

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, April 24, 2003  
9:40 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair  
ROBERT D. REISCHAUER, Ph.D., Vice Chair  
SHEILA P. BURKE  
AUTRY O.V. "PETE" DeBUSK  
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DAVID F. DURENBERGER  
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ALAN R. NELSON, M.D.  
JOSEPH P. NEWHOUSE, Ph.D.  
CAROL RAPHAEL  
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DAVID A. SMITH  
RAY A. STOWERS, D.O.  
MARY K. WAKEFIELD, Ph.D.  
NICHOLAS J. WOLTER, M.D.

**AGENDA ITEM:**

Growth and variation in the use of physician services  
-- Kevin Hayes, Chantal Worzala, Joan Sokolovsky

DR. HAYES: We're here to report on some other work for the June report having to do with growth and variation in the use of physician services. Recall that we discussed this topic of the March Commission meeting and we tried our best to take the results of your discussion and distill that into a draft chapter that we sent to you before the meeting.

This is an ongoing project. It reflects a concern about growth in use of physician services. As you know, the Congress and CMS have pursued a number of initiatives to try and address concerns this area, everything from managed care to demonstration projects on disease management, even the expenditure target mechanism that we have for physician services is a reflection of those concerns.

The issue is an important one because of its implications for spending. From the standpoint of Medicare beneficiaries, growth and use of physician services results in higher Part B premiums, higher premiums for supplemental insurance coverage, higher out-of-pocket costs. For taxpayers, of course, this results in more competition for general revenues of the treasury. As you know, general revenues are an important source of funding for Medicare Part B generally.

Growth in use of physician services has been volatile at times. Particularly in the 1980s, we saw a range of growth rates from 4 percent to 10 percent and more recently we have seen an increase in spending and use of physician services, some evidence that that started in 2001 and has continued through 2002.

So to provide some focus on this topic, we looked at the data, looked at trends in use of physician services but type of service. We also looked at variation in use of services among geographic areas. And then, drawing upon the research that's been done in this area, we tried to interpret what we saw in data. And falling out of that was a road map for further work that we can on this topic. And that would appear at the end of the draft chapter for the report.

This is a table that you saw last time. I just wanted to review this briefly. We're looking here at growth in use of different types of physician services. Our measure of service use here is essentially spending where we have adjusted out the effects of the input price adjuster, the geographic practice cost index is for physician services, so that we have a pure measure of use of services.

Looking at that kind of a measure over a period of four years, 1999 through 2002, we've calculated it with constant 2002 dollars. We have data through the first six months of 2002. Full year data are not available yet, but we thought in the interest of making the results as current as possible, we would use data from the first six months of 2002. But that requires a caveat. And what we have here is essentially use of services for the first half of a year. If you were to try to compare these

numbers, the service use measures, to say numbers on spending for physician services, you need to realize that this is just for half a year.

But otherwise, what we see here is that overall growth and use of physician services was, on average for the period of '99 through 2002, 3.6 percent. The other thing I would point out here is the standout category, which is imaging services, which we'll come back to from time to time during this presentation. But that was growing the fastest at 9 percent per year.

This is a map that reflects a further step in analysis of service use here. We're looking at a geographic variation in use of services. And a couple points to make about this, the first is that you'll hear from David Glass and Dan Zabinski in a little about the factors that affect variation in spending. They talk about variations in the cost of providing services as one factor and variation in quantity of care provided.

So this is a way of looking at that second factor, that variation in the quantity of care provided. What we're doing here with physician services is to try and learn more about why that occurs.

To look at this, we have divided the country into -- I shouldn't say we divided the country. But we have looked at variation in use of services among metropolitan statistical areas and the rural areas in states outside of MSAs. To minimize the effects of random variation in and use of services, we have averaged together the data from the four years that we have been looking at. And because the disease and the burden of disease varies according to such characteristics as age and sex in the beneficiary population, we have aged and sex adjusted these use rates.

For overall service, all services, as you can see shown on this map, we see quite a bit of variation. The highest use areas, I guess it's fair to say, would be parts of the mid-Atlantic, Florida, some parts of the South, and a few areas in states out in the West.

DR. REISCHAUER: This is residence of beneficiaries?

DR. HAYES: Yes, it is.

The next slide is the same kind of thing, but it's for imaging services only, that service that we spoke of a moment ago where we see pretty rapid growth.

This is just use. This is the average for the four years. By once again we see some pretty high -- the patterns are somewhat similar, but we do see some differences, a high use in Alabama or Mississippi, one or the other there, next to do Florida there, and Texas, and parts of the West.

DR. MILLER: So Kevin, the fact that payment rates are different across the country are not reflected in this data.

DR. HAYES: That is correct.

DR. MILLER: That is essentially controlling for that?

DR. HAYES: That is right.

So then the next step was to try and quantify the amount of this variation and there are a variety of ways to do that. What we did here was to select the 50 largest metropolitan statistical areas. That was, once again in an effort reduce the effect of

any random fluctuation in use of services.

What we're comparing here is the area with the minimum and the maximum service use and calculating a ratio of the two.

I want to point out a couple of things about this table before we get into the details. The first is we discovered, in preparing for the meeting, that there is a bit of a difference between how we have defined say evaluation and management services on this table and on a previous table. For the report, certainly, we will reconcile that difference, but just bear that in mind if you try to compare numbers on this table with the previous table.

The other thing we did here was to take the procedures category of services and split it up into major and other. When we get to the literature on the subject in a few minutes, you'll see why that's the case. It seems like the research on the topic has made that kind of distinction and we wanted to do that here.

But otherwise, what we see is that the variation in use of services is greatest for two categories, tests and imaging, with ratios of 3.5 to 1 for tests, comparing maximum to minimum and 3.2 for imaging. The ratio of maximum to minimum for major procedures, however, is only 1.5.

So how do we interpret data like this? For that we turn to the literature on the subject. From our prospective, there's two major streams of research that might help us in this regard. The first is what you might think of as this whole area of geographic variation in use of services. John Wennberg at Dartmouth has done a lot of work in this area. I'm sure you're familiar with that. He puts out a Dartmouth atlas on variation in use of services.

Most recent work was by Elliott Fisher and his colleagues. He had a couple of articles that appeared in the February issue of the Annals of Internal Medicine, received a lot of press at the time when they came out. We'll talk about his results in just a second.

Let me first touch upon the other major area of research in this area, and that has to do with what's been called technological change. One of our Commissioners, Joe Newhouse, has done a lot of work in this area. The focus here tends to be on technological change that is specific to particular conditions. In the case of Medicare beneficiaries, a couple of the conditions that have been looked at are cardiovascular disease and cataracts.

Two types of technological change have been identified. The first has been called treatment substitution. Here we're talking about substitution of one service for another. Often it ends up being more technologically intensive services for less intensive ones. The other type of technological change that's been identified is treatment expansion. Here we see use of services by more and different types of patients.

I think it's hard to capture all of what's been done in this area in one or two sentences, but I think the upshot of it has been in a lot of cases there has been, as a result of technological change, some increase in spending for treatment of various conditions, but at the same time we also see some

evidence of better outcomes.

So it becomes a question of making that trade-off of spending more but also getting better health and better care for patients.

Coming back to the work that Fisher did, it's a pretty sophisticated study. I wanted to devote a slide to it here just to try and explain what was done here. They worked with four different cohorts of Medicare beneficiaries: those who experienced heart attack, colorectal cancer, hip fracture, and then one general cohort representative of the general beneficiary population.

Briefly, what they found was much variation in use of services among geographic areas. The variation was publicly in a category of services that they called more discretionary services, or services that are sensitive to the supply of resources in the area. These services, the categories of them are -- thinking about the earlier table that we looked at, they would be in the category of visits, imaging, tests, and minor procedures. Much less variation with respect to major procedures which was a finding that we saw in the data.

The other major step that they took with this work was to then couple what they found with variation in use of services with some measures of results of quality of care, access to care, and to look at these issues. They had data on improvements in functional status, mortality rates, satisfaction with care, and use of recommended preventive services.

Their overall conclusion with respect to quality and access was that often times it was no better in a high service use areas, and in some cases worse.

So when we put all of this together, this research on geographic variation in use of services, what's been done on the subject of technological change, there are different ways to interpret the results that we see in the data. On the one hand it is possible that there is beneficial technological change going on. We would certainly hope that that is the case, and it is leading to better patient outcomes.

On the other hand, there are these questions about whether all of the services that are being provided are necessary, and that's primarily what we see from the work that the geographic variation group has done.

Where does this lead us? What do we do next? For that, we laid out a road map here, which is summarized briefly here. Clearly we're not in a position to try and undertake the kind of work that has been done on geographic variation and technological change. Elliott Fisher was kind enough to give us a briefing in the office on his work. And he mentioned in passing that it took him eight years to do this. We certainly don't have the resources to do something like that.

But what we would propose to do is a more targeted approach where we would take the claims data, construct episodes of care, and look at some specific policy-relevant issues. Things like physician self-referral, whether or not use of services is consistent with clinical guidelines that have been established.

Then, depending upon what we find, we would hope that that

would put us on a path toward making recommendations for the Congress as appropriate. That's all I have to say.

DR. NEWHOUSE: Kevin, I thought there was actually some muddying in this chapter of two separate issues that I would like to see more crisply made because I think they have different policy implications for us.

The first is what do we make of the big variation in the cross-section that is at a point in time that I know Jack Wennberg has been hammering away at for four decades or so? And which Fisher is really the latest manifestation.

And it also actually bears on our work later that links spending per state with Jenks ordinal measures of quality per state. It's in that tradition, as well, that cross-section.

What I think that establishes fairly well is that areas that with more services don't -- at least as best we can measure things, which may not be very well -- don't get a lot for it. I'm reasonably comfortable with that conclusion but the issue is then what does that imply for us?

I would say -- I see self-referral and clinical guidelines up here. But I would say in general there is relatively few tools to deal with that. In fact, in principal, in the idealized world of managed care, that was what managed care was supposed to do. And that brought us a backlash trying to deal with that.

Now one can say well, managed care didn't really do that, they just beat up on provider's fees. But still and all, there were certainly tones in the backlash about patients were grumpy about their procedures not being approved.

So I think the issue there is granted there is this variation. I would have said it's pretty well known. And the issue is what to do. Now that's one set of issues.

But the other set of issues is a quite different set of issues around the spending increase over time. In this chapter, you've got table one actually goes to the growth rate. And then the issue is what does that buy us?

Well, you can't infer from the fact that variation at a point in time doesn't buy much. That spending more over time doesn't buy much, because as you say, the increased spending may be going for new things which may be very worthwhile. And while preserving all the cross-section variation, everybody kind of floats up as the new stuff comes along.

Where that comes back to us is the whole general issues of the update. It certainly comes directly into the discussion over the physician update, but all other updates, really. How much should the pot increase to accommodate this?

One could, in theory, try to bridge them by saying well, maybe the excess will get squeezed out if you hold down the update. But I think we've had enough experience to say that that really doesn't -- the world doesn't work that way.

So I just thought, when we're dealing with growth rates we need to focus on what have we bought for the growth? For that purpose, Fisher and the Dartmouth work doesn't help us. Or at least none of it that I've seen helps us. The Dartmouth does set up another issue, which is what do we do about the cross-section variation? But that's not really the update factor discussion.

So I'd just like those two things better distinguished than we have, both in this chapter and in David's chapter.

DR. HAYES: Would you say that it's okay to include them, to include both of them, but to just make the sharper distinction between the two?

DR. NEWHOUSE: Yes, because I think they go to quite different decisions that we have to make. And as I say, the issue with the cross-section would seem to be what do you do about it? It's there. The results, the implications are probably -- there's a lot of reason to think that, as I say, more spending doesn't buy much or even buys less if you believe the quality slide that we have on order -- that state 51 spends the most and has the lowest quality.

So then the issue is to go to what to do about it. I don't think self-referral is going to do very much about that variation. That's not to not say we shouldn't necessarily do something there. But as Bob said, the way the DNA of the traditional Medicare program setup makes it almost impossible to do anything about that.

But you still have to make a judgment about the update. And in terms of the discussion that we just had about the SGR, I would have thought what we really do need to establish is something about the value of the increase. That's much harder to do, at least this way.

MR. DeBUSK: Kevin, in looking at the geographic locations where the annual growth rate is going up and looking specifically at the imaging piece, has the certificate of need states been taken into consideration?

DR. HAYES: They've been taken into consideration in that they are on the map. But as we continue to pursue this issue, that too could be on the list of factors that we take into account, just like self-referral. What you're proposing is what, that we look to see the effect that certificate of need has had on availability and use of imaging services?

MR. DeBUSK: Right now there's an explosion of MRIs across the country in the states that do not have a certificate of need. So ultimately I would think that that would have a real impact on utilization of services.

DR. HAYES: It could.

DR. REISCHAUER: Joe said a lot of what I was going to talk about, but I was wondering do we have any kind of feel or could we find out whether over a period such as you have analyzed, rapid growth occurs in regions of the contrary where initial levels are low?

DR. NEWHOUSE: The technical problem with that is some of that could just be regression to the mean.

DR. REISCHAUER: Was there a chart in here about that?

DR. NEWHOUSE: in one of those two chapters, I thought a chart like that --

DR. HAYES: It's not in this one.

DR. NEWHOUSE: It's in the Dan and David one.

DR. HAYES: We had such a chart in an earlier version of the chapter, where we tried to look at the relationship between growth and baseline use of services and the contribution to

growth that was made, low service use areas versus high service use areas. In a nutshell, what we found was that the high service use areas were, I believe, contributing more to growth than the low service use areas were, despite the fact that growth was highest in the low service use areas.

DR. REISCHAUER: The other thing I was wondering is whether we have any ability to compare this situation with that which exist in the non-elderly population, whether Alice or Jack or somebody could provide some insight on that. You have some private companies like ExpressScripts which has done analyses of medication use across geographic areas, which are rather interesting for the non-elderly population and whether we have a situation which, because of the payment methodology in Medicare, is worse or is better than what you get in the way of both growth and of variation across regional areas than is the case in the private sector.

DR. HAYES: We're developing a database of private sector claims. As you can imagine, there's some serious risk adjustment-type problems associated with comparing the under-65 population with Medicare. But that's out there as a possibility.

DR. NEWHOUSE: But it's also trying to hold the population you're comparing from year to year constant in the under-65. And that's done for you in Medicare.

DR. REISCHAUER: Aetna's a pretty big outfit.

DR. NEWHOUSE: But it's had a big decline in enrollment.

MS. ROSENBLATT: It would be a very hard analysis, just thinking about it on the spot, because of the benefit plan issue, HMO versus PPO issue, because on the HMO if you capitate it you don't have a physician experience. So if we were going to do that, you'd have to think through all that stuff to get something that made sense.

DR. WOLTER: I just have a question about the data and the terminology so I understand this. This service use, when we say that it looks to me like we're talking about the percentage increase in dollars spent on that service from year to year; is that correct?

DR. HAYES: That's one way to look at it. It's we've stripped out the effect of the price adjustments, the input price adjustments. And the effect of the updates that happen every year.

DR. WOLTER: But specifically my question is if you looked at the number of MRIs done from year-to-year, as opposed to the dollar amount of the number of MRIs done from year-to-year, would the percentage changes be closer to the percentage changes in E&M codes, since once you apply the RVU and the conversion factor and move the dollars, the actual number of services delivered, that might look a little different? I'm just asking.

DR. HAYES: Yes, it might look different because what our measure captures is both the number of procedures performed and any change in their what's called intensity. We go from what -- I'm out of my area here, but an MRI with contrast media -- without to one with would be a higher cost service. The number of procedures might not change. But in any case, that kind of shift in intensity is also captured in our measure, as well.



DR. WOLTER: It might just be interesting to look at the number of MRIs versus the number of E&M codes. It might be interesting. I don't know.

MR. HACKBARTH: I have Alan Nelson, Carol and David Durenberger.

MS. RAPHAEL: Kevin, I was wondering about our confidence level in terms of your road map to future work. You say that there are clinical guidelines that now tie imaging to CPT codes. I was wondering about whether or not you felt that we could go ahead and really draw some conclusions about the appropriateness of imaging procedures? Because then you also talk about the fact that there may be underuse of imaging procedures, there may be the wrong imaging procedure used in certain instances.

DR. HAYES: It's hard to do work like this. A lot of the work looking at imaging procedures and other diagnostic procedures has involved examination of medical records, which is something that we cannot do. So we know that going in, that there are some limitations to what we can do. But we feel that there are some pretty well developed guidelines out there that will allow us to at least try do this. If we find out, upon further examination, that it's just not going to work we'll show you what we find and then we'll decide.

But going in anyway, we have some optimism that we can do some of this.

DR. MILLER: Kevin, in some of our discussions with imaging people, the kinds of things that came up were questions of whether there are any standards out there in terms of putting something in your office and whether there are minimum standards being met. And then the notion of how the technology is changing but the payment system isn't necessarily changing with it.

The payment system may say I'm taking a picture of this and this area of the body -- obviously I'm that way out my depth here, too -- but the technology has changed and you just get the whole torso. And yet, you're being billed in Medicare for pieces of it, even though the technology allows you just to move to an entire shot of the area that you're looking for.

And some of the discussions with the imaging people brought a lot of that out. I think some of what we're talking about looking at here is, to the extent that we can look at that even with administrative data and make recommendations about changing how the payment system is paying for it. Is that fair, Kevin?

DR. HAYES: Yes.

MR. DURENBERGER: I'd like to respond to Joe's two questions because they're kind of like critical foundation questions. The first is on the what are we buying and what do we do about it. Every time I see a map like that, and this is quite a few years we've seen maps just like this, I recall the time in 1995 that we sat down with then senior senator from Iowa, who's now the chairman of the Finance Committee with a map just like that. And it took five minutes to convince him about the issue of geographic equity.

Unfortunately we didn't have the second question answered which was -- we knew what to do about it but it wasn't necessarily the right thing to do about it.

So my first response is that the importance of putting this kind of information in a visual sense simply to get people involved in what it is you intend to do about or don't intend to do about present policy is very, very important. It's a matter of stressing the value of this analysis and the deliberate way in which you're going about the analysis itself.

The second one, with regard to the growth rate point, it just strikes me that if you're going to focus on some area on growth rate it ought to be on imaging. I know so little about what is causing it to happen except that I see it in some other work that I do in other parts of the world as well. People asking the question why all of a sudden are we getting so good at seeing so many things and then having to do something about it? And how much of that is appropriate, inappropriate, who's making the decisions? Where are the incentives?

I don't know any of these answers except it strikes me that were we to take -- particularly take the second part of Joe's question about going into the growth rate part of it, that the whole imaging issue is a critical one for people to better understand. Even though we didn't look up in the upper Midwest like we were an offender, compared to other people, we are. It's going on all over, but at probably different rates of growth.

So the last thing, I guess, is I've always had the impression that with a half dozen huge managed care companies in this country collecting huge amounts of data from huge numbers of people, that they would already have the answer to the question we're asking. Maybe they do. I just don't know.

But it seems like there ought to be a fairly large volume of experience in the private -- on that side of the private sector in these national plans that could help us.

MR. HACKBARTH: Let me pick up on Dave's comment and ask the Commission whether they think that the road map that Kevin has described is the right path for us to be following. We've basically said that the SGR, the current legislative mechanism to control expenditure increases resulting from volume increases is a problematic approach, from our perspective.

Having said that, we could say don't worry about volume increases at all. Just let it go. Or alternatively, we could say we don't like SGR as the tool for controlling total expenditures. We ought to look for perhaps a sharper tool, a less blunt tool. And I think that's basically the path that Kevin's road map describes.

Once you start down that path, a logical first step, I think, is to try to identify the areas of the rapid increase in volume and he's done that in the case of imaging.

Now there is this school of thought, as he noted at the outset, that well, there's a lot of benefit that comes from that innovation and efforts to target that for control may come at a substantial price in terms of improvements and quality.

I think that's the basic policy crossroads that I'm at in wrestling with it. Do we continue to go down this path? Joe?

DR. NEWHOUSE: I don't think the road map helps us very much with growth because as I -- unless we're going to say in 1995 imaging, X percent of it was appropriate or whatever work we want

to use, and in 2002 Y percent was, which is not what I hear being discussed. I hear much more we're going to go into the cross-section variation and look at Minneapolis versus Miami again.

In fact, I would have -- I think imaging by itself is too narrow. I mean, to the degree I understand what's going on here to do -- if we're going to do, for example, minimally invasive surgery -- Nick or somebody should help me -- we need more precise and more images. And maybe that gets the person out of the hospital faster with fewer complications, all which I think is going to be very hard to identify and probably impossible in the cross-section.

The other two points I wanted to make is I thought there was a certain tension between David and Dan's chapter that said gee, health status explains half of the cross-section variation and then -- actually, within that chapter even. But also here. And then the emphasis on the Dartmouth work, that 30 percent of what we do may have no benefit at all. Now both may well be true but there's a kind of mixed message there.

The final point I wanted to make was on self-referral. I'm under no doubt that there's some abuses here, but I think there's a problem in doing the analysis in that if I'm a physician whose case-mix or practice style is going to lead me to do a lot of imaging, I'm more likely to buy a machine and have it in my office than in the opposite case when I may send a few patients across town.

I don't know how to interpret that at the end of the day, or interpret these correlations. Actually, other the studies cited, I think, have that problem.

MR. HACKBARTH: You've expressed reservations about Kevin's road map. We could just stop with the June report and do a descriptive analysis that says here's what we see in terms of where the increases are occurring and stop there.

I, for one, have been pushing Kevin to go further than that and say if we don't like SGR, what do we like? But I don't want to be pushing down that path if you or other commissioners don't think that that's a productive course.

DR. NEWHOUSE: I don't see that analyzing cross-section variation is going to help us with the SGR.

MR. HACKBARTH: I hear that. Where would you look?

DR. NEWHOUSE: I would think -- I mean, I haven't spent a lot of time thinking about it, but you have to go to looking at what was going on in growth rates which means, as I say, going back in time and looking historically at point A and then at point B at some later point in time.

That's a much harder study, obviously, just trying to retrieve old data, codes have often changed, and getting access to charts if you need chart data -- which you probably do to do this study right. I'm giving you my off the top of the head reactions here, but I think that's what you have to do.

DR. MILLER: Let me just say this about the road map, because I think there's a couple of different ways to think about it and I think there might be at least some degrees difference in terms of the cross section in what you're saying and what I'm about to say.

I think you could think about this, and I don't think the paper is meant to leave you the impression that it's growth or cross-section. I think we feel like we're trying to look at both of these to figure out what's going on here and where the path will take us, the first point.

The second point, you could organize some of this analysis on the basis of SGR, since we are out there saying it's not working. And then to say nothing else there's little bit of a burden of proof problem where people were saying well, then tell us what will.

My feeling about that is you can actually look at that through growth, which I think is completely fair. But I also think you make the argument that to the extent that you find vast variations in utilization and you can begin to get inside and figure out that it's multiple providers coming together on a patient and a lot of redundant services, you might say well, I don't know exactly if this is going to change the growth rate, but I can identify a redundancy of services here and, through the payments system, begin to address that and make this argument -- I realize this is a stretch -- that it may help control the growth in volume down the road.

But you could also take that same analysis from the perspective of many of the things that we've been talking about here, about coordinating care, disease management, quality outcomes, look at this redundancy and numbers of providers involved, and make the same sets of arguments and say I just need to construct my payment systems to work in a way that encourages those kinds of outcomes.

Think of a bundled payment for a given diagnosis that looks across it and you don't run the MRI six times, you run it pre- and post-procedure, for example.

I think that's some of the thinking here.

DR. NEWHOUSE: I think that's fine. I just can't make the stretch into the growth implication.

MR. MULLER: I just echo Joe's concerns about how hard it is to do the growth, and I think trying to put together the cross-sectional analysis with the temporal. I think part of the hypothesis that we have is that as physician practices change, innovation occurs, more drugs, more technology is available, it starts changing not just their patterns but the use of this whole cluster of services. So perhaps there's less hospitalizations, or less nursing home care, more care in the community, all the kind of things we commonly talk about.

So one thing that one can use in that second bullet point there of constructing the episodes of care, trying to get some sense of how care clusters -- and that goes to the point that Mark was just making about how do things perhaps -- do we have any sense of how things interrelate in terms of does everything go together? The old supply arguments, the more you have, the more you use it, which is kind of the early Wennberg stuff, going back 30 years ago. If you have it it will be used.

And therefore, one way that you keep it from being used is to not have it. Which is the way other countries tend to do it.

I would suggest getting to understand more of the episodes

of care. I don't know exactly how to construct that. I think it would be helpful in terms of seeing whether if I hypothesize that certain technologies would therefore reduce other things, is that true? If in fact, you have minimally invasive surgery, you would hypothesize that would at least reduce hospitalization lengths of stay. Does it reduce other things as well or not? More use of images, and so forth, to make sure that the surgery came out well, et cetera, and so on.

So I think trying to construct episodes of care that way on a cross-sectional basis could be helpful in terms of our understanding what the relationship is of the physician utilization to other medical utilization inside the Medicare system, and to see what kind of associations there are. That's one thing one could look at. I, too, despair of doing it over time because of all the data problems and how much the practices do change over time.

Where this takes us then, in terms of what to do about it, aside from go back to bundled payments of smaller or bigger portions, I don't quite know where to take us. That seems to be the conventional wisdom that people have been dealing with for 30 years, you just have to aggregate the payments in some way. As we discussed just before lunch, having some experiments in bundles that are lower than the plan level and some that were above the fee-for-service level strikes me as a good place for the program to keep experimenting. So I think that discussion, as about as far as I know where to go on that.

MR. HACKBARTH: The political challenge here is that it appears that the rate of increase in volume and intensity has gone up somewhat. Under the SGR, of course, that produces significant reductions in the update factor. So the problems that we've been concerned about are likely to get worse in the short run as opposed to better. And what I envision happening is that when 2004 rolls around and we express reservations about cutting fees again, the question that will be posed to us well, if not SGR, what do you propose to do about the increasing volume and intensity?

So what I'm trying to do is get us on a path where we'll have at least some organized thoughts in response to that question come next January.

DR. NEWHOUSE: I'm not going to help you with that -- sorry.

MR. HACKBARTH: Let's get some other people involved. Alice and --

DR. NEWHOUSE: I have to leave in about five minutes.

MR. HACKBARTH: Do you want to go ahead then, Joe.

DR. NEWHOUSE: I was just going to make final point which was there's a chart or a table in a paper by Vic Fuchs in Health Affairs in '99 that shows for several procedures dramatically higher growth rates in the over-85 than in the 65-to-69 for both males and females. Which I interpret as basically people are learning how to do things better and so they're willing to do these things on people that are at a higher risk.

That may be actually one thing to do, is to look at that for a broader range of procedures or update that sort of thing,

because then you would say -- that would tend to say you want to pay for some of this stuff, or at least you make a judgment about do you or don't you, but you see more about what's going on than just that Minneapolis has a more conservative practice style than Miami.

MS. ROSENBLATT: When I read this chapter again, my reaction to it was that we should stop it with what we found, the maps and stuff like that. And not present a road map. And I talked myself out of making that comment because I thought I was being a pessimistic actuary.

But after hearing what Joe and Ralph said, they've rekindled my initial reaction to it, which was there's often a lot of analysis that I do looking at Wellpoint, where I'll look at 10 things and be able to draw conclusions on only one or two of the analyses that I do. You just get caught up in inconsistency of data and you just can't draw conclusions. So I'm a little bit worried about having in the report here's what we're going to do, when it's likely that 50 percent of it may lead to us being unable to draw any conclusions.

MR. HACKBARTH: I think that's well taken and I feel entirely comfortable with taking the road map discussion out of the chapter and just stopping, for now, with the descriptive. Then we can, in subsequent iterations of this, add to the descriptive material by looking at differing rates of increase by age segment. I think that's potentially a very interesting thing.

At some point, though, relatively soon, if we're going to have anything in the way of a policy proposal for next year, we've got to start formulating. And maybe there's nothing we can propose other than bundled payment of various types. But I just want to make sure we don't arrive at that conclusion by default, we've looked down every possible avenue.

DR. REISCHAUER: I guess I'm willing to bet at this point that we're not going to have the silver bullet. I mean, what we're trying to -- we've said we don't like the current system for moderating growth in physician services expenditures. That's a long way of saying we don't like rationing. But can we come up with another way that is politically viable? I'll be damned if I can think of one.

I look at the analysis in this and ask me where does it point me? It points me to a place that I might be willing to go, but I can't imagine the political system going that direction. And that is what we're looking for is areas where there's high service utilization that involves low value or no value services. If we can identify them, then the appropriate policy response would not be what we have now with the SGR, which is to lower everybody's payments. But to say Minnesota, you'll get the full update, but Miami, Los Angeles, Louisiana, you get minus four.

Given the way our representative democracy is represented, that is not going to go anywhere. So I would stop this, as Alice says, where we are. It's some interesting stuff and maybe somebody can come up some other mechanism but I don't see it.

MR. DURENBERGER: I'm just left uncomfortable with doing nothing, just floating it and saying the pictures are nice, and

things like that. If this isn't the right road map, that's fine. But there's something about the coincidence, as everybody pointed out, of the three chapters, that needs to be addressed here.

On purpose we're looking at the issue of value from three somewhat different directions. One is variation, another one may be the growth in variation. Another one is what's quality and things like that. And we really are doing this on purpose because when you look at that map, there's inequity there.

Whatever explains it, this is a national program and much of the growth is taking place in certain parts of the country and not -- and I'm just speaking from the reality of people that live in my area who do see all the money going someplace else. They can talk anecdotally from their specialty profession about where it ends up.

Now I understand that everything we do has to have a solid foundation under it, but the little deal in the campaign last year in Iowa, which we in part referenced when we were looking at the variation thing, that's another political reality Bob, that we haven't --

DR. REISCHAUER: What is the inequity if another article tells me that the quality of care people were receiving in your part of the country is better? What's the inequity?

MR. DURENBERGER: The inequity is that these doctors are taking less money and the other third party payers are subsidizing Medicare and Medicaid.

DR. REISCHAUER: But the way our system works usually is if you earn less money doing a task in Minnesota than you do in Florida, people move, resources move there. You don't equalize it by paying more than you have to to get the service you want.

MR. DURENBERGER: It doesn't work that way. It is not going to work that way. It may work that way for people from Alabama going to New York or something like that, but it doesn't happen when you look at communities such as the communities that we represent.

You change, you take some less money, or if some opportunity presents itself, you take your imaging out of the hospital, take your orthopedics out of the hospital, take your hearts out of the hospital, go somewhere else with it, you do that. That simply increases the cost in the system.

It reminds me of the debate we were in in 1989 when we were talking about should we call this resource-based relative values because that's the name it had been given? Or some of us said we ought to call it value-based relative value system. Except we didn't know how to measure value. Gail Wilensky said she didn't know how to measure value. So we dropped off it.

But the comment element that these three studies seem to have for me is the potential that if we could ever measure value, we would compensate through a big program like Medicare for value. And that seems to be what is common in the quality analysis, the variation analysis, and the one we have before us.

Having said that, I don't have an answer to what Alice recommended, but I just hate to let go of the study.

DR. MILLER: What I would like to come out of this is I have no problem with dropping the road map from the chapter, because I

think questions like are going to come up, where we're going to go with SGR is going to come up, and while I can't articulate it as well as I would like, I truly do see some value or some ability to bridge this research to some of the things we were talking about this morning.

For example, one thing I would say to Bob's comment is you're absolutely correct, you're not going to go in and say the update for Minnesota is going to be different than the update for Florida. It's never going to happen.

But if a group practice, either on a demonstration basis or not a demonstration, was to say look, I'm looking at these patterns, I'm bearing some of the outcome of this, and we practice our medicine differently, and would come in and say I want to be treated differently -- and by the way, I can get better outcomes and all the rest of it -- there are problems with that approach. How do you define the population? And all those kinds of things?

That's some of the stuff I'd like us to continue to think about, and maybe pull together more than just the couple of chapters we're talking about here. Also think about, down the road, bringing in outcomes as well.

MR. HACKBARTH: We need to move on unless it's really urgent. We're falling still further behind. We won't get out of here until too late.

Thank you, Kevin, wherever you might be.