

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, April 25, 2003
9:04 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Agenda for improved data on Medicare and health care
-- Helaine Fingold

MS. FINGOLD: Good morning. This is the initial presentation of a product that we're hoping to do on an annual basis. It's an agenda for improved data on Medicare and health care. It's an effort to highlight data issues because I think the concern is that the data issues often don't get the emphasis that they really deserve. Sometimes they're brought up in our chapters but sometimes they don't quite get the emphasis. Some people see them as technical or mundane, but in fact policy analysis that we complete and other policymakers complete are really only as good as the underlying data that we have.

Some of the issues we focus on in this paper are from previous MedPAC reports. Others are new. Again, most focus on specifically Medicare issues. In the future we're hoping that the scope might be broader.

This first issue we address has to do with monitoring access to post-acute care. Previous MedPAC recommendations in our March 2000 report requested that the Secretary continue to monitor access under the new PPS's. In fact the OIG was conducting surveys on access to SNF and home health services with reports being issued each year from '99 to 2001. However, those surveys were discontinued.

We did recommend in our March 2003 report specifically that the Secretary continue surveys of beneficiary access to SNF and home health services. We believe those surveys should be continued. That is what our recommendation was and we're reiterating it here. We believe the access information is important, not merely to monitor access, but also in that MedPAC uses a lot of this data to assess the adequacy of payment rates. MedPAC itself is developing tools to assess access but we believe this information is important. One of which I think you were just discussing, the database on post-acute care again, but we think this is also equally important as a source.

The second issue is also related to home health. CMS has separate data sets on home health claims and patient assessment information. In that MedPAC is encouraging in another portion of this report, CMS efforts to move forward in quality, pursuit of quality in the system, we think that these two data sets, if linked, could provide some important information on quality outcomes. Linking the data sets would enable analysis of the relationship between service usage and outcomes.

Although CMS has begun to link these databases it's not really focused towards quality issues. We do urge them to move as quickly as possible in linking the databases but we believe they should, in addition to the way they are conducting the linkage, they should include information on patient assessment at discharge to allow for measurement of improvement of stabilization, and stabilization of conditions. So I guess the way they've approached it up till now it really hasn't -- they're

linking the information but not in the way that would best facilitate looking at quality issues. So we're hoping they'll pursue the linkages and do it in a way that we can use it for quality information.

The next issue is on physician practice expense costs. CMS currently uses what it calls a top-down approach to calculating practice expense relative value units. The data in the calculation have come from the AMA's socioeconomic monitoring system and information collected by CMS under the CPEPs, the clinical practice expensive panels. The CPEP information, CMS currently has a private-public effort to refine, to update. However, the AMA has discontinued its SMS system and the most recent data available are from '99.

So we're concerned if CMS continues to use the top-down methodology, and in fact the alternative methodology, the bottom-up methodology also relies on this data though to a lesser extent, that CMS needs to identify an alternate source for this information. We believe that one way to ensure the availability and integrity of the data would be to use a collaborative approach to identifying a new source involving CMS and another federal policymakers, the AMA and other physician specialty societies.

Information on costs and charges of ASCs, again is a repeat of a recommendation included in our March 2003 report. Facility costs of ASCs are paid on a fee schedule. This aspect of the program was added in 1992. The initial rates for these facility costs under the fee schedule were set using survey data that was collected by CMS, though it was not required at that time by the law. The law didn't require that the survey be completed.

In '94, Congress added the survey requirement requiring that a survey be completed, the legal requirement that the survey be completed, and requiring resurvey every five years to update cost information and revise the facility rates. However, that survey has not as yet been completed. The most recent rate data available that the rates are based on is a survey from 1986. CMS did complete a survey instrument -- excuse me, they did complete the survey in '94 but Congress actually blocked implementation of those rates. So we're still relying on the '86 information. We think that it would be important for CMS to actually complete the survey to update the ASC information.

MS. BURKE: Do I not recall correctly that Congress, and I think I remember reading this in the documents, Congress required them to do a post '99 survey, did they not?

MS. FINGOLD: I believe the post '99 was the resurvey.

MS. BURKE: To do one. And they have not done it.

MS. FINGOLD: They have not done it.

MS. BURKE: But was there not a statutory requirement that they do so, or was it simply --

MS. FINGOLD: There is a statutory requirement. My understanding is there was a survey instrument completed and that it has been stuck at OMB for --

MS. BURKE: Right. So the reason for their holding the rates, I remember clearly, was the fact that the data -- they viewed the data as being so old and required that CMS at the

point do something more updated.

MS. FINGOLD: Do something more updated, right.

MS. BURKE: But that has not occurred.

MS. FINGOLD: Right, it has not occurred.

The next several slides and topics have to do with cost report data. We want to emphasize that cost report data is central to our ability and other federal policymakers' ability to understand and assess provider status and payment adequacy. We think this is important information. We think the collection of it must be maintained. The data, we believe, must be timely and accurate, but both are really at issue.

There are concerns that the time for accessing the data has increased and in fact we don't have a good sense of how much that's increased but over time there have been issues about accessibility and we've addressed that here. Several years ago I believe our hospital update was delayed. We included it in our June report because we didn't have sufficient information early enough to get it into our March report, so we've addressed it ourselves.

There have also been public questions about the integrity of the data. CMS has been dealing with a large increase in responsibilities and often competing priorities in the wake of the BBA dealing with the lingering effects of reorganization and other resource limitations. It is our strong belief that CMS must continue to take active and public responsibility for maintaining the integrity of the cost report data.

MR. DeBUSK: What is the current age of that data?

MS. FINGOLD: I believe -- I should turn to Jack. What are we working on now?

MR. ASHBY: We worked in the March report this year with three-year-old data. That's the worst situation we've been in, and we've been in that situation about two years.

However, I think it's only fair to point out that that is gradually improving this year and if all goes according to schedule we should pick up a year this year so that when we look at payment adequacy next year we'll be two years behind rather than three.

MS. FINGOLD: So that's still a concern. So it's better than we have now but we still think --

One mechanism that has been proposed is the use of an early sample to facilitate access. CMS could require or pay providers to file, a representative sample of them to file early. However, CMS and the fiscal intermediaries would certainly need to commit to processing and auditing the information on an expedited basis. That way policymakers would be assured of data access. This is just an initial suggestion and we really need to explore all the ramifications of collecting an early sample to ensure that it was reliable and unbiased data.

We additionally believe that it's important for policymakers to have access to data on private payer rates. We have had some of that in our analyses this year. We've looked at rates for physician services. We're hoping to look at some broader scope of rates but we think there needs to be a real comprehensive source of data on private payer rates. It would allow us to

gauge factors that could impact the Medicare market but may not be evident from the currently accessible Medicare data, first of all because of the timeliness of that, what we just spoke of, but just generally even. It could help us, again, in assessing adequacy of Medicare fee-for-service rates. It could facilitate the use of competitive pricing by providing additional information. And again, we really need a consolidated source of that data. We believe FEHBP information could serve as a starting point for collection of this information.

In conclusion, we think there needs to be exchange of information among federal policymakers. In the future we may need a more formal mechanism to bring policymakers together, to have more active interventions and exchanges on these issues, to continue to identify issues to improve data analysis. We also believe that we want to be vocal in supporting CMS in its efforts to collect and process data. We think that CMS could use support in terms of money, technical input, flexibility in contracting and hiring, and that these could facilitate their processing and collection of data information.

I'll take any comments you have and written comments on the chapter.

MS. BURKE: This is like the mouse that roared. I think our attention to this is absolutely critical, and I think it was a terrific overview. I think in some cases it actually understates the challenge that we face and the importance of this effort. In it you raise a number of suggestions, including creating an incentivized system to encourage providers to provide us data early. I think we ought to look at a whole range of opportunities, and I think we ought to not be shy about stating the need for support for CMS and the development of this information.

I think one of the challenges that we face, and certainly the Congress is in part to blame for all of this, although we were always the first ones to scream, is the lack of the quality and the current data that forces us into making assumptions about what costs are being incurred in the delivery of services undercuts all the credibility of the numbers. So that we end up in a debate over the adjusters instead of what the reality is.

I think that has gotten much worse, and I think the three-year-old data -- this last conversation we had on the hospital payment rates underscored how poorly informed we felt in doing this, and I think it is across the board. The ASCs was another example of just the hypocrisy of a system that pretends that we can guess based on 1980 and then moderately updated, that we've even close to reflecting what people are really doing.

So one, I think doing this is exactly right. Two, I think, if anything, we should even state more strongly the need to support this kind of information and look for ways to incentivize people to provide it to us or to access it. Finally, I think the suggestion in terms of doing the top-down on the docs rates, in the text you talk about turning to other organizations in a collaborative way, including the specialty groups, I think makes enormous sense. I think we ought to look broadly at getting information from organizations who have access to very current

information that will in fact vary by specialty and out to be accomplished.

I think, again, the only way we're ever going to get buy-in is the sense that there is credibility to the information we produce. I think it was great thing to do and I think we ought to be doing it every time, so I think the plan to do that makes tremendous sense.

DR. WAKEFIELD: Until that time when data are available in a little bit more of a real-time fashion I really like that notion of early sampling being done. I think, frankly, it might have been Joe Newhouse's suggestion. I think he's mentioned it on a couple of occasions.

Two questions about it. Have you had any -- just out of curiosity, any informal conversations with folks at CMS about the feasibility of doing that?

Then secondly, you raise a number of questions in the text about what stands in the way by way of barriers. One of the questions or points that you make is whether or not payment for early completion might bias the information that's reported. On that point, were you thinking that that bias would emanate from the difference between those providers who selected in to participate versus those who didn't, or were you thinking that somehow it would create a difference sort of bias? I'm wondering what prompted that question.

MS. FINGOLD: I think it was probably somewhat both. We just wanted to be sure -- again, with credibility you don't want to collect the data and feel like somebody could then raise the question, because these people said they would participate or for some reason because they were being paid, that that would somehow undermine the credibility of the data they were submitting. I think we just wanted to be able to cover everything, to make sure that when we assess that the data would be valid. We want to look at it from every angle.

DR. WAKEFIELD: Any preliminary comments from CMS about this?

MS. FINGOLD: We haven't talked to the upper level. We've talked to several different groups, so it would certainly need to be a more comprehensive discussion with CMS about what this would entail. So yes and no.

DR. MILLER: Just on the bias. Sometimes the providers who are able to respond early may be systematically different than the other providers. I think that's probably the main piece that we're thinking about there.

MR. ASHBY: Could I add a clarification here that might add a tad bit of optimism to this? That is that we're not just talking about the ability of hospitals to process the data faster and CMS' ability to process the data faster on their end. We're also talking about a more basic factor and that is that hospitals in particular, really all of the providers, have different reporting periods. So we're partially just talking about tapping into those that happen to early reporting periods versus those that have late. That, you would think, doesn't enter in as much possibility of bias.

However, having said that, I also in fairness have to point

out that at least in the hospital data set we have noticed over the course of a number of years that the late reporters -- not the early reporters but the late fiscal periods tend to be slightly better performers on our measures of Medicare margins, and that's even after we attempt to control for teaching status, urban-rural, and that sort of thing. We've never really quite been able to figure out why that is. They just seem to be a little different for reasons unknown.

MS. BURKE: Jack, do I not recall that they tend to be loaded in July and October? Are there that many left in January?

MR. ASHBY: No, there's a number in all three. Almost all hospitals are in October, January, or July. The largest of the three is actually October, but all three of them are sizable, so that you are losing a good piece of the industry by not picking up those July ones. But for the effort that Helaine talks about here, we can concentrate on the October reporters and make some significant progress there.

MS. ROSENBLATT: I want to echo what Sheila said about how important this chapter. I'm very pleased we're going to do it on an annual basis. But I also want to echo what she said, I think we need something in the introduction that really gets people's attention so that people don't think, this is just something that health care researchers worry about, but this is something that everybody should worry about.

On the subject of the cost reports, this is 2003. To me it is unfathomable that we are using three-year-old data, let alone two-year-old data. I don't think we are shooting high enough. Even the IRS is allowing online filing of income taxes. We should be asking for quarterly filing of cost report data, or something totally different. We talk about the Medicare program being a 1965 program, and I think in terms of the data how many billions of dollars does this represent and we're using two-year-old data? It's just crazy.

Having said that, let me now shift gears and talk about your recommendation of getting private payer data. You have about two, three paragraphs on that. The difficulty of collecting private payer data is --

DR. REISCHAUER: Quarterly.

MS. ROSENBLATT: No problem. We report it quarterly. I mean, it's there. That's the problem. I don't know if everybody heard Allen, the difference is due to benefit design, types of reimbursement. I really think you need to add a paragraph about how difficult it's going to be to get comparable data. Plus, we are competing on the basis of our deals with providers. If that information is made public, we lose all leverage, because the lowest price out or the highest -- the providers are always going to say, look, that one is paying a lot more than you. We want that rate. So that's a difficulty. The comparability of the data is a difficulty due to the wide range of benefit designs. I just think we need to embellish that, to talk about the difficulty of that.

DR. REISCHAUER: I'm going to repeat some of the stuff that Sheila and Alice said, and that was that there was like two sentences at the beginning to motivate this that were sort of

geek kind of sentences -- you know, good data. I think what you want to point out that data is very important to the credibility of the program, to maintaining constructive relationships between providers and CMS. Right now there's a lot of confrontation based on the fact that data is old or bad. And it imposes burdens on Congress because providers go for redress to Congress, when if we had better system a lot of that would be reduced. And it would allow Congress to identify emerging problems before they hit them in the face and have something more than anecdote to judge those on.

This is an undifferentiated list of things that we would want to do and I'm wondering if there's some way in a summary we could prioritize what makes the most sense to move forward on soonest? One dimension is, where would better data move large amounts of money around? When you have bad data and it's not been moved around, then it gets harder and harder to move it around when you have good data.

The other is, where are there the most egregious gaps, even though the money amount isn't great, between what in a sense should be paid and what is being paid that undermine the system?

Third, what's the cost of doing some of this? If we have a limited amount of resources, where should we be going? I'm not sure we can do all or most or maybe any of that between now and June, and this might be more how we look at this next year and the year after, but I applaud you and Mark for pushing forward on this initiative.

MR. DeBUSK: I have the same thought as Sheila, talking about the importance of this information. We've talked about this for as long as I've been on Commission. It's a major issue again and again and again. It looks like somewhere along the line somebody would bite the bullet and realize that the cost report as it is is old. It's outdated and it's inadequate. We've talked about are there other alternatives and we've gone all around this, talked about quarterly reports and what have you. There's real-time information and even the for-profits, they've got the information because they've got to report it quarterly. The non-profits, they're in a situation where they've got to know better what's going on. They're essentially in the same ballpark.

If we could go bite the bullet, go to a modified GAAP real-time it would solve a lot of problems. But it is beyond my comprehension how we can stick with this old cost report. It just doesn't make any sense whatsoever. Why can't we put somewhere in the chapter that a rework needs to happen, and we need to do this, and we need to move forward? What's to keep us from doing that? That's what we're supposed to be about. Let's make the big move.

MR. FEEZOR: Sheila started us off, I think on a conversation that we had yesterday about the increased sense of urgency, and I think we were talking about who was more rabid in terms of demanding the kinds of data that we need, so I would echo that. I was going to pick up on Bob's point. I think we probably do need though, however, to prioritize what we think would produce the best outcomes for us to, or the best data for

us to help guide Congress in this program.

The one other thing though I think I'd like to see us move towards, and that is making explicit a responsibility within or urging that Congress make explicit a responsibility of CMS to not only make available to leverage the data that they have relative to Medicare, but in turn to try to leverage that in getting access to some of that other data, perhaps private payer data or secondhand market data such as that we're investing in at CalPERS, where we're spending \$12 million to begin to aggregate all of our four or five major payers' data into some sort of single format. Again, I think there is an opportunity there that needs to be more fully explored by CMS.

MS. RAPHAEL: I just wanted to follow up on the CMS issue because I think it would be helpful if you could tease out of this some of the comments you made. I wasn't entirely clear, if we had our wish list, what are the most important things that have to happen at CMS for this to really change? You mentioned consultant use, some kind of flexibility. But I would like to have a better sense of what are some of the barriers at CMS and what concretely could we recommend and try to size and cost that could overcome those barriers? Because I think, as Allen said, they are pivotal to our success on this landscape.

MR. DURENBERGER: I just discussed, because it's not my field, with researchers in my community the proposal and they were all very excited and very complimentary of what I told them was the general approach. The one issue that they asked me to bring up does relate to private plans, and that is the decision by CMS last year to back off of requiring diagnostic code, limit the number of procedure codes by private plans, which at least they believe limits the amount of information that is available about exactly the procedure, what went on in the particular -- I don't if that happened or not. I'm just repeating what I was told.

MR. FEEZOR: In the risk adjustment factor in Medicare Choice?

DR. MILLER: I think that's what he's referring to, is that the decision was to scale down the instrument and the data collection for the purposes of doing the risk adjustment. I think that's probably what you're referring to. That was in response to -- CMS worked at least a year-and-a-half with the industry to come to that conclusion. There were differences among the plans. Certain plans felt ready to do much more detailed types of reporting, and a lot of other plans were steadfastly against the detailed reporting. That's what led to where we are on the risk adjustment, if that's what you're referring to.

DR. WOLTER: Just a couple thing of interest to me. One is, when we look at outpatient hospital margins, I've heard the comment a number of times since coming on the Commission, that the negative margins are influenced by accounting practices. I'm wondering, especially with the introduction of the APC system and all the changes in these first two or three years, if there would be any way to put data together that would help us clarify that. I think it's confusing to people that we make update

recommendations in the face of what appear to be significantly negative margins. If there are issues there, maybe part of our improvement in data would be to understand that better so we have a better sense of where we really are.

Also on the inpatient side -- and I may get over my head pretty quickly here, but my understanding is that as the DRGs are reweighted over the years that's done on charge to cost ratios, and that it's been some time since actual costs related to DRGs, there's been a study of that. I'm wondering whether in the universe of DRGs, since we're now introducing concepts such as covering the marginal cost of an individual DRG when we have transfer rule payment discussions, et cetera, whether at some point we should be looking at DRGs in terms of the actual margin around different individual DRGs. I raise this too because I think there are behaviors now, carve-out hospitals, et cetera, which may in fact be driven by realities of margins that aren't necessarily reflected in the way we look at inpatient DRGs.

Then lastly, on the cost report I'd just second some of what Pete said. In addition to more timely submission, are there changes in that that make sense? Are there non-allowed costs that should be looked at? The Commission may have discussed that in the past. I don't know. But that may be worthy of some attention as well. I know I just added to the list and prioritizing what's already there is an issue.

MR. HACKBARTH: I want to add my voice to those saying that this is really important stuff. But I also agree that if year after year we just produce a laundry list, that the impact won't be what we want it to be. Assume one of the principal audiences for this is CMS and HHS, and in fact I think they probably would agree with many of the items on the list. The reason these things aren't happening is not that there is not the desire there, but something else is missing, in some cases perhaps resources. So I'd second Bob's suggestion, to the extent that we can establish priorities and have some method for thinking about priorities, I think that adds to the power of any suggestions that we might offer.

In addition to that, to the extent that we can talk not just about needs but also about solutions, innovative solution, perhaps lower-cost solutions, I think that too adds to the power. In fact we may want to think in terms of having the needs according to some priorities and in each edition focus on one of the highest priority needs and try to bring together some really good thinking about how it might be solved in a way that's efficient and least burdensome to all involved. Just a list though isn't going to have much impact on anybody.

Thanks for taking this on. This is important stuff.