MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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

COMMISSIONERS PRESENT:

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

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AGENDA PAGE

P R O C E E D I N G S

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

90 percent of Medicare enrollment.

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

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

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

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

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

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

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

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

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

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

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

In the plans that only have caps on hospital-covered

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

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

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

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

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

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

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

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

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

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

$5,000.

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

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

DR. SCHMIDT: Thank you.

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

Is there any lookback analysis at how well people choose

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

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

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

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

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

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

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

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

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

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

DR. BERNSTEIN: Yes.

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

distribution to try to address the question.

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

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

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

burdens of this order of magnitude.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Okay, thank you very much. Good job.

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

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

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

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

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

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

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

These discrepancies between counties led to perceptions of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Any other comments?

Okay, thank you very much.

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

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

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

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AFTERNOON SESSION [1:35 p.m.]

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

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

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

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

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

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

This table shows some of the differences between SNF patients

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

wondering.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. KAPLAN: Exactly; never been done.

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

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

MR. HACKBARTH: Thank you very much.

Next up is measuring quality in home health care.

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

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

to payment. We recommended that Medicare consider this strategy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OBQI set.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We do know that satisfaction ratings for home health agencies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. RAPHAEL: I don't know.

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

MR. HACKBARTH: Any others?

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

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

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

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

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

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

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

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

Sharon, are you going to introduce the next subject?

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

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

MR. HACKBARTH: Welcome, Chris.

* DR. HOGAN: Thank you.

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

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

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

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

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

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

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

The following slide then discusses what actually happened.

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

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

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

was unlikely in 1996.

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

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

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

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

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

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

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

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

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

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

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

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

Questions?

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

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

MR. BERTKO: Interpretation, please?

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

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

DR. HOGAN: That's correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Anyone else?

As always, Chris, very good.

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

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

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

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

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

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

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

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

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

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

Finally in step three, for services provided by multiple

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Nancy will continue.

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

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

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

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

With that, we are finished.

MR. HACKBARTH: Questions or comments?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

just increased the education requirement in their case.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

It also would not address the duplicate payment issue.

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. SMITH: I understand.

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

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

MR. GLASS: Yes.

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

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

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

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

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

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

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

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

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

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

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

DR. REISCHAUER: Always have them?

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

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

efficient?

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

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

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

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

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

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

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

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

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

[Show of hands.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

that next time.

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

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

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

MR. SMITH: Or you move 85 to 82.

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

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

MR. HACKBARTH: Any other thoughts on this?

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

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

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

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

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

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

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

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

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

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

Does that help?

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

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

Thank you.

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

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

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

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

MR. HACKBARTH: This is the practice expense?

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

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

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

MR. HACKBARTH: Thank you.

We will reconvene at 9:00 a.m.

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

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 10, 2004

COMMISSIONERS PRESENT:

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

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Good morning.

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

* MR. WINTER: Good morning.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

penalties.

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

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

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

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

probably only a small additional financial incentive.

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

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

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

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

The MMA prohibited the development of new physician-owned

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We developed a criterion of concentration based on Medicare

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

About half the specialty hospitals have an emergency

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

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

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

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

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

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

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

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

MS. CARTER: Yes, they are.

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

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

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

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

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

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

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

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

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

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

There are couple of limitations in the cost report data.

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

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

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

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

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

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

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

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

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

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

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

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

Carol will now talk about those site visits.

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

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

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

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

emergency medical services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Surgical and orthopedic specialty hospitals had much more

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Thank you. Very well done.

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

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

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

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

Did I miss any of the big ones?

DR. STENSLAND: Cost differences.

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

DR. STENSLAND: And utilization.

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

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

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

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

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

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

MS. CARTER: That's right.

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

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

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

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

MS. CARTER: Right.

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

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

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

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

profitability or lack thereof of the hospital is fairly small.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

also for what we believe to be the cost of the standby capacity associated with having to accept transfers in when patients don't do well and need to be handled by community hospitals.

And then last is this question of patient outcome. Are we pursuing opportunities to partner with the American College of Cardiology or the Society for Thoracic Surgeons, both of which maintain the only really good quality risk adjusted outcomes database, at least for heart care.

I know that at least some of the specialty hospitals that I've interacted with do participate in those programs and they do the best that science can now do for us in terms of a good risk adjusted comparison of outcomes for two of the primary procedures being done at least in heart hospitals, being bypass graft and various PCI procedures.

So we have limited time, limited budget, but I think our confidence we would have in our recommendation will very much hinge on the quality of our analysis.

MR. MULLER: Let me also commend the three of you and the rest behind you who did all this work. I think it's very well done and I look forward to the work that Mark indicated is to come.

Some of my comments really have been anticipated by what Jay and Glenn and Arnie had said.

But I think the thesis as to why is it in heart? Why is it orthopedics needs to be tested a little bit more. Why don't we have a lot of birthing hospitals? Why don't we have neurosurgical hospitals? One can surmise that perhaps in neurosurgical cases there just aren't enough to create a hospital.

Why don't we have breast cancer or prostate cancer hospitals? My sense is some of it has to do with volume and some of it has to do with the thesis of where the payment system may be skewed and therefore we should look at that.

But if you look at societal need, if you did it on the basis of need, one might think that there are other kinds of specialty hospitals that come forth if we look at societal need and they may be more linked to payment system than it is to need.

So I think we need to look at some other specialty areas and see whether there's something in the payment system and so forth that doesn't cause them to come forth.

I'm not going to repeat the necessity of getting the outcome and margin data, which I think is very important in this, so I look forward to that coming forth.

I do think we have to, and we've discussed at other times in other settings how well the DRG recalibration goes on some kind of basis. But since at least the number of these hospitals, more from

what your analysis indicates on the orthopedic side than on the heart side, have a lot of private payers where the charge system -- which we'll be talking about later -- may have some effect on the margins.

My sense is that if the charges are higher in certain areas within a year or two, the DRGs should be recalibrated to take that into account. But there seems to be something going on that over the years -- I mean heart hospitals and heart services with general hospitals have been more profitable than other services for probably 10 years or 20 years, since 1983 and so forth.

So there's something going on here where recalibration doesn't work quite as well. I'm not quite sure what it is and whether, Glenn and Mark, you want to do that inside this study or elsewhere. I think it's something we have to keep looking at because there does seem to be consistency over a period of years in certain services being more profitable and other services being less so, even inside the Medicare system let alone inside the private payment system.

So to sum it up, I think Jay's points about looking at the effects on the community is something we should look at.

Certainly if there's any way of trying to capture those standby costs that general hospitals or community hospitals have to sustain that are not captured in hospitals that don't have ERs – I mean, you don't want to judge off anecdotes but certainly if you have

to turn the lights on in an ER, then the marginal costs of running that ER have to be pretty low.

Therefore, the staffing may not -- my guess is there weren't staff standing there in the dark. So they probably didn't have a lot of staffing costs in that ER.

So I think looking at those kind, whether there's some kind of way of capturing what the general standby costs are of these community hospitals vis-à-vis the specialty hospitals. The drive toward specialization, not just in specialty hospitals but one can see it in imaging centers and labs, et cetera, and so forth, is not going away. And given that is by and large where our economy develops, there's no reason to think that even if there's some changes along the lines that may or may not come out of Jay's comments in terms of what kind of limitations we put on these, the drive towards specialization is going to continue.

So thinking about what the advantages are of specialization vis-à-vis the general role of community or facilities and what they can do in general for the needs of the public that Medicare serves, I think is an important thing for us to keep looking at because, in fact -- once you undermine that general capacity it takes an awful long time to bring it back.

So the whole sense of what we get out of specialization

versus the costs of it, whether this is the right time to take that on. But I think that's a theme we have to keep going on, not just in specialty hospitals. Because at this moment we don't have whole imaging hospitals. They still tend to be imaging centers. But based on the work we did a year two ago, we know that's one of the biggest proliferating areas within Medicare. I think we had growth rates about 14 or 15 percent in imaging. So one could conceive that three or four or five years down the road that we have whole imaging hospitals. There's reasons to think they're not 12 months away but one could see this happening, as well.

So again, looking at the community hospital costs, vis-à-vis the specialty hospital costs, looking at the margin outcome data, looking at, looking at the DRG recalibration system I think is very important to see why after 20 years we still have some services continuing to be making more margin.

And then any thinking we have about why there's some services that are very much needed by communities. Around the country right now, due to malpractice crises and other issues, the availability of OB services is being restricted. If there's a community for OB services, why don't we have birthing hospitals being created to meet that need?

MR. SMITH: Much of what I wanted to say has been said by Ralph and Arnie and Jay. So let me just try to dig in on a couple of

those points.

Glenn, I thought your three-part distinction was right, the professional judgment/community impact/payment accuracy. I want to pick up on something Jay said, sort of linking the question of how this economic arrangement works out to the question of community impact. It's important to understand that the impact on community hospitals is going to be the same whether or not the competing local heart hospital is investor-owned or physician-owned or some mix. And I suspect that the normal financial transaction here is investor initiated and who recruit physicians rather than, as was adjusted in the slides, the other way around.

So as we look at community impacts, I want to make sure that we look at the impact of specialty hospitals, the kinds of broad specialization questions that Ralph was raising, not simply the impact on community hospitals, the ones where physicians are part of the ownership mix. And concentrate on the physician side on the impacts on professional judgment.

The standby capacity. we should remember, there are two pieces of this. In the report from the site visits, Carol told us both that community hospitals had become more efficient, had invested more and had improved their general performance, and that they had also shut down some services. We need to think about how those things interact.

And it's partly a function of just reduced income because payment is flowing to new competitors. But it's also the question of whether or not you can then any longer afford to maintain a services or to keep it open. The community impact question is a complicated one.

And lastly Jay, I'd be a little concerned about thinking we can capture how much is corrupting and decide that the dividing line is 15 percent or 13 percent and that at 16 percent you're hopelessly underwater, for a couple of reasons. One, because I think it's very hard to do that. But second, because these financial arrangements are very complicated.

I could have as big a financial stake in my referral pattern because I owned a real estate investment trust that invested in a lot of hospital real estate without ever having an equity stake in the actual operating hospital.

So I think it's awfully hard to say this much, both as a matter of sort of ethical analysis, but also the financial transactions I think bedevil this in ways that we ought to be careful not to think that we know more than we do.

MR. DeBUSK: As you know, the hospitals right now are going through a real increase in the number of uninsured patients that's showing up at the doors. And going forward, I think if we can get at some more recent data about the uninsured, that would be very important

to look at in this report.

MR. BERTKO: I'd just liked to add a thought about one of Arnie's comments. Sometimes getting to quality and outcomes data can be very difficult. I'll point to, I think, the transfer comment on slide 30 to say maybe some of your analysis on the costs might be patient-based as opposed to admission or episode based. If you could link them together, that is if a patient starts in one facility and transfers to another, what's the overall average cost in say some of the site visits? I would hope that that might be a more practical approach in some cases.

MS. RAPHAEL: I was very interested in the concentration of specialty hospitals in four states, I think it is. I was wondering if we could learn more about what's happening in the states?

For example, can you tell us what led to Florida prohibiting specialty hospitals? And are there any studies that have been done at the state levels that have kind of informed some of the decisions whether to allow for licensing or to prohibit it?

MS. CARTER: I would have to get back to you on those. I know that a number of hospital associations are conducting their own studies of specialty hospitals, so I can look into that for you.

MR. DURENBERGER: First, I'd like to start, too, by complimenting the staff and not just for the presentation that's in

front of us now, but the work at the retreat where everything was a little bit more relaxed and getting your consultant in. That was really, really helpful, Mark, in the way in which we were able to prepare for the subject, for me and I think for everybody else, laying the groundwork for this was really great.

Secondly, I want to acknowledge that every once in a while somebody leaves the policymaking arena who makes a significant contribution by doing something with looks negative, and that's John Breaux. I think about all the people that are going to be missed around that place, as the number of good folks dwindles. John is probably -- for those of us who had experience with him -- going to be missed the most.

He's the guy that contributed the moratorium, which I don't think he necessarily believes is the ultimate solution to the problem. But he made everybody stop in their tracks and say this is really an important issue.

And I want to endorse the comments of all of my colleagues about not just looking at this as fulfilling a mandate or something like that. But I think as you pointed out, Mr. Chairman, this covers a lot of the other work we're doing. And so I want to endorse your three categories. I think that's the best way to say it.

In the issue of conflicts of interest and physician judgment

one of the most important judgments -- that's why I like Arnie's suggestion to work with ATS, working with AAOS, those kinds of people -- the connection between physician judgment, ownership and productivity is really very important. And how we define it, whether you define it as a Permanente, you define it as a Mayo, a Cleveland, whatever it is, there's something very, very important to all of us in terms of enhancing the quality of the work, the quality outcome, in having some kind of an interest, if you while, measured financially, measured profession and so forth, in that outcome.

So however we look at this so-called -- conflict of interest sounds like a negative connotation. It would be nice to flip it over and say there's a positive side to this, as well. And then, as we deal with the positive side of it, how do we guard against conflict of interest or something like that?

But there's a whole lot of issues that my colleagues have commented on that belong in there. But the importance of the connection between ownership and productivity, I think, is really critically important.

And then the other two that we've already commented on, that I simply want to endorse because of their importance, the whole issue of the pricing distortions. We already know, from our work, that we're overpaying hospital outpatient compared with ambulatory surgery

centers. We'd love to know why. A lot of other people would love to know why.

But we're already doing that kind of work. So it seems like some of that work is incorporated in here. I haven't read Joe's book yet, but I'm looking forward to reading Joe Newhouse's book on this whole issue of price distortion because I think we're not going to solve it in this study but I think it's really critically important to look at that in the light of the other things we're doing. And that includes the efficiency analysis and stuff like that.

And the third one that's really hard to deal with but it needs to be referred to is the issue of cross-subsidies because that's the one that distinguishes one community from the other and it gets really very difficult, from a public policy standpoint, to deal with it.

And yet, if we're thinking about beneficiaries and we're thinking about high-quality care and we're thinking about how to get the best that medicine has to offer to everybody in every community, we do need to deal with that issue of cross-subsidies, as you pointed out. And in some way at least point policymakers to the failures in the current system that deal more appropriately with issues like uncompensated care and Medicaid payments and a variety of things like that.

So I basically just want to endorse the comments of my colleagues and the work of the staff so far.

MR. HACKBARTH: Just to pick up on your first point, it's difficult not to feel ambivalent about some of these issues. On the one hand, people are understandably concerned about compromising professional judgment through inappropriate financial incentives. But in many instances over the years, we've talked about the need or the potential for aligning the incentives of physicians and hospitals to do good things for patients and improve the efficiency of the system.

So there is little that's black or white. The trick here is to find an appropriate blend and it's a very interesting problem, as well as a difficult one.

DR. WOLTER: Just an observation and pick up a little bit on something that Jay said earlier. I think one of the things that is happening is there is this blurring on between ASC, specialty hospital, and whole hospital. And as ASCs add overnight capacity, as ancillaries of one kind or another are added, specialty hospitals are of one size or another. Some do several service lines. Some are primarily one service line. And that really complicates, I think, this issue.

Which is why I think the core issue around self-referral and what Stark covers and what it doesn't cover really is one of the key things that we need to address.

I like Dave's suggestion that maybe there's a way to flip this and look at it positively. For example, in the Stark regulations there are the group practice exceptions where physician ownership is certainly allowed of some of these services but there are distinctions about how salaries are created directly related to the referral to certain service lines versus sort of how the organization as a whole performs.

So I think there are some distinctions that we may be able to get into that would help us as we move forward.

DR. SCANLON: I'd just like to make a short comment. I think that the prior comments have really revealed some of the complexity of what we're dealing with here. And I think, given our time frame, the ability to deal with many of them is going to be constrained.

Unfortunately, I want to add another issue to the table which is that the idea that we are talking about hospitals may be a misnomer in terms of how we characterize this issue because our hospital, in some respects, is a building concept. It's what goes on in a particular building. The entities that we're talking about may be something that's owned by a system, owned by a chain. And I think that totally changes the economics that is underlying the issue here.

If a community hospital chooses to do its cardiac surgery in another building that is independently certified, that's completely

different than if an independent entity opens up and takes patients from that community hospital.

If we think about we're going to change rules with respect to referrals under Stark, how are we going to think about all of the permutations that may exist in terms of the kinds of arrangements that might exist?

Jay's idea of a threshold in terms of ownership, that may be an interesting avenue to pursue. But then again, when we're talking about a chain, how the threshold rules would be adapted to deal with that issue.

Given all of this, I think I comeback, Glenn, to your characterization and think that you really have hit on the three big areas. And at a minimum we maybe should be very intent in focusing on the question of the payment system and what is the payment system doing here? Is it, as Ralph indicated, failing in terms of the recalibration effort? And that we need to be worried about what the consequences of that failure are in terms of creating incentives for the system to operate in one way or another.

I think that may be, at a first step, the most important piece of what we do.

MR. SMITH: Glenn, I was struck several times during this discussion but particularly at Dave's last comment about how seamlessly

we have made a transition from a conversation we've often had about impact on Medicare beneficiaries to impact on the entire health care system at a community level. We've asked ourselves, and we are entering in this one in a significant way, to what extent should we think about Medicare's role in the health care system or simply Medicare's ability to provide high-quality services to its beneficiaries?

We haven't in this discussion, not a single one of us has confined ourselves to beneficiary or access issues. we've talked about much broader impacts. I think that's a step forward but it struck me as an important transition.

DR. CROSSON: Just a couple of last comments on the physician incentive issue, and I do agree with Dave that probably characterizing it as incentives or the appropriate balance of incentives is a better way to put it. Because that's really what it's about. It's really about trying to get incentives or trying to influence incentives in such a way that they're balanced, balanced between quality, professional judgment and the finances, the complex finances.

It is messy. There's no question about it. You're mixing up law, finance and human motivation. If we can only get rid of that last part it would be a lot easier, because once you get that in it is messy.

And I would say again that while that's true, yet other laws that we have heard summarized earlier have attempted to do that. So that as the Stark laws were put into place, people tried to wrestle with these issues and accepted some things and allowed other things. For example, the whole hospital exception. I believe that was done because folks looked at the likelihood of extraordinary incentives and decided that they were not present and therefore that should be allowed.

So even though that is messy I think nevertheless, to be responsible, those kinds of judgments need to be made when they can and when they're appropriate.

The last note is, having said all that, I think we did get a case presented by the staff that there were other reasons why physicians involve themselves in creating these hospitals, some of which were subsequently addressed by the community hospitals, others of which were not.

I would just say that while the incentive issue is a real one, there's a separate issue of physician governance. And as we work our way through this I think we should, if we can, consider those things differently because there may be a compelling reason in these hospitals to have physicians involved in governance in a major way. And yet, there may be reasons to separate that from ownership, if

that's possible.

DR. REISCHAUER: Just a footnote on that point, and that is to go back to Ralph's question which has why haven't these specialty hospitals sprung up in other specialties? Because certainly it isn't only the cardiologists that are upset with the management of the community hospital. And so I think we get, as you said, right back to the getting the payments right issue first. And then see what the ramifications of that are.

Just one comment on the community repercussions and how complex this is really going to be for us. Everybody is concerned that proliferation of specialty hospitals could reduce the social benefits that come from having a community facility. But the question we et into immediately is how much do you need of that?

We're often talking about communities with three full-service hospitals and the fact that one of them is having a huge problem because the heart and orthopedic business went somewhere else can be true for that hospital, but in a sense may not be true for the community as a whole because we don't know what that threshold level is of this social benefit that we want to preserve. And we want to preserve it for the community but also for the Medicare beneficiaries in everything else that they might do.

MR. HACKBARTH: I was struck also, Dave, by that seamless

transition. And I think a complete analysis of this issue requires careful consideration of the community impact of this development.

On the other hand, there are huge issues in terms of how you finance those desirable public goods. At one extreme you finance them through cross-subsidization. You basically protect from competition. You allow the payment system to be inaccurate and people to reap large profits here to cross-subsidize social goods there.

The other end of the continuum is that you promote competition, especially competition that is quality enhancing and efficiency improving and then say if we want those public goods we pay for them directly.

I think one of the intriguing aspects of this issue is that it forces that discussion out into the center stage.

DR. NELSON: I think we have to recognize also, though, that the development of heart and orthopedic surgical techniques has come a long way in the past 10 years. There are people walking around with their knees done that we wouldn't have thought of that 10 years ago.

By the same token, the advancement in cardiovascular surgery, because of new technology and transfer of that technology, there is obviously an increased need for facilities to handle that.

You can't say the same thing about gastrectomy because that's gone the other way. And endoscopic surgery has changed the face of a

lot of abdominal surgery.

So I have no doubt that payment policy is a factor but it's certainly not the only factor.

MR. HACKBARTH: Any other comments or questions?

Okay, thank you very much. Good piece of work.

Next is results of a study done of hospital charging practices that may have some relevance for the specialty hospital study.

* DR. WORZALA: Good morning. I'm here to talk about a survey that was recently conducted on hospitals' charge setting practices.

MR. HACKBARTH: Can I just interrupt for a second? For those of you who are leaving, could you please do so quietly so as not to disrupt this presentation?

Thank you.

DR. WORZALA: We recently had a survey completed by the Lewin Group of hospitals about their practices in setting charges. Although I'm giving the presentation, Jack is here with me because he was also involved in the project.

The survey was motivated by a number things but primarily by the center role that charges play in how CMS is setting payment rates for hospital services under Medicare and also the lack of systematic data and information on how hospitals set their charges.

As Glenn just mentioned, this study is relevant to our work on specialty hospitals and it's also relevant to a mandated study that we have due next July on how we are paying for pharmacy services under the outpatient PPS.

Under the inpatient acute-care PPS, the relative weight for DRGs are based on average adjusted charges. On the outpatient side, once CMS sets payment rates it uses charges reduced to costs using cost-to-charge ratios from the cost reports. So you can see that the relationship of charges to payment rates is fairly direct.

On the inpatient side, if markups over costs vary across services the relative weights could well be too high for some services and too low for others.

More explicitly, where the markets are higher the relative weights would be higher relative to costs and vice versa.

On the outpatient side, the connection is a little bit less straightforward. However, given the methodology used, differences in markups across services can still affect the relative weights. I'm not going to go into detail about now but I'd be happy to talk about it later if you're interested.

The survey consisted of 57 structured interviews and the survey instrument is in your packet if you want to refer to it. Some of the interviews covered a single hospital while others covered a

system where charges were set centrally for a collection of hospitals. In all, the interviews represent the charge setting practices of 251 hospitals.

The Lewin Group interviewed charge master managers and/or their supervisors in the finance department. The sample was non-random, although the contractor did try to make it representative by region, teaching status and ownership. Recruitment was quite difficult for this study despite repeated assurances of anonymity.

The sample did have an equal representation by region, so Northeast, South, Midwest and West. But it includes a greater share of teaching hospitals than the national average and a smaller share of rural hospitals.

In addition, we found very few for-profit hospitals willing to participate and this may be due to the proprietary nature of the topic. We also ended up with few government-owned facilities.

We were looking at a number of areas in this survey and we included questions about the structure of the process hospitals follow when they set their charges. We were looking at the factors they consider, the relationship between costs and charges, and the information used to set charges, the extent of variations in markups across services and examples of where markups may vary.

We also focused on two areas that have received considerable

policy attention recently, one being cardiac services and the other pharmaceuticals.

The rest of the slides will present the major themes emerging from the survey. As a caveat, I want to note that this was a qualitative study and we're sharing general impressions from the 57 structured interviews that were conducted.

Regarding the structure of the process, we found that hospitals maintained a database of services and items that they supply to patients and they attach charges to each item. This is called the charge master.

Charge masters are large and complicated and they encompass tens of thousands of items. As I'm sure you know, the Medicare program requires participating hospitals to maintain one set of charges that apply to all payers. That's what's in the charge master.

Hospitals set their charges for individual services and items. This slide gives some examples, such as a daily room charge, charge for an x-ray, the charge for a block of minutes of operating room time, the charge for an individual supply, be that bandages of some sort or a cardiac implant, and charges for a particular dose of a drug.

Hospitals do not set their charges for the bundles of services that Medicare pays for, that is the DRGs or the APCs, nor do

they generally set them for a different bundle such as admission or an ambulatory surgery. Rather hospitals bill for an individual patient the charges for each of the services or items that they have offered during the stay or the encounter. These bills are then later classified into a DRG or an APC.

So the charges that we are using when we set payment rates for a DRG or an APC will vary both by the patient and by the hospital.

The process of setting charges is generally overseen by the finance department but involves most hospital departments to some degree as charges are set for each department's services.

Hospitals generally change their charge master for one of three reasons. First, there is often an annual update or increase in charges which accounts for cost increases or to satisfy other financial goals. These increases are not necessarily uniform across departments. Some departments may see a higher across-the-board increase than others.

Second, on an ad hoc or periodic basis, hospitals will review and revise some of their existing charges. Sometimes they will look at all the charges for a whole department but more often they modify the charge for a specific service or set of services that have been noted to be problematic. An exhaustive review of all of the charges is very rare due to the large number of charges in the charge master.

Finally, hospitals do modify their charge master to add new services.

A major theme arising from the interviews was that setting charges is a core business function. As such hospitals are responding to many different pressures and balancing many different calls when they set and modify their charges. Some of those factors include accounting for changes in cost, both overall and for an individual service or item. In addition, they think about the financial goals that they have. They also think about other missions which may, as previously discussed, include the need to cross-subsidize some services with others.

Hospitals also face competitive pressures that they factor into their charge setting, both from other hospitals as well as from ambulatory settings such as ASCs.

Hospitals also have to consider their arrangements with payers, which range from discounts off charges to per diems or fee schedules or capitation. And depending on the relationship with payers, charges may be more or less important to a hospital.

Hospitals also take community perceptions of the fairness of their charges into account.

Another theme that emerged from the interviews involved the relationship between costs and charges. When asked an open-ended

question about the information they used to revise existing charges only half of the hospitals mentioned costs. Hospitals indicated that they use many other sources of information as well, including public data, market information, advice from consultants as well as information from their payers which would include Medicare's payment rates.

So you might get a little circular issue of using Medicare to set charges and charges to set payment rates.

Hospitals reported that costs do play a greater role in setting charges for supplies and pharmaceuticals as well as for new services. And on supplies and pharmaceuticals we did find most hospitals reporting using a formula or a table where they developed their charges based on the costs of the items. These formulas generally contain cost categories with the size of the markup over costs depending on the cost of the item.

The survey had a set of questions on variations in markups by service and hospitals reported that markups can vary by service for a number of reasons such as payer mix, utilization and market forces. One of the most cited examples of variation would be that low-cost items have higher markups than high-cost items. Some of that has to do with the notion of sticker shock. If something is very expensive and you mark it up a lot, it becomes very, very expensive.

Other than that, responses concerning how markups vary were not systematic across all the hospitals. But when asked to provide examples of services with low markups, some hospitals mentioned room and board and other visible services. Examples of services with high markups included outpatient and diagnostic services.

Interestingly, some hospitals reported that they no longer charge at all for very low-cost items such as aspirin.

The instrument contained a set of questions about charges for cardiac services and we have heard anecdotally that these services are more profitable than others under Medicare, as we were just discussing under the specialty hospital study. One way that could be possible is if the services that make up the cardiology DRGs had systematically higher charges than other services. If that were true, then the relative weights for cardiac DRGs under the inpatient PPS would be higher in comparison to costs than the relative weights for other DRGs.

However, hospitals reported using the same process for sitting their cardiac charges as for other services. One exception is that some hospitals with a catheterization lab develop charges for an entire procedure rather than billing for minutes of the operating time and other inputs as they generally do when something is done in the operating room.

Although hospitals report using the same processes to set charges for cardiac services, responses to other questions do suggest that the services may receive closer attention. First, many cardiac services receive high dollar values which hospitals said they often look at more closely. In addition, many of the cardiac procedures are new.

The survey also focused on charges for pharmaceuticals for a couple of reasons. First, setting payment rates for drugs has been very problematic under the outpatient PPS. In addition, we have a mandated study to consider whether or not there should be a payment adjustment in the outpatient PPS to cover pharmacy services other than the actual cost of the drug. That study is due in July 2005.

We found that hospitals reported charges for pharmaceuticals as being handled separately and often with considerable involvement of the pharmacy director. Almost unanimously the hospitals reported that they have one charge that covers the cost of acquiring, preparing and storing each drug. They do not have separate charges for their pharmacy services.

About three fourths of the hospitals reported using a formula based on acquisition costs or average wholesale prices where they converted costs into charges. Some of the more sophisticated formulas might also vary the markup by the type of drug or the route of

administration, is it oral or is it IV, or the form of preparation, are they starting with a pattern or a liquid? In most of these formulas hospitals reported that lower cost items have higher markups than higher cost drugs.

So I've presented you with a number of findings from the survey and this slide summarizes the major points. The charge master is large and complex. Hospitals are weighing numerous factors when they set their charges such as financial goals, other missions and competitive pressures.

The survey results suggest that there is no systematic relationship between costs and charges but that is more likely for supplies, drugs and new services than for other existing services.

We also found that markups can vary by service. The most common example was low-cost items having a higher markup than high cost, as I've said. The other examples were not systematic across hospitals.

The findings of the survey are relevant to several of our studies. You just heard about the analyses being undertaken for our mandated study on specialty hospitals. Another analysis that will be done will compare the relative weights for DRGs that result from using charges versus an approach of using charges reduced to costs.

In addition, questions on charges for the pharmaceuticals

will be appropriate for our mandated study in that area.

And finally, we also have a project to model CMS's approach to setting payment rates under the outpatient PPS and we will try to look at alternative approaches for setting payment rates that might, for example, adjust in some way for this difference in markup between high and low-cost items.

I'll take your questions.

DR. CROSSON: Chantal, do you have any information on how other countries such as Canada or the U.K. or Switzerland would handle payments to hospitals in relation to their costs? How they calculate an appropriate payment?

DR. WORZALA: It's going to depend on the country, and I'm going back to information I learned many years ago, but in Canada a lot of it is I believe budgeting and negotiation. I actually am not sure about what happens in England now with the GP fund holding, whether the hospitals discharge. I honestly don't know.

DR. CROSSON: I wondered if they had anything analogous to a cost report that formed the basis for beginning their negotiations and whether indeed they based it, for example, on acquisition costs plus a percentage rather than just sort of taking a stab, like we appear to be.

DR. WORZALA: I can look into that but I can't answer right

at the moment.

MR. DURENBERGER: A question or two on the charge side and then one question on the cost side.

On your slide, PowerPoint number seven, the hospitals balance many factors when setting charges. One of them was arrangements with payers. I wonder if you wouldn't just talk about that a little bit.

And then another question occurs to me, and that is would not Richard Scruggs have a lot of information that might be valuable to us, if you follow my question?

DR. WORZALA: On the arrangements with payers, the importance of charges really depends on whether or not charges play into reimbursement for the hospital. So if the hospital has a lot of contracts where it discounts off of charges, they'll spend a lot more time thinking about their charges than if they have a lot of capitated arrangements or where they are responding to a payer's fee schedule or a negotiated per diem rate.

MR. DURENBERGER: I know you're not an expert, nor am I, on the lawsuit against nonprofit hospitals and so forth but is there not something to be explored there that would be informative? I'm just asking the question because I don't know the answer.

Obviously, they are digging into some of this same kind of an area, I would assume.

DR. WORZALA: I think both have to do with how hospitals set their charges but I think there's a pretty key distinction where what we're really looking at it is pretty much relative markups across services and how that plays into Medicare's process of setting payment weights. We don't care so much about the absolute level of the charge because when Medicare is setting its payment rates it all becomes a set of relatives.

Whereas when you're thinking about what the uninsured pay, for example you really care about the absolute level of the charges much more than the relatives across services. So I think that would be the key distinction.

MR. DURENBERGER: My other question relates, and again I don't know the answer to it and I don't even know if it's relevant. And that is the group purchasing organizations. Again, I don't know exactly how they operate except that there has been some suggestions over the last year or two that something is going on, and I don't know what it is, between certain of the group purchasing organizations and their members. And it varies from one to the other kind of a member.

Is there anything in there that is of value to us in determining what is actual cost to the hospital?

DR. WORZALA: That's an interesting point. I can certainly look into it. I'm not sure how hospitals would translate that into

their charges but certainly it could help us understand hospital's costs.

MR. MULLER: While the chapter and your presentation showed that a lot of these hospitals do in a very incremental way, we also have seen evidence in the last few years, at least in the press, about one chain at least that seemed to have doubled its charges routinely, and so forth.

Remind me again, what's the relative advantage or disadvantage of having charges of like 10 times cost versus just a little bit above cost? So if somebody has charges that are like -- let's say your cost-to-charge ratio is 10 percent versus 90 percent. Are there any, off the top of your head, advantages of a place that has charges that are 10 times higher than costs?

I know there's that kind of short-term advantage for that chain, in terms what are the systematic reasons one might want to have charges being a big multiple of costs?

DR. WORZALA: Most of it pertains to non-Medicare.

MR. MULLER: I know about Medicare.

DR. WORZALA: Within Medicare, the only way -- and Jack can correct me if I'm wrong -- but I think the only way that that's going to play into how much you're paid is in the pace with which you increase your costs and that will determine outlier payments.

So as we've discussed in the past, if you're increasing your charges much faster than your costs and you have this time lag in the cost-to-charge ratio that CMS is able to use to adjust your charges to costs when calculating outlier payments, you will have an advantage there.

I guess the other thing that I would say is hospitals with higher --

MR. MULLER: Any sense of magnitude of that? I understand that have a one year lag but how much is this worth to a hospital? And if you double or triple your charges the day a new administration walks in, is that worth 5 percent or 10 percent per year? Do you have any sense of magnitude?

DR. WORZALA: I'll let Jack answer that.

MR. ASHBY: One thing I think that we have to make sure that we understand is that outliers is really the only area where it makes any difference. On all of the other allocations, the costs and the charges are for the same period of time so it literally does not matter how much the markup is because the cost-to-charge ratio adjusts for it directly.

Within the outlier arena, I think that we should add that CMS has made some substantial moves to reform the system so that they are more closely aligning the time period of the charges and the costs also

to get to the point where it will also make very little, if any, difference in the outliers that hospital gets.

So that's the goal, is to get to the point where they're exactly the same and it won't make any difference.

MR. MULLER: At least that one chain seems to have had -- I'm sure there's other reasons as well -- a considerable collapse of its financial fortunes with the changes in the outlier policy. So if you're basically saying that we're pretty close to not being able to gain the system any more, is that the inference I should take from that?

DR. MILLER: I don't think we're saying that. I guess what I would answer in this situation is they have clearly tracked on the example where it was an advantage and that, given that the cost reports lag behind the charging practices, you could clearly game on that front.

As Jack said, CMS has moved in to deal with that. I think what I would like to do with this question is I would like to actually think about it. It is correct that when you have the cost reports from the same time periods, in theory when you track through you should, in fact, be relatively close. And then for Medicare purposes -- and this goes to Chantal's point about there may be other reasons to do that -- you should be relatively close.

But I also think this goes to the question you were asking in the last session, which has to do with the issues around recalibration and do we truly understand why some DRGs remain profitable and others don't, if that's in fact what our empirical work turns out?

So I think there may be a couple of issues, even inside that process, that we either need to think through to answer this question or maybe we're not yet aware of in answering.

So I just don't want to end up with a flat statement of we've basically eliminated the gaming possibility here.

DR. WORZALA: I wanted to get to that second part which is just to say that hospitals with higher overall charges will have more weight in setting the relative weights because you're taking averages. So the bigger numbers have more weight. So in that way the relatives, in their charges, will have some influence on the relatives across the system. We need to think about and diagnose that but that would be the logic.

MR. HACKBARTH: It's different from the outlier situation. The outlier situation, especially pre-reform, you could immediately directly benefit yourself as opposed to what it's all blended into the relative weight process the benefit to your institution is vastly diluted.

DR. REISCHAUER: Dave and Ralph brought up the two of the

three topics I wanted to talk about but you gave, Dave, a less specific answer than I had hoped for. What I sort of want to know is for an average hospital how much of the revenue is dependent on charges as opposed to these other relationships? And I know it sort of varies around.

But the way you described it it's really a very minor fraction of the total. Because you have Medicare, you have Medicaid, you have many big insurers are paying on a capitated basis, on a DRG basis, or adjust DRG basis, something like that. I don't know whether this is the tail on a very fat dog or it makes a difference. Why don't we do issue one?

DR. WORZALA: I think that is going to vary a lot by hospitals. I think some of the hospitals that we spoke with did indicate that charges are becoming less important to them. But there are still services and you may find that, for example, your services weren't being paid discounted off charges or a specific set of services. It's less likely to be the services the elderly provide, for example, as the services that the uninsured and the people who are insured by smaller insurance companies.

DR. REISCHAUER: But the uninsured, 60 percent of them aren't paying their bill anyway. So what does it do, determine your bad debt? What I'm wondering is is this 20 percent or 60 percent?

MR. MULLER: The APCs really haven't come to the private outpatient side as fully yes. So for example, you're right, the insurers by and large, after 20 years, have picked up the DRG system for inpatient but they haven't really picked it up yet on the outpatient side, by and large. So charges still make a difference on privately insured outpatient, by and large. That's still the big open field for charges.

DR. REISCHAUER: The second thing was with respect to outliers and you answered a lot of the questions I had. But that raised sort of the question about the sample that Lewin talked to. And I wondered if anybody went through those hospitals and just checked -- if Lewin did because I know we aren't supposed to know who they are -- and checked where they were, in a sense, on their dependence on outlier patients and whether you didn't get participation by that subgroup of hospitals that, in fact, has shall we say gamed the outlier system and so we really have a biased sample of the honest guys here.

The third issue was, if I read this right, this gets to Mark's inquiry. A hospital spends a lot of time working out charges for the little things that come in because they're relatively easy and for new procedures. And if the costs of new things follows the pattern that you see in most of the economy, they are relatively expensive when you begin doing them. Then you learn how to do them and you specialize

and all of this, and the prices, the cost of it goes down.

And the hospital goes back and it reviews the things where the costs are going up and there's sort of a problem. But it would never review the things that costs are going down on unless there's sort of competitive pressure or something like that. And that's where we get into things like the cardiac area.

Is there any way we can look at two or three different areas where there's been a lot of technological advance in the procedure that we think will lead to lower cost? Laparoscopic surgery kinds of things and things like that where maybe this is where the margins exist that can cross-subsidize the other things.

MR. HACKBARTH: Was there anything in the survey results to the question of whether charges for some services actually do decline due to growing scale, experience and the like? Did anybody address that?

DR. WORZALA: We didn't address that specific question but we asked them why, what do they pick to change? And that certainly never came up as an example.

MS. DePARLE: I was going to make a different point sort of related to what Bob was asking. I think there's something circular here, a lot of circular things.

I don't think I fully understand the extent to which charges

influence the DRG process at bottom because I think they do. I think it's probably going to turn out that it's always in the hospital's interest to have higher charges, even though we're kind of focusing on this cost-to-charge ratio issue as it relates to outlier payments.

To the extent that other payers -- Bob, you were suggesting that other payers have moved to these same sorts of systems. But many of them are based on DRGs. So underlying all of this is some building block that may or may not be quite influenced by how high you set your charges.

DR. REISCHAUER: I think, as Chantal said, it's just that in the great scheme of things you have a slightly higher weight in figuring out what the DRGs' weights are then you would otherwise, right?

DR. WORZALA: The logic of how the relative weights are set, where you're taking the average adjusted mean charge so you're taking out the wage index, you're taking out the teaching and the IME which, if those are things are done correctly you're taking out those influences in the charges. What you're really thinking about is the relative between one DRG and another.

So what will really influence, if you want to think about the profitability of one DRG versus another, is the relative markup over costs of the services in one DRG versus the services in another.

Nobody sets charges for a DRG, so you can't talk about the charge for the DRG but you talk about the bundle of services within that DRG. And that's the most direct.

I think we do need to do some more thinking about the influence of higher charges and escalating charges in that process.

MS. DePARLE: Maybe it goes so far back that it isn't relevant but weren't the original DRGs partly based on historical charges?

DR. WORZALA: My understanding is that when the weights were set the first time it was charges reduced to costs. And then with the first recalibration they went straight to a charge-based methodology.

DR. MILLER: At the time they felt that the correlation between charge-based weights and cost-based weights were the same. One of the issues that we're going to be taking apart when we think about the profitability of DRGs is to begin to see if we can look into that.

To my point earlier on this line of questions, and to the point where if you engaged in charging practices can it have a big impact? Remember, all of this travels through a cost-to-charge ratio which are based on different revenues which, as Chantal said, are not directly aligned with the DRG.

So the impacts of raising your charges for certain services is probably hard to track through and probably very specific to a

hospital. They may feel, and this survey says that hospitals are engaged in a lot of different behaviors. They may feel that there's a certain set of services that if they raise the charges on they'll see the effects. And the effects could come through in the Medicare payments but that's probably hard to see and judge and know in advance, although you might establish it over time as a hospital.

Certainly the private site has been acknowledged by everybody. We've acknowledged the outliers. Bad debt payments might be influenced by this.

You made a statement if there at the margins --

MS. DePARLE: So would there ever be an incentive to ever do anything other than have higher charges? And have you ever found an example of charges that have been lowered? You asked the question of over time if services diffuse or whatever.

I would suspect you're not going to find that.

I'm probably making this too complicated, but I just think it's human behavior. This is all so complicated, so why would any hospital ever assume it was in their interest not to increase charges?

If they aren't doing it for any untoward reasons.

DR. WORZALA: The conversations we've had leave me with the impression that a charge is set and then it stays unless there's a problem and it simply gets increased annually. I don't know of Ralph

or others have other...

DR. WOLTER: On the question of do hospitals ever reduce charges, yes, on rare occasions. But they are rare and it would have to do with recognition that out-of-pocket expenses have gotten very, very high for a given procedure. That might be an altruistic reason to do it.

And there are some cases also where ASCs or others come into a market and to be competitive in your outpatient department you really do go and try to make some adjustments downward. But that is certainly not commonly done.

I was just going to give an example from our place for whatever that's worth. We, on the inpatient side, are just over 50 percent Medicare, 50 or 55 percent. We probably have 25 or 30 percent of our inpatient business that's commercial. Some of that's discounted and some of it's discounted heavily. Some of it is actually based on payment methodologies that's not related to our charges.

This is my observation of our finance department's behavior on charge setting. They are looking at that 25 or 30 percent of business more than they're looking at Medicare. Because when you raise your charge, at least for the short run, your Medicare reimbursement is not affected and people are not thinking about three year or so cycle of re-weighting of DRGs as much as they are about how to get out of the

margin problem they're having in their given fiscal year.

So when those behaviors occur over 15 or 18 or 20 years, which they now have since DRGs were originally put in place, their actual relationship between your costs and your charges really does start to change considerably.

And to the extent that the commercial payers pay you very well in cardiology, orthopedics, neurosurgery, et cetera, you reinforce in the Medicare system, through your behaviors of creating charges aimed at the commercial market, weights that then drive payment that are also a bit better in the Medicare system.

So my question has been, as we do this study, will we find that that, in fact, tends to be the fact as we get more and more information? It's sort of also my thesis.

I think the issues that raises are when we look at individual DRG profitability, which we did to some degree in the transfer conversation, we may not be looking at very good information on individual margins anymore because those cost-to-charge ratios have gotten so distorted over the years.

But more importantly, we just had a big conversation about specialty hospitals and the focus on physician behavior. In the not-for-profit world there are huge strategic decisions and capital allocations being made around where the profitability is. And huge,

huge decisions about ortho and heart hospitals. And those behaviors are very strong right now.

And yet, if you really want to look at how we might want to apply resources into geriatrics or mental health or these non-surgical areas, right now the payment system, I think, is driving us in a direction that maybe doesn't balance how we might want those resources to be allocated.

So this is very complex and it's very hard to get this data but the importance, I think, is significant if we can get a sense of how we might chart a new that direction.

MR. HACKBARTH: I think your observation, Nick, that this is not just sort of a one-time problem but actually it accumulates potentially the errors, the disconnect accumulates over time.

For example, one way it might would be a service that's initially expensive when it's new. But as it expands in size and experience the costs come down but the charges always stay up. And you do that over a 20- year period and you're problem could be getting dramatically worse over time, as opposed to the disconnect being relatively constant.

MR. MULLER: Can I just make a narrow point on that among the several very good points that Nick made. I'd like to at least follow up on one in terms of what we can analyze, which is I agree with him

that the behavior of not-for-profit hospitals is especially much more shaped by the opportunities on the private site than by Medicare because of the administrative pricing in Medicare.

On the other hand, if you do have 20 years of higher charges in neurosurgery and orthopedics and heart care and so forth, I'll go back to the question that Jack took a crack at earlier. Does that have an effect on the DRG weighting in a cumulative way? And perhaps doing some arithmetic simulations of that might be worth it because it's not hard to figure out that people with heart disease and prostate cancer tend to be better insured than women who are 17-years-old and deliver babies. They're just better insured and you have higher charges and so on. And so after 10 or 20 years there are higher charges in heart care than there are in delivering of children.

Does the cumulative effective 10 or 20 years of that have an effect on the DRG rating? I think that is worth looking at. And whether we want to do some arithmetic simulation of that, it may be worth doing to see -- I grant Jack's point that it has more to do with outlier policy but there may just be some skewing that we should look at.

DR. MILSTEIN: My comments are somewhat overlapped with Ralph's. Two comments.

Number one is, as Ralph was suggesting, the answer to this

question is modelable. That is both for Medicare and for non-Medicare we can establish a quantitative sensitivity of the impact of a dollar increase in charges on how much Medicare in the next year pays you and how much non-Medicare payers pay you in the subsequent year.

There's a relationship there that relates to Bob's question that relates to the size of the tail and the size of the dog. We don't know that but I believe it is modelable.

Secondly, it would help me to get clear on the scope of the question we're asking. We could have a narrow scope question, which is post these adjustments that have just been made on gaming outlier policy, what is the remaining sensitivity of how much Medicare pays to every dollar increase in charges? That's a narrow question.

The bigger question is what are the indirect effects on the Medicare program intermediate-term related to whatever sensitivity does or does not exist with respect to charge increases that hospitals make with respect to non-Medicare payers?

One could make the argument, I think Ralph referred to for example the ambulatory non-Medicare areas -- this is not your exact words -- but the last sort of arena of unconstrained hospital charge setting or price setting that has some significance for revenue.

What does that do for the Medicare program intermediate-term to have -- I'll call it from a purchaser perspective an unguarded

frontier, as it were, in terms of where there's a lot of remaining price flexibility, a lot of payment systems based on charges minus X percent?

That does have impacts intermediate on Medicare because to the degree hospitals do not feel price constrained in any important dimension in their revenue stream, their incentive to seek the kind of efficiency capture that the IOM is talking about is reduced. And that then has implications for the Medicare program.

So it would help me to understand whether or not we're trying to, through our analytics and our modeling, answer the narrow question or the broader question that would include indirect feedback loops on the Medicare program from less charge flexibility on the part of hospitals with respect to non-Medicare payers.

MR. HACKBARTH: Others can respond but my feeling is that we've been talking primarily about the former. We're worried about the direct impacts on the Medicare program and its mechanisms for setting prices and therefore differential profitability and the like, as opposed to the broader second issue.

This has been a helpful conversation for me. I think on the one hand my impression is that the opportunities for individual hospitals to game the charging system are primarily in the area of the outlier payment and they have presumably been reduced, at least

somewhat, by the steps that CMS took.

On the other hand, I think it still may be true that Nick is right that, although it's not conscious gaming activity, just normal human behavior means that accumulating errors over 20 years could mean that this important tool in the Medicare system is getting more and more out of whack.

I don't think those are mutually exclusive possibilities.

Any other questions or comments?

Okay, thank you.

The last presentation is on state lessons in the drug card.

* DR. SOKOLOVSKY: As part of our continuing work of the implementation of the Medicare drug benefit, you might remember last spring we contracted with a team of researchers from Georgetown University and NORC at the University of Chicago headed by Jack Hoadley here from Georgetown, to look at what states were doing in terms of enrollment and education, what their plans were for low-income beneficiaries and dual eligibles.

What Jack found and what the team found was that states were much more concerned with getting ready for the discount drug card. And so we continued the project, looking at how the discount drug card was implemented and particularly what lessons could be drawn from that that would be relevant to the Medicare drug benefit.

Jack is going to present the results of that study.

MR. HACKBARTH: Welcome Jack. Good to see you again.

DR. HOADLEY: Thank you. I appreciate the chance to be here and talk about this project.

Basically I want to go through several things, talk about experiences that beneficiaries have had with the discount card program seen through the filter of counselors and others who help beneficiaries work through enrolling in a card and working with the cards.

Also comment a little bit about how the cards work a little bit differently in the states with pharmacy assistance programs, what the experience counselors are having with this process of doing this counseling process, and then also we asked the same counselors a little bit about what they were expecting looking forward to Medicare Part D.

This slide just basically runs through a few of the basics. To refresh your memory, we haven't been in this discount card process for very long. The card sponsors were selected back in March. Cards first became effective in June. So we really, at most, have about three months of experience with the cards actually being in place and so I think that's an important caveat in thinking about what this experience has been.

I also mention here the different aspects, enrollees select one card with an enrollment fee of no more than $30 and they have the

possibility of another card in the second year. Also the possibility of signing up for transitional assistance of $600, and we gave a lot of attention to that particular aspect of the program for those low-income beneficiaries eligible for transitional assistance.

Enrollment, the most recent numbers suggest that about 4 million beneficiaries have signed up for the cards, which is a bit below what expectations were. Not clear whether these numbers will continue to grow over the rest of the year and into next year or whether we've sort of hit the plateau on this. There's no way to know that. About 1 million beneficiaries have signed up for the transitional assistance and there were actually expectations that as many as 7 million beneficiaries could be eligible for transitional assistance. So again this number is well below expectations.

It's also important to note that many of the people who did enroll for these cards were auto-enrolled through one of two ways, through their Medicare Advantage plans, those who are already in Medicare Advantage plans could be auto-enrolled directly into a card. And those that were already enrolled in state pharmacy assistance programs in certain states, those states auto-enrolled people into the cards. That actually accounts for a fair proportion, portion, probably more than half of those that are enrolled in transitional assistance, and perhaps quite a bit more than half although there are no hard

numbers out on that phenomenon.

Basically, our study consisted of interviewing about 20 to 25 people over the two months of July and August and a little bit into the first of September. We talked to state health insurance assistance programs, either state coordinators or some of the local or county program folks for the different state SHIP programs. We talked to a few pharmacists about their experience in counseling beneficiaries and a few other sorts of beneficiary counselors who weren't directly affiliated with the SHIP programs.

We had a general protocol that we followed and I should emphasize this is obviously a qualitative study based on a relatively small number of interviews but what is striking is that the conversations we had across the different states were really quite consistent. So that the things I'll talk about really were repeated from across most of the interviews we had.

As the counselors report their enrollment experience, and I will reemphasize that it is the reports of counselors that we're dealing with, we didn't talk directly to beneficiaries for this study, what is it that has worked about the discount card program?

One thing is that the counselors do report that real savings seem to be available for at least some beneficiaries, especially those eligible for transitional assistance and those with no other coverage.

When they sit down with the beneficiary and look at what their drugs are and what their situation is, they often can find real savings for these folks.

They also report that although the web site can be confusing, especially for beneficiaries, it has improved. And from the perspective of the counselors, the web site and the web tool has been a very valuable resource to them in working with the beneficiaries.

Also, despite some of the speculation before the program started, there has not been a lot of fluctuation in drug prices, at least what the counselors have seen and this seems consistent with other studies of this, that prices, after at least the first few weeks that the discount cards were up, pretty much have stabilized. So people are seeing the discounts that they're expecting when they enroll.

The other thing, I think, that has worked is that counseling has been available to folks. The SHIPs and others have really made it possible for beneficiaries to get help in enrollment and working with the cards.

So what do they report has not worked as well? One of the consistent things we heard about was considerable confusion among the beneficiaries. Beneficiaries are confused by the large number of choices that they're facing, the fact that there may be something like

30 to 40 different cards to look at is really quite overwhelming to a lot of the beneficiaries according to the counselors that we talked to. In fact even, in some cases, overwhelming to the counselors.

That selecting a card is quite difficult for a beneficiary without the help of a counselor walking through this process.

There is even confusion about trying to understand what the discount card is versus what's in Medicare Part D. They're hearing a lot of the publicity about Medicare Part D and some of them are having trouble sorting out with the discount card does versus what Part D does.

We also heard that beneficiaries didn't trust the program, were just suspicious about this, what this was going to be. They were concerned about the fact that prices would change and wouldn't be what they were advertised even know, as I said before, that has tended not to be the case at least so far in the program.

Part of what hasn't worked is that a lot of beneficiaries have just decided not to choose a card. In being overwhelmed, their response is to just say I can't deal with it, I'm not going to pick one. And they can't seem to -- the counselors even have trouble convincing them that this investment up front may actually pay off. Some of them look at the up front enrollment fee and say well, I'm not going to put down $20 or $30 for something that I don't even know

really has value to me, again having trouble getting past that notion that there's this up front cost, even though there may be savings once they really get enrolled and start to see things.

They just see it as a big hassle and especially because it's a short-term program. They say this is going to come and go in 18 months. I'm just not going to bother. Obviously, this isn't everybody but this is a surprising number of people, and again we heard this repeatedly from the counselors we talked to.

Some others talk would talk about the fact that they already have easier access to other discounts. Some talked about the cheaper prices they get from Canada when we talked to states that are up along the northern border. Others would talk about getting better discounts from places like Costco or Target or wherever they tended to go. Empirically, this may not prove to be true. They may actually be able to get better discounts from the discount cards, but they're happy with discounts they're getting and don't seem to want to look for others.

Of course, in some cases people have other coverage and that's another factor. In those cases, the card isn't so relevant to them.

The specific case of the states with pharmacy assistance programs is a little bit different. Here we've got a situation where the state can save money if the transitional assistance eligible

beneficiaries do enroll in the cards and do enroll for transitional assistance. So what has happened is in all of the larger states with the larger pharmacy assistance programs and some of the smaller ones as well, were able working with CMS to set up auto-enrollment procedures which have proved to be quite effective.

In those cases, they pretty much got everybody who was eligible for transitional assistance enrolled in a discount card. In a number of the cases the states share the savings with the beneficiaries by reducing the copays that they otherwise would have had in the state program in order to provide some incentive for the beneficiary to see the value on this. In a few other state they just said well, it's saving the state money and that will benefit you in the long run even if it doesn't benefit you in the short run.

It's also true, however, that in most of these states people enrolled in pharmacy assistance programs who are not transitional assistance eligible are generally better off not getting a discount card. Their state program is providing them a better deal than they would get through the card. And so most of those did not enroll.

We did hear, though, that the Medicare discount card publicity generated some new enrollment in the state programs, which is a good thing. And also, in some cases, people would come in these states and folks who had missed the threshold for enrollment in the

program people, the counselors could now tell these folks you can enroll in this discount card and while it's not as good as the state program at least it's something. In some cases, that was an effective thing.

So what did counselors tell us that seniors did on their own in the process of trying to confront this program and learn about it? A very few number had tried the web site on their own, tried to work through the tool that's there on the web site. We heard that most seniors either don't know the Internet, don't have good connections, and in particular don't have high-speed connections. And without a high-speed connection, working with the web site tool is really pretty difficult.

I do have to put the caveat that we're talking to counselors who are seeing people who ended up talking to them, not to the people who could do it on their own and never even talked to the counselors. So it's hard to make a judgment of how many other seniors were successful with the web site or the 800-number and never made it to the counselors, although the number of people enrolled suggest that those can't be too enormous in numbers.

More people had at least contacted 1-800-Medicare for information but often found it was too complicated to work through their situation, again with this bias that we're hearing the people who

made it through to the counselors and didn't stop after talking to 1-800-Medicare.

Almost all of the seniors reported getting mailings from the card sponsors. Many had talked to friends, family, pharmacists, physicians and ended up getting referred to the state SHIPs for help through many of these other sources.

So what is it that the SHIPs are really doing? They're starting by doing substantial outreach efforts and I think I talked about this a little bit in the spring when I spoke to you about our previous project, that states were planning these kinds of outreach efforts.

Some states did really quite massive outreach programs. We talked to one county level counselor in one state and she personally had been out, I think, and done 18 different programs all over about a six week period, going around the county and talking to different groups of seniors. So there were a lot of those. And everybody we talked to talked about a systematic attempt to get out there and talk to seniors in different kinds of venues.

We did hear, however, that the turnout for these often was pretty substantial but wasn't always. In one case we were told about a program that was scheduled at a retirement community where they were accustomed to doing programs and getting quite high turnout, and ended

up canceling the session because the turnout was so minimal. People already seemed to be convinced that this card wasn't something they were interested in knowing more about, was the impression that they had as to why that happened. Some states did fliers and letters and other kinds of things. But mostly it was through these outreach presentations.

The other piece of it is the one-on-one counseling, that's really the bread and butter of the SHIP programs.

States definitely told us that their workload, their turnout for one-on-one counseling had risen but that the numbers weren't overwhelming. They had some concerns going into this that they might just really be overwhelmed by this process and that wasn't the case. People did seek one-on-one counseling in response to outreach or other publicity, and so they did get a fair amount of this.

What's a typical counseling session like? What they try to get people to do is bring with them a list of their drugs and their income information, the same kind of thing that they're told if they're calling 1-800-Medicare or going onto the web site that they need to do. And then the counselor sits down in a session that can often take as much as an hour and really works through, enters the drugs, puts in their information, puts in their location and tries to narrow down the choices. Many of the counselors, what they would try to do is identify

three or four programs that look like the best deals for the beneficiaries involved.

Typically, they did not recommend a single program to the beneficiaries. They asked the beneficiary to make the choice. They offered, in some cases, to fill out forms. In other cases they would send home the materials and the application form.

And then, in some cases a follow-up session was required. In fact, one counselor said they often ended up meeting the people three different times. The first time they would come in and talk and discover they didn't really have with them complete information on the drugs that they were taking so they'd come back a second time, maybe with a bag of pill bottles so they could go through and be very precise. And then sometimes come back a third time after they'd made a decision for help filling out the application.

So this tended to be a pretty intensive process. One counselor even said that she tended to call up the pharmacy where they got their prescriptions done to try to find out exactly what they were paying today for their drugs, so they could really get a fix on whether there was a savings.

So some of these counselors went through a very elaborate process to try to help people.

What do the counselors tell us that beneficiaries decide?

They said there were a fair number of people who ended up deciding, for the reasons I suggested earlier, just simply not to enroll. In some cases, a very logical decision that the cards weren't a better deal than what they were getting today. In other cases, perhaps they still has this feeling of being overwhelmed and just I don't want to deal with that. I don't want to pay the up front fee. I'm not sure I'm really going to get anything when it comes out.

But many did enroll. And those that do tended to pick one of three strategies. They either looked for the best savings across all the cards, even if it meant going to a new pharmacy to get a better deal. This was especially easy when the counselors narrowed the number of choices to sort of the best three or four cards.

Others tended to say I want to go to the pharmacy I'm accustomed to going to, so they'd look for the best card that had that particular pharmacy in the network.

Others seemed to really be bothered by the enrollment fee and so looked to those cards with no enrollment fees and would pick one of those, even if it was possibly not as good a deal overall but just didn't like the idea of paying that up front fee.

So what did the counselors say in their reviews of this whole process? They said overall these counseling sessions went smoothly. They were good sessions. They felt really good working with the

beneficiaries. They were lengthy sessions, as I've said before.

They also were pretty consistent in saying that the web-based decision tool for the counselors worked quite well. In fact, one called it a godsend, that this really made it possible to work through this process with the beneficiaries.

Most of them, as I said before, don't recommend a specific choice for the beneficiaries. And as they reviewed the card program itself, their reviews were more mixed. Some of them pointed to a lot of flaws in the program, and I'll come back to that in a minute.

They also, though, told us some very positive spillover effects. The fact that the publicity over this program got people to come in and talk to them gave them the opportunity to discuss other programs they might be eligible for and it generated new enrollment in the state pharmacy assistance programs. It generated new enrollment in Medicare Savings for people who were dually eligible for Medicaid.

It also gave them a chance to talk to them about other ways to get help in buying their drugs, some of the drug manufacturer assistance programs and the other things and other special programs that might be eligible for their unique circumstances. And so, the fact that they got in and talked to people really had a lot of positive spillover effects.

We also noted, through the interviews, that there was a lot

of variation in the SHIPs. In some cases, their resources vary quite a bit, the resources for outreach and counseling. You have to remember that these SHIPs, while they have a few permanent staff, the bulk of the work that is done is by volunteers. One-on-one counseling, in many cases, is done by volunteers. So they're spending a lot of time training volunteers and depending on the availability of volunteers to do these things.

Some of the programs are quite well prepared and quite well funded. They're building from a good base. They've had a lot of success in past years. They integrate this new program with their other counseling. They try to make it just seamless as part of their normal operations. As some of them said, we just built this in to one more thing we talk to seniors about.

It was also, as I said before, a chance to educate clients about other resources available.

In other states, the programs would really struggle with some of the basics. They had an absence of outreach sites or volunteers. And they had problems with computers. In one state they talked about trying to set up programs around some of the really remote rural areas of that particular state and they'd get out to the state and discover there was no computer available to use. Or if they had one there was no Internet connection available with the computer. Or if it had an

Internet collection it was a dial-up. And trying to do this, again, over a dial-up just was not very effective, especially trying to get through these things quickly.

I think the programs vary based on just the resources they have, the state funding as well as the federal funding that they have. But it's also a lot about the history and the partnerships they develop. Some of the best programs have really extensive histories and partnerships and go at it with a lot of enthusiasm.

We also, as I said, talked to a few pharmacists. Pharmacists generally reported a lot less activity on the counseling side. They did get a spike of inquiries when the program was new and all the publicity was initially out initially out but that quickly tapered off, we were told.

Some of them put signs in their windows and did other things to solicit inquiries. Some pharmacists really seemed to take a personal interest in trying to talk to some of their longtime clients who maybe had trouble paying for their drugs to try to get them involved in these cards.

There were other pharmacists, it seems, not ones we talked to directly but ones we were told about, that seemed unwilling to take the time to help. They were busy with their business and didn't really want to take the time to talk to customers in what they knew would be a

longer process.

There were also some concerns from the counselors we talked to that pharmacists had a tendency to recommend only the cards that their drugstores were cosponsors of or their chain or whatever was a cosponsor of and that was somewhat of a concern that we heard about as well.

What about the experience actually using the cards for those that signed up? The counselors did report -- first of all, we've only had this going on for a couple of months and a lot of the enrollment didn't even happen as early as the first of June. But they have not heard much about problems. They say our folks, when they talked us for this kind of counseling, if they have problems they're going to call us up again and they're not. We're not hearing back that oh, we went to the drug store and the card wasn't being accepted. Cards to seem to be accepted. The discounts people expected seem to be getting there. Or at least there is no evidence to the contrary, based on complaints back to the counselors.

We also heard more consistently or least from more different people that where the states had the pharmacy assistance programs and they were try to interact between their card for the PACE or the EPIC program and the new discount card that that interface had worked quite well, and there were really very few problems with that.

So to wrap up, what were the sort of assessments and recommendations that counselors told us about the discount card? They consistently told us they would prefer to see fewer choices. This idea of having as many as 40 choices was just too much.

They also felt that there were a number of people not being reached. And they have a real frustration and concern that they do not know how to get at some of these hard to reach populations.

One explicit comment we heard a couple of times was the need to make materials available in more languages, that while there are more than just English available, that there's a lot of languages in these communities where there aren't materials available.

But they are equally frustrated how to reach some of the sicker populations, the poorer populations, the ones who don't tend to come in, who don't know that these SHIPs exist.

They also said we needed more time at the beginning. They understood that was a program that was rolling out quickly. But they needed more time to learn about the program to be able to be good counselors. And that's something that they felt was a concern.

They also did say that the discount cards were a hard sell to the beneficiaries they talked to for the various reasons that we've talked about.

When we asked them about Medicare Part D mostly they told as

well, it's still far away. We're not sure what that's going to look like. But some of the concerns they did raise was that they were concerned that the program would be more complex and that that would make the counseling process pretty complicated.

They were also concern that the consequences of mistakes are greater, particularly because of the late enrollment penalty, which is something that they're very aware of.

From their perspective, they're concerned that more people will be affected. Now this isn't saying that that's a bad thing about the program, that it's simply something that they're going to have to deal with as counselors, not only the relatively few people for whom the discount card was a potential good deal but Medicaid beneficiaries, state program enrollees that could mostly not pay attention to the discount card will have to pay attention to Part D. So they know this is just a bigger process. They also know that it's a more complex program. There are a lot of complexities of benefit design, formularies, interactions with existing coverage and they know they've got a lot of work ahead of them.

Finally, one of their recommendations about Medicare Part D, they think it's really very important that messages about the program be clear and simple. I mentioned before the confusion about the discount card versus Part D. They felt that some that was because a

lot of the early publicity said here's this discount card rolling out and then there's going to be Part D coming after that.

They said what would be much better is talk about the thing that's there now. Don't also talk about immunizations, physicals and other kinds of things. Talk about the thing that they need to know today.

They also said that more choices is something that's going to complicate the education process. And if there are a lot of choices that that is a concern to these counselors.

They also say you need to allow plenty of lead time to prepare the counselors. They need to know about what's available in their community enough in advance to get on top of it before the onslaught of open season occurs.

They also would like to see more focus on educating pharmacists. They think they are an important part of the contact that people have and that they need to understand the programs.

They also point out consistently that seniors are not Internet savvy and that programs need to be wary of overemphasis of web use, even though web use can be very important to them as counselors.

And finally, they point to the need for more and better ideas for finding, educating and enrolling the hard-to-reach beneficiaries.

Thank you.

MR. HACKBARTH: Thank you, Jack.

DR. MILSTEIN: A few questions.

First, have any of these programs attempted to calculate what their costs are in getting somebody onto the program? And what relationships those costs bear to the likely incremental savings resulting from the card?

DR. HOADLEY: I don't think we ever asked a question that specific. We did talk to them some about the resources involved but nothing that was that focused, so I can't answer that.

DR. MILSTEIN: Another question is are any of these programs attempting to either expand the benefit of the counseling by moving into scope questions like obvious things like opportunities for generic substitution that a senior may not have appreciated? And/or already making efforts to improve the quality of the counseling, such as some Medicaid agencies who now have these handheld sort of Hertz check-in type things to help the Medicaid enrollment process go faster and be more accurate? I can imagine something similar for these programs so that your quality control on the counseling process goes up and the efficiency of the process goes up. Many programs making headway in I'll call it the performance of their services?

DR. HOADLEY: On the first question, I think there were very few states that do try to get their counseling very broad, so that they

might sometimes talk about generics just like they would talk about well, you have this Pfizer drug and Pfizer has this special program. Or we're looking at your drugs and there are some generic alternatives. Some of them do, I think, take an active role in trying to do that.

To the second question, I certainly didn't hear anything about that. And I think what we would probably hear, just to speculate, is the resources to do it in the front end. They are working on real shoestring budgets, in most cases, and I think they're struggling just to do what they're doing and would need up front investments, I think, to move in those new directions.

MR. HACKBARTH: Jack, could you just say a little bit more about the funding of the SHIPs, how much, sources.

DR. HOADLEY: I don't have numbers, at least not in my head. The sources, some of the money is federal and there were some additional grants available to the SHIPs through the MMA to help. And states certainly recognize that, the program folks recognize that. Although one complaint I did hear was that why do all of these new streams of funding always have to be a grant that we have to sit down and fill out a proposal for? And so they waste time, they feel, in having to go through an application process to get new funding instead of just getting the funding.

They get state funding in, I think, most cases. They're

generally based at area agencies on aging or other places within the state government, departments of aging. And so certainly some of their funding comes from the state. And then they have partnerships with private organizations. So some of them very actively work with, whether it be AARP chapters or other local senior organizations, to try to build partnerships. And then they use volunteers, as I said before.

But I think the bulk of their funding is a mix of state and federal, but the numbers I don't have with me.

MS. DePARLE: We also gave them -- I think at the time of the BBA they were mostly state funding and we gave them -- I mean, it's still pennies, but a substantial increase as part of the BBA because we were trying to build up their capacity.

But as you say, Jack, they're still tremendously under-resourced and that could be certainly one way to use some of the additional funds that Congress gave CMS to implement this benefit, even though they are disappearing funds, in a sense. But one would hope that Congress will recognize the need for this.

DR. WOLTER: This reminded me a little bit of the conversation yesterday on benefit design and copays and caps and the whole tension between innovation and flexibility and choice and options versus the complexity of the choice making.

I do think, as we have a chance to address those issues, how you would cast the balance of that I'm not certain. But I do think it's an issue. And right now it does seem like we're much more on the side of complexity than we are on clarity. And we may want to try to guide things in that direction.

MR. HACKBARTH: And by coincidence, there was a piece in the Post this morning, a column on the business page, about research on choice and how people process choices and whether they do well with open choice versus these types of constrained choice.

I don't know how much research exists on that question and what its utility might be, but it is a very interesting, and I think increasingly important, question for the Medicare program.

MR. MULLER: There's a lot of research at NORC on that.

MR. HACKBARTH: Anything else?

Thank you, Jack. Well done

We'll now have a brief public comment period.

* MR. FENIGER: You always preface it with brief, after lengthy and interesting discussions.

MR. HACKBARTH: And when you get up I say really brief.

MR. FENIGER: Because you've heard this before.

Randy Feniger with the American Surgical Hospital Association and, of course, I would like to comment on the beginning discussion of

the work so far on the MMA assignment.

Congratulations to the staff for what I thought was a very well done presentation about a very complex issue. And I was also very impressed by the depth of the discussion of the members of the Commission. You obviously have given a lot of thought to this and recognize that this is not a slam dunk one way or the other. There are many complex issues. And I think certainly as an industry we appreciate that.

We had very positive feedback from our own members who were visited in the site visits, in terms of their interaction with the staff. So I think that simply reflects upon the quality of your staff, the way they handled themselves out in their site visits. And they would be welcome back, which is not always what we say about government officials.

Some points I would like to have you keep in mind as you go forward in your consideration. A good bit of discussion about self-referral and the potential for conflict. I would only say what about the conflicts created when a hospital employees physicians or owns medical practices? There are silly pressures there to make referrals, to make judgments. I think we have to be extremely careful in if we're going to look at one, we look at all of them to try to sort that out.

The issue that was raised in a number of comments, trying to

analyze in a community the impact of a hospital, especially the hospital opening, and change in procedure level or capacity. What benchmark do you use to evaluate that change as either positive or negative?

I think that's going to be very, very important because an individual community may not be providing adequate amounts of heart care or orthopedic care. The specialty hospital adds to that. I'm not saying that's true in every case. But I think that the benchmark you use for the basis of your judgment will be important.

Most of this focused on investors. I would encourage you and encourage the staff to take a look at those physicians -- and perhaps they have and it was just not discussed as much. There are on average three times as many physicians with attending privileges at these hospitals as there are investors.

So obviously, there's something attractive about this model for other physicians who haven't put a nickel into the system. I think it's important that you understand that as a Commission, that the staff develop that to the extent that they are able to, because I think it goes right to the heart of whether this is driven simply by a financial issue or it's driven by other more complex issues related to physician efficiency, patient quality, et cetera, et cetera.

The point was made that heart hospitals are the dominant

Medicare provider in terms of a number of patients but they are not the dominant model in the industry. We have 71 member hospitals. Only five are cardiovascular hospitals. All of the others are mixed surgical hospitals. They provide, on average, six surgical specialties in their service mix.

So I would be concerned, and hope you would be cautious, about making decisions that affect everybody based on the heart model alone. It is a different kind of hospital and I don't mean this in any way critically. It is simply not the style of hospital that we see across the country that most physicians are involved in.

Also, the stories behind these, the point was made -- I'm not sure which commissioner made it -- that these companies come and hunt for investors in sort of build it and they will come theory. Most of these hospitals arise out of conflict between medical staff and hospitals. And then physicians, because they can't resolve it, rightly or wrongly, then may turn to an investment group or corporation to develop an alternative solution.

I think those stories may be important, perhaps a good lesson for hospital management graduate programs.

Financial impacts on community hospitals, as was discussed, are multifaceted. Isolating the specialty hospital is the cause of financial change in an individual institution or group of institutions,

I think is going to be very, very tricky. I think it's very easy, if your money isn't doing quite what you want it to as a hospital, to say well, it's that specialty hospital across town. I was fine until then. But we heard that about for-profit hospitals 20 years ago. We heard that about ASCs 20 years ago. We still have hospitals in business. So I'd be a little careful on that.

The rural issue is an important one. There are not a lot of hospitals. I have been told, and this is anecdotal, by people in rural communities, the presence of the specialty hospital is often a tool to recruit additional specialists who would not otherwise be willing to come to that community. And that may be something that, to the extent the staff is able to look at the rural issues at all, they might want to get behind that and see has it actually improved the quality of care.

And finally, I think you really hit on the debate towards the end and then the second discussion after that really got into it. This is an issue about the correctness or the accuracy of the payment system. Hospitals use subsidies to pay for things.

To the extent that we, as a society, agree community hospitals provide social goods that we want, we should be prepared to pay for them. If we are not paying for them accurately, I would think that should be the focus of the ultimate analysis. I realize you have

to make a report on specialty hospitals.

But I think the issues as you got into them in both your discussions are much broader and I think we would very much welcome a debate over the quality and accuracy of the reimbursement system, as opposed to whether competition should be allowed to develop in any given community under state or federal law.

Thank you.

MR. HACKBARTH: Okay.

Thank you, very much.

We're adjourned.

[Whereupon, at 11:49 a.m., the meeting was adjourned.]