 that calculation has changed that. It may, in fact, have
9 changed that group dramatically and they may, in fact, not
10 be largely rural.

11 MR. ASHBY: In the MMA provisions you would say
12 the same thing.

13 MS. BURKE: It would be interesting to understand
14 that because I think there is a legitimate question about
15 how long they are carrying on and what the point is and what
16 the dynamics are in that particular community because that
17 contributes to a lot of decisions about whether or not it's
18 the only physician in town and it's the largest employer.

19 There are a lot of dynamics like that that don't
20 make the right case but at least it would help us understand
21 who they are. But just an understanding of what the
22 urban/rural mix might be useful, particularly if the

1 critical access guys are pulled out, what remains in that
2 group would be useful to know.

3 MR. HACKBARTH: Refresh my recollection about last
4 year's financial analysis. My recollection is that the
5 affect of MMA was large enough that we were projecting that
6 once MMA is implemented that the average margin for rural
7 hospitals would actually exceed the average margin for urban
8 hospitals.

9 MR. ASHBY: Yes, we were projecting that one year
10 ago. We will have new information on that, that again
11 reflects the MMA provisions, at our next meeting.

12 MS. BURKE: That would be helpful because this is
13 pre-MMA. So this might be a radical change.

14 MS. DePARLE: I forgotten, I think you reported on
15 this at last meeting, too. How many hospitals have now been
16 designated as committee access hospitals as a result of the
17 new standards in the legislation?

18 MR. LISK: It's getting close to 1,000.

19 MR. ASHBY: 984, I believe.

20 MS. DePARLE: What's the universe? Is it 6,000 or
21 5,000?

22 MR. LISK: We're down to less than 4,000 PPS

1 hospitals now. I'm not sure exactly what the number is
2 going to be, but it is now less than 4,000.

3 MR. ASHBY: But keep in mind that we did exclude
4 critical access hospitals from this analysis, including ones
5 that became critical access later than the data. We still
6 excluded them to have the cleanest look that we could.

7 MS. BURKE: That's why it would be interesting to
8 know what's left in that little pocket.

9 MR. MULLER: Just anticipating some of the work
10 we'll be doing in December and January, especially when we
11 go to payment adequacy. In the past when we've looked at
12 that, we've looked at the annual numbers and the framework
13 and then said in light of our best estimates of margins in
14 that year we make a determination of whether the base is
15 adequate and then we look at the updates.

16 I wanted to think aloud a little bit about when
17 one has a multiple year perspective how that changes, if at
18 all, the payment adequacy analysis. And also I wanted to
19 tie it to a discussion we had yesterday and the prior month
20 on pay for performance, how we tie these things together.

21 I think some of the import of today's analysis is
22 that the hospitals with consistently negative margins are

1 just having a harder time competing in the marketplace in
2 terms of lower occupancy, higher costs. And some of the
3 higher costs may be a function of lower occupancy because as
4 we all know there's a high fixed cost to hospitals. If your
5 occupancy is low, your costs go up quite a bit. So those
6 things are probably highly correlated in terms of
7 performance.

8 But if we're thinking about then what we do as a
9 result of this, in the past analysis we have indicated if
10 there were a lot of consistent negative margins we would
11 have to think about how to -- what we do about that in terms
12 of payment adequacy. One of the concerns you had, Glenn, is
13 the update is a broad brush way of dealing with the
14 payments. Part of what we're trying to think about is are
15 there more targeted ways of using our dollars.

16 So I think part of what I'd like to see as we go
17 through our recommendations in December and January is how
18 to bring together some of the targeted thinking on pay for
19 performance with the adequacy framework so that we try to
20 mesh those things together.

21 I think it's also realistic, given Sheila's line
22 of query about the rural hospitals, we've seen there have

1 been consistent policy efforts to try to redress that. The
2 act last year went in that direction, as well. So some of
3 the problem of the margins in those hospitals, if indeed
4 your hypothesis -- and it's a hypothesis -- comes through,
5 then some of the negative margins in these hospitals may, by
6 that stroke of the pen, have gone away.

7 But I think we should try to put the pay-for-
8 performance together into the adequacy framework.

9 And I think if we're going to start looking at
10 multiple years, as I've argued in the past, we have to think
11 of it across various sectors and obviously the inpatient
12 hospital being, the hospital in all, being 45 percent of the
13 Medicare payment obviously always gets the most attention.
14 We have to think about if we're going to look at it over a
15 multiple year basis, what's the import of that for the
16 nursing home and dialysis, et cetera, and so forth.

17 So if we could be thinking in those directions, I
18 think that would be helpful.

19 MR. HACKBARTH: Any others? Thank you.

20 Okay, we'll have a brief public comment and we'll
21 have the usual ground rules.

22 MR. FENIGER: Randy Feniger, the American Surgical

1 Hospital Association. I apparently am the one who has to
2 apologize for forcing you to work in the dark. Normally I
3 like to shed light on government activities but lean to the
4 left and -- whether that's a political statement or not,
5 I'll leave to you.

6 Just a couple of points I'd like to make and I
7 will be as brief as possible. First of all, again
8 commendations to both the staff and the commissioners. The
9 quality of the analysis, its depth in a very short time with
10 a very limited sample to work with, and the incisiveness of
11 the questions and discussion points that have been brought
12 up throughout this debate, I think on a very touching
13 political issue lend credibility to everything that you've
14 done.

15 Quality measures, I can't speak for the heart
16 hospitals. We have very few cardiovascular members.
17 Unfortunately, most surgical hospitals or most areas of
18 surgery do not have the advantages of the STS database,
19 which is a very good one. We have tried to look at proxy
20 measures such as nurse/patient ratios, postoperative
21 infection. That data has been shared with your staff in
22 aggregate. And we would be more than happy to make that

1 available in greater detail from our own internal surveys.
2 It is self-reported and I understand the limitations of
3 that. But to the extent that it sheds any light on quality
4 questions as proxies, we are more than happy to share that
5 with the staff in greater detail if it is appropriate.

6 Your discussion at the last meeting, I think, on
7 DRGs I think really was reinforced by comments today. At
8 the heart of this is what is happening to the inpatient
9 hospital payment system in Medicare over time and what
10 incentives does it provide or not provide all of the
11 hospitals in a system, irrespective of their ownership.

12 Our organization feels that this would be an area
13 we what certainly encourage a very hard look by the
14 Commission and by the Congress. Obviously, you're not going
15 to get it done between now and your report. It's a large
16 task. But we think that this is an area that would be very,
17 very productive for analysis.

18 Finally, the bottom line of the slides suggested,
19 at least in the analysis you've been able to do so far, no
20 real difference, no harm, no foul. I recognize that you
21 have been working with small samples and that limits your
22 ability to really -- and we are sort of on the upward slope

1 perhaps of the new development. That limits your ability to
2 really determine what might be happening in the future.

3 However, I think the fact that the conclusions
4 that your own staff reached and presented to you, the small
5 samples that you have so far which you've acknowledged in
6 your conversations, suggest that recommendations that come
7 from the Commission be very cautious. I think it would be
8 unfortunate to have recommendations that send a signal that
9 we wish to preserve the hospital system as it exists today,
10 and we wish to discourage new entrants to the market
11 irrespective of their ownership or shape or form.

12 I think that, in fact, we probably need lots of
13 new innovation and experiment to deal with some of the
14 issues in health care and in the Medicare system. And I
15 would just, on behalf of our association, urge caution based
16 on what you have been able to look at with all the hard
17 work, very cautious recommendations coming from the
18 Commission.

19 Thank you.

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

21 [Whereupon, at 10:45 a.m., the meeting was
22 adjourned.]
