MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, September 12, 2002
10:14 a.m.*

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID 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.

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P R O C E E D I N G S

MR. HACKBARTH: Good morning, everybody, and welcome to our guests. We're kicking off a new cycle for MedPAC so most of our discussion over, in fact all of our discussion over the next two days will be preliminary and reviewing some old topics and opening some new doors.

We begin this morning with an old friend, our framework for assessing payment adequacy. And then that will be followed by a discussion on monitoring beneficiary access to care, which is a key issue in the same framework. Jack, will you lead the way?

MR. ASHBY: With this session we begin the annual process of developing our update recommendations, and those recommendations that generally comprise the bulk the material for our March report to Congress.

As we see in this first overhead, we are planning to develop recommendations for eight fee-for-service sectors this year. The first six that you see there are the same as we dealt with last year. And then we are going to try our hand at developing updates for two new sectors this year, hospice and ambulatory surgical center.

As most of you remember, last year we developed a

new system for assessing payment adequacy and updating payments. This year we're looking to refine that system to some degree. So this morning I'm going to be explaining how the system works and in the process discussing some of those potential refinements.

Then when you've had a chance to ask questions and discuss these methodological issues, Ann Marshall and Ariel Winter will be on to present some trends in fee-for-service spending across the sectors that we will be assessing.

As you see in this first schematic, our system calls for asking two basic questions and asking them sequentially. The first is is the current base rate too high or too low? Followed by how much will efficient providers' costs change in the next year? Each of these processes results in a percentage change factor, and then we simply sum the two percentage change factors to result in the update.

As you notice, in the last step before finalizing our recommendation, we will be comparing the figure that the model calls for to the update in current law. That's sort of a new addition to this outline of our process and we'll talk a little bit more about that later.

For the first part of the process, this is assessing the adequacy of current payments, this next schematic shows that we have three steps. In short, we're estimating where we are now, then assessing whether this is the right place to be, and then adjusting accordingly. So I'm going to walk through each of these three steps, returning to the list of market factors and policy factors that you see here as we go along.

So now we're in the first part of the process, assessing the adequacy of current payments, and looking at the first step in so doing, which is to estimate our current payments and costs.

We have to realize that the word current here is somewhat of a misnomer. Since we are recommending updates for the 2004 payment year, the current year refers to 2003 and the government fiscal year 2003 doesn't even start for two more weeks. So right off we are left with having to project out one year to find out where we stand.

Then if CMS' cost report data system is operating well, we would be forced to project for a second year because it takes a year to process the date. So we always have at least one additional year of lag.

But since the data system is backed up at the moment due to a raft of policy changes they've had to accommodate the last couple of years, we are in the position at least for this year, of having to project for a third year. So we have a three year lag between data that we have on hand and the so-called current year that we're trying to estimate.

Just as an aside, next year at this time the CMS people tell me that we should have picked up a year. So that in next year's process we will be projecting only two years rather than three. But that doesn't help us at the moment.

The last point here is that the analysis also takes into account other policy changes that are scheduled to be implemented in 2004. The idea here is to start with base figures that capture the effect of all policies that providers will be facing in 2004, except the update which is our subject decision. An example of a policy that is scheduled to go into effect in 2004 is the sunsetting of the hold harmless provision for small rural hospitals in the outpatient PPS.

In the next we look at the appropriateness of our

current cost. We, unfortunately, have no direct indicator of whether the cost basis is appropriate, whether it represents costs of efficient providers in the absolute. But we can at least look at the trend in cost per unit of output. All else being equal, we would expect the growth in cost per unit of output to approximate the growth in the market basket. But that expected rate of cost growth can be affected by product change, such as the major decline in length of stay that we experienced in the hospital sector over the last decade. When length of stay falls, we would expect growth in cost per unit of output to rise less than the market basket. How much, of course, is not an easy question, but at least this is the concept.

If we believed, in the end, that costs were too high or too low going into our assessment, we would probably want to adjust those costs before deciding whether payments are adequate relative to costs. The best example of this issue is actually from the past. Our predecessor commission, ProPAC, declared several years running during the late '80s and early '90s, that cost growth was essentially excessive and that consequently our update recommendations were not going to stay up with the rate of

cost growth.

This may be an issue that we'll want to examine this year, at least in the post-acute care sectors.

Then once we're comfortable with the cost base, the next step is to assess the relationship of payments to costs. And in doing this, we look at the market factors that we have listed here. As just one example, if we see a substantial increase in the number of providers, that may indicate that payments are too high. And conversely, if we see a substantial number of providers close or stop accepting Medicare patients, that may be an indicator that payments are too low.

Along with those market factors, we also have to consider this one policy factor: the target relationship of payments to cost. If we had a standard relationship here, expressed as a margin, it certainly would make our job easier. If we estimated a base margin that's above the standard, we'd know the payments are too high and vice versa. But after some considerable discussion, we've concluded that a fixed standard is not going to be feasible here.

For one thing, the appropriate relationship is a

function of the risk that provider face, and certainly that varies all over the map. It varies from provider to provider, by sector, and probably by sector over time.

Besides that, we have to remember that if we believe that these market factors that we just looked at do influence the adequacy of payments, then we have to be prepared to respond to evidence of changes in those factors.

So the bottom line is that we have no practical alternative but to have the Commission decide on the appropriate relationship of payments to cost, or a range in that relationship, one sector at a time and one year at a time.

The last step is to adjust current payments if we were to find that current payments were too high or too low. Usually this would take the form of a simple plus or minus percentage factor applicable to all hospitals. But it could well be combined with a distributional payment change, as was the case in at least three of our sectors last year, the hospital inpatient SNF and home health sectors all had recommendations that combined distributional changes with the update.

But just to clarify, if the distributional change

that we are contemplating will have no impact on overall payments, that is if it's being done budget neutral, then there's no point in muddying the waters by bringing it into our update discussion.

But if the distributional change would also increase or decrease the amount of money in the system, which is often the case, then it's really quite important that we do take it into account in developing our update, because it's the overall amount of money in the end that we're trying to make a decision about.

Moving to the second part of the process, accounting for provider's cost changes in the coming year. The most important factor here is the expected change in input prices which CMS measures and forecasts out to the payment year with a market basket index. The actual payment update will be based on that forecast, although the forecast that we have available to us now will not necessarily be the final one that determines payments next October.

But in addition to input price inflation, we also consider the impact of quality enhancing but cost increasing technology and we expect that at least part of the cost of that new technology can be offset through productivity

gains. And we may also consider the cost of one-time factors as we did with the 2000 computer problem.

Basically, the Commission has to decide whether it is appropriate to assume that the cost of technological advancement can be offset completely by productivity improvement. We may wish to do additional analytical work or to search out the research of others if we have reason to believe going in that we are looking at a situation where the impact of technology costs might be substantially different from what we can reasonably expect in the way of productivity improvement.

A special consideration we now have in accounting for cost changes in the coming year is the new technology pass-through payments which apply in both the hospital inpatient and outpatient sectors. Now these payments were intended to be temporary. They are to operate for two to three years while CMS collects data with which to permanently adjust the rates.

By law the pass-through payments are to be made budget neutrally. Actually, that wasn't done initially with the outpatient pass-through, but it's the way the law reads and as far as we know it's the way the pass-through are

going to be administered from here on out.

An important factor then is that this means that the extra payments that are going out for cases where these technologies are used will be offset by lower payments in all other cases. Because there, in the end, is no increase in overall payments, it remains necessary to account for the cost impact of new technology in our update framework. Basically, the same as always.

But we are left with a situation where the data from the pass-throughs, the unit cost and the utilization of all of these specific technologies, gives us data that we've never had before for doing our assessment. And that should, by all means, be useful in deciding whether the cost impact of new technology exceeds what we can reasonably expect with productivity growth. So we're going to make an attempt to use those data in that way this year.

Back in the initial schematic, we noted that before finalizing our recommendation we would consider current law. This begins with simply noting what the legislated update is for the payment year, and actually we have always done that. But we think that we also should be aware, as we make our decisions, and actually state in our

report, how spending under our recommendation would differ from spending under the current law provision.

That raises a host of questions about our approach for doing this, how we would estimate the impact, how we would coordinate with CBO and the like. We're going to take up some of those issues at a later meeting.

But finally, we think that we should also ask whether there's sufficient reason to change current law. For example, if our model suggested an update of market basket even and current law called for market basket minus a half or market basket minus one or something, is the current law level within the range of what we consider adequate payments? And as a consequence, is there sufficient reason to change what is in current law?

That approach may lead to stating our conclusions and recommendations relative to the current law. A statement such as current law provides an adequate payment increase, or perhaps something like current law is at the high end of our range of payment increases we believe would be adequate, or something along that line. We have occasionally expressed things in that form. It hasn't been our usual approach, and it's something that we might want to

consider as we go along.

The last issue that we wanted to cover is handling policy objectives other than our primary one, which is to ensure that Medicare payment rates cover efficient providers' unit costs.

In the current PPS', the best examples of payment provisions that pursue other objectives are first, a disproportionate share adjustment, which is designed to protect the financial viability of hospitals that treat low income patients. And second, the indirect medical education adjustment, supporting the activities of teaching hospitals through a portion of the IME that exceeds the measured effect of teaching.

A similar issue arises when other payers' rates differ substantially from the cost of treating their patients. A couple of very current examples are Medicaid paying well below cost for nursing facility services, and private payers paying unusually high rates to rural hospitals.

After some considerable discussion the Commission's outlook on this general issue is that other policy considerations should be essentially confined to

policies that affect the distribution of payments. And the implications of that statement are twofold. One is that our decision, the decisions that we have forthcoming in the next several meetings, are decisions about the overall payment adequacy, how much money should be in the system, should not consider other payer policies, particularly since responding to other payer's rates risks influencing their rate making.

But then secondly, the implication is that the funds for the IME and the DSH adjustment, or any other payment adjustment that pursues a different objective, must be included in overall payments as we assess payment adequacy.

So that's our system, and some of the things that we have in mind for operating a little bit differently this year. We probably want to open up discussion now on this, before we turn to the trends.

MR. HACKBARTH: Jack, I have a question about efficient providers. As you know the House passed a Medicare bill that has language saying that we should explicitly take into account efficient providers. And implicitly, if not explicitly, we had basically said, I think, that the efficient provider is the average. Because

we look at average margins as our indicator of financial performance, recognizing of course that there's a range around that average. Sometimes we look at the distribution and not just the average itself.

On what basis do we conclude that the average is efficient? Or maybe to put it in another way, you alluded to the fact that ProPAC, at an earlier point, had specifically reached the judgment that the average increase in at least some years was not efficient and therefore the update should not accommodate that.

How did ProPAC decide that the average was not efficient in those years?

MR. ASHBY: They basically did what I think we are stuck with doing, the best that can be done, and that is looking at the trend. We look at the rate of cost increase and if it differs from the market basket increase, which is what you would get if everything remains constant and we accommodate inflation in the items that providers must by, if the rate of increase is higher than that -- or for that matter, if it's lower, you sort of have to ask why.

Is there a justifiable reason for seeing costs growing at faster than what inflation would accommodate?

Then we have to look at the factors that we've talked about in our update system. Is there reason to believe that the growth in technology really needs to be higher?

There was once a question of whether wage inflation would be higher than in the market basket because of some problem in how the market basket was constructed. Various factors we can look at like that to attempt to explain why cost growth would be higher. But in the end, if we don't see any justifiable reason, then we have to conclude that we are getting into the territory where the average cost base is getting too large.

But I think that general approach is about all that we can really do.

MR. HACKBARTH: So basically we're assuming that in a system where there is an incentive to hold down your cost, you receive a financial reward for holding down your cost, and when you have a mature system that's been in place for a long time, you assume that everybody's trying to do as well as they can financially. And so the average is pretty efficient after a period of time.

MR. ASHBY: Right, in a competitive market in a situation where providers are under major pressures from all

payers, you would expect that situation to unfold.

DR. NEWHOUSE: I think your final question did hit the nail on the head in terms of the incentives, but I would just note there's a couple of conceptual problems with our language about efficient provider.

One is that there is some presumption of what the quality of services is. We now know that staffing ratios, for example, seem to correlate with the rate of errors. Well, that means that I can be efficient given some rate of errors or given some staffing ratio, but what do I want? Rolls Royce may be efficient at producing Rolls Royces, but maybe I don't want to pay for a Rolls Royce.

The second issue, I think, about using the average, implicit in some people's use of that anyway may be that there are some people that are more efficient than the average. And if we're really serious about paying for the efficient provider, then we should be looking at somebody that's lower cost than the average.

The corollary to that is if we pay less than the average, we risk putting people out of business, which we may want to do, particularly since the average that we're looking at is the national average and implicitly we're

operating in a great many local markets. If we're really serious about the efficient providers, really the efficient provider in that local market, but the system isn't set up in a way that easily accounts for local price variation.

So I think we are back to where you ended up, that the inherent incentives in the system are what we rely on here.

MR. MULLER: Jack, have we looked back over a reasonable period, three or five years, to see how the cost increases and the volume increases and maybe the residual in which you can throw a lot of things like technology and so forth, have compared to our estimates, to get a sense of how well our estimates or anybody else's estimates actually come to what is seen as the cost increase after the year of the buy increase?

I know that in the tables we have here, where we looked at the expenditure increase -- I think it's just being a little bit below nine for the 2001 year -- we said we weren't able yet to kind of parse that out and see how much of that was volume and how much of that was cost and other factors.

Is that something that we do routinely, where we

look at a multi-year period to see how we come up against --

MR. ASHBY: Absolutely we do, and the hospital sector in particular we have, in general, been looking back about 10 years or so because of the major transformation in the system that's occurred over that period. But keep in mind that when we look at spending information, and you talk about the 9 percent increase, that includes volume and this is a per case or per unit of output system.

So generally, we're looking at the rate of increase in per unit costs and the rate of increase in payments per unit. And the payments and the costs per unit are generally what we're looking at with our margin, for example. So when we look at these trends, even in the margin over time, that's what you're looking at is whether the payment increases have stayed up with the cost increases.

MR. MULLER: I understand that fully. But obviously when volume is changed in any dramatic way, either up or down, it has an effect on expenditures. And some people tend to confuse that with being cost increases. So to the extent to which one can point out -- in fact, one can hypothesize that costs may go up one and volume goes up

seven. And then people don't differentiate that very well.

So I think the fact that -- one of the implications of the technology breakthroughs that everybody is worried about what they cost, is also there are many more opportunities now to do interventions than there were prior to those technologies. So that leads them to more and more activity increased. And that's one of the reasons I'm interesting in seeing how much of the technology gets played out, in terms of activity increases, versus just in terms of cost increases per unit.

The aggregate of activity, I think, becomes substantially important in addition to the individual per case.

MR. ASHBY: Absolutely. It's certainly part of the landscape and, as we said when we listed our factors we're looking at, volume changes are indeed one of them. So we do want to consider it. But in the end, this is a per unit payment system and we need to look and track per unit costs, as well. And then we get into the larger picture which we need to keep in mind, as you're saying.

DR. REISCHAUER: It seems to me futile to look back and ask whether we've been right or wrong because in

the end the provider will adapt to whatever payments they have to produce a service, and they will adapt by changing the quality, changing staffing ratios, whatever you have. So unless you are going to look very carefully at some kind of qualitative measures or changes in the way inputs are put together, you're never going to get really definitive ability to say yes, we hit the nail on the head or we were in the neighborhood of the nail even.

Maybe, over a long period of time, what we want to do is try and develop more measures or indicators of qualitative change.

I have another comment which is disassociated with that one, that has to do with technology. If I understand this correctly, the distribution among providers, hospitals in this case, is budget neutral.

MR. ASHBY: You're referring to the technology pass-through payments? Yes.

DR. REISCHAUER: Pass-throughs. But we are including it in our analysis. And so in the great schemes of things, it's not budget neutral.

MR. ASHBY: All I was trying to do is to remind people that since it's budget neutral, the system does not

provide funding for new technology. And I think that's a misconception that a lot of people --

DR. REISCHAUER: But on the other hand we have provided it in our mechanism here.

MR. ASHBY: Right.

DR. REISCHAUER: So in a funny way the distribution isn't but the system is. I'm sort of wondering, are we schizophrenic here?

MR. HACKBARTH: It almost seems like if Congress has explicitly said that the pass-through must be budget neutral, to them, in a separate part of our analysis, our framework, say there should be an increase for new technology that is or is not partially offset by productivity. It just seems schizophrenic. It seems illogical and inconsistent to do it that way.

If we're going to have budget neutral technology, let's do it. If we're not, let's not. But to do different things in two parts of the analysis is odd.

MR. ASHBY: But I think the way to understand it, the key to understanding it is that the system that we work with here, and what we've been doing for years, is dealing with the level of payments. Pass-through payments are

dealing with the distribution of payments. The level and the distribution are always two different things, but they tend to interact, causing us lots of nightmares and confusion.

But I think that we can see the potential benefit of distributing payments correctly here. Those providers that have to bear the cost of the new technology need to be paid appropriately for their cases. And so you can see the advantage of that.

But it's just that that, in and of itself, doesn't do anything to address the question of whether we've provided adequate funding for all of the new technology and everything else providers have to pay for.

DR. REISCHAUER: Forgetting about the latter, the budget neutrality, in a sense, guarantees in the distribution that we pay nobody correctly because what we've done is we've said hospital A uses new technology and it costs $100 extra. Hospital B doesn't. So we'll create this pass-through payment and then reduce everybody's payment by 9 percent. And so we're underpaying one and overpaying the other.

MR. ASHBY: I think you're correct in saying that.

If we were confident --

DR. REISCHAUER: But then we're jacking up the total which would overcome this and make the payments wrong in another direction. And it strikes me that the logic -- I mean, to get ourselves out of the schizophrenic position we're in, what we should say is there's a chunk of things that we've identified for pass-throughs, and they're over here. But there's a whole lot else that's going on in the way of technological improvement. And that component should be what we are making this aggregate adjustment for.

MR. ASHBY: We could do that. If we didn't make it budget neutral and we just let payments increase with the new tech things then, as you say, all we would need to accommodate in our update is the impact of anything else that is not captured by the tech pass-through. For example, information systems would not, by definition, be captured by the tech pass-through.

MR. HACKBARTH: It would be helpful to me, if we were to go down that path if we would clarify what is technology A and what is technology B. What's covered by the pass-through versus what isn't covered by the pass-through. I don't know what's in the two categories.

MR. ASHBY: In generic terms it's limited to patient care applications. So as we say, by definition, it's going to exclude information systems. And it is limited to major new technologies. It has to meet a threshold. But you always have the suspicion that there's a lot of small ticket stuff going on, too, that certainly can have its impact. So those are the two major ways that you are carving out a segment of the costs.

MR. HACKBARTH: Logically, if those are no longer included under our traditional S&TA adjustment, presumably that number should be lower than it has been historically.

MR. ASHBY: Right.

MR. HACKBARTH: What we've assumed it to be historically.

MR. ASHBY: Right. I think implicitly, what you could suggest is going on here is that we know that these technology pass-through payments, as a measure of the cost of new technology, are questionable at best. I mean, there are several different factors one could site that affect the accuracy of these payments.

So by making the system budget neutral, what Congress is really saying is that we're going to make sure

that the level of payments is not distorted. If there's going to be any distortion, it's going to be on the distribution because they may overdo it on some things, which means that somebody else is going to be underdone.

MR. MULLER: But to go back to Bob's point, at the macro level we say that the productivity enhancement offsets the technology improvements, so it has a distributional aspect that you and Jack are talking about if it doesn't have an overall spending effect because we offset it on the analysis of the productivity adjustment; correct? The new technology.

DR. REISCHAUER: The question is, compared to what? If we had no cost-increasing technology change, we would expect not to give a full update. Or else we would be fattening the margins of providers. And so I think you want to compare it to that as the counterfactual.

MR. MULLER: But I'm just saying we just make an explicit assumption that technology equals productivity, don't we? We make the assumption that technology equals productivity.

MR. ASHBY: We can make that assumption.

MR. MULLER: We do make that assumption.

DR. REISCHAUER: We do that as a bow to our ignorance with respect to both of these factors, but imagine that we collect more data and there's more information on these pass-throughs, and five years from now we really have much better estimates for what? The cost increasing impact of technology is or much better estimates of productivity in the medical center is, and we find that these are different. One is .3 and the other is .9.

MR. MULLER: No, I assume they are quite different. I assume for the purpose of analysis we equate them, but I would assume that they are quite different. I don't have any evidence, aside from watching it for a while.

That's why I was asking about the activity increase earlier, because I think one of the ways in which you really see the technology hitting is through activity, not necessarily always through price. Because there are just more and more kinds of interventions that are possible to populations that weren't affected before.

DR. NEWHOUSE: Ralph, remember some of that will get picked up in the payment system because there will be a DRG code and there will be more admissions or procedures for that purpose, and there will be more payments without an

adjustment in the update factor.

MR. ASHBY: I wonder if I can make a point to extend what Ralph is saying? And that is that I think the general picture is that on the hospital inpatient side, generally speaking, the new technology that is covered by the pass-throughs is not going to add additional activity in the form of cases. These are items that are used in producing these cases.

On the outpatient side, what you're saying absolutely prevails. That generally the new technology is going to produce new units of service and Medicare is paying for it. That means that how we treat the cost impact of technology may very well need to be different for inpatient payments than outpatient payments. And that's why we should not go around blithely saying that we're going to assume that the cost impact of technology will be offset by productivity, because it may or may not, depending on how this plays out.

MR. DeBUSK: What happens in this scenario? A lot of the new technology, the implants and what have you, certainly the manufacturers are going after the surgery center, the outpatient market. When you have a product

that's being used in a hospital on a DRG basis, now with some new technology you can take it to an outpatient basis. And you reallocate the dollars to go with the activity on an outpatient basis and it's budget neutral. What does that do to the base dollars for the surgical procedures in the hospital? It's going to decrease them substantially as time goes along, right?

MR. ASHBY: Hospital inpatient you mean?

MR. DeBUSK: Yes.

MR. ASHBY: I don't know that there can be any fixed answer to that.

DR. NEWHOUSE: You mean the quantity or the price?

MR. DeBUSK: Price. I'm not talking about quantity. I'm talking about price because if you're budget neutral, those dollars are going to come from someplace.

DR. NEWHOUSE: Not from that DRG. That's based on what's left in the hospital.

MR. DeBUSK: On what's left in the hospital. Yes, but the other procedures, budget neutral, it's going to come out of that whole market.

DR. NEWHOUSE: No, I mean what's left of that procedure in the hospital. If the whole thing shifts out of

the hospital then it will just disappear.

MR. ASHBY: We do have to clarify, Pete, that budget neutral only means with respect to a given PPS, such as the outpatient PPS. It's not budget neutral for the entire enterprise worth of payments.

MR. DeBUSK: I understand.

MR. HACKBARTH: Jack, could I go back to the efficient provider discussion for a second? Bob made the observation that over time at least hospitals or other providers have to accommodate themselves to the payment level. And so if the payment levels are held way down, they need to adjust the services they provide or cost structure. And as Joe pointed out, that could include a change in the quality of the ultimate product.

If we look back at the historical pattern in hospital margins under PPS, we see peaks and valleys, some periods of very high margins, at least one of significantly lower margins. Has anybody ever looked back at that historical pattern and analyzed what hospitals did to accommodate themselves to those lower payment levels in the late 1980s when the average margin was quite low?

DR. NEWHOUSE: They upped their rate to private

payers.

MR. HACKBARTH: Clearly, that was one thing that they did.

MR. ASHBY: First and foremost was to do that.

MR. HACKBARTH: But what about in terms of their cost structures?

MR. ASHBY: Second and foremost was to reduce length of stay and whether that was occurring with --

MR. HACKBARTH: What about staffing in particular?

MR. ASHBY: There's certainly evidence that there were some reductions in staff levels and other things that one might really call efficiency improvements if we had some notion that quality was constant, which we generally don't. But there was indeed some evidence that there was cost cutting going on in addition to the effects of length of stay reduction.

We don't have good measures of staffing ratios, but the cost data certainly would lead one to suggest that there probably were some reductions going on.

MR. HACKBARTH: In my little world in Boston at the time, and I don't know how representative it was even of Boston let alone the rest of the United States, but there

was a period of very contentious relationships between the hospital administration -- at a hospital that shall remain nameless -- and the nursing staff in terms of the conditions of work, the nursing ratios and the use of non-RNs to take over some of the tasks, et cetera.

Now subsequent research has shown that in fact there is a relationship between those ratios and the ultimate quality of care produced. If what was happening in my little piece of the world was representative of the larger world, maybe there were some quality issues then, some things happening in response to low margins that were reducing the quality of care offered.

Has anybody tried to look systematically at that?

MR. ASHBY: We have not.

MR. MULLER: The reference Joe made earlier to some of the recent analyses on staffing, and there was -- interestingly enough, about two weeks -- a new article in the British Medical Journal on staff turnover in nursing in British hospitals, where it was up to 38 percent, and having at a very crude level consequences on quality, which is pretty intuitive but also now seen in the outcomes data.

So I think, in retrospect, the notion that one

could dramatically hold down staffing increases for a while, as a result of these cost pressures, and have no effect on quality, at those times people were suspicious that those hospitals could become that efficient overnight. And in retrospect, it seems as if it did have some effect on quality by doing so.

Whether one can afford to pay for all the things that people want is a question that we debate all the time. But the notion that you can just hold down staff due to cost pressures and have no effect on quality, I think in retrospect, seems to be quite suspect.

DR. REISCHAUER: This is on a different part of this. This is on the issue of including DSH payments when we evaluate payment adequacy. I guess my question is what the legislative intent of the DSH payments in Medicare are. I mean, are they to compensate for the excess costs associated with elderly and disabled patients? Or with the hospitals overall problem with respect to treating low income and underinsured patients?

Because if it's the latter, then there's an inconsistency with the way we're treating it. Because what we're saying is let's look at your payments, add in DSH, and

then compare them to Medicare costs and get the Medicare margin. And if that's just right for DSH hospitals, then the payment is adequate.

But of course, it's leaving nothing for this larger social purpose, if the large social purpose includes helping the hospital deal with low income patients in general. And if that's the case, then you might want to see margins in those hospitals, which get DSH payments -- Medicare margins, not total margins, Medicare margins -- higher than the average for the others. And of course you do, I know.

MR. ASHBY: Actually the other way that you can express that is that the hospitals that receive the DSH payments, if you look at them as a group, absolutely, they get more than an adequate payment for the cost of their care. So that the concern is the relationship for the hospitals that don't get the DSH payments. It is a distributional matter and so one might argue that there is some underfunding for that group of hospitals relative to efficient costs of care.

But that's what we buy into when we use this mechanism for distributing part of our payments. And no one

ever suggested that we were adding in this additional amount of money into the system on top of what it would cost to provide care to patients. So I think that's kind of what we're stuck with, unless we want to recommend changing it.

MR. MULLER: But I think you just granted that Bob's second point was accurate, that these payments are -- not for Medicare patients, but for other patients. You just said that, right?

MR. ASHBY: Yes, but I didn't just make that up.

MR. MULLER: That's the law.

MR. ASHBY: It's not only in the law, but it is what the Commission has said in the past, as well, is that we believe that the purpose of this is to maintain access to care and to protect financial viability of hospitals that incur these revenue losses. Not extra costs, but essentially revenue losses.

MR. HACKBARTH: We should probably move on to the next piece of this. Carol, do you want to have the last word?

MS. RAPHAEL: Yes, I just have a question; something that would help me. I understand that we are in a very primitive state in regard to understanding

productivity. But it would be helpful if we could just have a little amplification as to how we currently think about productivity in each of these sectors.

MR. ASHBY: That's definitely a hot seat question.

MS. RAPHAEL: Then I'm glad I have the last question here. We don't want to let Jack off too easy.

MR. ASHBY: Let me just say this, we have attempted in the past to measure the trend in productivity and we had repeated difficulties with it, much of which really centers around the fact that to really say you are measuring the productivity or the change in productivity, you really have to know that you're holding the quality of care constant and there's virtually no way to do that. So the measurement process is extremely difficult and I don't know that I feel very optimistic about our ability to do that.

So in essence, what we have been doing, I think in all of the sectors, is saying that we want to expect a certain minimal growth in productivity and we're making that statement of expectation without regard to any measurement of what's been happening in those sectors. It's really just sort of establishing a standard. And the closest we've

gotten to developing that standard in some quantitative way is to look at the change in productivity in the general economy. And we observed that, for total factor productivity, which as we talked about earlier we think is the right way to look at it, that the change is, at best, in the neighborhood of about .5 percent per year, in terms of our long-term trend in the economy. Now it changes a little bit from year to year, but not a great amount. That's generally what we're looking at.

But is that the right level for home health agencies or whatever? We really have no way to make that translation. We just have to establish our policy.

MR. HACKBARTH: The good news is we'll have many more opportunities to discuss these issues in the coming months. Right now we need to move on to the next piece of this presentation on trends in Medicare spending. Because we started a little bit late and ran over a little bit in the first part, we'll need to go through this fairly quickly.

MS. MARSHALL: Good morning. It's important to consider the payment adequacy framework that Jack has just discussed in the context of current payment levels and

recent trends. Of course, the given level or trend does not itself tell you whether a payment increase or decrease is appropriate. However, this information should help you to understand at least three things.

First, the proportional impact of a proposed update. For instance, a small change in inpatient payment rates affects a large proportion of total outlays, whereas a large change in a sector such as dialysis affects a relatively small portion of total outlays.

Secondly, trends highlight how growth in one sector compares to growth in other sectors. Growth or decline in different settings may be related. For instance, distributional changes, as you know, may reflect substitution among settings.

And finally, large spending changes in any one setting may signal a problem with payment adequacy in that setting.

Today we're presenting data on total fee-for-service Medicare payments, including both program cash outlays and beneficiary cost-sharing. We've divided the payments into the eight sectors that Jack and others will be examining, in terms of payment adequacy.

Out of a total of $240 billion in Medicare fee-for-service payments in 2001, by far the largest component, 43 percent, was hospital inpatient payments. This was followed by physician payments at 23 percent, and hospital outpatient department at 8 percent. Post-acute care, including skilled nursing facility and home health, accounted for 11 percent. These proportions have remained roughly constant over the last five years, with the exception of home health which has fallen from 8.5 percent to 4.4 percent.

Over the longer term, however, we have seen tremendous shifts, for instance from inpatient to outpatient and post-acute settings. In 1980, inpatient dollars accounted for 68 percent of payments compared to the 43 percent seen here. Hospital outpatient was 5 percent compared to the 8 percent here in 2001. Home health and skilled nursing facility combined for 4 percent compared to the 11 percent seen here in 2001.

Interestingly, physician services have remained relatively stable at 24 percent in 1980 and 23 percent in 2001.

For the period 1996 to 2001, the past five year

trend, total Medicare fee-for-service payments grew at an annual rate of 3 percent. Of particular note are hospice and ambulatory surgical centers which saw significant average annual increases while home health experienced a significant decline.

Some year-to-year fluctuation is not reflected in this table. For instance, the BBA caused total fee-for-service payments to fall slightly in 1998 by approximately 3 percent. However, by 2001, payments increased at 12 percent growth, primarily due to BIPA and BBRA provisions and a shift of Medicare+Choice enrollees into fee-for-service.

In fact, this 3 percent average annual increase for this five year period is an anomaly and it's important to know that growth rates are historically been much higher and are projected to be higher in the future, as this next slide shows.

This longer term trend reveals a historical 10 percent average annual increase for the period 1985 to 1997 after early PPS implementations and prior to BBA implementation.

The trend reflects increases in payments pre-BBA until 1997 with flatter growth rates post-BBA until year

2001. And then around 2001, payment rates increase again and are projected to increase at an average annual rate of approximately 6 percent between 2002 and 2011.

Of course, it should be noted that these rates of change -- this has already been discussed this morning -- reflect a host of underlying dynamics such as changes in volume, price, and intensity of services. These other factors and their implications for payment adequacy, access to care, and quality of care will be discussed over the next months by MedPAC staff. In our background materials at Tab C, staff have summarized key payment adequacy issues they will address in this regard this year.

In conclusion, to provide commissioners greater context in which to consider their recommendations, in future meetings, staff will review additional spending and budgetary information. This will consist of Medicare expenditures compared to national health expenditures, private payer premiums, and other government health program spending such as Medicaid, information on health care spending and trends including projections from sources such as OMB, CBO, and the Medicare trustees report, budgetary surplus or deficit projections, and underlying demographic

trends that impact spending, such as an aging population.

Thank you and we welcome any questions or comments.

MS. ROSENBLATT: I think looking at these trends is great and I think one of the comments you made is really important, that you're going to try to disaggregate the trends so that you're looking at cost trend, utilization trend, demographic trends.

But one of the things I'd like to see is looking at trends on a per beneficiary basis, as well as just straight dollars.

DR. REISCHAUER: Just a footnote on that, what's striking about that second chart is that this is just fee-for-service and so you obviously have the overall growth in the Medicare population, which is something around 1 percent. And then you have the shift of people from Medicare+Choice into fee-for-service.

So you probably, on a per participant, could lop almost 2 percentage points off of these numbers, which suggests that over the last five years, in some categories, that they've been basically flat.

And these are nominal dollars?

MS. MARSHALL: Yes.

DR. REISCHAUER: So in real dollars you've seen probably a decline in many of the areas.

MR. HACKBARTH: With a recent acceleration.

DR. NEWHOUSE: That was the intent of BBA, given where we were in '96.

MR. HACKBARTH: The 6 percent per year increase that's in the projection going forward, that of course presumes current law, which in turn assumes that we will cut physician fees by a very large sum over the next few years, and some other features of current law that may or may not be sustainable.

So if you mentally add those things back in, then the rate of increase projected going forward is now substantial. So we have this period where rapid increase, then this decline, and then rapid increase again.

MS. ROSENBLATT: Just one other point on that disaggregation. The trustees' report disaggregates a lot of the trends into cost versus utilization and various aspects of utilization. I think it might provide a very good way of looking at how you might want to look at trends, as well.

MR. HACKBARTH: Any other questions or comments on

this?

MR. DURENBERGER: Just one and that is, looking at this from a beneficiary standpoint, rather than the money to providers, I would find it interesting to know more about the cost rise in Medigap, Medicare, Medicare Supplemental, all that sort of thing. Because I assume somewhere in the future there's policy changes that would be much more appropriate if we look at that particular area where people are currently spending their money, and what are they getting for their money. I don't know if that's the charge here, but I wanted to add that.

MR. HACKBARTH: I can't remember if we had data on that in our June report. I believe we did have data on -- so we can pull that out pretty easily for you.

Any other questions or comments about the spending trends?

Next up we have Karen talking about the overall subject of monitoring access to care, which again is a critical component of our payment adequacy framework that we have not focused a lot of attention on in the past. It's one leg of the stool that we need to develop going forward. It's not enough just to look at the financial results. We

also need to look at access to care, and at some point hopefully the quality of care, as well.

This afternoon we will have some subsequent presentations specifically about one of our currently hot issues in the access area, and that's access to physician services in the wake of recent changes in payment policy.

So Karen and Jill will introduce the broader subject.

MS. MILGATE: Thank you, Glenn. First I wanted to acknowledge four other members of our team who you don't see at the table, who provided valuable insights and analysis, both for the background paper and our work in this area. And that would be Kevin and, of course, his expertise in physician care, Chantal, Marian and Ann Marshall.

This really is a continuation of the retreat discussion which we had on access, where you expressed interest in developing an ongoing monitoring system to identify and evaluate beneficiary access. And then, as a first step to developing that system, charged staff with going back and providing more information on the three primary sources of information on access. Those would be utilization and other types of administrative data,

beneficiary reported information, and then also provider reported information.

And in the background paper which we mailed to you a few weeks ago, it included a discussion of each type, as well as some analysis of their limitation and suggestions for additional sources, and also included an appendix which told you basically what we already use, primarily for update purposes, the information we already use on access.

So today we're providing you an update on our progress and asking for some feedback on some priorities that we'd like to set in this area.

Before we begin though it's important to note that monitoring beneficiary access to care is really only a first step in a policy analysis on access. Sometimes, and perhaps oftentimes, beneficiary access problems will not be determined by Medicare policy, either payment or otherwise. There's many other reasons why beneficiaries may experience access problems. So in addition to identifying problems, we're also going to be faced with questions about whether it's appropriate to use Medicare payment policy or other policies to actually address those issues.

Having said that, our goals for today are really

to obtain your feedback on priority issues and then priority data sources and analyses. In terms of issues we'd like feedback on, specific settings where you think that more analysis may be needed related to payment policy, and also other broader issues where access might be affected by beneficiary characteristics, such as where they live or other program policies other than payment that may affect beneficiary access.

However, based on the retreat discussion and our subsequent analysis to date, later in the presentation we will propose some priorities for you in each of these areas for your discussion.

So why are we talking about creating an ongoing monitoring system for access at this point in time? MedPAC and its predecessor commissions have always used information on access. PPRC really started off doing some very good analysis because they wanted to look at the impact of the physician fee schedule implementation on access. We used access information, as Glenn noted, for payment updates. And we've also used some information on broader access issues, most recently in the benefit report that we issued in June. We talked about some access issues as well as last

year's June report on rural health care, we talked about access to health care in rural areas.

However, we think there are several reasons why this is a good time to evaluate our current monitoring efforts. The first reason is that there have been significant number of payment policy changes in the last few years, and it's important to monitor whether these changes may have had an impact on access. In addition, as the last presentation actually kind of set us up for, we know that there is going to be an increase in the number of beneficiaries, which will be coupled with an increase in the number of services and intensity and complexity of those services that are available to beneficiaries. So this dual whammy of the supply and demand of services going up at the same time will create tremendous cost pressure on the program.

In addition, we do have broad national data on access. However, those data sources are often not timely enough to provide us information that will be useful to Congress, particularly when they're asking about the impact of payment policy changes on access. They are often two or three years old, which doesn't give us quite timely enough

data.

Those same datasets often don't allow us the ability to drill down into geographic hot spots or to identify problems for specific services or types of services.

Thirdly, there are some newly available data that we think might provide us some more useful information on access. Two examples there would be the consumer assessment of health plans survey, which was originally designed to monitor access and quality to Medicare+Choice plans. However, CMS has now fielded that to fee-for-service beneficiaries as well. It's actually a huge database of 200,000 to 250,000 beneficiaries, which we're trying to see if, in fact, we could analyze some of those data.

In addition, another thing CMS has started to do is to develop a more timely analysis of physician utilization data, which we think would also provide us more information on access.

To provide structure to this very broad topic, we've broken access into three dimensions and have found that asking these three questions helped us to summarize access concerns. These aren't clearly differentiated. All

three of them overlap with each other. And the third one, whether beneficiaries obtain the right care, clearly interacts often with measures of quality of care, as well. However, we did find that asking these three questions generally got at most access issues.

So are there enough providers? This is basically a capacity issue. Clearly, it's very difficult to answer this question because we don't know the appropriate ratio between providers and beneficiaries. It's different for each speciality. It's different for each local. It's probably at least as important as anything. Given what other types of providers are in that area you may have very different ratios, depending upon where a beneficiary lives.

All that aside, we can still look at trends. We can look at changes in the supply. These are some of the same factors you saw Jack mention when we look at access for payment adequacy. We can look at the entry and exit of providers. And one other new type of measure we may want to look at would be staff vacancies, for example for nurses or clinical pharmacists, to get a sense of if there's actually practitioners at a deeper level than just physicians.

Even if there are enough providers there may be,

in fact, other barriers for beneficiaries to obtain the services. So the second question tries to get some sense of whether beneficiaries are actually obtaining services. Indicators here include the number of patients by a particular setting, number of services delivered, and so basic utilization data.

And then there's also information that can be gleaned from beneficiary and provider surveys. From beneficiaries you can ask, for example, if they're delaying or not obtaining needed care. And providers can also give you a sense of their perception of Medicare as a payer.

The third question, whether beneficiaries obtain the right care, is necessary because often beneficiaries can obtain services but they aren't getting services in either the right setting, with the right practitioner, or else getting the right services in those settings.

For example, if a diabetic is getting care through a hospital admission, you might suggest that the diabetic actually got care. But clearly, it would be more appropriate if they received that care before they had to get to a state where they were admitted to a hospital through ambulatory care.

There are various datasets that try to use those types of indicators. That's what's called actually an ambulatory-sensitive condition, and there are several of those, where you would look at hospital admission rates to see if, in fact, there might be some access problems to settings outside of the hospital.

So what are the purposes that MedPAC needs these data for? There's really two. One is to assess whether payment levels and types are appropriate to ensure beneficiary access. This we do routinely through looking at the payment update process, but there are also broader payment policies that we might look at. For example, there may be a need to analyze payment policies that encourage beneficiaries to use certain services in one setting versus another to determine if, in fact, that may create access barriers for beneficiaries to receive services in a more appropriate setting.

And then there are broader access barriers to look at, as well, which include whether beneficiary characteristics such as where they live, other types of variables such as race, age, or income, or whether they have supplemental insurance or do not have supplemental insurance

may affect whether they have access to care.

Another access barrier could be considered program policies other than payment. For example, some physicians have said that they might drop out of the program because of some of the paperwork burden or fear of fraud and abuse investigations. So that might be another thing that MedPAC might want to look at in looking at barriers to access.

The next three slides are just a summary of what we found in looking at the three different data sources, both advantages and disadvantages in certain types of data that you find in each of these sources.

First is utilization and other types of administrative data. Examples in this area are claims enrollment and participation files, discharge abstracts, and what we've called health care use data series. In there we're referring to -- it's NCHS, the National Center for Health Statistics, analysis where they combine administrative data with survey data, with other data like vital and health statistics and do various analyses looking at trends in health care. Those are not focused solely on Medicare, however they do have breakdowns by age which could be useful for us.

The advantages of these type of data are they're routinely collected and often extensive. So that means that their results are generally valid. And they're lower cost to collect. They may not be lower cost to analyze, but they're no added cost to the system to actually collect the data. Disadvantages, however, is they aren't targeted to our policy questions because they were intended for a different purpose.

We've listed here some of the types of analyses that have been developed using these data. The ACE-PRO indicators is something that was developed, actually I think at the behest of the PPRC, which basically looks at whether care that's been provided is necessary -- whether the necessary care has been provided. It identifies beneficiaries with particular conditions and then sees if, in fact, they've gotten the right care.

I won't go into details of the other indicators.

The second source of information that we looked at was provider-centered information. Examples in this category include the MedPAC survey, which you'll hear more about this afternoon, which was developed to provide quick turnaround and focused information on physicians. This was

developed, in fact, in response to needing more timely information on the results of the payment changes for physicians.

The Center for Studying Health System Change survey, which was also included in your background materials and was on physicians and professional organization physician surveys. For example, the AMA and the American Academy of Family Physicians surveys physicians to determine their perception of Medicare as a payer.

In addition, other sources are the OIG survey on discharge planners, which looked at access to care for SNF and home health. And then MedPAC is also planning on doing a focus group of discharge planners for somewhat the same reasons as the OIG survey, to get a sense of whether discharge planners were finding it difficult to place beneficiaries in home health or SNF. And in fact, one of the reasons we decided to do that was that the OIG wasn't planning on doing their survey this year. So it was a sense that we needed to have the data before the OIG was actually going to do their survey.

The advantages of these type of data are they identify provider-centered access barriers. They can be

more timely. And often you can go into more in-depth analysis to actually identify the reasons for the access problems.

Disadvantages of this data collection is that they're expensive to administer and often they have low response rates, particularly to the surveys. In addition, these less formal forms of this type of information, clearly the broad surveys would not be included in that category, do provide more in-depth analysis but are not often generalizable because they often involve pretty small sample sizes.

The third type of information that MedPAC can use to monitor access is beneficiary-centered information. Examples of this are the Medicare current beneficiary survey, and that's one of the primary ways of looking at access that we have today that has 17,000 beneficiaries in its access to care file.

As I mentioned before, I think a promising new source may be the consumer assessment of health plans survey that's applied to the fee-for-service program, primarily because it has such a large sample of, as I said, 200,000 to 250,000 beneficiaries. And it actually has questions that

are at least as detailed as the Medicare current beneficiary survey, and even provides some specific information on access to hospitals and specialist, which I think are probably more specific than the questions in the MCBS.

Two other additional sources that are beneficiary surveys are the national health interview survey which looks at health status, and then the medical expenditure panel survey which provides very useful information on utilization and reasons for access problems but is a pretty small sample. The last one, in 1997, had 3,700 people over 65. So it's a fairly small sample size.

The advantages of these type of data are it's a direct measure of beneficiary perspective, and it can provide some information on beneficiary characteristics that may drive access problems. One of the primary disadvantages is really that most of these surveys are not targeted at Medicare. However, the MCBS and CAHPS are, so we're looking at exploring, as I said before, the CAHPS further.

The other disadvantage, which isn't listed here, is they give you some general access information, but none of the surveys really focus on individual settings in any great detail. While it might be difficult to create a

survey that would focus on individual settings, it really provides us general access information. So it's hard sometimes to use it for anything other than say physician care, because that's a type of care that's more broad.

The next two slides are really our proposals for the issues we should focus on and the additional data analysis we might want to do.

After listening to the retreat discussion, and through subsequent analysis of these various data sources, we've identified several priority issues and analyses. Clearly, evaluating access to feed into analysis of payment updates is always going to be a priority for MedPAC, so we're assuming that work will always go on. However, this year we're taking a particular close look at care in two settings. That would be physician care and post-acute care.

In the area of physician care, we're looking at basically all the sources I just spoke of in terms of information that will come directly from physicians. That would be MedPAC's own survey, the center for studying health system change survey, the professional organization surveys, as well as the latest survey data from the Medicare current beneficiary survey.

In addition, we are going to be looking at CMS data on the number of physicians that bill the program, so it won't be looking at those that say they participate or not, but actually those that do bill CMS. And then another potential indicator of access, which you'll be hearing a little bit more about this afternoon, is looking at the differences between private payment and Medicare payment to see if the level of payment may, in some way, create a barrier to access to physician care.

For post-acute care, we'll be looking at the entry and exit of home health and SNF in the market, number of patients that are seen by these types of providers, occupancy rates. And the new analysis I described previously was that we'll be doing a focus group of discharge planners to get a sense of whether they are having difficulty placing patients in home health or SNF, and some of the reasons why they think they may be having difficulty placing them.

In terms of broader analysis on access, the two analyses that we're suggesting that we perform are to look more closely at beneficiary characteristics that might affect access to care. And while some of these have been

looked at before, we think that it would be a good idea to look at them more comprehensively than MedPAC has in the last couple of years. We've looked at pieces of this in our benefits report in June, and also in the rural report, but I think it's really been since 1998 that we've put all these pieces together.

And something new we'd like to look at is more about the interaction between the various socioeconomic factors. So the factors that we would look at would include race, age, income, health status, and we would get a sense of how these factors actually interact to create barriers to access.

The second analyses we suggest is that we look at emergency department trends. So it's really a place of service. While we wouldn't be looking at necessary access to emergency departments, because the consequences of inappropriate access in other settings are often seen in the types of people and the types of conditions that present in the emergency department, we think that looking at trends in use in the emergency department might give us more information on the types of access issues that people might be experiencing in other settings of care.

Access has always been difficult to measure. It is multi-dimensional. As I said before, there is no standard for appropriate access. And how and what questions are asked often lead to very different answers. Therefore, we propose to expand the range of sources we look at as well as to explore new data sources to make sure that we're getting enough information from enough different angles to be able to get a clear picture of what access problems do exist.

So these are the range of sources that we were talking about looking at on a more routine basis. They include the consumer assessment of health plan survey for fee-for-service, more of the NCHS data which gives us some information on trends in certain settings, the new CMS utilization data on physicians, and then to perhaps look at provider participation files or other information on the supply of providers to really look at that on a routine basis to see what kind of changes in the types of settings are occurring over time in Medicare.

The new data sources that we're suggesting that we should expand into are less formal and more timely data gathering through focus groups, polling, and targeted

interviews. While these are not the most valid data sources, we think they're at least a step up from anecdotes and would provide us some more information on how to focus further analysis on access problems.

So what's next? What we would suggest that we provide for you in October is an outline of the March chapter on access. In that chapter, we intend on including a description of the ongoing monitoring system and then preliminary analysis in the priority issues we've suggested. So these might change if you have other ideas for things we should look at, but that's what we would suggest we present to you in March.

Sorry my voice has been so hard to listen to. At this time we'd appreciate any comments or questions you might have on our proposed priorities.

MS. ROSENBLATT: I'm thrilled to see that we're doing this. You talked about timeliness of data, which I think is real important. When Jack talked about projecting out three years, that's just totally unacceptable. So if we can get current data, and if we could set up a track record so that we might not be providing the full extent of value in this March report but we're setting the stage for future

years. Because I think just looking at how things change over time will give us a lot of information.

I also think one of the things we were sent to read mentioned that if we just look at Medicare access we may be misled. But there may be overall access problems due to supply problems. So I think we need to do some comparisons there.

MS. MILGATE: With other payers you mean?

MS. ROSENBLATT: Yes, exactly.

MS. DePARLE: Will any of this data allow us, or any of the available sources, allow us to drill down further and determine whether there could be problems in a more discrete geographic area. When I was at HCFA, we didn't much information that could help us here. I was asked many times about particular areas of the country. We finally developed a way of looking at -- but it was more like these information surveys, where we looked at Anchorage, Alaska and Forth Worth, Texas just to see if what we were hearing anectdotally was really true, that there were access problems.

But it strikes me that a lot of these datasets really are too broad to give us that ability.

MS. MILGATE: Actually the CMS utilization data which I mentioned, which may have been developed just after you left I guess, is trying to look at it county-by-county.

MS. DePARLE: That is what we did there.

MS. MILGATE: So that piece seems like it could drill down. The NCHS also has some data that does break downs by state. Joe, you might want to add if you know of any others.

DR. BERNSTEIN: Actually Kevin would be the right person to ask but we did some exploration of whether we could set up tracking system that would make use of area agencies on aging, or some other local entities, to give us good information. So far that has not produced anything that we're real comfortable with, but we're looking.

MR. HACKBARTH: This is an area, Nancy-Ann, that I share your concern about, particularly with regard to physician access. And not only do you have the geographic dimension, you also have a specialty dimension as well with regard to physician access. We know from available data from other sources that, in fact, there is a lot of variability across markets in things like the relative payment rate between Medicare and private payers by market.

It's a very complicated issue, one that's very difficult to answer through broad, high level surveys about access to physician services. I'm sure we'll talk more about that this afternoon with Kevin.

DR. NELSON: You just made the point that I wanted to make, Glenn, but I would like to commend the staff for just a super comprehensive review of the data sources. It may very well position us as the authoritative voice in pulling all of these diverse pieces together into one place and provide an analysis that can be very useful. I really think you did a great job.

MR. DURENBERGER: As I said earlier, I'm on here to represent consumers, which is a wonderfully self-serving statement, beneficiaries and so forth. But it's also the reality.

I looked at this and I agree with what was just said about the importance of this whole issue of access. I think I would start by the next meeting of defining what's the policy question or the policy issue, whatever it is, and define that a lot better, as to why are we looking at the access issue? What does it mean in today's environment? Today's environment is very different from say five, 10, 15

or 1965.

But given today's environment, the health system that we have today, what do we mean by access? And then why is it important for someone as responsible as we for Medicare payment policy to be looking at this issue? Because I think then it will begin to open up other issues.

Secondly, in terms of working with others, whether it's the Center, it's CMS, whoever is out there, I think that's critically important, that we provide the leadership, whoever provides the leadership. I think it is really, really important to start bringing everyone together around this issue.

Thirdly, when I look at the last subject about efficient providers and this one, I tie them together because I think the policy issue is basically how do you provide incentives for efficient providers and then reward beneficiaries for choosing them, which the current system doesn't do. So that's a much larger issue that ties these two together.

When I looked at that efficient provider thing and I heard that it was an averaging, I said that ain't the way I would think about it. I mean, I'd worry not so much about

an efficient provider but ineffective service. I mean, I wish I knew what kind of services are being provided by these so-called efficient, average providers that people don't need but we're paying for.

So in that larger context, I think we have a great deal to learn from beneficiaries. A huge amount. I don't think we even know the potential.

This institute that I've been operating is not a research think tank, blah, blah, blah, blah, blah. Mainly, what we do is dialogues. We bring 80 people together at a time. Sometimes it's just docs, sometimes it's a stakeholders group. When you take on issues like this, or we just did one on emergency departments. And what you think is the problem never turns out to be the real problem.

It's an effort to use this process called appreciative inquiry. Back in time, all positive experiences, add, project the future, and then talk about the problems we may have experienced. When you put multiple stakeholders in this system together to look at that kind of a problem, and this is sort of a step beyond focus groups and things like that.

But I just wanted to endorse where you're headed

with the analysis which involves beneficiaries. And I would urge you to do it in many different places. I mean, go to Billings, Montana and do some. Don't just look at the data, but go and encourage the development of some of these in different parts of the country. Because I think we're going to be very pleasantly surprised at the power that beneficiaries have in helping us to understand the whole issue of access to what.

MS. RAPHAEL: First of all, I also think that you've really taken an important step forward in trying to begin to build an infrastructure here for doing ongoing monitoring on this issue of access. And I think the ongoing, for me, is very important. You need to begin.

I think I agree with your priority areas. I think post-acute care, we just saw the data on fee-for-service Medicare expenditures. Home health care is the one area where we have had a drop. I don't know if that is something we ought to be concerned about but that paired with the introduction of changes in the payment system to me is a strong signal that we need to take look at this area.

In regard to that, I really believe that just relying on discharge planners is inadequate because 50

percent or so of beneficiaries come through the hospital system. Discharge planners, as a proxy for access, I think gives you just one slice of the pie. Because discharge planners have one motive, and sort of the right motive from their point of view. And I don't think you're going to really get the issues that a whole range of beneficiaries face in terms of access. And you certainly won't get at the issues of segments of the population, who might not get service because they're not high on the discharge planner's priority list. So they won't get post-acute care and they may need post-acute care.

And I think, in particular, there are issues around people who have cognitive impairments, people who don't have any family member at home, as well people maybe more at the lower end who aren't the highest need and therefore kind of are the ones who get sent home without any care afterwards. So I just think we need to think through how else we can get at that issue.

But more important to me than sort of the initial access, is the question of whether or not people are getting the right amount of care, whatever that is, and we can't really get at how effective the care is. But from our own

polling, through Gallup and benchmarking nationally, the main dissatisfier is people feeling they're getting discharged too quickly. I don't know whether or not that's a national phenomenon. But somehow we have to be able to get at that issue. Because the incentives may be a lot of admissions but quick turnover.

And I don't know what we're doing that's going to give us good information on that set of issues.

I would also second what you're doing on emergency rooms, because we're tracking emergency admissions as an adverse event. It is sort of the default line in the system, and I think it is a good indicator of other things going awry. I'd like to understand better how we're going to go about doing it. But I think, for us, we view it as a failure in the system if we have to have someone go back to the emergency room fairly rapidly.

And I am interested in the socioeconomic status because I think in earlier reports that we've done, when we try to look at financial burden and what's happening in Medicare, there were definite differences by socioeconomic status. There were certain groups that really experience much more of a burden and were much more likely to delay

care or not obtain care. I think that is a very important area that we really need to explore.

MS. ZAWISTOWICH: Carol, just one point of clarification. What we are going to be doing over the course of the year is to develop an episode of care database for post-acute care that will focus on different kinds of episodes and attempt to characterize different kinds of patients within the post-acute care environment. So we hope to be able to get at some of those kinds of issues through looking at the combination of variety of different data source in constructing the episode of care.

But we really would look forward to additional comments from you on issues that we should be looking at, in addition to talking to the discharge planners.

DR. REISCHAUER: I add my congratulations to you, Karen and Jill, for this. I think it really is important. And something Alan said makes it even more important, which is this is an issue that Congress is always interested in. If we can become the source of objective, unbiased information on this, it would I think be appreciated by the Congress.

But at the same time, it's worth remembering that

Congress is a geographically-based organization and saying there isn't any access problem, on average, in the United States, isn't going to silence those living in areas that that may or may not be the case.

I was wondering about -- one aspect to being useful is to be timely. And so some of these data sources are a whole lot more valuable in the timely sense than others, even if they might be less accurate.

I was wondering how much of this data is place of residence of beneficiary, as opposed to place of service delivery, because you're going to get some very complicated issues of interpretation in this. And then there's also the whole issue, the confusion that occurs with a chunk of the population being in Medicare+Choice, and that chunk being very different sizes and different places, and making appropriate adjustments for that per fee-for-service person. How much is going on here?

I sympathize with what Carol and a lot of people have been saying, and Glenn, about what's important is that they have access to the right kind of care, or the good care, as opposed to just care. But it sort of sounds to me like we're saying let's figure out how to do gymnastics

before we know how to walk. It's going to be hard enough just to see if we can monitor in a reasonable way access to care broken down by broad types of care. And then interpreting what we're regarding as access, which in some sense is really utilization. What do we draw from it, which gets to David's point.

You might see differences in "access/utilization" and it might be attributable to differential supply of providers. There just aren't any whatevers, home health entities, skilled nursing facility entities, in this area. Or it might be because payment policies are inadequate, that people being paid by Aetna have no problem at all, but Medicare just isn't as attractive.

Or it can be a whole bunch of other factors. Folks in the Minnesota area don't go to doctors the same way that folks in Minneapolis do. What does that say about access? Maybe absolutely nothing.

What if it's differential provision of supplemental insurance? Then we're talking about sort of a much more difficult structural problem that doesn't necessarily say much about access in the narrowly defined Medicare program.

So I think this is great. I think we should go ahead full steam with it, but we also should realize that we're going to create some information that is going to be very difficult to interpret. And if you didn't like the interpretation of the Iowa utilization information last year, you're really going to have trouble with what we come up with now.

DR. NEWHOUSE: I agree with Bob's comment about walking before gymnastics, but I think one way to deal with that would be to include a portion on how we would like to see the data collection evolve. And if possible, with some sense of what the budgetary implications of that would be. And maybe there could be some staff effort along those lines.

MS. MILGATE: Just a note on that. That's an interesting point. I've been asked a couple of times, for example, if it's possible to replicate the ACE-PRO indicators, which really are indicators for ambulatory care, in other settings. Generally, as I've thought about it, I'd be interested in any comments on that. Because that really gets at the right care question. It identifies beneficiaries that have certain conditions and because, in

those certain conditions, we know they should get certain services, an absence of getting those services means there's either an access problem or it could be a quality problem. Maybe they got to the physician but the physician didn't do the foot exam, for example, for diabetics.

My sense of it, and I'd be interested in your comments on this, Carol, particularly in post-acute, is there's not as much definition of exactly what services or perhaps even collection of data are or aren't provided within that setting. And so it might be more difficult to define what services should be given to certain types of people. And then there's a definitional issue of who those types of people are.

But that's one area I would just throw out that we might want to think about further, and maybe even pull together some clinicians to help comment on that particular question. So that might be a directional data suggestion or analysis we could do, leading off of what you said, Joe.

DR. NEWHOUSE: I'd also urge us not to forget about the disabled and ESRD portions of this program. Many of these surveys include them, but we may need to oversample.

MR. FEEZOR: Just to join with my colleagues on complimenting both of you for a good summary of the data that's available and their various adequacies and inadequacies. I guess I had written down about four things that I hope we would keep in mind as we try to amass the access issue. And I think many of my colleagues said them.

One is the access relative to existence of other supplemental coverages. I think Bob picked up on that one. Looking at -- I think it was Alice said, to underscore her part -- about having some sort of comparative group. And not just the general population but probably -- and I think you referenced it at one point in your paper -- the 50 to 65 age probably is as good a comparison in mimicking some of the utilization trends. So to the extent possible, drawing that out.

And then whose comment was it, about care being either market or geographic specific, and it probably is even more important market specific.

And then underscoring -- I didn't hear Bob ask for it, but we've tended to sort of look at the access primarily on the fee-for-service side. But I think, assuming Medicare+Choice is still with us, that looking at

comparisons between those two groups, in terms of the use of access, at least in terms of the administrative utilization data might be very a very interesting component.

And then the final thing is to underscore -- I think Karen your last point -- that I think we do have to, at least in looking at this issue for the longer term, maybe beyond some of our terms on this panel, is looking at the right care and whether it's the source that you were talking about. I guess I had noted somewhere in your paper that most of CMS' data sources are not targeting ambulatory specific, or there was some reference to that, and I guess I was a little surprised at that, some of the ambulatory-specific conditions. Something you said in your paper.

MS. MILGATE: I'm sorry, I'm not sure what you'd be talking about. Actually, a lot of their data collection focuses on physicians, which is not the whole ambulatory, but...

MR. FEEZOR: I'll pull it out later.

MR. DURENBERGER: I've served on several groups with Bob and after I do one of these global things, he always says you've got to run before you run, and so forth. So I got my hand up after he said that, because my sense is

I've been at this 25 years and we're now crawling. We aren't even up walking.

But the discussion, for me at least, emphasizes the importance of starting with a definition of what do we mean. What do we really mean by access? Access to what? And a lot of the other environmental and other third-party payer issues that are involved in that. And my suggestion would be that we try to just work on that the next time, to see if we can get all this variety of discussion.

MR. HACKBARTH: The paper that was distributed before the meeting tried to break down the broad concept of access into some -- well, what exactly are we talking about sort of questions.

MR. DURENBERGER: I agree with everything Carol said and I could add a lot to it, I think, in terms of variety of populations, languages, a whole lot of things like that, the problems of the dually disabled have, the problems that I as a family member have, trying to steer my mother -- who's now gone through spend down and has Alzheimer's and so forth -- through the lousy system.

You probably don't want to get too far with a lot of these issues. And if you don't, then say so. But it

really -- there is really value in going out somewhere in this community, whether it's through research or analysis or something else, and find out what's really going on in America relative to access to the system, before we -- and I think about then new ways in which patients are going to monitor their own care. Patients are going to deliver their own care.

This thing has a lot of dimensions to it that go beyond access to a doctor, access to a hospital. And whoever said yes, we're paying a lot of money in rural America to a lot of hospitals is absolutely right. But it isn't providing any more access than we had before, and I think we ought to know something about that before we go to the next step of adding more money on top of it.

So for me it's kind of a dimensional question on which a lot of other things that I feel like I have to do around here is premised. The access, to me, is just as important as how much the docs get paid or the hospitals.

MR. HACKBARTH: Ralph, you're going to have the last word. Then we'll go to public comment and lunch.

MR. MULLER: We know from the work that the Dartmouth Atlas, Jack Wennberg and his colleagues, have been

doing for a long time that utilization varies enormously around the country, and even enormously within MSAs.

I think to analogize back to the discussion we were having a little while ago about efficient providers, I think it would be useful as we start doing this work to have some theories as to what we mean by appropriate access, given the variation we already know exists.

Because I think if one even looks at a mean the way we said in the cost data --

MS. MILGATE: You'd start there?

MR. MULLER: You don't necessarily want to start there obviously. But I'm just saying the disparity is so great right now in terms of utilization, that I think it's utilization and access insofar as we equate some of that shouldn't be just some threshold. It's obviously going to be some range or some variation that's tied to demographics and some other kind of indicators. But I think it does make sense to start having language in our evolving reports.

I think Carol said it first in today's discussion, that we should have ongoing reports and an evolving framework. But I would like to see us to also come to some reasonable -- if not some consensus, some reasonable

discussion about what it means to have appropriate access.

I agree with -- maybe Bob was the first person to say it today. It's going to be very hard to define what good care is given to variations inside this country. And there's enough controversy in the literature going back many, many years as to what's good care that I don't think we're going to solve that one anytime soon.

But just looking at some range of utilization and deciding whether we consider that to be a proxy for appropriate access, I think is an important thing to do.

So I would like, if you would consider this, to start as part of the reports, start evolving some kind of theory or sharing with us the theory as to what appropriate access looks like.

MR. HACKBARTH: Okay, thank you. We'll now have a 10-minute public comment period. As in the past, I'd ask people to please try to keep their comments brief and to the point and -- that's brief.

Okay, we're going to adjourn for lunch and we will reconvene at 1:15 p.m.

[Whereupon, at 12:06 p.m., the meeting was recessed, to reconvene at 1:15 p.m., this same day.]

AFTERNOON SESSION [1:19 p.m.]

MR. HACKBARTH: This afternoon we will begin with a continuation of our discussion of access issues. The first two presentations relate to that topic, the first one being the preliminary results from a survey of physicians about Medicare, including access questions.

Then the second presentation relates to how the rates Medicare pays physicians compare to rates paid by private payers. Once we've finished those two access-related topics, then we will turn to some other things, including some mandated studies.

Kevin, are you going to introduce the first presentation?

DR. HAYES: Thank you. We have with us today Julie Shoenman from Project HOPE, who will be presenting the preliminary results of this survey. Before I turn things over to Julie, though, let me just say a couple of words about the purpose of this survey, why we sponsored it, and also give you some background on how we came to develop this particular survey, how we built on our experience with the previous survey that the Commission sponsored, one in 1999.

As to the purpose, of course we heard this morning

about how access is in our method for assessing payment adequacy and making update recommendations. So certainly a survey of this sort feeds right into that kind of a process.

We sponsored, as I said, that last survey in 1999, and considered doing another survey last year. It just seemed like we were about due to do another one, but decided to hold off because of the anticipation of a payment reduction for physician services. It seemed like this would be the better year to do such a survey. And it seems like the timing is good. The payment reduction turned out to be larger than we had anticipated initially.

Beyond that, we have of course a great deal of interest in access issues right now, not only because of the payment cut but the Congress is considering legislation to change the way payments are updated for physician services. There was recently the results of an online survey by the American Medical Association released which talked about physician acceptance of Medicare patients and other aspects of medical practice.

In your mailing materials for this meeting, you received an issue brief put out by the Center for Studying Health System Change, which talked about not just access to

care for Medicare beneficiaries, but others as well, and showed that it appears that there is some problems with access not just for Medicare beneficiaries but for others.

We don't know whether these changes that we're seeing are transitory or part of something more fundamental, and all of that just lends further importance to this approach of continuing to monitor beneficiary access to care, as we discussed this morning.

As to building on the earlier survey, let me just say first that we reviewed the earlier questionnaire, the one from the 1999 survey, and dropped some questions that seemed no longer relevant, added some questions on topics that were more timely. I'm thinking in particular about the regulatory burden study that the Commission did last year. All those things were an integral part of conducting this year's survey.

We also reviewed the transcript from the March '99 Commission meeting where the Commission talked about the results of that earlier survey. And that review led us to change some of the questions on the questionnaire. We had, for example, as you'll see in a moment, we talk about physician acceptance of patients, not just Medicare

patients, but patients with other sources of payment. And there were some concerns in the earlier survey about the categories of payers that we used. We revised those. I talked to a few of you informally about the categories that we used this time, and we hope that we have that right now.

We also added some more detail on the way physicians are changing their practices. For example, in the earlier survey we had talked about physicians reducing their staffing costs. Based on comments we received earlier, we've made that question more specific, to ask not just about reducing staff costs but reducing the number of staff.

So anyway, that's kind of how we came to do this survey this time around. What I'd like to do now is to turn things over to Julie. Julie Schoenman is a senior research director at Project HOPE. She worked with a team of others at Project HOPE, as well as the Gallup organization, to design the survey, collect the data, and analyze the preliminary results that we'll see today. We're very fortunate to have such an experienced team working on the survey and look forward to Julie's presentation.

DR. SCHOENMAN: Thank you, Kevin, and thank you

for having me here. I'm anxious to present the preliminary results of the survey and get your feedback on what we've done.

As Kevin said, the purpose of this survey was to monitor access and other aspects of practices, especially in light of the most recent fee changes. It was very similar to the '99 survey that was conducted by MedPAC. Gallup collected the data using three different interview modes.

We began data collection in April of this year, which was a date that we chose specifically because it was several months after January and we wanted to give physicians several months to sort of gain knowledge and experience with the fee changes and perhaps react to those changes, make some changes in their behavior.

Gallup has just recently finished the data collection the very end of August. So what I'm presenting to you today is based on a preliminary database that reflects about 700 responses that had come in by the late July period.

DR. NEWHOUSE: This is all specialties?

DR. SCHOENMAN: It's all specialties except for a few, pediatricians of course, the classic exclusions. But

yes, it's all specialties.

In both '99 and 2002, there were several criteria for being eligible for the survey, but one critical one was that the physician had to spend at least 10 percent of his time with fee-for-service Medicare patients. Bias does not exist, as it were, but we don't have physicians in there who are seeing very few Medicare patients. So when you look at acceptance of new patients, those physicians aren't in there. But we wanted to get physicians who had enough experience with the program to give us informed opinions about how things stacked up.

The first line of inquiry dealt with their overall concerns with medical practice. These were not specific to a particular payer. We asked in general, for your practice as a whole, how concerned are you about the various factors that you see listed there. They could say they were anywhere from extremely concerned to not at all concerned.

What you see is there was the most concerned expressed about reimbursement. This is not Medicare-specific, it's in general, about reimbursement. And relatively less concern about external review of clinical decisions and the timeliness of claims payments.

Those patterns held pretty much when you add the category very concerned. Again, billing paperwork and reimbursement are the most concern to physicians, and the timeliness of payments and external review are relatively of less concern.

For the first four of those factors listed there, we also asked physicians to rate their level of concern relative to various payers. Fee-for-service Medicare was one of those payers and what we see here is how their concerns within the Medicare program stack up.

We also had one other question about how concerned were they about Medicare's actions in pursuing fraud and abuse investigations with the same extremely concerned to not at all concerned scale.

So here you can see that among all these factors, they're most concerned about reimbursement within the Medicare program. And they're relatively less concerned about the timeliness of payment and external review. And those patterns hold again, when you add the very concerned category reimbursement is still the factor that is generating the most concern among physicians within the fee-for-service Medicare program.

We are able to compare their concern ratings that they gave for fee-for-service Medicare to how they rated other payers on these same factors. These other payers were private fee-for-service/PPO, the indemnity plans, Medicaid which includes Medicaid HMOs, and then other HMOs which is where Medicare+Choice, the Medicare HMOs, should be classified there.

And then we had another question that asked them how difficult was it to get timely and accurate billing and coverage information from these various insurers. So that's the last row of the table.

What we see when we compare fee-for-service Medicare is that Medicare does better than other HMOs on factors that you'd think of as related to administrative hassles, the administrative paperwork, the timeliness of payments, and just the ease of dealing with Medicare as an insurer. And Medicare also does better than Medicaid on ease of getting information from the insurer.

However, Medicare does worse on external review than either the private indemnity plans or Medicaid. That's despite the fact that overall on the prior slide we saw that physicians weren't terribly concerned about external review.

The other factors were of much more concern to them. They still are more concerned about it under Medicare than they are for these other types payers. I think that's the fraud and abuse angle of Medicare that's coming into play there.

Finally, we see that they are more concerned about reimbursement for Medicare than they are relative to the private indemnity plans.

Because there's so much interest in the fee changes, we asked a couple of questions just to assess physicians' knowledge of the fee changes. First we said are you aware of the 2002 changes? And we found that two-thirds of the physicians said they were aware of those changes.

Now in 1999 we had a similar question on that survey that said are you aware of the Medicare fee changes that have taken place since 1997? Those were the practice expense changes and the single conversion factor, just to give you an idea of what they were being asked about the prior time. And we found very similar results. Again, two-thirds in the earlier survey were also aware of these changes.

So while the majority are aware of what is happening to their fees, it's no greater awareness this time

around than it was with respect to the prior changes.

In this survey, if they said they were aware of the changes, we asked them has it increased or decreased your Medicare revenue? And 91 percent said it, in fact, had decreased their revenue. So they're right on target there. And that was higher than the percent that we got in the prior survey, when in fact some physicians could have seen increases.

DR. NELSON: I'm sorry I didn't ask it when you were talking about the sample you surveyed, but do you have any idea what percentage of the sample was composed of physicians who are, for example, employed by a university or in an employed status where they are so insulated from payment implications that they wouldn't be aware, because they don't have to?

DR. SCHOENMAN: Right. It's quite possible. We do ask a question at the very end of what their practice type is and university full-time faculty is a category that we can look at. I don't have those numbers with me.

In terms of awareness, everyone was asked those questions. The level of concern, they actually to have 10 percent of their practice not only from Medicare but for

every other payer types, in order to get into the analysis that I was presenting earlier. So it's physicians who had at least some knowledge with whatever insurer we were talking about.

Let's turn now to the acceptance of new patients, which is one of our most critical ways of monitoring access to care. The first question that we asked was just, in general, are you accepting any new patients of any type, regardless of payer? In other words, is your practice open? 92 percent of physicians said that they had open practices, which was about what we had seen in the '99 survey.

For those with open practices, we then said are you accepting all, some, or no new patients with the different types of insurance? And here you see the '99 and 2002 results. The bars represent the sum of the all category plus the some category. So what you'd see is things look pretty good for Medicare when you look at it this way. 96 percent of physicians say they're accepting at least some new fee-for-service Medicare patients. Only acceptance of private indemnity patients is higher. And you can also see the Medicaid acceptance is low to start with and has declined significantly in the three years that

elapsed between the two studies.

This slide, though, is a bit misleading because it masks the difference between the acceptance of some new patients and all new patients. So in this slide it's exactly the same bars that you saw in the prior slide, but the blue represents the all new patients and the red is the some new patients. What you see immediately is that for the fee-for-service bars, there's a decrease in the size of the blue bar. There's a 7 percentage point decline in the percent of physicians who say that they accept all new patients, which could be distressing.

However, when you look at all of the other payer types, except for the private indemnity, you see the same type of tightening in access, the same sort of systemic situation.

We also wanted to explore what would be driving some of the acceptance decisions. So we asked specifically, for some of the factors that we had talked about before. If a physician had said that he or she was concerned or very concerned or extremely concerned about reimbursement, they got a follow up question that said has this concern led you to limit the number of new patients you accept with whatever

type of insurance you're talking about?

So what we see in this graph, the red bars show overall, for all the physicians who got the follow up question for that particular type of insurer, how many said yes, in fact, they were limiting access. And what you see is there are red bars. So that means that acceptance of patients is being affected by the physician's concerns about reimbursement. You also see the restrictions that are in effect for fee-for-service Medicare are right on a par with the restrictions for the private indemnity patients. And they're lower, much less pronounced than the restrictions that we see for Medicaid or HMO patients.

The other thing, the blue and the yellow and the green bars just show that the higher the level of concern about reimbursement, the more likely the physician is to say that he or she was limiting the number of new patients accepted.

We asked an identical series of questions that related the concerns about billing paperwork to acceptance of new patients. You see the graph looks almost identical to what we just saw for reimbursement. So all of the same points that we made about reimbursement hold for this

billing paperwork, as well. So there are restrictions in access not only to reimbursement concerns but also to billing paperwork concerns.

DR. NEWHOUSE: Medicaid HMO adds more than 100 points?

DR. ROWE: No, they're different. The red is different than the other three things.

DR. SCHOENMAN: It's 54 percent of those who said they were extremely concerned about paperwork under Medicaid said they were limiting access.

DR. ROWE: It doesn't mean those three are equally sized. The three subsets don't have to be equal size. So 54 percent of the people who are extremely concerned and limiting access, that may only be 100 doctors.

DR. SCHOENMAN: A bit misleading, but that's the right interpretation.

There was one other question that was specific only to Medicare, which was had their concerns about the Medicare's fraud and abuse investigations or possibility of being investigated led them to limit the acceptance of Medicare patients. 8 percent said yes, that they had limited patients because of those concerns. It's a lower

magnitude, but it's still occurring.

And again, the more concerned they were about the factor, the more likely they were to be limiting.

MR. SMITH: The percent limiting access, is that the sum in the no categories?

DR. SCHOENMAN: This is a question, it's a yes or a no. Did this concern lead you to limit your acceptance?

MR. SMITH: So we don't know whether they've cut it off.

DR. SCHOENMAN: It's just that they have made some restrictions in their acceptance of new patients with that type of insurance.

We considered a couple of other measures of access in addition to acceptance of new patients. First of all, we asked about how difficult is it to find suitable physicians or surgeons to whom to refer your patients with different types of insurance. What we found when we compared the answers for the different payers was that they viewed referral of fee-for-service Medicare patients as being more difficult than for their private indemnity patients and less difficult than for their Medicaid and HMO patients.

We also asked about in the past year have you made

any change at all to the priority that you give to fee-for-service Medicare patients who are seeking appointments with you? 11 percent said yes to that question, that they had changed their appointment priority. Now some of those physicians were increasing the appointment priority. It ran about two to one. They were about twice as likely to have decreased the priority than to have increased among those 11 percent that reported a change.

The appointment priority was more likely to have been decreased if the physician was aware of the fee changes in 2002, if they thought those fee changes had reduced their revenue, or if in general they had been reporting greater concerns about the various practice factors related to the Medicare program.

So what do we take away from all of this? I think there are a few points. It seems that physicians are quite knowledgeable about the fee changes. They are concerned about the fee changes, particularly relative to the reimbursement under private indemnity plans. We have seem some tightening in access for fee-for-service Medicare beneficiaries.

However, the access restrictions, the movement

away from the blanket acceptance of all new patients was seen for all other payer types as well, other than the private indemnity patients.

And we see that there have been access restrictions related to their concerns about reimbursement, but that there were also restrictions related to other factors, like billing paperwork and to a lesser extent fraud and abuse concerns. And that these restrictions that we saw for Medicare, they were on a par with the private sector indemnity plans and they were much less than the restrictions that were being reported for Medicaid and for HMOs.

Thank you. I'd really appreciate your comments and feedback.

MR. HACKBARTH: Last year when we discussed physician fees one of the questions that we touched on was whether we should recommend rollback of the 5.4 percent reduction that was scheduled for 2002. And ultimately, we decided not to recommend that. As I look at these data, personally I guess I draw some comfort from them. Even in the wake of that 5.4 percent reduction we still have 96 percent of physicians accepting at least some new Medicare

patients.

With however, a very important caveat, which is that these are national average data and so they don't speak to problems that may exist in particular geographic locations or in particular specialties. That's just my overall reaction to these.

Of course, looking forward, the potential for the additional cuts scheduled under current law, given this response to the initial cut I guess, is a little bit scary. What would happen after year two, year three cuts occurred?

Other comments?

DR. ROWE: Just a couple comments, Julie, or questions. One is that I think it would be interesting to see what proportions of variance with respect to some of these variables, particularly with respect to acceptance of some Medicare beneficiaries could be explained or associated with age. Age of physician or years of practice or date graduated med school or some measure of the duration that they've been in practice.

I think that, in my experience, may times younger physicians building their practice, or who cannot see the horizon of their retirement or whatever, are much more

likely to accept new patients of all sorts, and older physicians, closer to their retirement, changes in their lifestyle, different referral patterns, et cetera, might be less so.

That may be wrong, but if you have any data that would be a proxy for that, I think it would be worth asking that question.

DR. SCHOENMAN: We actually do. We have the date of birth. We can look at their age.

DR. ROWE: Age is a proxy for it. Some people go to med school later, but in general --

DR. SCHOENMAN: I believe we actually went back, excuse me, on the sampling frame and had that put back onto the sampling frame, the date of graduation. So we can do both.

DR. ROWE: That's great. I think that would be interesting. Secondly, I think it would be interesting if we could find some comparable data that give us a longitudinal perspective. For instance, the percent of physicians with concerns, be it extreme or less extreme or very concerned, with respect to billing paperwork reimbursement. It would be interesting to look back, maybe

even 20 years ago when everybody in retrospect thinks reimbursement was pretty good, to see what percent of physicians felt that they were not being adequately compensated.

To see whether or not we've made any change, or these are traits not state measures. I think it would be informative, as we look at these individual cross-sectional snapshots, so that we don't overreact one way or the other to, in fact, have some sense of whether or not there is any capacity for these things to move in one direction or another over time.

The last point I would make is I'd be interested in the billing paperwork question over time specifically, because there are vacuums or aliquots of physician practices in which auto-adjudication of claims has increased very dramatically over the past several years. Many physicians now might have, if they have a largely HMO practice, 65 percent of their claims might be auto-adjudicated, so much less paperwork.

One would expect that if that is really the case, that this complaint would start to erode. I don't know if we can identify specific practices. Alice may have a better

idea about this than I, or Allen, where there would be a higher penetration of such auto-adjudication presumptively. And therefore, you could look at those.

But I think that would be interesting because after all, it's in the best interest of everyone, the patient, the health plan, and the doctor to auto-adjudicate these claims, if we can do that.

MS. ROSENBLATT: Jack, do you mean auto-adjudication or electronic submission, or both?

DR. ROWE: I think I mean both of those, thank you. EDI or web-based. But a paperless transaction, if you will, Alice.

I don't if you agree with my point of view or not, but I think there have been some advances here.

MS. ROSENBLATT: I think it is a good point, but it is both criteria.

DR. ROWE: It's both, yes. Thank you. Those are my thoughts, Joe, thanks.

DR. REISCHAUER: One small comment and then a question. On this chart, how does fee-for-service Medicare compare to other payers? There was one box that surprised me by being blank, which was reimbursement relative to

Medicaid.

DR. SCHOENMAN: I think I can explain that. There are a couple of things analytically behind this table. As I said, you had to have at least 10 percent of the patient type to even get in the analysis. So the n for the Medicaid column is about half, for one thing. I think that's what's driving it.

I think the other thing is just that. If you got in the analysis, you weren't accepting 40 percent Medicaid, so it wasn't as big of a deal for the few Medicaid patients that you had. It just didn't rise.

DR. REISCHAUER: So the Medicaid line is really a tough one, just because of...

My question/observation has to do with the acceptance of new patient chart and the comparison with private fee-for-service/PPO. We know that private fee-for-service is an endangered species. There aren't a whole lot of those folks out there. So what we're probably talking about is PPO here.

In this question, is this sort of do you accept new PPO patients for the group that you've already agreed to provide services for? And if that's the question, I would

expect 99 percent, and I wouldn't expect to give you a particularly good comparison with -- I mean, I wouldn't get upset if Medicare was quite different, was lower than that. It's sort of like are you going to fulfill your contractual obligation or not kind of question.

So I think we can tolerate actually quite a difference here without being too upset. And what we really should be doing is comparing it to the other columns.

DR. NEWHOUSE: Why wouldn't that apply to the HMO group?

DR. REISCHAUER: Good point. Then you have reason to be even happier with the fee-for-service numbers here.

DR. HAYES: What was the point?

DR. SCHOENMAN: I didn't hear it.

DR. NEWHOUSE: I said why wouldn't that apply to the HMO group. That is, I'm not sure Bob's interpretation is right here.

DR. SCHOENMAN: The other thing that was interesting, I think if you look at the slides on the are you restricting access at all because of your concerns and the red bars that we were seeing, how could you restrict access to private PPO patients? Well, you can do it in a

couple of ways. You can just decide not to sign up with a given plan, or you can say I've capped my practice.

So there are ways to do it within those -- and the same thing exists, I think, for the HMOs.

DR. NEWHOUSE: I guess the difference may be that you accept the PPO if they come outside the PPO anyway, and pay your normal fees. That may be what this is reflecting.

MR. FEEZOR: Bob asked my question. I think we need to look behind when it says those are accepting, because when we do access surveys for some of our enrollees in certain areas, we find that if they, in fact, were under 65 and my patient then yes, I'm accepting. Or in some other instance, if it's a tight referral. So I think that is a concern.

And Glenn, to modify what you said, 5 percent of those accepting of those who in fact have a significant of amount of Medicare business. That's the other qualifier. So it's not a total set of the physician population.

The only other thing is I wonder if, in reacting to significant changes in the physician compensation, if there's not a natural time lag of about a year or so, at

least in the group practice models -- and I'd refer to the real physicians in the group, Alan or Nick or Ray -- but certainly I think in California it would probably be that at the end of a year under the new reimbursement system there is sort of an evaluation of what that's done to the total practice revenue pattern. And it's at that point time the decision -- so in essence, responding to the 5.6 percent, we're likely to have next year I think, at least in the group model, is where you might see some impact in that.

Again, that's more of an intuitive thing. I would defer to people who really are part of more of the medical practice as to whether that would be the case or not.

DR. NELSON: I'm glad that you included the question about difficulty referring patients, because I think particularly with subspecialist proceduralists, that may be an important canary in the mine. And I hope that we'll continue to ask that question because I think it may be revealing as time goes by.

DR. STOWERS: My question had to do with the relationship between the Medicaid and the Medicare. As a practice starts making a decision on cutting back, the first to go is the Medicaid patients and then the Medicare as they

work more towards the private pay or the PPO, as they get into difficulty. And I think the Medicare patients, in a lot of practices, even though the reimbursement isn't that good, it still helps carry part of the Medicaid expenses in your practice.

So I'm wondering if there's some way that we can get a feel for how much this Medicare decrease also affected the decrease in the willingness to accept Medicaid. Because I would bet there's a relationship there. I would bet that nearly 100 percent of the people who decide to start restricting their Medicare practice are making a similar decision at exactly that same time to go ahead and drop Medicaid.

I don't know of any physicians that get to the point that they're restricting Medicare in their practice that they haven't either restricted or totally eliminated Medicaid out of their practice. So I think that this thing not only is affecting Medicare patient selection, but I would be there's a real strong correlation with Medicaid acceptance. That's my first point.

My second point is Medicaid, being a state level administered program with tremendous variance in payment and

so forth, do we have enough numbers here? I haven't run them or whatever to get some state level data. But it would be interesting if some day we could see where the variance is and then see whether that is impact Medicare acceptance, also. I would also bet there's a correlation a lot different in different states regarding how much the Medicare population is being impacted.

DR. SCHOENMAN: Totally agree with you, unfortunately the numbers are just not going to be large enough to do that.

And the other point that I think you've touched on earlier today is acceptance -- Medicare either looks really good as a payer or not so good as a payer, depending on what market you're in and what the private fees look like in that market. And we can't say anything about that, either.

DR. STOWERS: I just didn't want us to take any comfort out of fact that Medicare was like Medicaid on here, and that there's been a decrease in both. I'm saying I think that's a natural response that it should have been. I don't think it gets anything off our back about the Medicare, I think because I think they're totally linked to each other, not independent.

MS. ROSENBLATT: When I hear about access problems I hear radiology mentioned. That was one of the specialty that we excluded from the study. I was just wondering why you were forced to exclude the various specialties?

DR. HAYES: We excluded radiologists, anesthesiologists, and pathologists because they are largely facility-based specialties, often have contractual arrangements with the facility where they work. And they just don't have much discretion over who they accept and don't accept. It kind of goes back to the point Alan was making earlier. It's the same idea.

There would be perhaps a host of interesting questions to ask about those specialties, but they but they would be different questions from the ones on this survey.

MR. HACKBARTH: Can I ask you a question about the survey sponsored by the Center for Health Systems Change? I think everybody got a copy of the issue brief.

What do we gain from our survey that we would not get from the survey that they do?

DR. HAYES: The first thing would be just the timing. They conducted their last survey spanning 2000-2001, and my understanding is that they will not conduct

another survey again for at least a couple of years. So the timing of our survey, I think, was good because it happened after the fee cut.

DR. SCHOENMAN: We were in the field for five months, which is as long as we could stay in the field, and we really struggled with that to get the responses. They're in the field for, I think, 16 months for a given survey. It's the timeliness of the data, I think.

Now their advantage, of course, is they have much larger numbers.

MR. HACKBARTH: Which the size and the much larger numbers presumably would help to get at some of the locality issues and specialty issues in a way that we can't with a much smaller survey. I just wonder if there's some way not to supplant one with the other, but look at them as partners, as complements to one another, so that we get the maximum information for the Commission and for Congress.

DR. SCHOENMAN: I think we are finding things that seem to be consistent, that the access restrictions are not just Medicare, they're occurring for other sectors as well.

DR. HAYES: The other thing that they bring to the table, of course, is the market-specific work that they do.

They go out, they interview people in each of these markets. And so I think we want to kind of draw upon that in what we write up for the March report, and intend to do so.

MR. MULLER: It might be useful to also look at the supply data, not to have our own independent source of that but to look at that, because compared to let's say the literature in the mid to late '90s, when managed care was in its heyday and there was all this oversupply of physicians being forecast, the more recent studies are now indicating that there may be undersupply in a number of areas.

So again, that work is being done elsewhere but it might be useful to include that in our work. I'm not suggesting we do our own.

DR. HAYES: One measure of supply that we -- you're talking about overall supply of physicians, right?

MR. MULLER: Yes, but more importantly I think one has to look at it on a specialty basis overall. In that sense, it would not be sufficient. But yes, comprehensively, I would say overall

DR. ROWE: Do we distinguish in these surveys the elderly from the disabled?

DR. HAYES: No.

DR. ROWE: There are 5 million or so disabled; is that right? I'm just wondering whether or not that would be informative, or interesting in terms of it may be that there is a problem for access for the disabled, for instance, that we're not seeing because we're not distinguishing them as Medicare beneficiaries and they're swamped by the five or sixfold greater elderly population. I don't know that there is a concern.

But if our goal is to assess access to physician services for our Medicare beneficiaries, given the fact that there is this non-trivial important, but relatively small -- on a relative basis -- subpopulation of 5 million beneficiaries, it might be helpful, at least in the future, to see if we could ask about that subject.

DR. SCHOENMAN: I think there are other data sources that can speak to that question. It may be better addressed through a beneficiary survey, and CMS is undertaking that type of work. I'm virtually certain they're sampled both the disabled and the elderly special populations. It's very hard to ask a physician, to even get them to distinguish between the categories that we've used. And I think to ask them to make a further distinction would

be very difficult.

DR. ROWE: That's fine. Thank you.

MR. SMITH: Julie, one quick question and two thoughts. The share reporting revenue declines, is that concerned on a per patient basis or is that a volume? So if someone were concerned that their overall practice was generating less revenue, where would they show up here?

DR. SCHOENMAN: You're talking about in response, do they know about the fee changes?

MR. SMITH: Right.

DR. SCHOENMAN: It was, how has that affected your Medicare revenue?

MR. SMITH: In aggregate or with respect to --

DR. SCHOENMAN: No, it's in the aggregate.

MR. SMITH: So if someone restricted her practice, they would show up here in having less Medicare revenue? This wouldn't simply be --

DR. SCHOENMAN: It's specifically tied -- it was linked to are you aware to the fee changes, yes or no. And if you said yes, have these fee changes increased your Medicare revenue a lot, a little, decreased it a little, decreased it a lot.

MR. SMITH: So it's specific to the fee change?

DR. SCHOENMAN: Yes, it is.

MR. SMITH: I just wanted to follow up on Jack's first comment. I'd be very surprised if the longitudinal data didn't show that reporting physicians were always concerned about billing paperwork and reimbursement. If they didn't, if we saw over time a significant change in that response, that would be important data. But it's not clear that, in the absence of an important change, that these reports aren't simply the reflexive state answer that you would always get. It would be very useful to try to come up with some way to test that.

MR. MULLER: I'm surprised it's so low, because even if you're happy about the reimbursement, you're worried it's being cut.

MR. SMITH: My other comment had to do with Alan's question of getting behind the data. It would seem to me it would be very important here, in some cases, to understand what share of a physician's total practice was Medicare. Not simply that it was more than 10, but that if it were a significant plurality of the practice, they might be more unhappy but less willing to restrict access.

Teasing out those interactions where we can, I think, would help make this data more useful to us.

DR. SCHOENMAN: You're absolutely right. We've actually done some analysis and I think that some of those tables were in the materials that went out in the draft report, where we looked at some of these dependent variables by physician characteristics, including share of practice. And there really wasn't much that was showing up along those lines.

MR. HACKBARTH: But didn't it show that in fact if you had a higher percentage of your practice involving Medicare patients, that you were less likely to close off the practice?

DR. SCHOENMAN: I think that that was true.

MR. HACKBARTH: I seem to recall that as one of the findings.

Let me go back to this question that's nagging me, at least, of the variation across the country by locality and by specialty. This is helpful. This is a significant step forward in terms of having timely information on this particular pay cut, but it still leaves unanswered many questions.

In terms of having a monitoring system going into the future, I would expect that if we start to experience access problems in the area of physician services that they won't happen across the board, that they will happen in particular markets were private fees are relatively high or in particular specialties.

Any thoughts on how we can start to wrestle with that problem?

DR. HAYES: Yes. We seriously looked at the options on surveying particular market areas with this survey and we realized very quickly that there were two major difficulties here. One has to do with just picking the areas, trying to decide at the outset which areas do you survey?

And then the other one just has to do with the expense involved. We have to have 250, 300 responses from each locality, from each geographic area in order to make some statistical comparisons among areas. You can see there that it would just be very expensive. This survey was a major hunk of our major research budget, to just do this.

So with that, we have to turn to our colleagues in Baltimore here. CMS has some interesting projects underway

that will help us, I think, in this area. They have, for example, access to 100 percent physician claims data and have the computing capability to summarize those data by state, by substate areas, by specialty. That's a tremendous thing right there. And they can look at changes in billings for individual physicians, caseloads, that kind of stuff.

That then puts them in a position to identify places where there may be problems. Then they plan to do targeted beneficiary surveys in areas where either the claims data or anecdotes, reports from area agencies on aging, whatever it is, tell them that perhaps there's a problem. And they can go in and do those targeted beneficiary surveys and give us all some results about where there might be problems.

The interesting thing that falls out of that, of course, is what do you do from a policy standpoint? We have a national payment system here and it is sensitive to some market conditions, input prices. We have a bonus payment system for health professional shortage areas, that kind of stuff. But beyond that, it's not clear where we would go to fine tune the system.

But the first step, I think you're asking, is how

do we at least detect the problems?

MR. MULLER: I think it's important to remember that the beneficiary access problems and issues sometimes are caused by factors that are not on this table at all. We talked earlier a little about the supply issues, and we do know about differential supply all around the country. But Manhattan is at one end and rural areas of Montana at another end these days.

And a lot of those supply issues aren't affected by things that Medicare can do, whether it has to do with lifestyle or educational opportunities for children, spouse, work possibilities, et cetera.

So when you look at the kind of supply issues around the country and how difficult it is to kind of rectify them with any single bullet, and how multifactorial those issues are -- and those, in many ways, are substantially outside the control of the Medicare program. So I don't think that Medicare should take it all upon itself to think that it's just these issues here that cause there to be differential access all around the country.

MS. RAPHAEL: I just had one comment. From what I gather from today, right now it appears that in the very

short period of time it's become the conventional wisdom that there are problems with access to physicians. And you just kind of read about this not with any great grounding in data, but I think an accumulation of a number of studies and recent commentary has led to these kind of blanket statements that I have seen with increased frequency.

So I want to better understand what we're going to add to this, and sort of shed light on. From what you said earlier, Glenn, I gather the main contribution we're making is the timing of our work, that this was done post-changes in physician payment. And therefore, it's much later than earlier studies that have been done in this area.

Is there anything else that we're doing that's going to help bring some more enlightenment to this area?

DR. HAYES: I think the key contribution the Commission can make is to take into consideration information like this and other assessments of payment adequacy and to advice the Congress on payments for physician services. I mean, I think that that's where we come in.

This by itself is just one source of information on access to physician services, and it's an important

contribution with the timing, as you say. But it's the putting of that together with other things that makes your efforts very important, I think. Does that answer your question.

MS. RAPHAEL: I think it does.

DR. HAYES: The other thing is we're still sending copies of the report that Julie put together on the '99 survey, we're still sending that to Hill staff and to others. It's viewed as a valuable source of information for the decision makers.

DR. NEWHOUSE: Glenn, I think somewhat reinforcing your comment about cold comfort, there is some tension I think between the notion that there is a substantial access problem then volume continues to increase. One can take both of those facts and still come up with a story that would cause concern but it at least becomes a more strained story, I think.

DR. STOWERS: Just back to Kevin on the timing issue, it said in our materials that we would come back with a final report in November, to kind of use some material for the March 2003 report. But this is a very hot issue on the Hill right now, this fall. Are we making any plans to get

this to the legislature decision makers? Is there any way that the Commission can kind of exit this concern not having to wait until next spring to do that kind of thing?

Even though we understand it's one study, but it is a study that the Commission has done and it seems to at least have a strong trend to it.

DR. HAYES: We routinely send the meeting briefs that go with these reports to Hill staff. I mean, they are aware -- not the report itself, but the meeting brief and we're in a position, of course, to respond from inquiries from Hill staff if they need further information on these documents. But they know, they're informed about what we're doing.

MR. HACKBARTH: Any other questions or comments?

Okay, thank you very much. Next up is Chris Hogan and Kevin. The topic is how to develop the necessary data to compare Medicare payment for physician services with payments made by private payers. Welcome, Chris.

DR. HOGAN: Thank you.

DR. HAYES: We have with us today Chris Hogan, who will talk with us about how the Commission plans to compare Medicare's payments for physician services with payments in

the private sector.

Beforehand, I'd just like to provide a little bit of perspective on where this analysis would fit in with our work. Recall from what we did for the March 2002 report that we went through a series of analyses to assess the adequacy of payments for physician services. We looked at the results of the physician survey that we did in 1999. We looked at the changes in the number of physicians billing the Medicare program. We had results from the Medicare current beneficiary survey.

And of course, for the March 2003 report, we would update all those analyses. We've got the new physician survey, and so on.

What we had hoped to do for that report, also, is to add an analysis that would compare Medicare's payment rates with payment rates in the private sector. The reason, of course, why the comparison is important I think is reflected somewhat in the physician survey data that Julie just presented. That is, I think it's fair to say -- maybe I'm wrong about this -- but from the survey it looks like maybe physicians are getting a bit more selective about the types of patients that they see, least selective when it

comes to the private sector patients, certainly the private indemnity/PPO types of patients. And so some kind of a comparison of Medicare's payment rates with the private sector would seem to be timely.

So what we asked Chris to do was to conduct a feasibility study for us and to come to you with a plan for making the comparison. Chris is somebody that many of you know. He's presented before the Commission a number of times. He's president of his own research consulting firm, Direct Research. We're happy to have him with us.

DR. HOGAN: Happy to be here.

I've been told that I have about 10 minutes to get my points across, so I will whip you through these slides as quickly as possible.

I'm not going to bother you with a lot of detail about the fascinating world of processing large claims databases. I love that stuff, but nobody else does. What I'm going to do is talk about why you would want to do this project and what you could expect to get out of it.

So the outline of the presentation is the following: I'm going to talk to you about why you would want to make the fee and volume comparisons. I'll show you

what kind of results we got the last time this was done. The Physician Payment Review Commission did this the last time in 1994. I'll tell you what your options might be for getting the fee data, although I think internally within the staff they've pretty much made up their mind that the largest claims databases give you the best of all possible worlds that you're going to be able to get. I'll describe the methods very briefly, and then give you a summary.

This is just a description of work that we hope to undertake this fall, get some claims, compare the fees, and get the results back to you in December. It sounds pretty straightforward. It's going to be quite a trick to do that. But our promise is to get you the information by December, assuming that all of the providers of claims will play ball.

Why would you want to do this? Adequacy of payment is obviously the number one consideration. Physicians aren't like hospitals. For hospitals you can get a profit measure. You can get an accounting measure somewhere that tells you profit or loss and you have a fairly hard measure of whether hospitals are making money or not making money from Medicare.

With physicians, as has been mentioned numerous

times around the table, it's a question of opportunity costs. It's not like you lose money by taking a Medicare patient necessarily, but you can make more by taking somebody else. The bottom line is if your fees get low enough, physicians literally will have better things to do with their time than to treat Medicare patients. They have an opportunity cost if your fees get low enough.

And Medicaid shows you what can happen if the fees get low enough. I have an estimate of 65 to 70 percent of the Medicare level, the Medicaid fees are about 65 to 70 percent of the Medicare level. That's old data. That's a soft number but you can use that as an approximation for about where Medicaid fees go. As you heard earlier, the number I have here is a third. That was just off some old information, but about a third of practices are closed to Medicaid. And if you ask physicians why, they say low fees.

So it's not rocket science. If fees get low enough, you'll have access problems.

I used the R word on this slide, for which I ought to apologize, rate setting. Private fees give you a better way to look at at least some aspects of Medicare rate setting, as well. If you have areas where you've got a lot

of beneficiary or provider complaints about payments and you had local private fees, you would at least be able to put those complaints in perspective. Is it Medicare's problem, with low Medicare fees? Is it lack of supplies? Or something else?

You want to integrate those with the other access measures. And I'll just put the thought out, you can also use it to identify services that look overvalued relative to private rates. If you want to talk about, as I see is next on the agenda, whether competitively bid rates would give you better rates than what Medicare can get, let's get some private rates and see areas where Medicare's administratively set prices look too high.

These sorts of measures are more useful when Medicare has problems than when Medicare doesn't. The last time we broadly did this was when Medicare was putting the fee schedule in. The Physician Payment Review Commission gathered a baseline of private payer data so that when that fee schedule went into place you'd have the information available to make judgments about whether things were going awry or not.

And of course, the context now is the SGR. I

wouldn't say that you'd want to do this every year. But if you think you're going to look at some tense times in the Medicare program, it might be good to have the private data around so that you can ask questions from it.

Volume trends. In addition to look at the prices, it's also very useful to have private volume trends. The near elderly privately insured serve as a control group, comparison group, however you want to put it. It's not a scientifically derived match control group, but it's old-ish people who aren't on Medicare. It's the best thing you can get.

With that, you can attempt to distinguish whether any problems you see in the Medicare program are Medicare program or whether they're system-wide problems. I think that also came up earlier. A lot of times you'll blame the Medicare program for things that are simply aspects of U.S. health care.

You can put the Medicare program in context. And to show you how that works, I'm going to give you two actual slides from the implementation of the Medicare fee schedule. I've got to set the story up first.

When Medicare put the fee schedule in place in

1992, they started with a series of overvalued procedure fee cuts. They started to pick on ophthalmology and urology first. They cut fees for cataract surgery. They cut fees for transurethral resection of the prostate. And these were sort of the poster children of the overvalued procedure approach, with the idea being that they were so lucrative in their current state that you had a lot of slack to cut those fees before anything bad would happen. That was the story.

And in 1993, this happened. This shows the rate of growth in services per person for cataract surgery and transurethral resection of the prostate.

Now as the people who had been looking over Medicare's shoulder about this, and sort of egging them on to think this was a good idea, this was not good news. These were, as I say, the poster children for overvalued procedures. The question was has Medicare priced itself out of the market or is there something else going on?

As it turns out, there was something else going on. That in fact, trends were down on the privately insured, as well. That was very comforting to the Medicare program to be able to say no, no, no, this dip in cataract surgery that occurred in 1993, this was nationwide. This

was people having gone through the pent up demand for cataract surgery.

And transurethral resection of the prostate, there was a lot of practice guidelines that came out at that time that said this has been overdone, you don't need to do it as much.

So to be able to compare Medicare to private on trend data, let us focus on real problems instead of problems that only looked like they were Medicare's problems, they weren't systemwide problems.

But mostly what we did with the data was this, this cute little graph here. I got into more trouble with this graph than any other piece of work I ever did. We used to call it the gap number. This is the difference between Medicare's fee and the typical private payer's fee. Almost no matter where I present this, someone doesn't like that graph. And I really can't say why.

It's the most amazing thing. Jack Ashby and his friends have been doing a similar graph for the hospitals for more than a decade and everybody sort of says uh-huh. And I did one for physicians and got into all kinds of trouble about it.

The only thing I want to say here is that ratio of Medicare to private fees, while there is some uncertainty in how you measure it, it appears relatively stable if you pick a set of methods and continue it, you can get a relatively stable measure.

I can explain the little dip in the middle. That's mostly the overvalued procedure fee cuts leading into the Medicare fee schedule in 1992. And after 1992, it wasn't exactly that Medicare fees went up very fast, but definitely that private fees came down very fast. Once you get to 1994 or so, there was an actual literal deflation in private fees as payers move from indemnity plans down to HMOs. It wasn't that individual payers were cutting the rates, but the mix moved toward lower paying cases.

So you get a nice looking graph out of it and the real question then would be -- I wish I had a pointer here -- so where are we now? Are we up at 80? Are we down at 60? Or does anybody know? The bottom line is the first thing we're going to do is try and extend this graph for you.

How would we do that? I'll talk about large claims databases in a minute because I think that's the preferred approach. Now you can just ask insurers. This is

one of the nice things about the fee schedule. Back in 1982, everyone had their own fee schedule and a lot of people paid UCR rates. And to know what a particular payer paid, you'd have to know an awful lot of numbers.

Now it's increasingly common that insurers price at Medicare plus or Medicare minus in a particular market. Or they might vary that by the specialty. So you could ask a number or a handful of numbers or a handful of numbers in a market to get an idea of the pricing.

Surveys of insurers are useful for when you don't have claims data, for example for HMOs. They're useful when you want to get something quickly because you can get 2002 numbers now. But there's a lot of haze and there's a lot of work to get a decent national number out of surveys. And you don't get any volume information. You just sort of know what the price level was.

You could actually use -- and I did in your feasibility study -- you could actually use a Medical Expenditures Survey out of AHRQ. Your tax dollars have paid for it, might as well use it. So I ran ahead and ran a regression there. I get numbers out of AHRQ's data that are similar to what I got, through a very different method.

I got Medicare paying at 80 percent of private rates. They don't have CPT codes on their records. You have to take the attributes of the visit and run a regression. It's a little hazier. But if someone says well, your claims data are obviously wrong, Medicare is the best paying payer around, I can say well, I took a completely different data source and I got a number that looked like that. So it's a nice validation of the price level, but it's too small a sample to do much with, and the methods are a little hazy because you can't really look at the CPT codes.

There are other surveys that can give you information on volume trends out of the National Center for Health Statistics, but none of them gather price data.

And finally, Kevin dug up one that I had missed in the feasibility study. The Bureau of Labor Statistics actually gets, for the producer price index, very good physician price data, claim level physician price data. It's just that it's not really their business to share that with anyone. I think Kevin investigated that and decided it probably would not do for our purposes to try and go after that, although it's very timely.

So of the options, large claims databases looks like it. Does anyone really care how I go about doing that? It's an awful lot of work and private payers claims are very difficult to handle in some aspects. We're going to try and do what we did the last time, the summary of methods. Try and get data from 1999 to 2001, change the methods as necessary to accommodate updating in the way payers actually pay.

It will be two very large private payers, and that's all we can say. We can't identify them. They're nationwide, they have -- in the aggregate -- tens -- that's probably an exaggeration -- more than 10 million covered lives in the aggregate, so it's a large slice of private payers. And they're big in most markets, so you sort of know what the market shares would be.

Take some survey to figure out how to weight them, along with a survey estimate of HMOs, and come up with the number. If all goes well, we'll get this by the end of the year.

Claims data, you know, claims data are what they are. You have to take them seriously because money was paid on the basis of them. That's the advantage of claims data.

But if you're an HMO and all you can provide is encounters -- we'll have some encounter data in this database, but HMO encounters generally -- they don't let you look at prices and the completeness is always questionable.

It's only going to be two very large national payers. So you can always question whether it represents the market as a whole. The last time, we also bought a third data source, the market scan database from Medstat. And their numbers look just like the aggregate of the two large payers we looked at. So we actually got the third data point and made sure they were all lined up nicely.

That seems like an additional expense at this time and so we're not going to do that.

Substantial effort to obtain results, I didn't mean to say that I will put forth substantial effort to obtain results. I mean to get any results it takes a lot of efforts. It's not like you can just sort of dip a toe in there. So there's a big chunk of money you have to put up to get some results.

Sometimes, when the contracts are more than just a claim-by-claim basis, you're going to miss some amounts of money. If there are withholds or give backs or bad debt and

that sort of thing, you won't get it on the claim. You just have to assume those aware or hope that they don't change very much.

I just did an analysis for the state of Maryland where everybody was okay with just sort of ignoring the withholds, give backs, and balanced billing amounts. And they were pretty much okay with the estimates you get out of their private claims database. So while it's an issue, it seems like it's an issue that people either ignore it because there's not much you can do about it, but they ignore it because in general the withhold and such are relatively small amounts of money.

Summary, why would you want to do this? Three different uses. Access to care, because the private fees give you basically physicians' opportunity cost for treating the Medicare patients.

A control group, so that you can tell whether the trends in the Medicare program are reflecting the industry as a whole or reflecting unique Medicare problems.

And rate setting, so that you can take private price information and try and find places where Medicare rates are really grossly out of line with private rates.

And our promise is to get the analysis to you in time for your December meeting.

DR. NEWHOUSE: Chris, thank you for a very clear talk. I see advantages to what you're proposing, but I think perhaps additionally we need to do the survey of insurers because of the timeliness. I don't see that data from 2000 are going to really be the critical piece of information when we come to the update recommendation. And we're going to want some more current data.

DR. HAYES: One thing we talked about is using the analysis that Chris does to create a baseline and then to trend that forward with PPI.

DR. NEWHOUSE: I don't know how you're going to get the behavioral response to the fee cuts by doing that.

DR. HAYES: We're looking at price changes and -- I'm not seeing...

DR. NEWHOUSE: You mean you're looking price changes between the early 1990s and 2000, and then you're going to infer from that?

DR. HOGAN: No. If we could carefully benchmark where Medicare and private rates are in 2001, and the PPI measures rate changes for the whole market, we could net out

the 2002 Medicare increase to get the private increase out of it. And so we can fix the prices in 2001 off the data, and then run forward, basically infer from the PPI the aggregate PPI increase, take out Medicare, infer the private, and run our trends forward from there.

MS. ROSENBLATT: I don't think so. Based on what I've seen I think the behavioral changes are causing graphs to switch. So I think if you just trend it from what it's been, it will give you a misperception.

DR. HOGAN: I'm sorry, I didn't mean to use the word trend. We will take the producer price index actual change in average fees from 2001 to September of 2002, we'll net out Medicare's piece of that. What's left ought to be the private piece of this.

DR. NEWHOUSE: But then how will you get the volume --

DR. HOGAN: We won't. That will just be a price analysis. The point notwithstanding, it will be better to have accurate surveys of the private side, but we sort of have our Mickey Mouse way of -- once we know where we are, to trend it forward over the short term, hoping the PPI numbers accurately capture the price changes.

DR. HAYES: We understand your concern and we'll take that back and see if there's some options. But now the survey is not going to help us with any kind of volume response. That's simply going to be a -- right, okay.

DR. NEWHOUSE: That's right.

DR. NELSON: I don't want you to think I'm ganging up on you because I had independently arrived at the same question Joe did. And I sense this disconnect between the meeting brief, which indicates that going to the insurers would certainly be direct and timely, but they might not give us the data. And then on page two of the executive summary, which says surveys of insurers may not be a viable alternative to the PPRC approach.

So I was going to ask if there's any good evidence that they won't give us the data. And I guess I was also going to ask what number of states are collecting these kinds of data. I know Utah used to, and I presume it still is, where they have an agency of the state government collect pricing and cost data for the private insurers.

DR. HAYES: Utah is collecting claims data, in other words, from private insurers?

DR. NELSON: I'm not sure about the method. I

just know they have a health cost data agency.

DR. HAYES: But in any case your main point had to do with the viability of the survey, and our judgment -- and it was just a judgment -- that we did not know what the response would be on the part of insurers to such a survey. We've had no experience with this.

The only experience that anybody's had, as far as I know, with that kind of thing is there's a consulting firm in Wisconsin that does a survey of HMOs every year. It's a rate survey. And so to the extent that those HMOs are using a version of Medicare's fee schedule, they can ask the question, what percentage of Medicare's rates are your rates?

But that's just HMOs, and my recollection is that their response rate to that survey is not all that great. I mean, they're doing it. They're doing it every year. They're selling their data. But we were worried at the staff level about whether that would be acceptable to the Commission. And so that's why we kind of went in the direction of the claims data approach. But we can revisit the rate survey idea if you want us to.

MR. HACKBARTH: You said you have two national

insurers. Two questions about that. One is, when we ask them what product are we getting information for? Or do their fee schedules vary by product line?

And then second, why do we believe that the information we get from those two will be representative of private payers more broadly? And maybe Alice and Jack can address that piece, as well.

DR. HOGAN: Yes, we ask them the product, they will identify it. So we'll know what's left of their traditional indemnity business, their PPO business, to the extent that there is HMO business in there we'll find it. Then we're getting encounters not claims for the HMOs.

Representativeness was always a big issue --

MR. HACKBARTH: Chris, before you leave the first one, what we're trying to get is their indemnity or their out-of-network PPO payment schedule?

DR. HOGAN: No, we're trying to get the average of all payers. I want it to -- so if the average private patient goes into the physician's office, I want the money to reflect that. So we're going to weight them when we're done, take their best pay and indemnity, take their PPO, take their out-of-network to the extent that it occurs, and

to the extent that we can find it take a survey-based estimate of HMO and weight them all together.

MR. HACKBARTH: So we want their real rate that they -- based on their mix of activity.

DR. HOGAN: That's right. So there's a little bit of art because the HMOs are always a missing piece, but we'll fill it in with a survey. They're not so big in the market nationally that it messes up the numbers.

Representativeness is always a thorn in the side of this approach. I can only make one claim, which is the last time we did this we actually got the third data point, which is Medstat, which claims to be a cross-section of Fortune 500 companies. The numbers that we eventually got off the Medstat database looked just like the mix of these two payers when it was appropriately weighted.

So as of 1994, they looked reasonably representative. Whether they're still representative now is going to be an open issue. You have two choices. You can make your results consistent with the results we've published in the past, which is kind of what we're doing here. Or you can try for a better frame. It's so difficult to get any insurer to play ball that if you want to go after

a sample of insurers, it's just out of the question. It's difficult to get them to play ball and each insurer's claims are different.

So there's always going to be that nagging worry that this is not representative of the typical payer. And yet I can tell you, these insurers are so nationwide and so big, that just by dint of having a lot of bodies in the plans, they're going to be reasonably representative of something.

DR. ROWE: I guess my thought would be also that the payment rates are driven by the marketplace and therefore the payment rate of a given national payer in a given market like California or Kentucky or Illinois or Georgia or someplace should be representative of that market. If the payment rates are much lower than the market then the physicians aren't going to be in the network for that payer there. If they're much higher -- if the premiums are based on the market, they're not going to support those.

So if we just take that into account, there's no a priori reason why you wouldn't get something that would be representative, I would think.

DR. HOGAN: I can say for the state of Maryland, I

just finished an analysis with them, and their large plans are very tightly clustered competing with one another. And you'll have the bit players, the life insurance company who also has a health product will have rates that are outside of --

DR. ROWE: Wait until Alice buys that plan in Maryland, though, and then things will change.

MS. ROSENBLATT: First of all I was going to weigh in as the third vote because when I read this chapter, my concern was the timing. What I mentioned before, I've seen a real change since the first decrease. So I'm really concerned in us drawing any conclusions from data that predates the first decrease in the Medicare fee schedule. And I think the second decrease, if it happens, is going to make things even worse. So I'm just real concerned about the timeliness of the data.

I also am concerned, however, about whether an appropriate survey can be designed for insurers. I mean, I would like to see us go that way. I would like to assume that my company and my colleagues and others will convince people to participate and to provide data. But I think assuming that most of the fee schedules are a percent of

RBRVS is not a good assumption.

Wellpoint alone, we've got four entities. Three of those four entities have proprietary fee schedules. The fourth entity, which is our national program, what Jack just said is 100 percent correct. It's not just statewide, but within a state there are microregions where, in some of those microregions we might be a percent of RBRVS and in other regions we might have a proprietary fee schedule.

And then there might be certain physician groups in that particular area that are so important to our employer clients, like the gentleman to my left, that we do special fees with them that don't look like the rest of our fee schedule. But there are special exceptions made.

So to get good data from the insurers you need to go into very local markets. You need to go in on a procedure basis, I think, and say I could give you for -- the way employers do it, when employers who are ASOs who are paying their own claims, and they're trying to say which insurance plan or which insurer is going to give me the best deal? Because we used to say, in the fee-for-service world, a claim is a claim is a claim and it's the service that counts. But you can't say that anymore because the

discounts are different.

So the benefit consultants have learned how to determine what one carrier's fee schedule looks like versus another. Now they may be another source of information for us, the employee benefits consultants, because they do this all the time. And if they have just put a large employer client out to bid, they may have a very, very good idea of what in a particular market it looks like.

But basically what they do is they either pull claims data and do it themselves, or they say for these procedures tell me what your actual fee schedule is. And because you want to bid on the account you're forced to provide the information.

DR. HOGAN: One of the reasons we backed away from the survey approach is we actually -- first, we went to one of our major national insurers and said can you give us the data? And they said we'll just tell you what our fee schedules are. And I said oh, that's great. That saves me a lot of time. And then we got into exactly these details. I said well, you're going to just give me one number, right? Well no, we actually have a different fee schedule for every market. So 20 markets, 20 numbers? Well no, actually, we

have a different -- and we sort of got down to where we were going to ask them for tens of thousands of numbers. At which point they said we'd rather just dump the claims than have to go through this.

That's sort of the genesis of moving in that direction. So I want to amplify that yes, I think it would be tough to get the right numbers.

But a general impression of where your fees are? Oh sure, you could ask them a number and they'd probably be able to tell you where they are.

MS. ROSENBLATT: Or you could ask for the most common fee schedule in each area, but it would need to be area-specific.

Actually, I do have another question. I don't understand why you're weighting it all.

DR. HOGAN: Weighting for what?

MS. ROSENBLATT: Why you're weighting for a given -- it sounds to me like what you're trying to do is weight how much is due to Aetna and how much is due to Humana and what is therefore the average fee that a physician is collecting from all payers? Why do you want to do that? That's where I'm getting lost.

DR. HOGAN: Because I want it to reflect the average. I want to see how Medicare compares to the average of what the physician is getting. You'd rather say is Medicare at the bottom of the market? Would you rather look at a spectrum of fees and see --

MS. ROSENBLATT: Yes.

DR. HOGAN: That's tough. The average I know what I got, or at least I think I know what I got. If you want to say how does Medicare compare to the 80th percentile of the payments in an area, that gets thin.

MS. ROSENBLATT: I just worry about that, particularly with the HMOs because again, when I read the paper and I saw the HMO estimate at 115 percent, I don't believe that for a minute.

DR. HOGAN: Right, that's --

MS. ROSENBLATT: I know that's coming from Millman and I don't believe it.

DR. HOGAN: I ran the numbers for Maryland and Maryland's a particularly tough payer, and theirs were 105 of Medicare in Maryland. The HMO number is always a hazy number but you have to fill in -- I tell you what, I didn't

have HMOs the first two years I did this and I got nailed for not -- you don't have any HMOs in there. You've left the bottom market out.

And you sort of have to make your compromises. Having tried anything but the average, I'm loath to move away from the average.

DR. NEWHOUSE: I have a couple technical questions that build on what's been asked about backing out the private from the PPI. My recollection of the PPI is that they will sample a few bills at each provider and then aggregate those nationally, because they're basically just interested in the national trend.

Now assuming it's the case that a number of the privates are not using RBRVS, they're going to come up with just a few CPT codes at each provider. And I think you potentially have a weighting problem backing it out. And that's compounded with Glenn's question about what product and what payer. Because when they go back they're going to try to find the same CPT code at that provider and the same payer, or as nearly as possible.

So if it started out not representative, it stays not representative. Now admittedly, all you're doing is

backing out from 2001 to 2003. So if the bias stays the same there's not a problem. But it's not clear to me that it will stay the same.

In any event, I think there's a problem here. It's not totally straightforward to just back out the private.

DR. HOGAN: Yes. I can't say we've thought this one through in all details. But it's going to be the short run expansion. So eventually then you'd get another year's worth of data. And you're looking at the cumulative error over a year or two.

If we could find any better price data source, we'd use it. But it was only by chance that Kevin was able to figure out -- not by chance, by dint of hard work --

DR. NEWHOUSE: Or sheer brilliance. This goes to, I think, augmenting what you're proposing with a direct survey if you could do that.

MS. DePARLE: I just wanted to follow up on what Alice asked. I share the concerns that have been expressed about the need for something timely but understand how complicated this survey idea is. And I wondered if you'd thought of doing what she suggested in picking out a couple

of procedures that might be particularly relevant for the Medicare population and just trying to survey for those? It won't be complete, but since we don't have that much time -- I don't know if that's any easier or not, Alice, or better than just saying your average fee schedule.

MS. ROSENBLATT: I think if you word it -- you have to word the questions very carefully. I think there's still a response rate question. And you have to word it very carefully in terms of most common for your PPO. You have to be very, very specific.

MR. DURENBERGER: I need to ask one of those, I'm here to learn questions, particularly to the economists. Back in the rationale for this analysis, MDs are not like hospitals, no profit measure. But the other one that's interesting to me, the opportunity costs argument.

Tomorrow morning BlueCross-BlueShield of Minnesota is going to announce to the folks in Minnesota that are listening that besides paying $4 billion a year for health services in the community, they're concerned about the fact that currently, just in the state of Minnesota -- and this is a big issue in Wisconsin, as well. Just in Minnesota, hospitals are spending $1.45 billion on new construction.

And after you discount $400 million of that for Mayo, or maybe $1 billion who knows, and then you take out the rural hospital improvement, which is a small number, they say most of the rest is in the big metropolitan areas and it's all for either cardiovascular or it's for orthopedic or...

And then what they do is demonstrate that from 2000 to 2001 the increase in demand, if you will, for cardiovascular went up 7 percent, for musculoskeletal it went up 8 percent. But for mental health, behavioral health, things like that, inpatient went up 32 percent.

So the issue is that they're presenting to the folks in Minnesota tomorrow is the opportunity cost issue. Hospitals need doctors. They particularly need specialty doctors. They particularly need heart docs, orthopedics and so forth. So they allege they are building a lot of new facilities against limited demand, and they're not building against a much larger demand. And I'm assuming that connects back to what the doctors actually get paid, and you can't survey that in two months.

But it seems to me that what it says is there is a direct connection, at least in our community or in the eyes

of BlueCross-BlueShield, at certain levels of medical specialty reimbursement, between a whole lot of where the doctors are going versus where the dollars should be going. And then they raise questions are hospitals in danger of starting a medical arms race? How can the community ensure an aggregate hospital building facility that's truly supported by patient demand? Are the reimbursement methodologies and fee schedules used by Medicare and Medicaid creating the right incentives for hospitals? What about health plans like BlueCross?

Which is why I brought this up because in this context that we're all in this together, it would appear from what they're alleging that to some degree the reimbursement system for the doctors is influencing the hospitals. And that seems to be something important for us.

MR. HACKBARTH: It doesn't necessarily have to flow through the doctors. It could be that the hospital services are mispriced and the hospitals see greater profit potential in heart and orthopedic than they do in mental health.

MR. DURENBERGER: I know that's true. But I also know in my community the hospital administrators refer to

the doctors as their customers, in this particular area of orthopedics, cardiovascular, and some of the other subspecialties.

DR. ROWE: Let me comment on this, if I may. I'm not sure if it's directly relevant to what you're doing but it may be more relevant to what Julie is doing. There is an important relationship between the physician payment rates and the hospital payment rates and the access to physicians. I don't know if it's important in private payers, and I'm not sure if it's important in Medicare, but it is very important in Medicaid. Let me just give you an example of how it works. I think it works for Medicare and you may want to take it into account.

There was a discussion earlier about hospital-based physicians or medical center-based physicians. I believe that what's happened in some large urban areas is that Medicaid has decided that they wanted to get rid of Medicaid mills where people came in and got a prescription, were seen for a very short period of time in underprivileged communities. One way to do that was to drive down the payment rate for an outpatient visit to a physician for Medicaid and drive up the hospitalization rate. Then it was

very much in the interest of the hospitals to have clinics where the Medicaid patients would be seen so that when they needed to be hospitalized they would get hospitalized at that hospital and get their heart operation or whatever. The physicians were generally salaried and were not disadvantaged by these very low rates.

In addition, in New York at least, the global rate for a visit was higher if you were a Medicaid beneficiary seen in a hospital than if you were seen for the same service in a freestanding office. So that this systematically drove the Medicaid population to the medical centers of New York City, and the medical centers competed for the Medicaid population. So here's this relationship between the physician payment rate and the hospital payment rate.

Now I don't know, but one can imagine that with respect to Medicare that there may be a similar kind of relationship because in an over-bedded situation where occupancy rates are falling and Medicare hospital payments are viewed as relatively important, as the lifeblood of a given hospital, they would be assured that all their doctors accepted Medicare patients, for instance, and all their

clinics would accept Medicare patients, et cetera. And they wouldn't push back very much on the physician rates in Medicare because it was the hospital rate that really mattered.

I don't know, David, whether this is directly relevant to the question but I think it may be relevant to some of the questions about what is driving the hospitals and why they're doing certain kinds of things. It may not be the physician at all, it's the hospital rate that is really driving the hospital decisions, as Glenn said. I don't know if that's helpful.

MR. FEEZOR: Chris, question on your two large insurers you're proposing. Both of those use their own networks and don't have a variety of phantom PPO networks that they can access for the lowest cost?

DR. HOGAN: That's a good question.

MR. FEEZOR: You don't have to answer it, but just check and make sure that's the case, because certainly on a lot of self-funded plans that are administered you may actually have five or six rental networks that you bounce your procedure against to see which gives you the least cost. So you may want to check on that.

DR. WOLTER: Just to follow up on Jack's comment, I don't think that there's any question that the differential payment rates, even just within the Medicare program for procedural and surgical things create incentives that lead people in a given direction. I think that's why we see heart hospitals and outpatient surgery joint ventures, and that's why people are struggling to provide mental health, et cetera. I suppose that's obvious to everyone, but I think those differential payment rates within the Medicare program and to some degree in the commercial market as well, have created lots of activity in terms of where investments are being made, and whether MedPAC looks at that or not eventually I think is a good question.

MR. HACKBARTH: I have a vague recollection of having read a summary of a study that was published just recently on this topic about mispricing of particular services by Medicare, including cardiac services. Maybe it will come to me later on exactly where I saw that. But it was just this argument that there are errors in the pricing and it drives a certain type of hospital behavior and major investment in cardiac in particular.

DR. NEWHOUSE: Actually I just had a doctoral student finish who showed that there's a big differential response between for-profit and not-for-profit hospitals in exactly these dimensions, with for-profits being much more responsive to the payment.

MR. HACKBARTH: So on this question we've had a host of questions raised and a few suggestions. I guess my question for you, Kevin and Chris, is do you know where you're headed on this? We've got a basic method -- I didn't hear anybody say we've got to go in a fundamentally different direction. What I heard was mostly suggested amendments to the methodology. Am I hearing people correctly?

MS. ROSENBLATT: I'm concerned about the method due to the age of the data. I'm not sure that I'm behind that method because you're required to use old data.

DR. HOGAN: Can I say one word to that? But it will be only as old as your Medicare claims. That's the response. So if the issue comes down to, look, my goodness, we've had a reduction in the use of office visits, then we would be able to look back -- by the time you get your reduction in the Medicare services you'll be able to look at

the private services at the same time. You've only got 2001 Medicare data now and are just getting in -- is that right? In the fall of 2002 you're just getting in your 2001 Medicare claims. So our private data will be in sync with your Medicare claims. It's only not in sync with the real world.

MR. HACKBARTH: The lag in the data, the age in the data would be a problem if, for example, private payers quickly followed Medicare in cutting fees, and somehow that wasn't reflected in the PPI data. So we would be saying, there's this difference but it's just an artifact of our analytic method as opposed to a reflection of the real market situation at this point in time. I don't know how likely that is but that's, to me, the obvious problem scenario.

MR. FEEZOR: To my colleague from California here, to emphasize that I think just the reverse is happening. I think that because of the price reduction, at least in -- and I happen to be moving at the same time 400,000 lives, which is causing some reaggregation into certain medical groups -- that there is a significant, significant push back. Whether I think it would have happened anyway, it

happens also because I have a higher risk exposure than the general commercial population.

But it also, I think there's very clear evidence, at least within a lot of the major physician groups in California, that the decreases they've received on the Medicare side are causing them to, I think, be a little bold emboldened on their private side. I think that's where the time lag is that Alice is talking about is a concern that we will have missed it. We will have made the right conclusions at the right time, but as Chris said, it may not bear with reality by the time it's printed.

MR. HACKBARTH: If that's our subjective assessment then we would be in a position of saying, this is a conservative analysis. That we think that if everything, because of this seesaw relationship between private payments and Medicare payments that the gap would even be larger than the one that we're showing here.

DR. HOGAN: Joe's comment not withstanding with regard to the PPI, we will take your price forward as far as we can get it, literally to the current month, with the projection based on the PPI. There would be uncertainty in that but you'll be -- that's as current as we can get them.

DR. REISCHAUER: I guess I'm not concerned about this at all, for a much improved estimate of what's going on. I don't even really follow what Joe was saying about the PPI, unless you think that the CPT codes that they have in their sample, behavior of them, if they keep them consistent through time, is different from the average of all CPT codes. Presumably they have a representative sample of procedures so that shouldn't be a problem really either.

DR. HAYES: That's what they aim to do, and they aim to do that by physician specialty. But we need to come back to you with some more details on the PPI and our ability to use that to roll forward the estimates that come out of the claims data. We will also give some further consideration to the idea of doing the survey to see what the cost of that would be and whether that's a viable option. From what we're hearing, this idea in general of doing this kind of an analysis is a good one, and it's just a matter now of making it as good an analysis as possible. That just becomes a question at some point of a resource availability. So we have to balance all that together and we will.

MR. HACKBARTH: I agree with that summary. I

think you're hearing us correctly, Kevin.

Alice, did you want to have the final word?

MS. ROSENBLATT: I was just going to say that I think due to my concerns and others about the data that if we can supplement with a survey. It's one of those things where if we've got three or four ways that all tell us the same story then there's comfort in it. Whereas, if we're looking at just one thing we can be totally fooled.

DR. HAYES: That's what Chris said, I think, is that in the past that's exactly what we tried to do is to construct a complementary analysis that gives us some reassurance that we're in the right ballpark.

MR. HACKBARTH: Okay, thank you. Look forward to hearing more.

Now we're going to leave our general topic of access and begin by taking up alternatives to administered pricing and looking at competitive bidding, in this case for DME, as the case study. Anne, you're going to do the intro on this?

MS. MUTTI: Yes, I'll do a brief intro. I'm just going to take a moment to give you a sense of the context of this presentation and then turn it over to Sharon. This

presentation and the supporting paper that goes behind it is the first step in a larger effort that we're going to be undertaking over the next few months to look at alternatives to administered pricing. We're hoping to put this analysis in the June report.

So in the course of the next several months we are going to be looking for models of alternatives, in the private sector, in other governmental purchasers, in the literature, and in Medicare demonstrations such as the competitive bidding demonstration for DME as well as the competitive pricing demonstration for managed care services. I think we're going to be looking at both models of competitive bidding, and then think outside the box or try to, are there other alternatives to administered pricing such as negotiation, mirroring rates that are achieved in the private sector?

We are looking to you for input of ideas and will be hoping that if you have any ideas today, that would be great, and then we'll be coming back to you probably at the next meeting or the one thereafter to get ideas and reaction to what we're planning to do. I imagine that we'll put together an outline that will give you a sense of the issues

that we are going to be tracking on, and the scope of the project, and ask for your feedback on that.

Today, Sharon will go through describing what the competitive bidding demonstration looked like and the results of a preliminary evaluation. We're hoping that as she discusses this you'll be thinking about those questions, those design issues that you feel are more important and that transcend a lot of different kinds of models of competitive bidding that you would like us to focus on. So with that I'll turn it over to Sharon.

MS. CHENG: As Anne alluded, we are looking -- this is really a first blush. This is an examination of one version of one alternative to administered pricing. The topic is a competitive bidding demonstration for durable medical equipment, prosthetics, orthotics, and supplies that is currently underway at CMS. This demonstration was authorized in the Balanced Budget Act in 1997 for up to five sites and CMS selected two sites in which to implement the demonstration, Polk County, Florida and San Antonio, Texas. The demonstration bids were solicited in Polk County in 1999. They began the second phase of it in San Antonio, Texas in 2001, and the demonstration as a whole is scheduled

to end December of this year.

They were required to include oxygen and supplies. They ended up, between the two sites, including eight items within the DME benefit. Bids were solicited to oxygen, hospital beds, enteral nutrition, neurological supplies, surgical dressings -- that is to say, wound care primarily -- nebulizer drugs such as albuterol, manual wheelchairs, and non-custom orthotics, so-called off-the-shelf orthotics.

The first five items in this list are the ones that were included in Polk County and Polk County is going to be the focus of our discussion of this demonstration. The initial evaluation of San Antonio, Texas is not yet available so we can't tell you quite as much about that second phase yet.

To implement this alternative method the designers had to face several issues. The first issue that we're going to talk about is definition. They had to define the market as well as a product.

In defining the market the issue was finding a market that would be neither too small nor too large. A small market would have too few bene's, wouldn't have enough suppliers to get a competitive environment. One that was

too large, they might find that the price that they set was not acceptable throughout the market area, or they might have incomplete, spotty coverage of the market area. To address this issue they found the two sites. Polk County has 92,000 beneficiaries that were served at least a little bit by 300 DME suppliers and was served substantially by over 40.

The second definitional issue that they had to tackle was that of product. For competitive bidding to work as an idea you need comparable products so that your bids are comparable. They looked within DME because within DME is primarily purchasing commodities. There's very little service component. So to define the product you really have to hone in on quality issues and describing a physical item rather than a somewhat more complex task of breaking down a medical procedure.

A very important design issue, obviously is the system for choosing bids within this competitive demonstration. They received a range of bids from bidders with a wide range of capacities. So they had to try to choose a market-clearing price, and while they were at it, err toward excess supply because they were very concerned to

ensure that all beneficiaries had access to high quality services. So they wanted to cut-off that was high enough to ensure capacity in the market, but also to generate some savings for the Medicare program.

For the bidding process, it was open to any supplier with good standing in the market. They were required to bid for all items within the category, and you could bid for one, some, or all of the five DME categories. Then they had a multi-step process.

Generally speaking, they created a composite bid within each DME category for each supplier. They then ranked the suppliers by that composite bid and identified a cut-off bid at the point where the cumulative estimated capacity of the lower priced suppliers equalled the projected demand for items in that category. Next, suppliers below the cut-off bid were evaluated for quality, and those that met the quality standards or addressed issues that were discovered in the examination were then offered a contract to participate as a winning supplier in the demonstration.

Another important design issue is how to make sure that quality standards were strict enough and were high.

This was to address concerns that many had about this process, that if the competition is drive substantially by price, that quality might suffer. In response to this issue, within this demonstration they set very high, very strict quality standards. They conducted site visits. They gathered references from each one of the winning suppliers and checked those references for the quality of the suppliers. They also created an ombudsman that was on the site to continuously monitor and make sure that the quality standards were met.

Another important issue in designing an alternative like this is to make sure you have appropriate stakeholder education. The CMS team did a lot of outreach for this demonstration. They wanted to minimize they disruption in the market and they wanted to ensure participation to make sure that everybody who was interested in it felt sufficiently prepared to participate and compete. They had several conferences with the bidders. Information went out to physicians, social workers and other referral agents, anybody who would be in charge of connecting a beneficiary to one of the winning bidders, and also had a very substantial booklet for beneficiaries to use to make

sure that they could identify the winning suppliers in the bid.

Finally, transition policies, which builds on the idea that we want to minimize the disruption for beneficiaries. As you know, under the current system Medicare sets the price and anyone who meets the program criteria can supply. In this instance where an important part of the project is to limit the number of participants they wanted to make sure that important relationships between the beneficiaries and suppliers were disrupted to a minimal amount. In most cases, therefore, non-winning suppliers could still participate and could maintain existing relationships with beneficiaries in the demonstration so long as they accepted the demonstration price.

After tackling these design issues we do have some preliminary evaluation results and these are generally positive. Again, these are based on Polk County. The first positive indication was that suppliers were willing to participate. Bidders were both large and small. There was one large supplier who was interested enough in participating, or so it seemed, that they actually

subsequently purchased two of the winning suppliers. Though we cannot draw a direct causal relationship there but it is an interesting sidebar.

Prices were reduced without a loss of quality or access in this preliminary evaluation. This was based on nine months of data for the five services in Polk County, that the average price was reduced 17 percent. There were no consistent reports of decline in quality of supplier, and they measured that in several different dimensions. They looked at response times, the number of service calls -- whether or not the beneficiary felt that they were getting appropriate training and understanding equipment that was in their home. And also product substitution, to try to get a sense from beneficiaries to make sure that they weren't receiving a product that was just at a lower rate that they weren't happy with.

Also in the preliminary evaluation the team felt that some aspects of the demonstration may be difficult to replicate. We have a couple of examples. Both of these sites were in medium size MSAs so it doesn't tell us the system's feasibility in a rural area where there might be few suppliers or few beneficiaries, or in a very large area

where the administrative burden may be substantially greater, or where the results of the demonstration would represent a much larger portion or perhaps all of the book of business of the suppliers.

Also, the services in the demo were essentially commodities within DME. The demo does not tell us about the system's feasibility for DME items with substantial service components such as custom-fitted orthotics, nor non-commodity services typical of benefits outside of DME.

After looking at the design issues that they faced and some preliminary evaluations we'd like to move on to what we feel are some broader questions that this example raises about alternatives to administered pricing. These include defining the market, how should the market or the product be defined? What is the market area? Should the product be a bundle of services and goods? What suppliers or providers can participate? How should Medicare identify the competitive price? For example, what are bidding rules and how is the price determined?

How should any savings be shared between the program and the beneficiaries, between the program and providers perhaps? How should the process by managed? What

actions are needed to recruit and prepare participants? How would disruption in service be limited? How would Medicare monitor compliance and protect beneficiaries. Also for a substantial change in Medicare's means of doing business, how do you encourage stakeholder buy-in to ensure participation?

So as we begin to shape our research for the June chapter we welcome any thoughts on the types of questions that you're more interested in as well as any questions you might have about this demonstration in particular.

DR. REISCHAUER: Thank you. Joe?

DR. NEWHOUSE: A few things. The first is just a question. You said that in the demonstration CMS actually paid at the average of the winning bidders. I don't know if you said that here but that was what was in our draft. Is that right? I understand the cut-off price, and then they averaged below the cut-off price, so they actually took some people's bids down to the average price?

MS. CHENG: There are two steps --

DR. NEWHOUSE: If I'm between the average and the cut-off, what happened?

MS. CHENG: Obviously there's another step. They

had to identify the cut-off bid, and that was the bid at which they felt they had sufficient capacity among the winning suppliers beneath that price. From the composite bid then they had to set item prices. The process of setting the goods within the item were based on the cut-off bid but were not necessarily equal to the same price as the cut-off.

DR. NEWHOUSE: It seems to me there's a potential problem here. Anne asked about other alternatives such as negotiation. I'd like to think about it some more but it seems to me that for either negotiation or competitive bidding to work well you need a number of suppliers, and in that case the issue is when would negotiation work well and competition wouldn't work well? Maybe that's when you have a service where it's hard to capture -- when it's not homogeneous. But I'm not sure it's obvious.

Then the last point I want to make is there literature now in economics on rules or how to do well in auctions that is largely based off of experience in auctions for oil and auctions for telephone spectrum, both here and abroad, and I can give you some references.

MR. DeBUSK: I've been in this business about 37

years and I've never seen a bid quite like this. Now let me see if I get this straight. The bid went out and the price was established, and after the price was established, said here's the price and you're capable of supplying the market, now for the people who didn't win the bid, if you'll meet the price of the low bidder you can have the business as well in your area. Is that what you said?

DR. NEWHOUSE: Yes, they did say that.

MR. DeBUSK: Why ever bid? What would be the purpose of ever bidding?

MS. CHENG: There were several different transition policies and that was one of them. Within oxygen, if you were a non-winning supplier, you could maintain the relationship that you had prior to the bid with that clientele. However, all subsequent new entrants, all subsequent new need went to the winning suppliers.

MR. DeBUSK: So there's a differentiation.

MS. CHENG: So the winning suppliers have an incentive because they are the ones that will share the new market.

MR. DeBUSK: When you get into prosthetic or orthotics, which is heavily, heavily based upon service, how

would you ever bid those kinds of services? I think there needs to be some real clear definition put in some of this because you can bid a wheelchair but when somebody is building you an artificial arm, am I going to take the wooden one, the plastic one, or the fiberglass one? I mean, you're getting into all kinds of services and quality problems. They've been 50-some years putting that L-coded system together and this is a real touchy area when you get into this service piece. So it will be interesting to see how it is going forward.

Now I can see part of the stuff can be bid out. I have no question there, with some of the durable medical, the beds, the wheelchairs. But the way the system works -- and I guess there was no place else to put it but the orthotics and prosthetics had to fit somewhere in the system. It didn't fit in the DRG area too well or the APC area too well. It fit into that coded world that's been established and it's going to be very tough, in my opinion, to take and bid that out in a traditional way, or the way they're trying to approach it.

MS. MUTTI: That will certainly be among the issues that we will try to tackle.

MS. ZAWISTOWICH: Pete, just a clarifying point. On your first question about why did they let those suppliers that bid higher than the established bid into the program. It was really an issue of protecting the beneficiaries. There was a lot of concern that this was the first time that anything like this had been done.

Then the second point about the prosthetics and orthotics, I think in this particular demonstration there was a real concern about not bidding custom devices. That's why they went with those homogeneous products. I think that's really an issue for the design of any competitive bidding system is not to deal with customized devices.

MR. DeBUSK: Or custom-fitted devices.

MR. MULLER: Obviously this is an initial effort but if I can analogize back to some of the efforts under capitated pricing for medical services in the late '90s and how they came apart in part on when it wasn't a commodity and when it wasn't fairly homogeneous goods, and when you got the kind of difficulty when you couldn't control for -- when utilization was not very predictable, when services were very heterogeneous. And whether the efforts were in the capitation of physician services or the capitation of a

complete range of services, they started coming apart very quickly when under a bundled price you started getting much more utilization and much more variation than expected.

So I would think by -- at least I'm thinking by analogy, one can probably do this in those parts where, as you said, there isn't a big service component, where it's a very predictable demand, where the goods are more like commodities. But as soon as you get into something more complex, which is probably most of Medicare spending, it becomes much more difficult to see how to do it. I know they've tried at times to reinvent capitation and I just don't see how they're going to come back to it until those kind of risk adjustment problems that we discussed very extensively last year in M+C get taken care of.

DR. REISCHAUER: I don't want anything I say to sound like I haven't been a big advocate of this effort, because I have, but one of the great advantages of competitive markets is that they run themselves or there's an invisible hand that you don't have to pay to make them go. But these, which I call managed markets, clearly involve lots of people having to define the parameters of the market and run the markets, in a sense, and you're

paying them all a GS-15 salary or whatever. So I think it's important for us when we think about applicability of managed markets to Medicare to think about the cost and complexity of actually operating these in 3,000 counties or whatever-thousand markets. We should collect some information on what kind of human resources are necessary.

Now obviously to run these demos there's a whole lot more involved than an ongoing procedure would be. But nevertheless, it might be a rather substantial chunk of change that you're thinking of devoting to these things which you'd want to balance off against the benefits.

A different point. At the end of the questions raised, share any savings with the beneficiary. Of course, these are Part B expenditures and there are coinsurance requirements so automatically beneficiaries do gain when prices go down. That was one of the arguments that was used, I know, with political officials when they were trying to get Polk County and San Antonio, and the judges, to go along with this. I'm not sure that there's any need to think beyond that. Presumably what you're trying to do is get the prices down to what they should be in an efficient market situation and then ask the beneficiaries to pay their

20 percent.

MS. MUTTI: Bob, we had that as a more general question, if you weren't dealing with just a Part B service, if you were dealing in a managed care environment or something. So we were trying to think a little broader, but your point is well taken.

MR. HACKBARTH: Any other comments, questions?

DR. NEWHOUSE: I think there's an issue about whether you pay people at some function of what they bid or at some function of what everybody else bids in terms of incentives to bid low. That's where I think some of this other literature could help inform that.

MR. HACKBARTH: Okay, thank you very much.

To complete the day we are turning to two mandated studies, both of which relate to the M+C program, the first one on social HMOs and then second, choice of SNF services within M+C.

MR. GREENE: The Deficit Reduction Act of 1984 established guidelines for a demonstration of the social health maintenance organization, also called S/HMO. HCFA initiated the demonstration in 1985 and the Congress extended the demonstration five times between 1987 and 2000.

The demonstration is currently scheduled to continue. CMS has extended it through December 2003, and legislation passed by the House would extend it through December 2004.

The Balanced Budget Act of 1997 required the Secretary to submit a report to the Congress that addresses transitioning S/HMOs and similar plans to the Medicare+Choice program. He submitted this report on February 1st, 2001 and is preparing a final report on the demonstration now. The Balanced Budget Refinement Act of 1999 required that MedPAC submit a report to the Congress containing recommendations regarding the project no later than six months after the Secretary submits his final report. The CMS final report on the S/HMO demonstration is expected to be submitted to Congress this November.

The social health maintenance organization tests a managed care model intended to integrate acute, chronic, and long term care as well as social services through health maintenance organizations. All plans are paid on a capitation basis. They receive payments 5.3 percent greater than the Medicare+Choice county rate. That is 5.3 percent greater than the old AAPCC.

There are two social health maintenance

organization models. Four first generation plans were started in 1985, as I indicated, and three continue in operation. Evaluation of this demonstration led to development of a new model. One second generation plan was started in 1996. Both S/HMO models are designed to integrate services through an expanded benefit package and care coordination. They offer three types of benefits, basic Medicare, expanded benefits such as drugs and eyeglasses, and home and community-based long term care.

All enrollees are entitled to basic and expanded benefits. In the S/HMO 1 plans, enrollees determined to be nursing home certifiable are entitled to long term care benefits. Case managers play a key role in allocating these benefits in the S/HMO 1. Benefits include things such intermediate nursing care, personal health aides, adult daycare and respite care.

One goal of the S/HMO 2 demonstration is to incorporate practices that geriatricians developed into the operations of a plan. These include measures such as comprehensive geriatric assessment for some patients, treatment of functional problems, and team approaches to care. In the second generation demonstration these benefits

are not limited to the nursing home certifiable as in the S/HMO 1 but are provided to those with high risk conditions impending disability and disabilities.

Payments to the S/HMO plans are risk adjusted and the methodology varies by the model. The S/HMO 1 demonstration uses modifications to the payment factors in the demographic component of the Medicare+Choice rates. The second generation S/HMO method is based on a regression model. Payment is determined by the presence of 10 chronic conditions, ability to perform four activities of daily living, and several other variables. These are MCBS variables.

CMS has exempted the S/HMOs from M+C risk adjustment and continues to explore alternative methods for reflecting frailty in the proposed comprehensive risk adjustment system.

As I indicated in the briefing material, in the tables there, enrollment in the S/HMO demonstrations increased greatly in recent years, from about 70,000 in December 1998 to about 108,000 in July of this year. Membership averages 27,000 per plan. However this really reflects two large plans and two much smaller plans. SCAN

in Southern California has 52,000 and Health Plan in Nevada, the second generation plan, has almost 41,000. So this is 90 percent of the entire demonstration. Of course, S/HMO members are a very small share of the total Medicare beneficiary population. In addition, members are a very small share of each market area's population with the exception of the Health Plan of Nevada, the S/HMO 2 plan.

HCFA first evaluated the first generation sites in the 1980s. The second evaluation, focused on the S/HMO 2 site, is nearly completion. The first evaluation found that the first generation plans successfully offered long term care services but did not develop well-coordinated systems linking acute and chronic medical benefits. This is important, because as I indicated earlier, this was a key goal of the original demonstration, integrating acute and long term care. The principal problem was that the projects did not establish good working relationships between physicians and case managers. Physicians did not change practice style and remained uninvolved with participants.

Since the evaluation, the first generation plan in Portland, Oregon, the Kaiser plan has moved forward with integrating care more successfully, and preliminary results

from the evaluation of the S/HMO 2 indicates some greater success in care integration.

The first evaluation found that the S/HMO plans varied in total cost, with some sites higher than fee-for-service and others lower. In addition, different cost components, physician, nursing home, and such, vary. Some are higher than fee-for-service and some are lower. Preliminary information from the evaluation of the second generation plan indicates no overall difference in service use between the S/HMO and Medicare+Choice plans in its market area. This doesn't directly address the question of cost or expenditures but it does suggest that costs do not differ between the Nevada plan and its neighboring M+C plans.

S/HMO members are generally no more frail than members of the M+C plans in the same market area. The evaluation found that based on measures of health and functional status, two of three first generation plans had case mix that does not differ from that of M+C plans. In addition, the health status of members in the second generation plan also does not differ from that of members of area M+C plans. The exception here is the S/HMO run by

Kaiser in Portland, a group model HMO. This HMO operates both a S/HMO and a regular M+C plan in the same market, which suggests that there may be a selection process of beneficiaries seeking or in need of greater care moving to the demonstration plan, and others selecting the conventional M+C plan.

The demonstration plans have mixed effects on health outcomes. First generation plans showed similar results as fee-for-service. There was no difference for case-mix standardized mortality between the S/HMO plans and traditional Medicare. Other measures of outcome were ambiguous; superior for some subpopulations compared to fee-for-service and not for other populations.

Preliminary results from the evaluation of the second generation plan show no greater improvement in member health and functional status than in M+C plans. Researchers concluded that there is no consistent evidence of positive effect of the S/HMO benefits on member physical, cognitive, or emotional health.

The Secretary is considering the future of the S/HMO demonstration. A report on transitioning the plans into Medicare+Choice presents two options; convert the

S/HMOs into standard M+C plans at the conclusion of the demonstration or make the social health maintenance organization an alternative under the M+C program. The report recommended converting S/HMOs into standard M+C plans with a transition ending in 2007. Supplemental payments to S/HMOs would be phased out while comprehensive risk adjustment was introduced. In 2007, the S/HMOs would be paid entirely with M+C comprehensive risk adjustment.

The Secretary is not expected to make a recommendation in the final report on the demonstration. This is the report that you're required to formally respond to. CMS may not repeat the recommendation made by the previous administration in its February 2001 report on transitioning the S/HMO into M+C, either in the final report or elsewhere. We don't know whether the recommendations I've just described will be the ones that CMS will be presenting in the future.

MR. HACKBARTH: Tim, I'm not sure I followed that. So in February 2001 they said we ought to convert these into standard M+C plans?

MR. GREENE: Right.

MR. HACKBARTH: Then you're saying you don't know

whether they will --

MR. GREENE: That's the last administration's recommendation so we don't know where they stand, and we can't tell from CMS staff contacts. So these are what we know but we just can't say for a certainty whether they're going to continue.

When the final report is available, staff will evaluate it and develop options for the Commission's response. We'll critically review the data used and the analytic methods employed. I could note in passing that there are major weaknesses in the evaluation of the S/HMO 2 which the CMS researchers readily acknowledge. That the evaluation was done as published, and even to some extent in the final form we'll see, based on a very early period of the second generation demonstration before many of the components were in place and when they were still developing.

Secondly, in terms of methodology, researchers note that -- based their analysis on a comparison of the demonstration with a comparison group in the overall HMO. The comparison group was closed down in the middle of the evaluation period and they conclude from that that it's very

difficult to reach firm conclusions. That's a methodological question we'll have to examine and consider. But the short of it is, the researchers are very conservative in their interpretation of the data and the methodology and we'll have to consider that in our response.

We will examine the options CMS considered and the recommendations it makes, both in February 2001 and anything further they come out with. BBRA requires that you contain recommendations regarding the project in your report. When the final report is available you can consider any options and recommendations in that report, or any recommendations made by CMS outside of the framework of the report. It's possible, as I said, there will be no recommendation for the future of the demonstration actually contained in the final report but there may be one made by CMS at the same time in parallel.

You may wish to consider both recommendations, other alternatives, the CMS continuing work on frailty and the risk adjustment system and other factors.

Thank you. I'll take questions.

MR. HACKBARTH: The idea of demonstrations going on as long as these have troubles me, let me put it that

way. I've got this thing about order. It seems to me that we don't want the demonstration process to be abused and become a vehicle for making higher payments or different payments to certain privileged organizations. So I would say there's a burden of proof that needs to be carried. That there's got to be, at some point in time, some reasonable evidence that these people are doing something new, unique, different, better that at some point in the future could benefit the entire Medicare program.

Based on what you've reported here, it doesn't seem to me that that standard of proof, that burden of proof has been carried, or anywhere near carried in these cases. In fact it's not even clear that they're enrolling a different population, which would be the starting point to show that you're doing something new and better for the frail elderly. You've got to have a different population. So I've got lots of reservations about this continuing and I guess my inclination would be to convert.

DR. ROWE: A couple of comments. Based on my experience with these kinds of things, this has several of the characteristics of long term clinical demonstrations based on the intuitive view that this must be better for

patients. The two that come to mind, just from listening to your comments, are first, you always blame the doc when it doesn't work because the doc didn't integrate well enough with the case manager.

The second uniform finding in my experience is that when the evaluation doesn't show that it works, you blame the evaluation; so your comments about the evaluation was flawed and it wasn't done right, there are questions about it.

The third, and final comment you'll be happy to know, is in my experience with these geriatric programs like the PACE program and the S/HMO and the comprehensive geriatric assessment programs, the determination of whether they work or not in the end in any large scale demonstration is very strongly influenced by the selection of the individuals who are put into this new methodology. Comprehensive geriatric assessment obviously works, but 20 studies showed it didn't because people weren't selected who were really likely to benefit from it. They weren't old enough, they weren't sick enough, they weren't on enough medications, they didn't have enough disability, et cetera, so you could never show benefit.

It's a design fault. It's the doctors, it's evaluation, and then finally when that fails it's a design fault.

So my question is whether or not -- not knowing enough about the S/HMO because I'm only 58 so I haven't been around as long as this demonstration. It was underway well before I graduated med school. But what if your sense, Tim, of how well targeted the intervention was to individuals who were likely to benefit?

MR. GREENE: The short answer is, I suppose it's not targeted to the frail. On the other hand, it was never intended to be. We classify S/HMO as one of the frail elderly programs, demonstrations. In fact it isn't, and as designed, as originally designed and described the demonstration was structured to avoid selection problems by deliberately going out to recruit a representative sample of beneficiaries. It was explicitly not designed as a program for the frail elderly and that's the way it's worked out, so we shouldn't be surprised.

DR. ROWE: So we shouldn't have this failure indicate that it doesn't work for the frail elderly, right?

MR. GREENE: Right, but it was never structured --

MR. DURENBERGER: I want to prove Jack's point about intuitive. I was in one of my son's garage in Minneapolis the other day, on Saturday looking for his power sprayer to clean my deck or something like that and he brought out this old box of plaques and he said, Dad, can I get rid of these damn things? Excuse me, darn things. So I started going through them and there's one that says, presented to me in about 1984 that said, the father of S/HMO.

[Laughter.]

MR. DURENBERGER: Also Jay Constantine who used to work for Herman Talmadge, he sent me out to San Francisco to look at this thing that became On Lok. So I'm the father of On Lok somebody told me. You look at PACE and you look at -- I was just at Evercare a couple weeks ago and they said, you're the father of the Evercare. I said, my God, I'm getting old, or I've been messing around fathering all these things.

But anyway, I agree with what the chairman said, why does it take 20 years to do it? But I just want to claim credit for the fact we're sitting here today talking about this.

MR. HACKBARTH: We should put you in charge of acronyms, too.

MR. DURENBERGER: We had one the same year called leaking underground storage tanks. That was LUST. And we had zap the ZIP, that was trying to beat the nine-digit ZIP code. So the intuitive level at which we operated was a direct reflection on what many of us brought to bear on the subject.

DR. REISCHAUER: You know how they measure success in the Senate, when Dave takes responsibility for something that the evaluations show doesn't work and then says, this is a success.

[Laughter.]

DR. REISCHAUER: I was wondering, Tim, whether these entities charge premiums or have begun to charge premiums the way other Medicare+Choice plans do, or has the 5.3 percent been enough to tide them over these tougher times?

MR. GREENE: The only one of the four that charges premiums is the Kaiser plan in Portland. That's also the one that appears to have suffered adverse selection so it's not surprising. That's the short answer; no, with an

understandable exception.

DR. WAKEFIELD: Tim, just two quick questions. I'm not very familiar with S/HMOs so are these plans primarily beneficiaries who reside in urban areas?

MR. GREENE: Yes.

DR. WAKEFIELD: Are they almost exclusively that?

MR. GREENE: Yes.

DR. WAKEFIELD: Then secondly, the beneficiary satisfaction data that you report, I'm following the health status and functional status data. For the beneficiary satisfaction --

MR. MULLER: [Inaudible.]

DR. WAKEFIELD: They do? Then I'm going to change my position on this, Ralph. Thank you for that heads-up.

The satisfaction data that were collected that are reflected on page four, I tracked on the health status and functional status data, but could you tell me the beneficiary satisfaction data you reported on page four, does that reflect both the phase one set of plans and phase two, or stage one and stage two, or are those satisfaction data collected on just one and not the other?

MR. GREENE: That's first generation plans, partly

because the data was very limited in the 1980s and early 1990s at the time of that evaluation. By contrast, the data available for the second generation plan are more extensive data available in the late '90s and now. Secondly, there's a continuing survey of member health and functional status at the second generation plan.

DR. WAKEFIELD: So can you just tell me what is it, what are the beneficiary satisfaction data on the second generation plan? Is that far enough along that they have it?

MR. GREENE: I don't recall.

DR. WAKEFIELD: You don't recall. So they probably have some but we don't know what it is?

MR. GREENE: Yes. It's reported in the evaluation, I just don't recall because the focus has been on the outcomes measures as opposed to satisfaction so that's been researchers and my principal concern. I can certainly check the satisfaction information in the second report.

MR. HACKBARTH: Tim, MedPAC twice previously addressed this issue, once in 1999, and once in 2000. I am a lawyer after all and so I'd like, if we're going to change

course I'd like to be able to explain what's difference today from the year 2000, for example.

I haven't gone back and reviewed the text, but I am looking at the 2000 recommendations which are on page 11 of what's in our book. Reading between the lines here is an implicit endorsement of specialized plans that care for the elderly. Basically we say, tread carefully. Don't force them back into the regular payment system until it's clear that there is an alternative that meets the special needs of these programs.

Refresh my recollection about the conversation surrounding the 2000 recommendation and help me understand why I feel so differently today than apparently I felt then?

MS. RAPHAEL: I do remember that conversation and I think it had to do with the PACE programs which serve a dually eligible, frail elderly population, and it's a very different population from the S/HMO population.

MR. HACKBARTH: Yes, very different.

DR. NEWHOUSE: And Evercare also.

MR. HACKBARTH: But I remember, albeit vaguely, also talking about S/HMO in that same basket. I think those points are very well taken, Carol. I think PACE and

Evercare are quite different programs and situations.

MR. GREENE: Several answers I suppose. First, you're correct we were talking about a whole range of specialized plans, frail elderly and otherwise.

DR. NEWHOUSE: We were asked to.

MR. GREENE: Yes, we were asked to. Now in this context and based on this mandate we're looking solely at the social health maintenance organization which, as I indicated, is a very different animal. So in that sense we had a different concern then.

Secondly, in terms of the 2000 recommendation, that was a report to Congress on risk adjustment, so it was a rather narrow, technical recommendation in the context of the initial PIP-DCG risk adjustment system.

MR. HACKBARTH: That's helpful. Any other comments on this?

MR. FEEZOR: Just for the record that when this issue comes up later I'll probably have to excuse myself. I think my organization has a financing relationship with one of them.

MR. HACKBARTH: I think we gave you a fairly clear direction on this one. Thank you.

MR. GREENE: See you in eight, nine months I suppose.

MR. HACKBARTH:

Next, the SNF issue.

MR. GREENE: Good afternoon. I'll be discussing we were addressing in a mandated report to Congress and our plans for the report which is due at the end of this year. Approximately 2 million Medicare beneficiaries lived in long term care facilities in 2000. Of these, 64 percent were in nursing homes and 7 percent were in continuing care retirement communities, CCRCs. Almost 60 percent of the CCRC residents lived in communities which offered skilled nursing facility services.

Most Medicare+Choice plans require that member receive care from providers with which the plans have contracts. Plan members who reside in CCRC or nursing facilities may require post-hospital care. In such cases, the member might prefer placement in a SNF on the campus of the retirement community in which they lived or in one in which they resided before hospitalization. However, the plan may require that a beneficiary receive care from a specific facility in its network of contract providers.

Disagreements between managed care organizations and managed care plan members with regard to post-hospital SNF placement have arisen in several states. For example, a plan required that a resident of a Jewish retirement community go to a non-sectarian home after hospitalization. This led her retirement community to prepare kosher meals and deliver them to her at the SNF where she was placed. The state responded by enacting a law providing residents of continuing care retirement communities and assisted living facilities a right to return to a SNF operated by their community or facility. Under the law, a resident of a CCRC may sue a plan if it refuses payment to a SNF not in its network.

Controversies such as this have led New York, California, and other states to enact laws addressing choice of nursing facility. Your briefing material presents the text of these laws, which is similar to those in other states. These statutes typically apply to managed care members residing in retirement communities or nursing facilities and relate to post-hospital referral, to payment, or both.

In the Medicare Benefits Improvement and

Protection Act of 2000, BIPA, the Congress established similar rights for members of M+C plans. Beneficiaries are assured of choice of SNF upon discharge if they resided in a SNF before admission, if the nursing facility is a CCRbased SNF and is located at the community in which they lived before hospitalization, or if their spouse resides in the nursing facility at the time they are discharged from the hospital. Plans must pay these SNFs at rates consistent with the payments they make to nursing facilities with which they contract.

BIPA requires that MedPAC evaluate the impact of the choice provision. Reports from nursing home and retirement community managers and representatives of long term care facility organizations suggest that the problem addressed by the BIPA provision occurs infrequently. In light of the infrequency of the problem and the implementation of the provision after December 21st, 2000 we would not expect to identify many cases. In addition, CMS data does not identify Medicare+Choice members who use CCRC or SNF services.

BIPA requires that we examine the impact of the law and the scope of additional benefits offered by M+C

plans, and on financial, administrative, and other effects on plans. That is, the report is to address the effects on plan, not on nursing facilities or CCRCs.

We're interviewing nursing home, retirement community and plan officials at this time to learn about the impact of state laws and the BIPA provision on M+C plans. We'll present information on the early effects of the BIPA provision. We'll provide you with a draft report at the November meeting for delivery to Congress by December 22nd.

That's my brief overview of the report which is in process. I'll take any questions or any thoughts on where we might go or where we should focus.

MR. HACKBARTH: Questions? It sounds like this should be fairly straightforward.

DR. REISCHAUER: This strikes me as one of these ones which an economy of resources would be the prudent attention that the commissioners and the staff paid to this one.

MR. FEEZOR: Tim, just one question. The obligation in the states for the plan to pay, even though it's not a network facility, I assume that obligation would begin after the release from the hospital. In other words,

as opposed to any of the time that that spot in that SNF would have been required to have been maintained while that person was in the hospital.

MR. GREENE: Yes, as far as I understand, as far as I read both the state and BIPA language it would work that way.

MR. HACKBARTH: Okay, thank you. We'll now have a brief public comment period.

MS. CUEVO: Good afternoon. My name is Acela Cuevo and I'm here on behalf of the Coalition for Access to Medical Services, Equipment, and Technology. CAMSET is a coalition of consumer advocacy groups and professional and trade associations. We have serious concerns about the appropriateness of competitive bidding as a model for the DMEPOS benefit.

We want to emphasize a few of the points that were raised by the Commission. In particular, we believe that the data that has come out of the demonstrations on competitive bidding remains very limited, and that in fact it may not be transferable to the DMEPOS benefit nationally as a permanent program for the Medicare beneficiaries.

As some of you noted also, competitive bidding may

reduce access, reduces access to items that require services. It's important to remember though that you need to understand very carefully what the services are and what their impact are on the clinical outcomes for patients.

For example, oxygen is one item that was addressed a number of times in the discussion. Patients who receive oxygen therapy require ongoing monitoring by respiratory therapists. They need access to on-call services because this is a life-supporting therapy that they're receiving in the home. Patients and their families need training on the use of oxygen and troubleshooting so that they know when to call. And there is a need for an environmental assessment of the home to make sure that it can be safely provided in the home. That's just a highlight of some of the important services that are required for this therapy. Of course, there are other services that include the routine maintenance and switching of equipment when it is broken and responding timely to those calls.

Many rehab products, and these include wheelchairs are individually prescribed and require a great deal of fitting and customization. So really it is very important to understand what services go with what products and why

they are important for the health of beneficiaries.

The other point to note is that the service standards that are part of the demonstration really do not reflect the standards that are required in the private sector generally, and we believe there remain some very serious questions about quality and service and standards in the demonstration.

Beyond that, I think it was mentioned that the demonstrations present an administratively complex model. Competitive bidding is administratively complex and it really is not clear what the impact of savings competitive bidding can have. CAMSET has some studies on these two issues and I will make them available to the Commission. We certainly would like to work with the Commission in addressing any further questions you may have. Thank you.

MR. GRAEFE: Fred Graefe with Hunton & Williams representing Invocare, a manufacturer of home medical equipment, and my client is also a member of Acela's trade association.

First of all, I thought the presentation by staff was excellent and the discussion was excellent. I would like to bring some real world reality to you, however, that

this is not an academic discussion. This is a very real issue today on Capitol Hill.

The President proposed nationwide competitive bidding in his budget this year. The House Medicare bill passed earlier this year includes nationwide competitive bidding based on that two-year study done in Polk County, Florida.

The Senate is now wrestling with that same issue of whether it should include competitive bidding in its Medicare bill this year or whether it should extend the demonstration authority which was granted, as staff pointed out, in 1997 to do up to five projects. CMS only started two. It's completed none, and there is no final report.

So I think you heard from your excellent staff today about some of the good things and a lot of the bad things, or premature conclusions that one could make. I'm urging you to reconsider waiting until 2003 because this issue is being decided today on Capitol Hill, and it's not unreasonable to expect that the Commission may receive a missive from somebody in the Senate requesting, since you've begun a study of it, to give the Senate Finance Committee your views as to the strengths and weaknesses of doing

national competitive bidding for all of DME products, even those requiring extensive servicing. And there are several hundred products, not just five categories -- based on the two-year study in Polk County, Florida. San Antonio has one year, and as you heard there is no study yet, let alone a final report on this whole project.

Dr. Reischauer mentioned the administrative cost. CMS has told people in response to written questions, they said, we expect no increase in administrative infrastructure to implement national competitive bidding for DME. It takes about, I think -- Nancy-Ann, correct me if I'm wrong, but probably 300 to 400 FTEs at CMS today to administer a similar appropriate, the Medicare+Choice. Is that wrong?

MS. DePARLE: That is wrong.

MR. GRAEFE: It is wrong. I asked somebody at CMS today in the administrator's office and that's the answer they gave me. But it's more than one but less than 300. So there will be an administrative cost to this. There is no reference to that at all. There's no reference to access to beneficiaries, and more importantly, the effect on competition. This may be an effect of the collision when Senator Durenberger was on the committee of antitrust policy

with health policy.

Lyncare controls a leading oxygen supplier; 70 percent of the oxygen market in Polk County, Florida. When this project is completed in three to five years, basic economics tells you that there won't be any more market power for Medicare. There will only be one major supplier left.

So all of these questions need to be addressed. It needs further study. It's premature, I think, to use a two-year study in Lakeland as a model. So I urge you to recognize that it has some real world application today for health policy, which is the reason Congress created you and wants your advice and counsel and discussion.

Thank you very much.

MS. WILBUR: My name is Valerie Wilbur and I work with the social HMO consortium which represents the four social HMO sites. I'd like to share with the organization written comments on the report that was submitted in 2001 so I don't take up a lot of time here. But I would also like to just point out a couple discrepancies that the social HMO consortium with the report. I would also like to thank Tim Greene for acknowledging that the report itself indicated

that there were some shortcomings and that some of the period of time that was used to study, some of the outcomes that were reported could have been longer.

I guess as a general comment in terms of overall comment I'd like to say that the consortium was disappointed that the report to Congress didn't look at some of the original protocols we set out to try to prove, like were we successful in keeping people out of nursing homes, were we cost effective in terms of reducing costs in other parts of the system like Medicaid by either keeping people out of nursing homes or keeping them from spending down. Those kinds of things weren't looked at.

In terms of health status which Tim talked about, the biggest concern we have about health status is that it indicated that the social HMO folks weren't any frailer or sicker than other M+C plans in the areas that they served, but yet in 1999 CMS itself published a report based on Health of Seniors data which was used by MPR and CMS to make the conclusion about health status, which came to a completely different conclusion.

What the CMS 1999 Health of Seniors data reported was that social HMOs had higher proportions of older

members, which of course is an indicator of risk, more reporting poor self-health, more reporting decline in health from the previous year, more with ADL impairments than comparison groups, both at the national and state levels. It went on to conclude that after adjusting for age, gender, and health outcomes, the 1999 reports conclude that on the basis of several physical and mental function scores Elderplan, the New York plan, had the frailest members of all 24 New York M+C plans, Kaiser had the frailest of all 14 plans in Oregon, and SCAN members had the second most frail of 39 plans in the state of California.

We hired an outside actuary to figure out why did Health of Seniors in '98 tell us one thing but HHS report comes out and tells us something completely different. What he concluded was that when MPR did the analysis they did the analysis at the county level instead of the state level, which resulted in smaller pools of people and had a greater likelihood of showing a bias in some of the outcomes. Also that MPR only adjusted for age, sex, and Medicaid status. That is didn't look at comorbidities and study design which the CMS study looked at the year before.

I think that when Congress passed BBA and said,

let's come up with risk adjustment it was acknowledging that demographics like age and sex alone aren't a sufficient indicator of risk. Hence, let's include the diagnostic factors. So we have a disagreement with the conclusions that come out.

The reason this is so critical is because the report then goes on to say, based on these conclusions, we don't think these plans warrant any different payment structure than the standard M+C plans, and we don't think it's fair that they are paid more than they would have been paid if they were a standard M+C plan. We believe that because, for example, the first generation programs have 20 to 30 percent nursing home certifiable, that they in fact do have higher risk levels as the 1998 data showed from CMS, and that they do warrant a higher payment.

The other point I wanted to make is the final report that Tim referred to only focuses on Sierra Health Plan of Nevada. It's only going to look at one of the four plans. It won't look at the first three plans. When we had requested that when they come out with the final report, if they would go back and make some changes that some of the staff at CMS themselves acknowledged could have been

interpreted differently, they said that this report would only focus on the second generation social HMO.

In terms of beneficiary satisfaction, which was a question that was raised, my sense is, from reading the report that beneficiary satisfaction within the S/HMOs was about the same as it was for all M+C plans, but it didn't look at any of the special features of the social HMO to see if the beneficiaries and their caregivers would benefit from some of the extended care benefits, the access to greater case coordination. In fact Senate bill 2782, which was introduced about three weeks ago will do -- if it's passed, require special beneficiary satisfaction that will look at the special programs offered by S/HMOs as well as whether caregivers were more satisfied because they got extra support.

On the queuing, Tim mentioned at the beginning of time, we wouldn't be different because we were allowed to queue to keep our risk levels down. It's been at least seven years since any of the social HMOs have employed the queuing. Once they learned how to do care management they dropped that and they haven't been doing that in many years.

Then the Senate bill also would require MedPAC to

do a cost effectiveness study to see in fact whether social HMOs are cost effective. It lays out some things they could look at like whether they kept people out of nursing homes, kept people from spending down, how their costs stacked up relative to other benefit levels for comparable case mix, that sort of thing.

So those are my brief comments. I will send more detailed comments but I just would ask that you might take a second look at some of these issues and I thank you very much.

DR. ROWE: I'd like to ask a question or two because some of that went past me pretty fast and it's been a long time since I've looked at this. Are you saying that institutionalization or admission to a long term care facility was not a dependent variable in the study, that it was not measured? I thought it was measured. Are you saying that --

MS. WILBUR: Let me put it in lay terms, if I may, so I don't give you the wrong answer. The study did not look at whether the social HMOs were effective in keeping people out of nursing homes or delaying the time at which they would enter so that maybe they'd be in the community a

year or two before they otherwise would have.

DR. ROWE: The members of your consortium at the outset of the social HMO experiment designed the experiment along with the federal government, right?

MS. WILBUR: Yes, sir.

DR. ROWE: So that if that's an important outcome measure that should have been included --

MS. WILBUR: Yes, sir, that's what we felt.

DR. ROWE: -- members of your consortium were around the table when the outcome measures were agreed upon; is that right?

MS. WILBUR: No. No, we had no -- we actually requested input in the study design and we had no input in the study design, sir. We in fact have done some of our own studies and some other universities have done studies that show that our programs, that the members of our programs are 40 to 50 percent less likely to go into nursing homes for a long stay, meaning more than 60 days.

DR. ROWE: The second thing is, I thought I heard you say that the patients were basically sicker.

MS. WILBUR: Yes, sir, that's what the CMS 1998 Health of Seniors data showed.

DR. ROWE: I guess I would just mention that, getting back to my earlier comment, then I think that would make it that much more likely that you would have been able to show a beneficial effect, not less likely. Because in fact the sicker the patients were, the more frail they are, the more disability they have, the more likely they are to benefit from the intervention. So if in fact it was said that they weren't sicker but you feel they actually were sicker, then that would have made it that much more likely that the intervention would have been effective.

MS. WILBUR: But they only looked at health outcomes on one plan, sir, and it was only for a year of time. It was when Sierra first came into being. They hadn't fully implemented their interventions. The two universities that did the study under CMS study said that even if the geriatric interventions had been fully in place, within the first year that they wouldn't have been reasonably expected to have an impact. They didn't look at health outcomes for the other three, not after 1989.

DR. ROWE: Thank you.

MR. GORSKI: My name is Walt Gorski and I represent the American Orthotic and Prosthetic Association.

Our membership includes the patient care facilities that provide orthotic and prosthetic devices as well as the manufacturers of orthotic and prosthetic devices. I'd like to thank the Commission and the commissioners for raising some serious questions about alternative pricing and specifically competitive bidding.

Our association has several concerns with the prospects of mandating competitive bidding for orthotic and prosthetic services. We believe that farming out health care services simple to a low or lowest bidder is unwise. That the upshot will be that it will restrict access to trained providers who are skilled in the provision of orthotics and prosthetic devices, and it will affect the long term quality of orthotic and prosthetic services.

Let me just give you a little bit of background about how O&P is paid for under the Medicare program. We receive one lump sum payment for all the services related to the provision of an orthotic device. What that includes is, once we get a prescription from the physician the orthotist or prosthetist evaluates the patient's medical condition. They then design, fit, fabricate, or customize that device to the individual patient. The payment also includes the

device payment itself as well as 90 days of follow-up care.

What we foresee happening under a competitive bidding model is that what will happen is you'll reduce or just eliminate the professional services associated with the provision of these types of devices. What this will do is that it will give some suppliers who have little or not training in the provision of orthotics and prosthetics a real advantage in the bidding process. That's what the real issue here is. It has to do with the quality and access to.

If you put forth a competitive bidding program what we think will happen is that you will have untrained providers providing these types of devices and that orthotists and prosthetists who are specifically trained for this will be the losers in this model, and ultimately the beneficiaries will be the ones who suffer.

Id' like to address one of Dr. Reischauer's issues with this and that had to do with, by lowering the device payment you're lowering the copayment for the beneficiary. Essentially, that may be what you find in the short term or on paper. What could potentially happen is that you will have untrained providers putting these types of devices on patients but that if the device is fitted improperly and the

patient needs to see a physician or they have to, if it results in hospitalization which some of these cases can do, you'll actually be increasing Medicare's costs.

I think my time is running out but let me at least offer my association as a resource to MedPAC as you move forward with your recommendations. Thank you.

MR. HACKBARTH: Thank you. We'll reconvene at 9:00 tomorrow morning.

[Whereupon, at 4:20 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Friday, September 13, 2002.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 13, 2002
9:02 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

P R O C E E D I N G S

MR. HACKBARTH: Let's begin this morning's session. Our first topic this morning is payment for new technology and we're going to hear a report about some structured interviews that have been conducted.

Nancy?

MS. RAY: Good morning. I'm just going to very briefly introduce the topic and then I'm going to go back into the audience and listen to our contractor, Penny Mohr.

In its fee-for-service program Medicare pays for services using about 15 different payment systems that are generally organized by the delivery setting. At issue is how should Medicare design and update its payment systems to take into account new technologies? New technologies include scientific and technological advances such as drugs, biologics, medical devices, and procedures that are true innovations or significant advances over existing technologies.

Now the Commission has discussed this issue at great length in the past and I just would like to remind you of a Commission recommendation in March of 2002 that Congress replace the hospital-specific payments for pass-

through devices in the outpatient PPS with national rates. Setting national rates is difficult to do, however, given the last of market cost data for new technologies.

Consequently, and in light of this, MedPAC contracted with Project HOPE, Center for Health Affairs, to conduct a two-stage investigation. The first stage of this investigation was a series of structured interviews with about 15 different private and public purchasers and payers of health care services. The goals of these interviews, and these were primarily telephone interviews, were to identify methods developed by payers other than the Medicare program to establish prices for new medical technology and to critically examine the relevance for paying for new medical technology under Medicare. Penny is here to present the findings from those telephone interviews.

The second stage of the investigation, which we will present to you next month in October, Project HOPE convened a panel of experts who considered available options for paying for new medical technology and weighed their relative merits for the Medicare program.

Let me go ahead then and introduce Penny. Penny is a senior research director for Project HOPE. She has 12

years of experience in looking at a variety of Medicare-related issues, including provider payment, outcomes research, and technology policies. Thank you, Penny.

MS. MOHR: Thank you. Today I'm going to be presenting some information from a series of structured interviews that took place over the summer and just recently ended. There were three major purposes for this project. The first was, as Nancy mentioned, to identify methods developed by other large purchasers of health care services to establish prices for their new medical technology. The second was to critically examine their relevance for the Medicare program.

We also were asked early on in the project to highlight commonalities or differences between Medicare's and other payers' coverage determination processes. You received a packet that did a summary of coverage processes that we presented as part of this. But today we're really focusing on what we learned regarding payment.

We conducted a series of qualitative interviews with very large purchasers of health care. We chose among the largest health care insurers in the United States, group purchasing organizations, integrated delivery systems, a

very large multi-hospital system, pharmacy benefit groups, and we also interviewed people at the Veterans Affairs and the military health system known as TriCare. We interviewed a large Medicaid program, and we also looked at two countries with national health care systems that use cost effectiveness analysis for coverage determinations.

Our project also looked at four case studies' technologies. The purpose for selecting case study technologies was to highlight commonalities or differences among the different large purchasers in how they approach pricing for new technology. Our case studies included drug-eluting stents, implantable cardiac defibrillators, biologically manufactured skin, and a monoclonal antibody for treating breast cancer.

The reason why we chose these four case study technologies was because they were on the pass-through list or were technologies that Medicare had recently dealt with, and also because these technologies provided an array of different types of technologies. We have two devices, a biological product and a pharmaceutical that we looked at.

I wanted to first start out with some general observations. Despite the wide variety of differences among

the large purchasers that we looked at there were some very common observances that we had. First of all, achieving a good pricing outcome is extremely difficult for everybody in the early stages of a product's diffusion. By this I mean that, particularly if a product is a breakthrough product and the product does not have a lot of competitors, the manufacturer basically charges the list price and that is what people pay for it. There's not a whole lot of negotiation that goes on at that particular stage.

If the product does have some competitors, it still is extremely difficult to obtain good information on the cost of that product, and it's also difficult to obtain information on the relative efficacy of that product early in its diffusion. So it's very difficult to negotiate a good price.

One other observation that I would say there is that Medicare sometimes is the innovator in terms of establishing prices for new technologies. That sometimes when Medicare does establish a price, a lot of other payers will follow suit.

The other thing that we noticed that despite the fact that establishing a very good price may be difficult,

other respondents use an array of other tools to control use during the early diffusion of a product. For example, they may use step therapy. That is, channeling the technology's use to the most appropriate people who would benefit most for the use of that technology. For example, within a monoclonal antibody, channeling the use of that to people who had failed prior chemotherapy or were currently using Paclitaxol.

They also used tiered copayments. If there are therapeutically interchangeable products, then you might channel people to use products based on their price, to use the ones that are cheaper. Copayments would be higher for those drugs or those other products that were more expensive that were listed.

Also, distributed guidelines for use educating physicians and educating consumers was a large part of what people did.

I would say without question that everybody that we interviewed had dedicated staff to aggressively monitor what is in the pipeline. That is so they can be well-prepared when a technology hits the market to negotiate a good price, and also to make a coverage decision early on.

Finally, nearly all respondents had very close linkages between their technology assessment, coverage determination, pricing and procurement decisions; a very integrated system. This is something -- because as you probably are aware, the Centers for Medicare and Medicaid Services have split their coverage policy from their payment policy divisions, and that's important.

Let me just briefly explain, this is one respondent that we looked at. I think that this process that I'm trying to describe here, it's a fairly comprehensive system that links their coverage determination process as well as their pricing process. This is not unusual, although this is the most comprehensive system that we saw out there, and this was an integrated delivery system so you would expect that they might have a little bit more cohesive process between coverage determinations and technology assessment and pricing.

Nevertheless, we also found that this type of system had been adopted by group purchasing organizations. This type of system was also being used by the large hospital, and was used by the VA and the DoD. So I think it's illuminating to look at it in a little bit more detail.

In this particular respondent they have a dedicated staff that's a technology assessment unit. They evaluate, I think it was in the nature of somewhere between 30 and 40 different products a year; quite a few products -- and make decisions on the basis of safety, efficacy, and most importantly, relative efficacy compared to other products that are currently used to treat a particular condition, about whether or not that technology should be considered for coverage.

At times some of the respondents -- this determination about the relative efficacy of a product, if it was considered to be relatively efficacious, did not necessarily mean that there was an automatic coverage determination that it would be used by all plans. I think that's important, too.

Once the technology was determined to be relatively efficacious, however, a new product committee became involved. The new product committee was supported by a variety of different specialty product teams. These were teams that were comprised of physicians that were specialists in their field. So you had, for example, organized on the basis of orthopedics or cardiology, you

have specialty product teams that sit down and look at, what is the price of different alternative technologies, for example, stents, that we might be using in the treatment of a patient, and what's the differences in terms of their clinical quality of the different products, and what should we think about in terms of the types of products that we might want to purchase.

This team was typically supported by a staff of business analysts that would look at this and try to understand contracting and get a better understanding of the pricing for the products that were out there by looking at information that available from industry analysts and other sources, and manufacturers in discussing with manufacturers.

Then once a decision was made about, okay, we believe that this is the quality criteria that we need for this particular product and these are the kinds of products that we think we want to purchase, then a new technology deployment team would go out and decide, what is the impact of selecting one product over the other, and do a financial analysis on the firm or on the organization. Then also enter into some negotiations with the manufacturers to try to obtain a better price. It was an iterative process to

try to look at the financial impact of different procurement decisions.

Supporting this was a new technologies hotline which provided real time information. That is that they subscribed to some of the commercially available technology assessment organizations, information lines, and they would basically turn information around --

Like, for example, if a physician was wondering if a technology was efficacious, would it be covered, or a consumer was wondering for their particular condition if this new technology that they had heard about would be something that would be considered, then that new technologies hotline would turn around a very quick technology assessment within three to four days. That information was fed into the new product committee, it was fed into the new technology deployment team, it was fed into the technology assessment unit.

So all of these -- sometimes information on a new technology came from the new product committee who was trying to track what was out there, and sometimes it came from this technology hotline. It was quite a cross-flow between the different departments in terms of exchange of

information about what new technologies were out there.

I wanted to also summarize some of the critical tools that were used by our respondents. The most important was the declaration of therapeutic equivalence. Once the product was declared within a particular disease treatment category to be therapeutically equivalent to another product, and medical evidence was key in this declaration, then the RFP process could be initiated and competitive bidding could be initiated. Competitive bidding was used widely and it was typically iterative. That is, that a manufacturer would come with a price, their best price, or several manufacturers would come with their best price, and then the respondent, the purchaser would get back to them and say, if we purchase this product then this is the type of deal we would get. And if we decide to purchase this other product -- so then the manufacturers would have a chance to change their pricing in response to that, so they could work it down.

Some of the sources of price information that I mentioned a little bit earlier were industry analysts, European experience, commercial databases, and also sometimes respondent's own experience either through claims

or member hospitals.

In the two countries that we looked at, one of them did require the submission of cost effectiveness analysis. While that did not necessarily -- sometimes it was the manufacturer's price that was used in that, both of the respondents that we looked at even in the U.K. -- though they do not require it, cost effectiveness analyses are looked at -- felt that because they are looked at seriously, that it really did influence a manufacturer's decision about how to set prices for a technology before they came to try to get a coverage determination for their product.

Also, several of the respondents required submission of invoices. This is the insurers. So for example, if you have a brand new technology that is out there, you will pay basically on a percentage above invoice price as opposed to a cost to charge type of ratio like is used in the Medicare program.

Now although I put everybody into this one pot there are obviously large differences between the different groups that we looked at. I thought I would just briefly walk through some of the observations by provider type. First of all, insurers, I would say, are relatively passive

actors in the pricing of new technology. They really pay for hospital services. They pay for physician services, and indirectly influence the use of technology through their payment decisions. Very similar to Medicare in that respect.

Most insurers that we spoke with, all of the insurers that we spoke with have typically carve-out agreements with the hospitals and the physicians, so that new technology, as coverage decisions are made about new technology, that technology is paid, for example, on the basis of invoice plus a percentage in that carve-out arrangement with the hospital or with the doctor until that's worked into their existing payment system and their negotiations.

The other things is that sometimes they will pay on the basis of billed charges if a technology hits, for example, a stop-loss within a hospital stay and exceeds that stop-loss, then they will end up paying billed charges. So this is quite significant and one of the insurers that we spoke to said that this could substantially increase the price of new technology for them. They gave the example of implantable cardiac defibrillators where the device would be

potentially $20,000 was what the hospital would pay for, but because it hits the stop-loss, then they end up paying more like four times the price of that so it's more close to $80,000 for the price of the implantable cardiac defibrillator.

Within group purchasing organizations I would say the major issue there is that a lot of new manufacturers are unwilling to list their product with a technology early in the life cycle of that product. Particularly if there's no competitors, there's no reason to negotiate a price, there's no reason to try to work through the group purchasing organizations. They try instead to work directly through physicians and through the hospitals to purchase their product.

I would say that some of the smaller manufacturers will use the group purchasing organizations in order to obtain market share, that don't have experience in marketing.

The integrated delivery systems, I think an interesting thing that we found here, and this was also included -- I would say that you could say that the Veterans Affairs is an integrated delivery system. Basically, they

used clinical trials, not only to support decisions about coverage of new technologies, but also to support purchasing and procurement decisions. So they collect costs within -- and clinical trials might be a little bit -- it's not like the randomized controlled clinical trial, though it may be. But it's really designed -- research studies that are designed in order for them to better understand the cost implications of purchasing one technology over the other technology.

Within a multi-hospital system that we saw, I thought it was very interesting that they were trying to move away from their reliance on the group purchasing organization and they felt that they really, really wanted to get a much better price on what they were paying for new technology. So they were working very hard at strengthening their internal capacity to be a prudent purchaser and a strong negotiator of pricing.

For the pharmaceutical benefit management firms, one of the mechanisms that they use is a preferential listing in formularies for products that are therapeutically interchangeable, and then a tiered copayment system. Within the VA and TriCare they used a closed formulary, which many

of you are familiar with, and made very prudent coverage decisions.

Within Australia and the United Kingdom, again --

MS. DePARLE: What do you mean by prudent?

MS. MOHR: I would say that they were -- actually this is an important point and I did -- for example, they do not cover routine ultrasound in the use of obstetrics. Why don't they do that? Because the medical evidence is not clear that it's beneficial for everybody. Although this has become standard of care across most -- most payers will pay for routine ultrasound. The DoD does not cover that.

They also will not cover universal screening for newborns, even though it's mandated by states, by some states to cover that, because the evidence is also not clear on that particular technology.

DR. ROWE: Screen for PKU?

MS. MOHR: Not for PKU. I think it's the universal hearing screening.

I think that the CDC, their U.S. preventive health services task force has been fairly clear that we don't really know if this is cost effective.

I would say also, when I say prudent, they do look

at cost. They look at the cost effectiveness of their decisions, and that's an important distinction there too.

Within Australia and the U.K., again Australia does require the submission of cost effectiveness analysis, both for pharmaceuticals and also now for devices. Within the U.K. they will look at a manufacturer's books and base a payment in negotiation with them on what they believe is a fair return on equity.

I wanted to just briefly talk a little bit about coverage because that was one of the objectives of this project.

DR. ROWE: Could I ask you, what is a fair return on equity?

MS. MOHR: Basically what they do is they look at -- I think that that is the important point, exactly. They look at investment in the U.K., specifically in the U.K., and they set a price. I think that a lot of people have been concerned, how do you determine what a return on equity is, and how do you determine what the right level of innovation is?

DR. ROWE: What percent do they come up with as a guideline.

MS. MOHR: I actually don't know that information but --

DR. STOWERS: 17 to 21 percent.

MS. MOHR: Okay, 17 to 21 percent, negotiated.

DR. ROWE: Return on invested capital.

MS. DePARLE: In the U.K. though you said.

MS. MOHR: Yes, it's specifically the U.K.

DR. ROWE: But 17 to 21 percent in the U.K. is 17 to 21 percent everywhere. The mathematical system -- it may be pounds instead of dollars but it's still 17 to 21 percent.

MS. MOHR: No, I think the important distinction here is they just look at investment in the U.K. So there may be investment in other...

I just want to contrast and compare some observations about what coverage determinations that were used in the private sector versus Medicare here. I would say that evidence-based medicine is widespread, both within the Medicare program and also within the private sector. And that cost or cost effectiveness information is not usually considered in technology assessment. It may be considered in the technology assessment, and it may be

considered in the coverage decision. Typically in the technology assessment they look at the relative efficacy of a product and cost is not considered.

But for example, in one particular respondent, if the impact of a technology exceeded a particular threshold then that would go to a benefits committee and they might look at specifically whether or not that technology should be adopted.

Medicare does not, by contrast, consider cost in their coverage determinations.

MR. MULLER: Just in terms of definition of terms, obviously ultrasound has been around a long time so when you use ultrasound in prenatal, that's not a new technology. It's a matter of using it in that process.

MS. MOHR: Right.

MR. MULLER: So how do you differentiate for a new technology that is something truly new, like the stents, versus something that is just being used in a different way than before? Just definitionally, how are you using those words?

MS. MOHR: I would definitionally determine something that's being used different than it's been used

before as a new technology. Something that's been around for a while and is applied to the same population is considered more standard technology. But you consider both the application of the technology and the device.

DR. STOWERS: They make it a coverage decision then.

MS. MOHR: No, not necessarily. If a device is covered, like for example, a monoclonal antibody is covered for a particular condition, then there may be off-label use. Sometimes that's controlled and sometimes that's not controlled.

I think another important point is that coverage determinations aren't necessarily all uniform. Medicare has, as a lot of people have pointed out, has a largely decentralized coverage determination process where 90 percent of its coverage determinations are made by its contractors. In a lot of insurers that we looked at -- well, we only looked at three, but basically we also looked at integrated delivery systems, there was not necessarily -- some of them had a very centralized technology -- they all had a very centralized technology assessment process, but some of them had a very decentralized coverage determination

process. And some of them, the coverage decisions were uniform across all plans a positive decision was made on the relative efficacy of a product.

I would say that although Medicare has done a great deal of work on trying to improve the evidentiary basis for its decisions, particularly at the national level, not all of the respondents felt that its contractor capabilities were equally as good, and that there was a lot of variety in terms of the strength of their abilities.

Some of the respondents -- basically these are lessons from respondents for Medicare. I would say that, first of all just stepping back, Medicare really is in the business of paying hospitals and doctors, and not necessarily in the business of paying for new technologies or devices, per se, although this was changed somewhat with the transitional pass-through mechanism. And that the prospective payment system, particularly on the inpatient side at least provides incentives for efficiency and for providers to become more prudent purchasers. That's where Medicare exerts its influence.

There were also some approaches that they felt Medicare might consider. Potentially they could pay on the

basis of invoice rather than on cost-to-charge ratios. They could potentially implement sliding copayments for products that were within therapeutically interchangeable classes, that were equally effective. They could potentially strengthen their ties between coverage and reimbursement policies. That is, using the medical evidence for negotiating prices or setting prices for technology. And potentially they could require cost effectiveness analysis be submitted for coverage determinations and also for pricing policy.

So at that I will open this up for questions. I'm sure you have many.

DR. ROWE: Just on that last slide, Penny, based on your work thus far, do you have any basis on which to make estimates of savings to the Medicare program if they were to adopt any of these strategies?

MS. MOHR: I think if we go back to the invoice plus 15 percent, which is kind of the standard used among insurers for paying for some of the devices that are used by hospitals and we look at what happens when a technology hits stop-loss and becomes basically on the basis of billed charges, which is closer to what Medicare is paying. We're

talking about a four to five-fold difference there. That's important. I don't know globally the impact of adopting what this would be, but I would say that for those occasions where they're setting prices that are based on billed charges there's potential for gaming, and that a requirement of invoices could potentially move this substantially.

MS. DePARLE: I'm sorry, I don't follow what you're talking about about the way the Medicare pays. Can you use a specific example? Maybe that would help. So in an inpatient setting, what are you talking about with invoices?

MS. MOHR: If I'm looking in an outpatient setting -- let's look at the hospital outpatient department. You have this transitional pass-through mechanism.

MS. DePARLE: So under the pass-through --

MS. MOHR: It's under the pass-through. We're really looking at new medical technologies. So they look at the history, and they look at the claims information, and they look at a cost-to-charge ratio and they establish a price for that technology for those that are on the pass-through list for the first few years that it's --

MS. DePARLE: For the first three years.

MS. MOHR: Yes, for the first three years. This is the important point, that we're really looking at those brand new technologies that Medicare is grappling with in terms of the transitional pass-through mechanism.

MS. DePARLE: Because after that it's built into the APCs or the DRGs.

MS. MOHR: Correct.

MR. HACKBARTH: Penny, could you go a step further though? What I hear you saying is that using the cost to charge method, that Medicare ends up paying much more than it would under the invoice plus 15 percent.

MS. MOHR: Right.

MR. HACKBARTH: Could you just explain why that is?

DR. NELSON: Would you also explain the stop-loss component of that, because I don't understand it.

MS. MOHR: Basically with the -- let me again go back to the implantable cardiac defibrillator. Let's say the hospital's acquisition cost is $20,000 for that. The carve-out agreement with the hospital is that if they put this implantable cardiac defibrillator in the course of a stay, then that goes into this carve-out or this wrap-around

clause for brand new technologies that an insurer negotiates with the hospital. They will agree to pay on the basis of invoice, $20,000, plus 15 percent, for the implantation of that cardiac defibrillator, for that specific device.

Now if you hit a stop loss -- and again, I don't know exactly what the magnitude is. Jack, you may know better what this is because actually we got a lot of information from these large insurers about this. But it's for a particular stay --

MS. ROSENBLATT: Penny, I was going to say, I can help you. It varies by hospital. It's part of the contractual arrangement. It's often -- for a large hospital it would be like $100,000. So if the per diems exceed $100,000 then you get into the stop loss. For smaller hospitals it could be down at $30,000, $50,000.

MS. MOHR: So if that exceeds the --

DR. ROWE: It's stopping the loss for the hospital.

MS. MOHR: Correct.

DR. ROWE: Most more modern or current contracts don't have this provision in it as much as contracts used to a couple years ago. But the idea is that the hospital has

accepted a per diem payment or a case-rate payment for certain kinds of services based on their overall global experience. If they have an outlier who's using much, much, much more hospital resources they could lose the whole --

MR. MULLER: It's basically a crude form of risk adjustment.

DR. ROWE: That's right. So they're limiting the risk of -- it's a catastrophic coverage for the hospital, if you will, is what basically it is. It's at a number which is based on what kind of hospital it is and what kind of experience they have.

So what you're saying is what about the stop loss?

MS. MOHR: So what I'm saying and as I understand this mechanism is that that stop-loss amount, that $100,000, is based on bill charges; is that correct?

MR. MULLER: Yes.

MS. MOHR: So basically if you have billed charges for an implantable cardiac defibrillator and the margin is set 400 percent, 500 percent higher than what the invoice cost of that device was to you, so the device is no longer $20,000, but it's $80,000.

MR. HACKBARTH: That's the step that I don't

understand. How did we get from 20 to 80?

MS. BURKE: It's not just the device. It's the cost of the --

MS. MOHR: I understand the stop-loss includes the cost of the stay. It's the cost of the stay. But the markup on the device is what kicks them often into the stop-loss.

DR. ROWE: How does that influence Medicare?

MS. MOHR: How does that influence Medicare? Because Medicare pays on the basis of billed charges to cost ratio. So eventually that cost gets folded back in; that's the true invoice cost.

DR. NEWHOUSE: I believe Medicare just ultimately folds the charges into the relative weight for the DRG on the inpatient side. But that's not the point I wanted to make.

I think there's two different issues here. One is the issue of the price to the manufacturer and how the manufacturer of the device or the drug prices. The second issue is the markup above that to the hospital and/or physician, or potentially a distributor. It seems to me the invoice is basically cost to the hospital. So we have cost

reimbursement. That seems to me to not address the issue of what are the incentives to the manufacturer to control the price in any fashion? So that problem remains.

Then the invoice plus something, the plus something it seems to me goes to the incentives to the hospital and tea physician to disseminate or use this drug or device. So there's really two different issues here it seems to me, and going to invoice does not really do -- if everybody paid invoice, I'm not quite sure why terre's any incentive for the manufacturer to keep the price down in any fashion at all.

DR. ROWE: I also don't understand why -- and I'm not an economist. I don't understand why there's an invoice plus a certain fixed percent of the invoice. Because the cost of delivering the service or the technology may not be proportional to the cost of the technology. If you buy a $20 bottle of wine in a restaurant or a $2,000 bottle of wine in a restaurant, it's the same amount of effort to open the bottle of wine and pour the wine for you. You might not give somebody a 17 percent tip on $2,000 for doing that.

So is it that we give a fixed percent of the cost of the technology to deliver it? The nurses' salaries are

the same, the cardiologists' salaries are the same. One pacemaker costs $10,000 and another costs $100,000, why are we adding so much more for the second one than the first one?

DR. REISCHAUER: But why wouldn't -- if you have some vision of what the acceptable or appropriate margin for Medicare services is, why don't you add that, 4 percent rather than 17 percent? You aren't arguing against profit, are you?

DR. ROWE: No.

MR. DeBUSK: Did we not just go through the exercise of the stent, the Medicare stent where we set national rates on that in anticipation of the FDA approving it sometime early next year?

MS. MOHR: Right.

MR. DeBUSK: How about going through the structure of how that was set?

MS. MOHR: My understanding is that they looked at the medical evidence and they decided that this was indeed a potentially breakthrough product, although it's preliminary evidence. The FDA is expecting, I think they're expecting approval sometime early in the spring. Then Medicare sat

down and looked at, how should we set a price for this? My understanding is that they basically looked to the European experience and what they're paying for stents there, and they set a price there for stents.

MR. DeBUSK: Was there not some formula though of how they did that?

MS. MOHR: There's no real formula, no. It was just basically sitting down and saying, what type of information do we have, what's the array of information that we have and how can we potentially put this into the right bucket?

MR. HACKBARTH: How frequent is it that we can look to Europe? Is that the typical pattern that things will be on the market there?

MS. MOHR: I think that's a good question and my understanding is that it varies, but there are quite a few products that do diffuse in Europe first. A lot of the respondents that we talked to, particularly -- I mean, even when we talked to people at the VA said, we wouldn't use European prices, because the health care systems there are so different than the health care systems here. So there's pros and cons to that approach, but that data may be

available for some technologies.

MS. BURKE: Glenn, it's not infrequent that something would be diffused overseas earlier because of the time for the FDA clearance.

MS. MOHR: Correct.

MS. BURKE: It is very unusual, in fact almost without exception never happens, that we would go to a European market for a price. In fact I can't recall Medicare having done this --

DR. NEWHOUSE: And if we did that, the manufacturer would surely take that into account in setting the price to Europe.

MS. BURKE: Absolutely. That is not the --

DR. NEWHOUSE: In the end this is circular. Everybody is looking at everybody else.

MS. BURKE: Right.

DR. REISCHAUER: But it's a little absurd saying we wouldn't go to a place where they're selling this product cheaper. Why wouldn't we?

DR. NEWHOUSE: Are we importing drugs from Canada?

DR. REISCHAUER: Should we?

DR. NEWHOUSE: No, are we?

DR. REISCHAUER: So they take the U.S. market into account, what's wrong with that?

MS. BURKE: Bob, I'm not arguing whether they should or shouldn't. My point is simply, we never have, as a method of setting a price.

DR. REISCHAUER: No, we saying we never have, but I'm trying to think of what the logic is and the logic seems to be, because they're buying it at a cheaper price than we should buy it at?

MS. BURKE: No, in this case the logic was we've never bought it --

DR. NEWHOUSE: No, it's just I don't think this is Nirvana because I don't -- it's not likely -- if we're 40 percent of the world market, surely the manufacturer is going to jack up the price to the rest of the world if we copy the rest of the world. Or just withhold till they get to the U.S. market, and the U.S. is established --

DR. REISCHAUER: Then everybody would pay the same price for the same product. Boy.

MR. MULLER: One of the themes we discussed yesterday was, as these pharmaceuticals and devices and new procedures come into play, not just the issue of how to

price them but also how they affect activity, because obviously as these spread into populations this brings many times a new set of possible patients into the system.

I think one of the things we should look at, Glenn, is how these new technologies do over a period of time affect the kind of broader coverage possibilities inside the program. I think Joe has written about this but it strikes me this is where, in many ways some of the most, in addition to the demographic trends we discussed last spring, this is where some of the considerable pressure on the program will be over the course of the next few years, because the rate of growth of innovation strikes me as still accelerating. Therefore, as new populations can be covered for things that were not possible five, 10 years ago, we'll have to estimate that over the course of the next few years.

So in addition to the very difficult issues of how one prices these things, how they make it possible to provide considerable benefits to new populations, and therefore the consequence of that -- and I'm in favor of covering these new populations but also it has a very considerable cost consequence.

DR. NELSON: Apart from these very difficult

issues of pricing and coverage and what kind of recommendations we might consider to try and make that more coherent than it is now, and I think we're a long way from considering any of those recommendations at this point, I want to commend you for the explanatory material in the paper, and a good solid review of new technology and processes used in making coverage decisions, and the role of the Medicare coverage advisory committee, the difference between local coverage decisions and national coverage decisions. This, by itself, I believe is a major contribution and I'm glad that we're planning on including that as a chapter in our March report.

So what I'm saying is that this material by itself has value, because there's an enormous amount of confusion out there about how these pieces fit together, at least within the physician community. So that's a good contribution for MedPAC in itself, apart from whether we come to grips with any recommendations with respect to how to make it more coherent.

MS. MOHR: I would like to say that the report on payment which regretfully -- this is really hot off the press as I'm speaking to you. We just finished this

basically last week. That report will be available for you before your next meeting in October. I think that that will enlighten this topic a little bit more because the coverage piece was really a small piece of what we were doing but it was something that we could get to you in advance.

MR. HACKBARTH: Penny, could you help me understand the intersection between the highly decentralized coverage process with the vast majority of the decisions being made locally and these new technology pass-through provisions on the payment side? What happens when a piece of new technology is covered in some areas and not in others when we've got the pass-throughs? How does that work?

MS. MOHR: The pass-through is a fairly systematic process and a fairly centralized process. It's really CMS sitting down and saying, with all the manufacturers coming up to them with a list of, we want to be on the pass-through. These are things that have potentially been in use and covered by Medicare and are --

MR. HACKBARTH: But does that mean a national coverage --

MS. MOHR: It does not mean a national coverage determination. I'm trying to think. Implantable cardiac

defibrillators may be a good example. It's something that's been around but there are marginal changes and there's some major changes in the types of device. So basically that type of product is now listed in a product category nationally and it's paid nationally on that basis.

Typically, in a very decentralized process the way the contractors do this is very similar to what the private sector does, is a lot of new technologies get paid for even without a formal coverage determination. A lot of new technologies just get absorbed into the system because they fit within existing categories. An example of this, I guess one that's commonly looked at is like the laparoscopic cholecystectomy that was done -- even though there was open cholecystectomy procedure, the laparoscopic cholecystectomy was done within that open cholecystectomy category.

So some new technologies may come along and become unlisted because they don't fit very well within a particular thing. A contractor has to sit down and say, is this something that we cover for this particular person under this particular circumstance? There may be some kind of an exceptions process which automatically brings a review, an audit of that procedure. Then determinations are

made -- it sort of trickles into the system is what I would say.

But the determination about what categories for the transitional pass-through is a national process.

DR. REISCHAUER: But in those instances you're talking about there isn't a payment adjustment though, right? They're doing it within the existing payment structure.

MS. MOHR: They're doing it within -- yes, exactly. But they may, for example, like with the biologically manufactured skin, a contractor may sit down and say, there's these types of CPT codes that are out there and we recommend that you use, for example, debridement with some kind of surgical procedure in conjunction -- and that will probably cover the price for this biologically manufactured skin, even though it's not -- so Medicare goes along and it basically pays for biologically manufactured skin.

Then the decision that is made is when these types of decisions, if there's a lot of controversy, a lot of contractors are making different determinations about whether or not they're paying for it and whether or not

they're covering that particular procedure, then that might get kicked into a national coverage determination process. But it's rare.

MS. DePARLE: Glenn, just to go back to your question. I think it's a good one. I don't think in practice it came up, because I think in most cases the manufacturers who were applying for pass-through status were already -- were applying for that with respect to products that had already been either nationally approved or had been diffused around. I think the ones who might have only gotten local coverage decisions, in most cases they chose to go that route because their product hadn't been very well diffused yet and the evidence might not be of a nature where they could get a national decision.

So I think that the issue you raise is a possible problem but I don't think it actually came up.

MR. HACKBARTH: So in that latter case where something hasn't been widely diffused, is it still possible to get on the national pass-through list?

MS. DePARLE: I don't think so, but the next part of my comment was going to be, I would just -- this is a very complicated subject and I think that Penny has done a

good job of laying out some of the issues, although I do find some things about the paper that are not consistent with what my understanding was. I would just urge that if -- I think Ralph is right, this is an important topic. It's going to be something I think this body should be interested in, and I would urge that we ask Dr. Tunis or others from the agency to come and speak with us at some point about where they are with it, because things have moved forward even since this paper came out.

MR. SMITH: There is no such thing, if I'm right, as a non-national pass-through. So the extent to which a new technology is in use and off the pass-through list it's incorporated into the regular payment system. There's no added payment or separate payment. Am I right about that?

MS. MOHR: Yes, you're right.

MR. SMITH: So the question of an off the list new technology is not a question that impacts the payment system.

MS. DePARLE: Yes, it does, because it can be paid for on a local level. They may not have applied for a pass-through but it's being paid for. So it's feeding into the payment system.

MR. SMITH: But the code is for some other product.

MS. DePARLE: That's true.

MS. MOHR: But presumably that gets adjusted, too.

DR. REISCHAUER: It costs no more and presumably has a better outcome.

DR. NEWHOUSE: Or may be used in a whole new population.

DR. NELSON: It might hit the outlier. It might be dealt with as an outlier if it really drove up --

MS. DePARLE: This is really complicated.

DR. WAKEFIELD: I was just going to say, Chantal, you might, if you haven't already, check in with the folks at the University of Minnesota who have got a pretty significant study underway and it might augment Penny's work a bit, looking at variation in payment decisions at the Medicare contractor level. Senator Durenberger would correct me if I'm wrong about that, but I think they've got a pretty significant study. I could give you the name of the contact there.

DR. STOWERS: I don't mean to be repetitive but I was going to basically say what Mary did. I think it's a

great paper but I think when we just say there's flexibility with the local coverage thing, I think we really need to take that further and quantify this variability that we're talking about. I practiced between two different carriers and it was amazing the difference in services available, pacemakers and different things between -- just right across the state line. So I think we really need to look at that.

Then I think we kind of mentioned it back in our December report on the -- is this because of the difference in the difficulty of the approval process? And is the national process so difficult, is that what's keeping more diffusion of this to the general Medicare population? So I think for us to go through all of this and not look at the approval process itself, or at least reexamine that a little bit, would be maybe leaving a whole in the process there a little bit. So I think we need to see what the burdens are there.

MR. DeBUSK: On the four case studies in our book here, I understand there has been provide rates set for these case studies, right? I think at a future meeting it would be very interesting to see how CMS arrived at the payment structure for these four products. Maybe there's a

message here in how they had to arrive at that, and ultimately may be an area that we may end up in in trying to figure out what the solution or the best solution would be at this time.

MS. BURKE: I was only going to suggest that as we move this forward, because it is so complicated, I think the use of specific examples will be helpful and the case studies will give us that opportunity. But I also think, in your description, Penny -- and you have done quite a good job -- I think part of what is missing in terms of explicitly stated is there's a certain amount of subterfuge that goes on today. That in fact there is adjustment made without an explicit decision having been made; that is essentially burying it within existing codes.

So there is the explicit, overt process of a national decisionmaking and an adjustment and a pass-through that is quite explicit, and then there's all the stuff that actually takes place at the local level that reflects in all these weird variations that Ray points out between carriers or contractors that essentially they make a decision at some point that it's just not worth the fight at the moment and they just bury it in the rates. So I think there are a

couple of things that go on. There is this formal process which is becoming increasingly formalized, but there is still all of this other stuff that goes on that has an enormous impact over the long term.

So I think as we look at some of these specific case examples, we ought to look for those issues as well that occur at the local level which will add to this over time and certainly add to the confusion for the providers.

MR. MULLER: Not all technologies are more expensive than the ones they replace, so obviously one looks for the pass-through when it's more expensive, and either the APC or the DRG doesn't quite cover it. But many times -- this goes back to the query that David had -- as device manufacturers or pharmaceutical companies compete for market share with doctors, hospitals, et cetera, then they can come in within the existing DRG or the APC and just go put their product in versus somebody else's product. It doesn't necessarily have to therefore trigger some kind of either outlier payment or pass-through or so forth. It's just kind of competition -- I mean, all of us who have worked in hospitals know that each of the knee guys has a different knee and some of them cost so much, and some cost this much,

and so much. And they can oftentimes fit within the DRG and others don't. The ones that don't you start thinking about how you get an outlier payment and so forth, and the ones that do you don't worry as much.

So I think this goes back to the theme, there's an awful lot of action going on below the APC and DRG level. That's why I keep coming back to this theme of activity. So it shouldn't just be, let's just look at when it triggers an outlier. Let's look at the kind of diffusion of technology independent of that.

MS. BURKE: You also have the point that Joe made which is that there's also the -- there's whole new populations that occur and that are suddenly being involved for different uses for traditional things. So it's a combination of things.

MR. MULLER: When you look at the laparoscopic surgery that started 15, 18 years ago, and now they're doing hearts. So the uses of that has exploded year by year. Now it's a much better outcome for many patients. It's less costly in some ways. Sometimes it's more. But those kind of technologies as they diffuse have, as I say, an enormous impact on the program and they accelerate much faster than

anybody can keep track of. I think that's part of the kind of swirling that we're dealing with here is these things happen so quickly, they're going on inside many part of the country and you can't even keep track.

For many physicians and other caregivers, just putting the technology into play is more important to them and their patients than trying to figure out how to get paid for it. Therefore, they put it in and in some case -- somebody else has to then sort it out how you get paid for it and so forth. But the diffusion goes on, in many cases, without any explicit kind of permission being asked as to whether it can be used or not, because many of the things don't have to go, as you know, through FDA approval, and especially on processes.

So in fact -- that's the point I want to keep focusing on is that this stuff happens even if there's not an explicit payment for it.

MS. MOHR: Could I just interject something here? I'm sorry, I just really would like to also go on record as saying that I think it's important, when you're thinking about the coverage of new technologies, that you have to pick your battles. It's impossible to assess all new

technologies. It's impossible to do coverage determinations for everything that's out there. The evidentiary standard varies a lot by different types of technology. It's extremely complex.

Basically the way the Medicare program is set up now, it's a small percentage of technologies that get up to these national coverage decisionmaking level, and partly that's because of the nature of the available evidence that's out there too. I think that it's important to keep that in mind. I think lots of times people say, we should just assess everything, and I think there's big trade-offs to be made there.

MR. DURENBERGER: Thank you, Mr. Chairman. Sheila, good morning.

I haven't said anything because in my past I represented a medical device company and covered some of these issues so I didn't feel this was the time to try to make a contribution. I also currently, as far as bona fides are concerned, I currently chair a 501(c)(4) called Medical Technology Leadership Forum, which for now six years has been trying to bring the continuum of people from patients to inventors to academics together to find answers to these

similar questions. I think Penny was at one of our last sessions. It's a most difficult challenge.

The rest of my bona fides is I'm also married to the woman who's the principal investigator on that study and who also wrote, at one point in time at least, the book on medical technology policy and probably illustrated then, and since then, just how challenging this whole subject is.

So again, when I look at it, the importance of -- I look at the top of this paper -- I'm a new member and I look at the top of the paper and it says, how should Medicare design an updated payment system to take into account new technology? That's my goal. Then it says we're going to have a chapter on Medicare payment for new technology and I'm saying, I'm not quite sure exactly what my charge is between now and then to try to think about this subject which has been bedeviling people forever.

So I think Nancy-Ann and some people here have this experience. You predecessor as chair had it as well. But the suggestion that Nancy-Ann made relative to Sean Tunis and the people that are making both the coverage and the reimbursement decisions is important. I would add to that the people from the FDA, particularly David Feigel and

Kathryn Zoon in doing the biologics. They're just as trapped into some of these issues as -- not trapped, but I mean they're right in the middle of all of it. I would add in AHRQ, because you are talking about cost effectiveness and some of these other issues.

So there's a lot of experience in this community on the governmental side that I haven't heard was involved in this. It may have been in the past year as you were looking at the issues. But focusing on what it is we really want to do and sort of framing up the chapter, what is that chapter going to look like, would be very, very helpful, at least for me. I'll just only speak for myself -- in terms of thinking about what resources I would like to hear from or I would like to see examined in the context of making some conclusions. Just what's the framework of this chapter? So that when you answer the question about payment policy you've taken into account a whole lot of history, a whole lot of current interest.

The last thing I'd like to say relative to the international side, which is where I am beginning to spend my time rather than in this community, you're not going to find answers because every one of those systems is so

different. The Japanese system we were talking about last night is incredibly different; no way to go there and get answers to questions. But there are places where just in terms of efficacy, not necessarily in terms of payment but in terms of efficacy, a lot on the device side at least, a lot of people are spending time doing a lot of good work.

So that's just sort of a cautionary flag from my own experience about literally transferring what you may have seen or heard someplace else into decisionmaking in this country.

MR. HACKBARTH: Dave, for me the personally the first step is simply understanding. We've had this issue of payment for new technology put on our agenda by the advent of these new pass-through systems that raise issues about appropriate payment and whether we're establishing correct levels of payment, correct incentives.

We wrestled with this for our March 2002 report. We had a chapter on the outpatient PPS pass-through system and at that point bumped up against several issues that we didn't have answers for that we thought were very convincing answers. We didn't like the incentives created by the pass-through system and using the cost-to-charge ratio as a

mechanism for calculating the appropriate payment, but we didn't know what to offer as an alternative.

So we've embarked on this conversation, I think in recognition of the fact that we've got a lot to learn and figure out about this area. I think the idea of having some exchange with people at CMS who are responsible for this, I personally would welcome that, but we have to figure out how to do it within our allotted time.

So I don't know what that chapter is going to look like. I think we're in the midst of trying to figure out where we can make a reasonable contribution and we need some more education to be able to do that. It's not like we're headed somewhere real specific and you've not been brought into it yet.

Chantal, you wanted to add something on that?

DR. WORZALA: Yes, I'll just follow up on that and just say good morning. I apologize, I was completely tied up in the Red Line mess this morning and missed the opportunity to introduce Penny and maybe lay a little bit of the groundwork that explains why exactly we undertook this study. I think Glenn did a fabulous job in summarizing now what I would have said.

What we've asked Penny to do is actually a two-step process. The first was to go out and listen and find out what other large payers are doing, and she's presented those results here.

Then the second step was to convene an expert panel, which actually happened this week, to focus exactly on what to do in Medicare. We did bring people from various viewpoints, including three representatives of CMS. Sean Tunis was there, Tom Gustafson was there -- I'm sorry, two representatives of CMS. Kathy Buto was there but she is no longer a representative of CMS. We did have manufacturers in the room, some academics. It was far too big of a job for Penny to present those results today as well, so she will be bringing that in October.

We had thought in terms of focus that we would narrow in on payment because our impression was that in these discussions there has been a lot of work on coverage but maybe not as much work on payment in the whole policy community. But I am hearing this morning a lot of interest in the coverage process so we may want to expand our focus and look at some coverage issues. So hopefully in October or November we can bring to you a much better, concrete

outline of what we would like to do for the March report. I think at this point, as Glenn said, we're in the information gathering stage, and you've certainly given us some great ideas of where to look for more information.

MR. HACKBARTH: Thank you, Chantal.

DR. REISCHAUER: It seems to me that the current payment system has built into it incentives to develop and disseminate technology that reduces unit costs, and that's fine because you can stuff it under the existing payment system or get it approved locally if that's necessary. There are three dangers that arise from that incentive and one of them is that the technology might be cost reducing, but it also might be quality reducing as well, and you rely on doctors' desire to do good to avoid that. But they, like the rest of us, are mesmerized by new technology often and the evidence isn't there, so you've got to keep some eye out for that.

There's also the danger that Joe raised which is the new technology can jump diagnostic limits and be applied for something that you never thought it would be applied for and there's no real rigorous test of efficacy or whether we should be covering this.

And the third danger is that while all of this cost reduction is going on it's not reflected appropriately or in enough time in the overall payment level, which should be falling for that particular treatment. But there are ways in which we try and deal with this, so I don't really get worried about all that Penny talked about going on underneath that we aren't keeping our eye on.

The real issue here, of course, is technologies that cost more and promise better outcomes. I think the hurdles for paying for those, adopting them, should be high. We should have some rigorous and relatively uniform national mechanism for doing that. What we should focus on is how to bring that structural change about.

DR. NEWHOUSE: The problem is harder, Bob. You could have something that's cost reducing for the system but not cost reducing for the agent. Say I have something that was going to raise the price of the hospital admission but lower the probability of readmission downstream, on the current DRG payment it may be unprofitable for the hospital to adopt it even though it would be cost reducing for Medicare to have it in place.

DR. REISCHAUER: But that's the sort of thing we

should examine because it's a complex decision that can't be decided by the hospital.

DR. NEWHOUSE: It's inherent in the way that we pay for it, given the unit that we pay for just can't accommodate it.

DR. NELSON: I'll be brief because to some degree I'm going to repeat what I said before. I see two different pieces to it and each piece has two components. How coverage decisions are made, how payment and pricing decisions are made. Each of those, how it is now and how we would like to see it in the future.

I think we make an important contribution if we simply take the very first part, how coverage decisions are made now, and emphasize how goofy it is to some degree. It makes no sense for a Medicare beneficiary to go into a hospital in one Medicare area and have something covered, and if they go into another hospital in another Medicare area it isn't. It's a national program. I understand the importance of individual local -- respecting local differences. But I think at least we ought to describe this in a way in our report.

MS. MOHR: I just wanted to point out that the GAO

is currently doing a study also that's looking at national versus local coverage decisionmaking and that report is due out in the fall.

MR. HACKBARTH: Okay, thank you very much, Penny. We've got a lot more to do and learn about this subject.

Chantal, you're next up, aren't you?

DR. WORZALA: Yes. It's the morning of difficult topics.

MR. HACKBARTH: Yes, my favorite, the hospital outpatient PPS. I always look forward to this.

DR. WORZALA: Good morning. I'm be discussing the proposed rule on the outpatient prospective payment system for 2003. It was issued on August 9th and we are planning to submit a comment letter on this rule. A draft of the comment letter is in your briefing book at Tab J. Comments are due to CMS by October 7th, and that is, of course, before our next meeting. So during this session what I'd like to do is give a brief overview of the payment system to refresh our memories, and to review the salient elements of the rule and get feedback from you on the draft comment letter.

As we learned yesterday, the outpatient PPS

accounts for about 8 percent of total Medicare spending, or approximately $18.5 billion. It covers services delivered in hospital outpatient departments and classifies them into something called ambulatory payment classification groups, or APCs, for payment.

The APC system includes bundled services such as a full outpatient surgery, insertion of coronary artery stents, angioplasties, fairly high level surgeries as well as very narrowly defined services such as an x-ray or the administration of a vaccine. So all of these things are covered under the same payment system. Hospitals bill for each service that is provided during an encounter. This is very different from the DRG system where you bill for one diagnosis in an episode.

In addition to the standard service categories, the outpatient PPS includes pass-through payments for new technologies. The pass-through covers items that are an input to a service, such as an implantable device or a drug. So these are not separably identifiable services, they're inputs to another service that is being provided.

We have talked about the pass-throughs in the past and we've noted that the payment formula for devices, which

takes hospital charges and reduces them to costs, does provide hospitals an incentive to inflate charges, and manufacturers an incentive to inflate price. Payments for drugs are set at 95 percent of AWP, which most observers believe is an overpayment.

The Commission recommended changing the payment mechanisms for pass-throughs to have national rates for devices and to use some alternative to AWP for drugs and biologicals. The pass-through is implemented on a budget neutral basis and is subject to a cap of 2.5 percent of total spending, or about $458 million. If the cap is exceeded, however, pass-through payments are subject to a pro rata reduction to stay under the cap.

I'm sure you remember that last fall the pass-throughs were a very large issue. Legislative and administrative actions led to a very large volume of items becoming eligible for pass-through payments. Consequently, CMS estimated very high spending and a large pro rata reduction in 2002.

To avoid such a large reduction, CMS took 75 percent of device costs and folded them into the base rates for 2002. This fold-in was done in a budget neutral manner,

so that meant that while APCs, including medical devices, saw payments increase, APCs for other services saw their payments decrease. Even after that fold-in there was a large estimate of spending so there was still a pro rata reduction of approximately 64 percent.

Given that difficult history, we do think that moving ahead, the pass-throughs will be less of an issue. There are more stringent criteria for eligibility, and most of the items currently receiving pass-through payments do lose their eligibility at the end of this year so there should be a much smaller volume.

That was just the overview of the payment system. Now turning to the rule. The rule includes essentially revisions to the APCs. This does draw upon the recommendations of an external advisory panel, which is something unique to the outpatient payment system. It proposes relative weights for each APC group based on hospitals' 2001 claims and the latest available cost reports which are generally fiscal year 1999 cost reports. This is the first year that the outpatient PPS has had claims data from hospitals operating under this payment system in order to set the rates for the following year. So this is a

little bit of a watershed year in that way.

Again, the vast majority of items eligible for pass-through payments lost that status at the end of this year and the rule proposes mechanisms to integrate the cost of those items into the basic APC structure. Finally, the rule provides for an update to the conversion factor.

In addition to refinements to APC categories, the rule does propose a new category for angioplasty that includes insertion of a drug-eluting coronary artery stent. We referred to this a little earlier. This is a rather unusual step. It was taken in both the inpatient and outpatient payment systems. It's unusual because these stents have not yet in fact received approval from the FDA. There will be no payment before approval is granted by the FDA, but once it is granted hospitals may immediately begin billing using these codes and receive payment for use of this technology.

I think this is a step that shows CMS can be responsive to what is thought to be a truly breakthrough technology. On the flip side, it does establish a precedent and CMS will need to be very judicious, and I guess very tough, in limiting the number of times it creates a payment

category in this way.

One aside -- it's not exactly an aside but it's an interesting point. Drug-eluting stents, one would think is the perfect item to fit into a pass-through category. However, they could not use the pass-throughs to pay for drug-eluting stents because they can be described by what is currently an existing category. There is a category for coded stents generically and it was determined that drug-eluting stents are in fact coated stents that are described by this category. So by law you cannot create a new category for something that can be described by an existing or previous category. So since coated stents lose eligibility for pass-through payments at the end of this year, coronary artery stents would not be eligible for pass-through payments.

So they took the step of setting a new category. To my knowledge, this is the first time that CMS has set a payment rate for a service that is not -- temporary without having hospital claims data and cost data to base the payment on. The payment differential for using a drug-eluting stent versus a non-drug-eluting stent is about 1,200. The payment, as Penny mentioned, was established

basically using data from the United Kingdom, also based on information from manufacturers.

There was no negotiation, simply provision of information from the manufacturer. This does suggest that in at least some cases CMS is able to set payment rate for new technologies. This is something that we recommended last year, that if we can have a very small number of pass-through items, perhaps it's possible for CMS to set national rates for those items.

Then the key question is, where does the information come to set that payment rate. Here we have an example of where they went out and did that and the information was in fact prices in the U.K. I think there are a lot of questions about the availability of data like that for every technology, but it was done here.

Back to pass-throughs. The rule integrates devices losing pass-through eligibility into the standard APC groups. They took a different approach for medical devices versus drugs, so we'll focus on devices right now. The vast majority, that is 100 categories of devices, lose their pass-through eligibility on January 1. So the cost of these devices will now be fully integrated into the relevant

APC base rates. The proposed payments were set using the median of hospital charges reduced to cost, the charges, of course, of the pass-through device, or added to the charges for the relevant procedure.

This is the normal way that CMS uses to set payment rates in this payment system. However, it is noted in the rule that there are large changes in payment between 2002 and 2003 for APCs that include medical devices. One reason for these price swings is probably the use of data sources to set the payment rate.

You'll recall that when they did the fold-in of 75 percent of device costs when they set the 2002 rates, information was basically derived from manufacturers. CMS tried to massage that data a little bit but that was the best information that they had available. In contrast they are, of course, using hospital data, hospital charges reduced to cost for the 2003 rates.

Most of the changes in payment are declines in payments, some of them rather steep. I think there just is a question, which data source more accurately reflects the true cost of these items. In principle, of course, the Medicare payment system prefers using hospital cost data

over other sources and, all else being equal, I think that's the right approach here.

However, there is some concern about the accuracy of coding that hospitals used in submitting those claims in 2001. This is a very new payment system. It's remarkably complex. Hospitals have reported great difficulty with coding, especially for pass-through items. That's not surprising given that there are over 1,000 individual items eligible for pass-throughs and they were added to the list at different times. There were quarterly updates. We went from individual identification to categories.

So I think probably the best approach to this is to say that we prefer use of hospital data because it shows what -- we assume that hospitals' charges reflect their costs, and this is the same data that we use to set payment rates for every other service. But that there does need to be some careful attention and work with stakeholders who can really present credible evidence that payments for a specific service may be inaccurate due to coding problems.

So that's what we've written in our comment letter. I definitely welcome your feedback on that point.

Moving on to payments for pass-through drugs and

biologicals. The vast majority, of course, lose their eligibility at the end of the year. As with the devices, payment rates were set using the median of hospital charges reduced to costs. Again, this generally leads to reductions for payments from 2002 rates. We would expect that because those rates were based on 95 percent of AWP, which generally is overstated.

As with devices, I think we generally prefer the use of the hospital cost data. But again, given large changes in payment I think it would be prudent to listen carefully to people who can present credible evidence suggesting problems for specific items.

An issue that I think we want to speak to is a distinction CMS is proposing to make in its treatment of low cost drugs coming off the pass-through list, and in fact most drugs, and payment for high cost drugs. What they propose to do is bundle the payment for low cost drugs into the related APC group, but pay separately for high cost drugs. The rule defines high cost as $150 per treatment or administration. So they're taking the price times the number of units and that's where they're setting their threshold, at $150.

This appears to have been an arbitrary cutoff. It leaves about 60 percent of drugs below that threshold and 40 percent above that threshold. I wasn't able to find out volume or payment. I'm sorry, I just know percentage of actual drugs.

Clearly, paying separately for high cost drugs does help ensure that beneficiaries have access to them and that's very important. In addition, this approach means that CMS doesn't have to try and match each drug to various APCs, which is a technical challenge.

However, assuming that the payment rates are sufficient, this division also provides a clear incentive to use the high cost drugs. Also if this policy is maintained over time it provides an incentive for hospitals to set their charges and for manufacturers to set their prices so that these drugs hit the threshold in any given year and qualify for separate payment.

We have spoken to that issue in the rule. The rule does say that this is a temporary measure. They're only guaranteeing to do it for one year. So I would be interested in your feedback on that.

Finally, many of the drugs that were previously

eligible for pass-through payments are also delivered in other settings, such as physicians' offices. In those other settings payments will continue to be paid at 95 percent of AWP barring any change to that system. Joan will speak after me exactly on this issue of payment for Part B drugs. But barring any changes, payment for these Part B drugs will be higher in other settings than in the outpatient setting. This could very plausibly lead to shifts in the site of service away from the outpatient department for financial rather than clinical reasons.

As anecdotal stories, you do see in the health management literature and some of the trade press, we want you to note that the payment will be different in these settings. So this is not something that's exactly providers' attention.

So what about 2003 pass-through items? Given that most pass-through items will be integrated into the base APC we don't have very many items eligible: five device categories, 2,000 drugs and biologicals. If you're interested, I did copy the list from the rule if people want to know what the specific items are, and I will just pass that around; get a little more concrete.

The adoption of stringent criteria for eligibility means that there are likely to be very few additional items added. These are currently eligible. There could be more approved but it's not likely to be many.

The proposed rule at this point does not include an estimate of pass-through spending in 2003 or suggest a pro rata reduction. It seems likely that there will be one. If you tote up the numbers on that table that I sent around, they're already pretty much at their cap. But I guess the thought is that the inclusion of a pro rata reduction is much less of an issue in 2003 than it was for 2002. It's not likely to represent a particular concern for access if they implement a pro rata reduction, for a number of reasons that I've laid out in the comment letter. We do think that there's overpayment in these payment formulas. We think that --

DR. ROWE: Could I ask a question on what you just passed around? The 2002 payment rate then, that actually represents 95 percent of the average wholesale price; is that right?

DR. WORZALA: That's correct, in 2002.

DR. ROWE: That's 95 percent of the AWP.

DR. WORZALA: Right.

DR. ROWE: And the 2003 portion pass-through payment portion is what? A portion of what?

DR. WORZALA: This is a table that is helping to understand how they might calculate a pro rata reduction. What they do in estimating costs for pass-through items is take what they will pay, which is 95 percent of AWP, and subtract out what is considered to already be included in the payment system for that item.

DR. ROWE: So the 118 doesn't go to 34, the 118 goes to 118 minus 34.

DR. WORZALA: Correct, and that would be the actual size of the pass-through payment that they tote up.

DR. ROWE: Thank you.

DR. WORZALA: So other reasons that we might not think that pro rata reductions is that important in 2003 is what we've talked about all along, that these are new technologies. Physicians and hospitals are interested in using them. They have reputations for excellence to maintain. And they see that they improve care and they want to use them for their patients, and they may find other mechanisms to pay for them, as Ralph noted.

Also we've seen no evidence that the pro rata reduction in 2002, which was 64 percent, led to any access problems. I haven't seen anyone address that issue. And finally, I think asking hospitals to share in the cost of new technologies does provide an incentive for them to assess the value of the technology, which is perhaps where these decisions are best made.

Now I'll move on to the update to the conversion factor. The proposal is to increase the conversion factor by the hospital marketbasket index. That's consistent with current law and consistent with our recommendation last March. The latest estimate for 2003 is 3.5 percent. The rule does not address two issues that may become more important as this payment system becomes more mature.

The first is to track increases in the volume of services delivered and thinking about implementing some mechanism to control excessive volume growth. This is a very tricky issue and I think we're looking at it in a physician payment arena right now. I think it may also arise in the hospital outpatient setting.

The second issue is really tracking changes in how hospitals code for these services to identify and

potentially correct for any upcoding.

So these are issues that may be on our plate in the new future and really ought to be on CMS' plate in the near future.

Finally we'll turn to the rule's estimated distributional impacts across types of hospitals. The effect of integrating the pass-through items into the base payment rates has been a general decrease in payments for APCs that include those items. Given that the recalibration of the relative weights is done budget neutral, that means that payments for other services generally increase significantly in 2003. It appears from my calculation, and I hope it's right since I'm here speaking to the public, it looked like payment for mid-level clinic visits went up by over 10 percent between 2002 and 2003.

So this basically reverses the effects of the fold-in, and you can see those changes in these distributional impacts that are up on the chart. These are mainly driven by differences in case mix. There's also some issue of changes to the wage index and reclassification, but mostly it's differences in service mix. So you see that hospitals providing more services that use pass-through

items, such as major teaching hospitals, will see smaller increases in payments. The estimate is 1.7 percent. By contrast, rural hospitals which do not provide many of these services, will see a fairly large increase in payments. What is listed here is 7.6 percent.

One last note on distributions and rural hospitals. We wouldn't want to forget our rural hospitals. We did suggest in the past that CMS look very carefully at the performance of small, rural hospitals which are currently receiving hold harmless payments under this payment system, and I think we repeat that here. They do have one more year of their hold harmless status, through 2003.

I'll stop there.

DR. ROWE: This is very comprehensive and I think very important. I think there's an opportunity for us here within the confines of the usual language and structure of a letter like this to be, I would say, a little more directive and a little stronger, in my opinion, with respect to one items. Commissioners should be aware that 95 percent of average wholesale price is an enormous price. It is an Olympic record price. It is not the price you would expect

the largest purchaser to pay. It is at least twice what I would have guessed would be the number. It is just a very -- there are noneconomic, non-clinical factors that must be at play in determining this price. If the idea to be a prudent --

DR. NEWHOUSE: What makes you think they're not economic?

DR. ROWE: If the goal is to be a prudent purchaser and we're here to help Medicare, then I think that this is something that we should really focus on. I certainly support strongly getting away from that. If you were to do a survey of the large health plans and the PBMs and what the PBMs, either Merck Medco and Advance PCS, Express Scripts, Caremark, and the Wellpoint PBM and the Aetna PBM pay for drugs -- and they're smaller purchasers -- it is, I think, very substantially south of 95 percent of AWP.

MR. HACKBARTH: In fact our next topic this morning is just that.

DR. ROWE: I understand that. So with respect to that, and we're going to hear more about this, I just want to heighten people's interest in this issue that physician's

offices, particularly specialty physician's offices such as oncologists, are still going to be getting paid of 95 percent of AWP. I think that this is an exceptional -- there's something wrong with this.

So we'll hear more about this but I would like to think that if we're here to help not spend less money or more money, but the right amount of money, that we would be able to make a very forceful statement with respect to that rather than have it in the middle of the fourth page of a six-page letter with a sentence saying we're a little concerned about it. I mean, it really leaps out at me anyway as probably a multibillion excessive expenditure.

DR. NEWHOUSE: I agree on the AWP.

I thought the letter was, on the whole, a very good letter and I had no real substantive change, but I wanted to make a remark that may be for the future on the $150 cut point for drugs. In the past we, and maybe others, had taken the point of view with respect to the outpatient PPS that it was too coarse a system, the APCs were too coarse a system. We recommended a more disaggregated system and there was a more disaggregated system. I don't know whether there was cause and effect there.

What this is saying to me is that it's still not disaggregated enough. I can't see that the $150 current treatment is going to work for all the reasons you outline. The problem is basically that we've put high cost drugs and low cost drugs into the same category and when they're reasonably equivalent then that's appropriate, and when they're not, then that's a problem. It looks to me like somebody is going to have to go back and work on the basic architecture of the APCs to resolve this problem. If CMS is saying this is only in place for a year I'd like to know if they've got plans to be working on that in that year, otherwise we're going to just be in the same place a year from now.

MS. BURKE: I would agree with both Jack and Joe on the points they made. The issue I wanted to raise was going back to a conversation that we just had, and that is the issue of using, as a method for pricing, something other than cost. The letter seems to suggest, and I'm really just probing to find out where we want to be on this, it seems to suggest that we think the decision to go to Europe, the U.K. in this case, for a method for pricing is a good one. We note early on in the letter that we are pleased that CMS has

shown its capacity to be flexible and to adjust quickly to an opportunity, which I think is in fact something that we do want to say.

The question I really want to ask, because of the point that you made, Chantal, which I think was right which is the issue of precedent. I mean, is this in fact something that we want to continue to encourage? Whether we want to address that more directly as a question that ought to be raised. As Bob suggests, maybe that is a good system in the absence of specific information which may arise again because of earlier diffusion that occurs outside of the U.S.

But I think it is incumbent upon us to ask the question whether in fact over the long term this is a strategy we think makes sense and not simply to note it -- you do note in the letter that you think the sources are less reliable, which is an interesting reference, interesting language to us. But I think the Commission itself needs to think about, do we want to encourage this? Is this something that ought to be probed more deeply? What does it say about what we know about the way those prices are set overseas? Do they make any more sense than simply picking a number or picking a wholesale price or whatever it

happens to be?

So I'm concerned that -- I do think the letter is quite good but I'm concerned in that case that we simply pass it over without noting that there is an issue here and there is one that I think ought to be probed over time.

MR. HACKBARTH: Good question. Let's pause for a second and have people specifically address Sheila's question.

DR. NEWHOUSE: I think the issue ultimately goes to the role of the financial incentives in the rate of innovation or desirable innovation. My assumption is that basically our willingness to pay for these drugs, devices, or for that matter procedures, is higher than most other places. So if something is out there and we can get it at the price that they're paying for it, on balance the U.S. consumers will be paying a lower price. That may have some feedbacks back to innovation. So we're back to that old conundrum again. So I don't think it's a slam dunk that we should be adopting the prices of the other countries. As I said earlier, I would expect the existing differentials to narrow if we did.

DR. REISCHAUER: It strikes me that in a situation

like this, for many technologies there is a falling cost curve. That when the U.S. comes in and begins purchasing this, production volume increases tremendously and unit costs should fall. We are slow to take advantage of that, by and large, so I don't think I would worry about --

DR. NEWHOUSE: But that's only relevant if there's a lot of competition. If I have a product that there's no good substitute for and I have a patent on it, then I'm pricing in accordance with what the market is going to pay for it, not what my costs are.

DR. REISCHAUER: But you have sold it to Great Britain assuming a much smaller volume and now you're going to get a much larger volume. So if you were maximizing revenue before you're rolling in it now.

DR. NEWHOUSE: So I'll just roll. I'm still going to want to set the profit-maximizing price if I have a patent.

MR. HACKBARTH: As a non-economist listening to this conversation what I hear you saying, Bob, is that because of the ramp up in volume and falling cost curve there will still be ample opportunities for profit and reward to innovation even if we use the European price.

DR. NEWHOUSE: That's an empirical question.

MS. BURKE: I think Joe's also saying that over time if we do that, the price goes up.

DR. REISCHAUER: Maybe not as much as there would have been otherwise, but remember the people developed the coated stent not knowing whether we were going to buy it and with some knowledge that Great Britain --

MR. HACKBARTH: If in fact there is the feedback loop whereby then they start charging higher prices in the U.K. knowing that that's also going to affect the price they're paid in the U.S., turn-around is fair play I guess in my book. I wouldn't worry much about that myself.

DR. NEWHOUSE: No, the point is that we shouldn't think we're going to get it at the current prices we're observing elsewhere.

MR. HACKBARTH: But why not get them at that price while you can even if later on there is some subsequent increase over time as they learn this system and they start to price higher?

MS. BURKE: Just as a passing note of interest, do we have any concept of the basis upon which the U.K. sets its payment? Do we have some reason to think that there is

something other than they take the price --

DR. NEWHOUSE: For drugs it's the rate of return that was described earlier.

MS. BURKE: Which is this number which is the investment number. What about technologies? Do we know across the board -- I mean, if we're going to turn to the U.K. for price setting --

MR. MULLER: First of all, they buy a lot fewer because they have less money. And secondly, they're one purchaser so they've got a lot of purchasing power.

MS. BURKE: So we're assuming that the price-setting mechanism is a rationale one, it's just a smaller amount because there's a smaller volume and they had this return which they set at 17 or 12 or whatever number they happen to choose.

DR. NEWHOUSE: But the drug manufacturer could just withhold from the U.K. until he gets established in the U.S. That's what I would probably expect.

MS. BURKE: Mine is really the more fundamental question which is, if we assume that the price, assuming a smaller volume, the price will decline my point is really, what do we know about the way the prices are set to begin

with, and is it a base upon which we think it makes sense to build? If it is a price with a return on equity that is X percent to the U.K. market, is that a basis upon which we think it's rationale for us to set a price?

DR. NEWHOUSE: My own view is it may be the least bad system, but that's a controversial view.

MS. BURKE: That's reassuring.

MR. HACKBARTH: I want to bring some other people into the conversation. The one thing that we know is that they're willing to sell at that price. That's the one empirical fact.

DR. NEWHOUSE: In the U.K.

MS. DePARLE: Just one point. I agree with Sheila that we should explore more this basis and make sure we understand it. My understanding is that in this case, this device is being used in a few people, maybe not even as many as around this table, in the U.K. and that it's part of a clinical trial. It's not like it's being sold out there right now. But it was the only thing out there, given what Chantal said about the unprecedented nature of this decision being made at this time.

But I think Sheila's underlying point is right,

that we should understasnd better what the options are out there and what we're saying when we say that we endorse that as a method of doing it.

MR. HACKBARTH: To provide appropriate guidance for Chantal, I would like to agree on how to address on how to address Sheila's issue. One approach, Sheila, would be simply to observe that in fact it's an issue. We don't know the answer to it but we have to think about the long term consequences of particular pricing strategies like adopting a foreign price. I assume there's no objection to adding that sort of language to the letter.

DR. WAKEFIELD: Chantal, is there anything else you can say about, in those rare circumstances perhaps where there are problems in the adequacy of payment for specific items, what the options are that can be pursued? So you talk a little bit about access to new technology in the sense that there probably won't be problems for a number of reasons. In those rare instances where there could be, what options, what's the vehicle for pursuing redress or adjusting payment for a device supplier, for example?

DR. WORZALA: I'm not sure if you're talking specifically about the pass-through payments or generically

payment rates in the fee schedule.

DR. WAKEFIELD: Just generically.

DR. WORZALA: First of all, the proposed rule is in fact a chance for interested parties to comment and bring these issues to CMS' attention. And CMS has a long history with this particular payment system of working with people to fix problems, so I don't think that's too much of an issue.

There is also a formal mechanism, which is the APC advisory committee, which meets, I believe it will start to be twice a year, and people can bring issues to that committee and that becomes a formal mechanism to bring these problems to the attention of CMS.

DR. WAKEFIELD: So any evidence that a manufacturer would have, they could bring that then, or a user would have, they could bring that to that committee and that's where those issues would be heard?

DR. WORZALA: Right.

MR. MULLER: Given that many of the pass-throughs lapse this year and they've being folded in and you showed those different payment increases in the 2003 rates based on classifications, I would assume that the APCs are varying

quite a bit, fluctuating quite a bit from year to year. Do you have a sense of the kind of range? Is it 5 percent, 10 percent, 50 percent, 80 percent? How much are they varying?

DR. WORZALA: I think that's really going to depend on the actual service. Some of the rates that I've looked at have been as much as -- and I assume this is the steepest decline -- is approximately 60 percent in one case. Then the increases, I haven't actually looked at every single payment change.

MR. MULLER: Do you have any sense of the dispersion? What does the curve look like?

DR. WORZALA: I'm sorry, I don't. I should have done that, but I didn't have a chance to do that.

MR. MULLER: But is it your sense it will be considerable or clustered or --

DR. WORZALA: My sense is that there are significant changes for those APCs that include pass-through items. So that's a relatively small set of codes, but very large changes. And that the changes in the other services are generally all positive and of a more stable, lower level. That's my sense but I haven't actually gone through and done a distribution.

MR. MULLER: So the tide went up for those that weren't in the pass-through, and the ones that were in a pass-through category might go down considerably.

DR. WORZALA: Right. There are a few cases where those type, those that include pass-through devices clearly went up, but it's not as often as those that went down. I guess this really puts a lot of attention on how the Medicare program sets payment rates and the way that this is very much built on averages, it takes hospitals' accounting and assumes that cost accounting is correct for setting payment rates for specific items, which may not be a wonderful assumption although I think, again, it's probably the best data we have.

This goes back to the issues Joe raised, which I think are very important future issues about the granularity of this particular payment system. We model things on the inpatient PPS where you have very large bundles and problems like this are fairly well masked, and you have a large payment and you can do a lot of different things under that payment for an episode. But here where you're trying to set a payment for a specific drug or item using hospital cost data, it's just a much more challenging task and I think it

will continue to be an issue for this payment system.

MR. MULLER: If there's any way of getting any sense of this distribution for when we come back to this topic, because if in fact the fluctuation is -- I mean, we talk a lot about changes of 1 percent, 2 percent. But if things are changing 20, 30, 40 percent it might be interesting to speculate on what the behavioral response might be to that, if they're of that magnitude. I just don't know what the distribution is, but my sense is based on those numbers you showed there's going to be some pretty big changes in the payment rates of some of these, 50 percent or so. You said there was one of 60.

MR. HACKBARTH: Chantal, can you help me understand this distributive issue, the consequences of having pass-throughs for new technology, perhaps using payment methods that really promote the use of the technology because they're relatively generous, and then ultimately folding them back into teh base payment system? My understanding, based on our discussion last year had been that the effect of that was to, since it's all done budget neutrally, is to redistribute money towards the users of this technology, of the new technology, because you get more

of it and it increases the weights ultimately of those units. So once it's in, money shifts in teh direction of those particular services using the technology.

Here at the end of the letter we say that there's a shift back and a reversal of that. I didn't follow exactly why that's the case.

DR. WORZALA: Essentially, there seems to be a fairly large difference in the estimated cost of these items for the two data sources that were used. So with the fold-in, these were manufacturers' essentially list prices, although there were some -- the form did say, your estimate of hospitals' acquisition cost, but it appears that --

MR. HACKBARTH: So the reversal is specifically due to shifting to the new data source?

DR. WORZALA: It appears that way, yes. So that previously the estimates of the cost for these items were much higher when they did the fold-in for 2002 than the costs that they're estimating now using the hospital data.

MR. HACKBARTH: Let's project ourselves forward then to where we're out of the transition and over the long term the net effect of these pass-throughs for new technology then is to redistribute money towards the users

of the technology. We're doing this not just on the outpatient side but also on the inpatient side. So long as this is all done budget neutral does that then mean that the institutions being paid are basically being shifted, their limited finite resources, away from hiring more services or paying more for nurses to buying new technology or adopting technology into their operations? Are we, as we've embarked on this path, now skewing the system more away from investment in the people that provide the care to devices and so on, even more than the system has been skewed before?

DR. NEWHOUSE: It would depend on the update when it gets folded back in. The update, in theory, could accommodate it.

MR. HACKBARTH: This brings up back to the conversation that we started to have with Jack yesterday about whether we have a separate technology update even after we do the budget neutral.

MR. MULLER: But, Glenn, wouldn't folding it back in, as is occurring now -- I mean, my sense of the answer to your question is it would reduce the incentives towards taking up the technology because you had the pass-through which, at the margin, gave you an incentive to use it and

now you're folding it in for all but two dozen drugs and for some devices. So in a sense it's not an anti-technology -- that's too strong a word -- but it kind of suppresses the incentive use technology.

MR. HACKBARTH: But when you fold it back in the weights for those items go up. The recalibrated --

MR. MULLER: No. By being a pass-through they got a lot more, and then when they get blended in they get a lot less.

MR. HACKBARTH: But relative to other things within --

DR. NEWHOUSE: It depends how heterogenous the category is.

MR. MULLER: That's why I would like to see the response -- but my sense is the folding in kind of puts it on the average whereas before it got, whether it's AWP or -- my sense you got a lot more payment in the old system than in this new; is that correct?

DR. NEWHOUSE: Yes.

MR. MULLER: So in that sense it's anti-technology. That's too strong a phrase, but it suppresses the --

DR. REISCHAUER: It's not biased towards the selection --

MR. MULLER: It's not biased towards the introduction of technology.

MR. SMITH: But it would be unlikely I think, Ralph, to have an anti-technology effect unless the windfall were recaptured once you folded the device or the drug into the base. It's not recaptured, it's just better price.

MR. MULLER: No, it's recaptured for the system by being budget neutral.

MR. SMITH: It's recaptured by the system but it is not recaptured from the user. The user can continue to use the new technology without having their prior windfall recaptured.

MR. MULLER: If the prior was a windfall.

MR. SMITH: Some of this comes back to Jack's point, one of the consequences of the way we have priced the pass-throughs is that there are windfalls. Folding the initial pass-throughs back into the PPS lops off the windfalls but it doesn't recapture that gain, and in that sense should be neutral with effect to adoption I would think.

MR. MULLER: That's why I think it would be helpful to actually look at the numbers here because I think part of the experience with the APCs is that almost every year it's been like a whole new ballgame in terms of how they get done, so any kind of averaging over three years would really miss a lot of dispersion. So therefore I'd like to get a sense of what these numbers look like in whatever year we're going into, '03, versus what they are today, two weeks from the next year. Is it January or -- it's January. So what the prices are in calendar '03 versus now and get a sense of how those things vary.

So then I think that will help answer the question that Glenn was raising. The more I hear this conversation the more I expect that these prices are going to -- there are going to be a lot of 20, 30, 40 percent variations as opposed to 3 or 4 percent.

MR. HACKBARTH: We're running short on time right now. We've opened a couple big issues that we can come back to later on. But let me focus attention specifically on the draft letter. Any other comments related to the content or wording of the draft letter.

DR. REISCHAUER: This is a stylistic comment and I

don't know if -- I really haven't focused on this in the past. But the letter is written in a sense from the Commission to Tom Scully. We congratulate Tom Scully personally for doing this or that. Much as I like Tom Scully, just procedurally I think it would be better if we congratulated CMS.

MR. HACKBARTH: Any other comments on the letter?

Okay, thank you, Chantal.

DR. ROWE: I want to reiterate my thought about strengthening that section in the middle of page four. Somewhere we need to put it in caps or something.

DR. WORZALA: I'm also happy to get your comments by e-mail if people have specific language.

MR. HACKBARTH: Thank you. Next we in fact turn to the subject of payment for prescription drugs under Part B. Do you want to introduce Joan since this is her first time?

MS. ZAWISTOWICH: I'm pleased to introduce Joan to the Commission. Joan joined our staff mid-July. We stole her gladly from HHS, from the assistant secretary for planning and evaluation. I believe Joan has a doctorate in sociology. We welcome her to the Commission. Thank you.

DR. SOKOLOVSKY: Good morning. I feel that much of my thunder has already been stolen.

I want to focus more attention now on a small but very rapidly growing category of Medicare expenditures, and that payments made under Part B for outpatient prescription drugs. What I'll try to do this morning is briefly describe the current payment policy, what Medicare pays for, and how it determines how much to pay. Next I'll present some of the many problems with the current payment system, many of which have received considerable public attention in the past year through GAO reports and congressional hearings.

Thirdly, I'll categorize some of the alternative payment systems that have been suggested. And lastly, and I think more importantly, I'll suggest a structure for analyzing these alternatives and ask you for any additional concerns that you think would be important to consider.

Currently, Medicare pays for about 450 outpatient drugs, but that number is really quite deceptive because in fact only 35 drugs account for about 82 percent of all spending in this category, and 95 percent of all claims volume. So it's really quite a concentrated category.

Although these are outpatient drugs it's important

to keep remembering that these are not generally drugs that you purchase at a retail pharmacy. They're drugs that mainly people get at physicians' offices, for example, injectable drugs used to treat cancer, also oral immunosuppressive drugs like those used following organ transplants, and then some drugs that are used with DME, particularly drugs used with inhalant therapy.

Statutory changes in the past few years have increased the number of covered drugs. Preliminary estimates from CMS suggest that this year Medicare has spent more than $6.5 billion for these drugs. That's for 2001. That doesn't include Part B spending that was used in the outpatient department that Chantal spoke to you about. It also doesn't include spending used in dialysis facilities where we estimate there was another $2 billion.

For the past three years expenditures have been growing at a rate of more than 20 percent annually. Of this expenditures, physician-billed drugs account for more than three-quarters of the total. As there has been some discussion already this morning, since 1997 Medicare pays 95 percent of the average wholesale price, or AWP, for brand name drugs. The formula for generic drugs is a little bit

different but it's still based on 95 percent of some AWP.

When it comes to physician-billed drugs there's also a fee for drug administration. For most drugs administered with DME there is no dispensing fee.

What is AWP? Despite its name, AWP does not represent the average wholesale price, as I think everybody here knows by now. AWP can be thought of as the published suggested wholesale price or a manufacturer's suggested list price. The actual prices charged often reflect substantial, very substantial in some cases, discounts.

However, because the drug market is a very segmented market, prices are different for different purchasers. For example, hospitals tend to pay less than retail trade. Then within each segment there's a lot of negotiation that goes on. So manufacturers treat as very proprietary information their pricing structures. AWP has come to be used both in the public and the private market because it's one of the few publicly available numbers. It's been used as a benchmark for both public and private payers.

Another thing that's very important to understand is that AWP is not defined in law and it's not defined in

regulation.

I want to just briefly mention three of the problems with the current payment system. In the briefing paper that I supplied to you I went through many more of the problems.

The first problem, and this is one that's come up quite a bit already this morning, is that Medicare does not pay market price for drugs. In fact there is no clear relationship between what Medicare pays and the market price of a drug. GAO concluded that Medicare paid about $1 billion more in 2000. That was out of a total of $5 billion in 2000. Medicare paid about $1 billion more than provider acquisition costs, and that only included widely available prices in catalogues. It did not include rebates and discounts that many providers are able to achieve.

When we talk about these prices we also have to take into effect the payment is 95 percent of AWP, but in fact beneficiaries are responsible for 20 percent of that payment as coinsurance.

One of the examples that got a lot of attention and I think brought a lot of people to pay a lot of attention to this issue is the example of one chemotherapy

drug where the AWP for it was $740, which meant that the beneficiary copayment was about $150. The physician was able to purchase that drug for $7.50.

The second point is that the incentives in the current system mean that the current payment system actually can provide incentives for higher prices. So that in general when many generic drugs come onto a market for a single drug, the drug becomes more like a commodity; price is drive down. But under this system, the GAO found that the differences between AWP and the widely available catalogue prices actually were largest for the products where there were more generic substitutes available.

I included a slide which is not in your package just to illustrate why this should be. I should say I stole this from a National Health Policy Forum briefing. I want to give credit here. Take an average drug with an AWP of $150 where Medicare reimbursement then would be at 95 percent would be about $142.50. GAO found a typical discount would be AWP minus 23 percent. Here it would be $115.50. The provider would net from billing Medicare $27 for that drug.

Let's consider now that this becomes a generic

drug and there are many drugs available. In the private market you would expect the provider -- you don't just expect. The costs would go down for the provider. Instead of $115 they would be competing to get providers to purchase their drug. Here the way competition seems to work is that that $115.50 remains the same. AWP goes up, and if you do that subtraction the resulting profit or the provider margin for that drug goes up without the cost to the manufacturer going down.

MR. HACKBARTH: Joan, this is an empirically observed phenomenon as opposed to a theoretical possibility?

DR. SOKOLOVSKY: Yes.

MR. HACKBARTH: So we actually see patterns in the use of the drug change based on people applying this strategy?

DR. SOKOLOVSKY: Yes. For example, the most commonly billed drug, the drug with the most generic substitutes available is albuterol. For albuterol the GAO found that the average price, again not taking into account any proprietary discounts and rebates, was AWP minus 85 percent.

The third problem with the system that I wanted to

highlight here is that these high drug prices may be used to subsidize payments for drug administration that are not included -- either that are in the fee schedule but don't reimburse providers for their cost, or in the case of pharmacy suppliers where there are no dispensing fees at all. Little attention is given to this because it's cross-subsidized by the price of the drug. But it means that if you want to fix the price for the drug you also have to take into account what's happening on the other side.

As this subject has received a lot of attention there have been many suggestions about how to fix the system. Most of the suggested alternatives consist of two parts. First, choosing a price measure to replace AWP that you can also use for benchmarking, or in fact using AWP but changing the way you use it. But you need to have a benchmark in most systems. Then once you have the benchmark, developing a payment method based on that benchmark whether it's AWP minus 20 percent or whether it's a new benchmark plus some percentage.

The first set of proposals say keep AWP, that's what's in the law, but change the way you use it to reduce Medicare's costs. One of those possibilities is simply to

change -- I say simply, but it's obviously not simple at all, but change the way AWP is calculated. As I said before, there is no law that says how AWP should be calculated, so it can be changed theoretically. In fact this is the one change that could theoretically be done administratively without congressional action.

Another thing that you can do is increase the discount from AWP. Thirdly, you can make the system a little bit more --

DR. ROWE: Can you do that administratively?

DR. SOKOLOVSKY: No. The only thing that you could do administratively is the first one, with the possibility of the inherent reasonableness authority is a little bit -- theoretically, I suppose you could do that without law but I think it would be very difficult.

MR. DURENBERGER: Could you indicate why that is the case when you earlier said that AWP is not either a legislative or a regulated process?

DR. SOKOLOVSKY: What is legislative is the 95 percent of AWP. We don't say what AWP is but we say we're going to pay 95 percent of it.

With legislation you can increase the discount

from AWP or you could create a system more like Medicaid. Here you wouldn't be affecting physician rates but by having a rebate from manufacturers you would be changing the price in that way, or at least reducing Medicare's costs.

Fourthly, you can use the inherent reasonableness authority but attempts to do that have not been successful.

DR. ROWE: Is that a statement about the entire Medicare program?

[Laughter.]

DR. SOKOLOVSKY: As I understand they've been successful once in using it.

The second set of alternatives say, let's come up with a different benchmark method rather than AWP. Let's create a benchmark that's tied to actual transaction costs and that can be audited. Then once we have that, and there are a number of them in your briefing package. I won't go over them now although I will in the next few months. But whatever benchmark you come up with, then you have to decide what to do with it. Once you have that benchmark, will you add a percentage, will you look for a rebate? All of these options that I presented in the first slide also would be involved here if you create a new benchmark system.

MR. HACKBARTH: We chuckle about the inherent reasonableness but I assume the problem is ultimately you have to come up with a pricing method. It begs the question of exactly how you're going to determine what reasonable is. Then if you're an administrative agency trying to do that, you're subject to all of the requirements of process and legal challenge, whatever, and it can be a very cumbersome process I think is probably the problem, right? It's not like inherent reasonableness is an answer. It's a question, what is inherently reasonable?

DR. SOKOLOVSKY: The provisions in the law talk about what an inherently unreasonable price might be, and they set ways in which it can be fixed. But having said that, then you go through -- the first time that CMS attempted to use it it was challenged on the idea that it hadn't gone through the whole regulatory process. A second time Congress stepped in and said, wait a minute, stop; don't use it. This is only in the case of drugs.

Finally, there are a third set of alternatives that involve getting away from a benchmarking system. One of them we discussed a bit yesterday which is the idea of using competitive bidding to get the price of drugs. This

is being tested for albuterol in San Antonio right now. I understasnd that there are congressional interest in creating a wider system of use for competitive bidding for drugs for Medicare.

A second alternative that has been suggested is to pay based on physician and supplier invoices. Finally, the last one is to empower an independent commission to recommend payment updates for drugs based presumably on some idea of inherent reasonableness.

What staff would like to do in the next few months is to look at these options and any others that the Commission might propose and analyze them on the basis of a few major concerns. The first is, does the proposed new method affect beneficiary access? Oncologists in particular, but also other physicians and pharmacy suppliers have argued that high drug reimbursement has been necessary to subsidize administration of chemotherapy because Medicare does not pay enough for this service. They question whether they would be able to continue serving beneficiaries if drug payments were changed without corresponding increases in the fee schedule.

The second question we want to ask is, does the

proposed new method affect site of care? Here this is something that came up in teh previous session. Reducing reimbursement rates for drugs in one setting, for example, the outpatient department, may shift care to an alternate setting not for clinical reasons but for the idea of maximizing payment and with results for patient outcomes that none of us know at this point.

Thirdly, does the new system create new administrative burdens? Here the burdens can be for the agency, for the contractors, and also for the providers. For example, who's going to compute these new average prices, how often are they going to be updated, would physicians and suppliers be required to submit their invoices to CMS, how would those be handled? And how would the cost of these new administrative tasks as, for example, in the case of competitive bidding, how would they be figured into the methodology?

Fourthly, how would this new system affect the prescription drug market? We know that when the Medicaid rebate system was introduced and discounts to private payers were affected by the fact that those discounts would have to be given to Medicaid, the CBO did an excellent report on

this and found that in general prices for other payers went up. So we would like to know whether, if in changing the Medicare payment formula will we increase payments for private payers and also for public programs like Medicaid and the VA?

We would also like to know whether a new method was equally effective for all kinds of drugs. For example, could one method work for generic drugs but be very different if you tried to apply it to some kind of breakthrough therapy?

Lastly, and this question I've answered in most cases, would the proposed new method require legislation?

In the coming months we will be evaluating these proposed alternatives based on these issues. We'd also like guidance from the Commission about other issues that we should be considering.

MR. HACKBARTH: Thank you, Joan.

DR. ROWE: Thank you, Joan, and welcome. It's unfortunate that the first item with respect to the Medicare program that you get to analyze is one in which there is apparently some egregious if not unethical activities going on. I just couldn't be more concerned about this.

I think it would be helpful for us to consider a recommendation that -- because these different approaches you have might take different periods of time and have different susceptibility to various stalling techniques. I think it would be helpful for us to send a clear message that it is really not worth closing down the infusion center at the hospital and building one in the doctor's office because it's not going to happen. We should send a two-part message. That we should do an administrative change immediately that doesn't require legislation and doesn't require a commission and all the rest of it, that would be in place in the interim until there is decided what the ongoing mechanism should be to create a fair payment.

So rather than just say, we're going to think about it, we're going to study it, we're going to create a commission, et cetera, which could take years, we're going to require legislative and it may never happen. This is just -- some of this is, and I'm not suggesting all of the providers are in that situation but obviously $7 for the drug and $700, including $150 out-of-pocket for some poor Medicare beneficiary, that's not right.

So I would suggest we do a two-step thing so that

we'd send a clear message that there will be a change.

MR. HACKBARTH: Nancy-Ann, since you have the most recent experience, is this an issue that you actively looked at when you were at HCFA, and what are the issues posed by administrative action of the sort Jack is requesting?

MS. DePARLE: It is an issue that we looked at at the very end of my tenure there. The administrative issue with respect to doing something, with respect to the agency going forward with some new payment methodology is getting it right. What we started to do while I was there was ask each of teh carrier medical directors to produce a list through, I guess a survey or talking to physicians in their areas, about how much they were actually paying for the drugs.

It isn't easy to get this information, for reasons other people have talked about. It's not transparent. I wasn't there when this was initially set but I understand that the reason why the pricing data that was used as a proxy for AWP is in a compendium that is widely available and that was the only thing that the agency had. So to come up with something new gets into what you were discussing with inherent reasonableness. What is reasonable? What is

fair?

The minute we started doing that there was considerable push-back, primarily oncologists who said they would not provide the service in an outpatient setting any more, chemotherapy, if we were to go that route. That we didn't understand how expensive it was to administer the drugs, and there were concerns about that.

So that's why it -- it was moving forward administratively and then in 2000 in, I guess that was the BIPA, Congress said that the agency couldn't move forward until I think a GAO report was issued on this, which has now happened. In fact in this year's budget, my understasnding is that the Bush administration assumed about a 25 percent reduction in Part B drug spending and said something about there would be a policy issued. What I understasnd what the administrator has said is that if Congress doesn't act, they will.

So if I could add another comment, I guess I think Joan's presentation was very good. My concern is there's a lot of interest in this right now so I guess I sort of agree with Jack that it behooves us, if we have a view on it, to be stating it now as opposed to waiting several months.

MS. RAPHAEL: I think there are very serious issues here and I agree with what Jack and Nancy-Ann have said. I'm not an expert in this area but I have some very recent experience because we, along with many others, just closed an infusion pharmacy because Medicaid, in reacting to what's happened around AWP, in my state dropped the prices and swung the pendulum in the other direction, very understandably.

As a result of that, we could not sustain our infusion program, which was the main program providing services to the Medicaid population because we did cross-subsidize the service. We did, through the price that we were paid for the pharmaceutical, send a nurse in to set up the pumps and the therapies, to really educate the patient, to work with the family to monitor what was going on, to go out in the middle of the night if there were a problem. When that price dropped it just -- we were hemorrhaging and were not able to sustain it.

So I just think there are some issues that we should just be careful to look at as we move ahead to address the price in this area.

MR. HACKBARTH: Other comments?

DR. STOWERS: It's a little bit of another quirk. Our carrier required that we administered the medication, and some of them were simple injections and some of them were traveling 40 miles a day to come in and get their injection. Then of course we charged an administrative charge, a level 2 E&M or whatever, for that. So there's another issue here that sometimes the cost to Medicare could be compounded even more in simple administration by requiring that they come in in order for me to bill for the drug.

So I think the type of administration -- we had the same problem Carol had on the infusion. On the other hand, some very simple administration of some of these drugs required the administration be administered in the office. Then that was billed back to Medicare when the patient had other alternatives to receive it outside of the office free essentially.

So this administration part and the cost of it and how it's reimbursed I think does integrally tie into this whole thing, and the total cost to Medicare.

MR. HACKBARTH: I imagine we could, if we revamped the system, could pay many times over for the reasonable

cost of administration out of the savings and still have a lot left over. So I'm very sympathetic with those issues but they can't be a barrier to action. They need to be addressed along the way.

Nancy-Ann, you made a suggestion that if we wanted to do something here we do something quickly. Do you have a proposal

MS. DePARLE: No, but the reason I said that is because it's my understanding that a change to this was built into the budget without a policy really attached to it. Maybe that's fine, but that means that something will happen soon, I think, and Congress has said they're going to act on it. So if we think our views need to be taken into account, we should put them out there. But no, I don't have a specific proposal.

MR. HACKBARTH: My sense of where we stand right now is we think, looking around the table I think most people if not everybody thinks, this probably doesn't make any sense and there's an opportunity to save the Medicare program a lot of money. On the other hand, we don't have an answer.

So if in fact somebody in CMS or on the Hill

thinks that they've got the proper path, maybe that's a case for being quiet and just let them go ahead and do it, then we can continue to study it. If in fact nothing happens in the ensuing months, maybe we can have a sensible recommendation come next spring. However egregious the problem, I'm always wary of saying, here's a solution that we just made up on the spur of the moment.

DR. ROWE: My concern about that approach would be while we may not yet have a specific recommendation, if in the absence of that we remain quiet the provider community that is supportive of the status quo can say, MedPAC discussed this at great length and decided everything was fine. They didn't want to say anything.

I think we should at the very least say, this is really something that should be changed and should be changed as quickly as possible. That there are major savings here, there are out-of-pocket expenses for beneficiaries who can't afford this. Talk about the poor beneficiaries. And that we think something should be done very promptly, even if we don't have a specific -- but just to remain quiet just sends a message to Congress that we're not interested in being prudent purchasers.

MR. HACKBARTH: Regrettably, that has happened on some past occasions where our silence has been used as tacit support.

DR. ROWE: Exactly, as assent.

MR. HACKBARTH: And for sure, I wouldn't want that to happen in this instance. As you pointed out when we talked about the outpatient PPS letter, there is an opportunity there to say that we think that there's a severe problem here, even if we've not yet identified the specific solution to it. We could always take the additional step, or the staff could take the additional step of, in their discussions with people on the Hill saying, this came up at the Commission meeting and here's evidence of it in the outpatient PPS letter, and there is unanimous concern about it. Again, we don't have the specific answer right now but this is something that we're taking up and we would like to see future action on.

So we can make it clear that silence does not mean a lack of concern.

DR. NELSON: I like that approach, but I agree that we need the opportunity to develop some alternatives to deal with the problem that Carol was talking about. I think

the worst thing we could do is go along with reducing -- changing it so it's AWP minus 15 percent, some kind of knee-jerk thing that doesn't get to the root of the problem which is sensible pricing in the first instance.

But if indeed there are alternative costs that are incurred in providing and supervising and managing the administration of these products, at least some of them, then that needs to be identified and we need to develop some recommendations that will fix that. It doesn't make sense to have the same profit opportunities for handing somebody a pill as giving them an infusion and managing the side effects for the next eight hours and so forth.

So I agree with us taking a more studied approach to this, at least as a second step.

MR. HACKBARTH: Any other comments?

MR. DURENBERGER: Maybe this one is more political, but having raised the issue we need to say something, as we have said here, about it and I agree with Jack in that respect. The timing of raising it is not necessarily -- it could either be great or it could be not good at all. Listening to what Mark had to say yesterday morning about the relationship to the Commission and the

Hill and so forth makes you not sure to whom you are speaking when you speak to everyone, particularly during September of an election year in which these issues have been so much a part of politics.

Having said that though, I suspect that in the next several weeks on both sides, the Senate and the House, there will be some advice given MedPAC in some form. Either somebody will lobby to give us some advice, or whatever the case may be. So that on this issue I would suggest that maybe there's a two-step process here.

One is a conversation with HHS, CMS. Then the other would be a conversation, again both sides of the aisle, both side of the Congress, and that probably ought to take place within the next week or 10 days, and see if they can't, in a bipartisan way, state the issue that they would like Medicare to explore and whether it ought to be stages or something else.

I think it would be helpful to go into those conversations though with the outline of a proposal, because nobody likes anything more than having language handed them. But I would want to emphasize, as all of you already know I think, that the political environment around these kinds of

issues is fairly difficult and the closer you get to an election it can be made more difficult with regard to the same folks who two months from now it wouldn't be difficult at all.

But I feel, having listened to this and then having listened to the reaction to it, that it is something that at least needs to be explored. I would just suggest the outline of the approach that I gave you.

MR. HACKBARTH: Any other comments or suggestions on this issue?

Okay. We will take that advice under advisement and figure out exactly the correct and deft way to handle this.

We are now at our public comment period of about 15-minutes. Let me issue my standard request, Fred, that people please keep their comments succinct. If somebody before you in line makes the same comment, don't necessarily feel obliged to repeat it.

MR. GRAEFE: Thank you, Mr. Chairman. Fred Graefe of Hunton & Williams representing the Proton Therapy Payment Consortium which consists of seven world class hospitals, M.D. Anderson, University of Florida, University of

Pennsylvania, New York Presbyterian, Mass General, Indiana University, and Loma Linda. We're here to raise a concern about the outpatient PPS rule. That, I guess for a moment it reminds me of 1983 when Senator Durenberger and Sheila and her boss were the leading forces for the establishment of the inpatient PPS system.

CMS' proposed rule collapses four payment codes for proton therapy into one single lowest paid code. We're requesting that CMS reinstitute a complex payment code for that. I have from M.D. Anderson here with me Mr. Mitchell Tinkick who is the expert who set it up at Loma Linda and now at M.D. Anderson. We would urge consideration by you to include in this draft letter you were referencing earlier in the discussion, a reference to this. We have given your staff a long position paper about it, as well as some draft suggested language.

Thank you again for your consideration.

MR. TINKICK: I will keep my comments very brief. Thank you for the opportunity. I had the pleasure of being involved in proton therapy when I first joined Loma Linda University Medical Center in 1990 and am now involved and speak today on behalf of the consortia, but I'm involved

with the M.D. Anderson proton therapy efforts.

The new rules, as Fred suggested, collapse four distinct proton therapy treatment deliveries paid under two APC codes into a single code which simple does not recognize issues of acuity, resource differentiation associated with complex therapies. We feel also, based on our review, that the rule of the payment rate, the single rate may be based on the data of a single provider or principally from a single provider.

This issue requires broader input from the proton community, which I represent today. We are going to be visiting with Mr. Scully in the next two weeks to discuss this issue. It's one that's of importance to our representatives on the Hill. As Fred suggested, to whatever extent you can, we would appreciate this issue being addressed in your letter.

Thank you.

MR. CONNELLY: My name is Jerry Connelly, representing the American Academy of Family Physicians. I just wanted to make a couple of brief comments relative to your last issue on the agenda that you dealt with relative to physician-administered drugs in the Part B program.

The academy commends MedPAC for examining this issue. As it was pointed out, this is something that is growing at 20 percent per year. Because of that it's an important issue for you to deal with. We'd like you to understand and recognize, which I think you do, that there is an attempt built in in a policy to suppress the growth, or at least the payment for these kinds of things, these drugs. It is done by including this particular expenditure in the formula for determining the conversion factor for the Medicare physician fee schedule that is called the sustainable growth rate.

However, these drugs, as was pointed out, are not paid for under the fee schedule, yet they are used to calculate the conversion factor that is applied to determine what the fee schedule will be for procedures. These procedures are delivered by physicians, and by non-physicians, I would point out, who in some cases do not have a license to administer drugs and therefore don't administer drugs in their office. Widely, physicians of a lot of specialties do not administer drugs procedurally in their office. So this is something that is used to calculate the formula for a conversion factor for procedures, yet those

drugs are not paid for under that sustainable growth rate.

This is, therefore, something that we would -- we know that MedPAC has dealt with before. You've talked about the SGR, you've made a recommendation relative to the SGR and modifications or revisions to the SGR that should be made. That has not been taken up yet, but we believe that this particular anomaly is another compelling reasons that the SGR needs to be revised, not only in the short term but in the long term. We urge you to continue to take that under consideration as you deal with this issue as well.

MS. SCHRADER: Hi, I'm Ashley Schrader representing the American Hospital Association. First of all, we really want to applaud the commissioners for their discussions on technology; very difficult topic, especially the incorporation of new technology payments into a fixed payment system. We know that this is a challenge and a struggle and we look forward to both discussions in October and your March upcoming report.

However, I'm up here to make a comment about the outpatient prospective payment system discussion. The AHA agrees with MedPAC staff and the commissioners in assessing that it's incredibly new, it's incredibly complex, and

potentially there have been wild, dramatic swings in payment rates, both from '01 to '02 and again from '02 to '03. Congress when they developed the system put in place these transitional corridor payments and the hold harmless payments that are due to expire at the end of December of next year. We're concerned that in light of this system that's still undergoing significant changes that we would urge the commissioners to consider a recommendation that would keep those corridor payments in place for a little longer.

Thank you.

MS. SMITH: Good afternoon. My name is Kathleen Smith. I'm a nephrology nurse and I'm here representing Frizentius Medical Care. We're the largest provider of dialysis services in the country serving about 26 percent of the dialysis population. I wanted to comment on the last topic, the Part B drug coverage in Medicare. We also applaud the Commission for looking at this most important area; a significant area where Medicare reform is needed.

I wanted to comment that the dialysis composite rate was a very early prospective payment in the Medicare system implemented in 1983 along with DRGs, actually I think

just ahead of DRGs. However, over the years as these new drugs came on the market they've been treated as pass-through payments essentially, and the composite rate is no longer a prospective payment. MedPAC continues to report about 35 percent of what's paid to dialysis providers is paid outside of that composite rate.

Frizentius would very much like to see Medicare reform that reestablishes prospective payment for dialysis. That would involve, obviously, including the drugs administered today in the composite rate payment. We believe that it's linked obviously to the AWP discussions, although we brought this up prior to the AWP issue being discussed at this level.

So we would hope that the Commission would recognize that, as MedPAC has in the past, the composite rate does not cover the cost of a dialysis treatment. We have shared with MedPAC staff four years of our history of our actual drug costs for the drugs administered in dialysis settings. Certainly as the largest provider, the discounts we receive would be higher than any of the other providers. MedPAC staff does have that at their disposal. It shows the extent to which we've become dependent on the revenue from

the drugs to offset the underfunding of the composite rate.

So we would like to see MedPAC, for the drugs administered in the outpatient dialysis setting, to support ESRD payment reform that would include those drugs in the payment and reestablish prospective payment in dialysis.

I thank you very much.

MR. THOMAS: Good morning. My name is Peter Thomas. I'm here on behalf of the Consortium for Citizens with Disabilities Health Task Force. I am speaking on behalf of consumers, consumer organizations, but also disability related organizations that may have a provider focus as well who are part of the coalition. I happen to have two artificial limbs. I've used a wheelchair and I've used braces. So today I'd like to speak about competitive bidding and apologize that I wasn't here yesterday to offer my comments during that discussion.

I have heard what was discussed yesterday and I'm told that there was some degree of skepticism on some portions of that competitive bidding discussion. I'm glad to hear that because I can tell you that the consumer groups and the disability related organizations that I work with, and I've got a letter to this effect where 25 groups have

signed on, strongly oppose competitive bidding of durable medical equipment, some orthotics and supplies, primarily based on the fact that we're very concerned about access issues, primarily concerned about the quality of care which may arise under a competitive bidding scenario, and also concerned about the choice of provider and the lack of choice of provider that will inevitably occur when certain providers are given contracts and certain providers are not.

Presumably the low bidding providers receiving the contracts, and of course what that might do for quality is a very strong concern of ours.

Right now there's a Medicare fee schedule where people or providers essentially compete with each other. They just don't compete based on price. They compete based on how well they serve the physician who refers them, how well the patient is satisfied with the service that they have provided, how quickly they get back in touch with the person whose wheelchair or other kind of durable medical equipment needs servicing, how quickly they pick up the phone and respond.

When you go to a competitive bidding scenario, all that becomes secondary and the sole focus becomes the price

alone. There are ways that Medicare can adjust prices. We're very concerned that competitive bidding is not the way to do it.

When you have competitive bidding, right now that would represent a fundamental change in how the Medicare fee-for-service program is run. Essentially what you'd be doing is turning the fee-for-service program into a PPO where you'd get certain providers who would agree to decrease their prices in exchange for additional referrals. That's just a fundamental change from where the fee-for-service program under Medicare current stands. In every Medicare debate on Capitol Hill that I've ever heard, people go out of their way just to mention how the fee-for-service program won't be touched and will always be available to people who want to stay in it. This represents a major departure from that.

Durable medical equipment and orthotics and supplies are not just widgets. There's a lot of service connected to them. There's a lot of customization, even involved in things that you might not think. Oxygen therapy, there's a huge service component in oxygen therapy that literally could mean the difference between life and

death of the patient. Customized wheelchairs, how a person sits in a mobility device is a major professional service that's provided. Orthotics shouldn't even be included in durable medical equipment. It's really more of a professional service that results in a device at the very end.

But the fact is that when you start competitively bidding those kinds of devices and services, you're really getting into competitively bidding professional care. And if you're going to reach that conclusion, that you're ready to competitively bid professionally bid care under Medicare, than why stop at this benefit category? Why experiment with this area that disproportionately people with disabilities and chronic illnesses rely on to be functional and independent? Why not extend it to hospitals? Why not extend it to physician fees and therapy services?

Obviously, the political winds would be very strongly opposed to that, and that's exactly why I'm mentioning it. Why is it that it's okay to do it in this area but it's not okay to do it in those other areas?

I'll just say that the most important quality assurance mechanism is the ability in the fee-for-service

program to choose a different provider if the provider that you're currently going to isn't serving your needs. To restrict that in any way would be a real shame.

I'll distribute this letter for those who are interested in looking at it. Thank you.

MR. HACKBARTH: Thank you everybody. We are adjourned until October.

[Whereupon, at 11:58 a.m., the meeting was adjourned.]