MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
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Washington, D.C.

Tuesday, November 15, 2006, 10:07 a.m. *

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: First up this morning is a discussion of the draft chapter on context for Medicare policy.

Rachel?

DR. SCHMIDT: Good morning.

This is a follow-up to our discussion from last month about the draft chapter. This is going to be the last time we're presenting on this so I'm particularly looking for your comments about the tone and content of that draft chapter. As you know, that draft chapter will turn into the first chapter of the March report to Congress.

So last month we talked about some of the major changes that are underway to the Medicare program. First of all, Part D is due to start, and today actually is the first day of the open enrollment period for Part D. There's the coming retirement of the baby-boomers. Those factors, combined with rapid growth in health spending that's affecting all payers in the U.S. health care system, because of those factors, Medicare costs are projected to grow much faster than income into the foreseeable future.

You've seen this slide before several times and

I'm showing it you once again just to remind you of the Trustees projected mismatch between Medicare expenditures and financing over the longer term. This mismatch is likely to trigger the MMA's warning mechanism, called the Excess General Funding warning when general tax revenues are projected to make up 45 percent or more of program outlays. Under this trigger the President must propose, and the Congress must consider policy changes to reduce the level of general revenue financing.

Some policy analysts have criticized this 45 percent level as arbitrary, and there's some merit to that argument. Nevertheless, the provision is in the MMA probably to force policymakers to debate whether to use general tax revenues for Medicare or other alternative uses that are also valuable to us. The MMA's warning mechanism could be triggered in as few as two years from now.

Last time you asked for some more information about growth in beneficiaries' Medicare premiums and that's the point of this slide before you. The bottom line that I hope you take away from this slide is that health care spending is growing faster than income so beneficiaries, too, are feeling the pinch of growth in Medicare premiums

and cost sharing. This chart was in the 2005 Trustees report on the shows projected growth in average monthly Social Security benefits -- that's the red line -- relative to growth in Medicare SMI premiums and cost sharing. That's covering both Part B and Part D and that's shown on the green line. You can see that over time the green line takes up a growing share of Social Security income over time.

Now to be fair we need to point out that if a person enrolls in Part D the Medicare program will start subsidizing nearly 75 percent of the premium for that benefit. The light blue line, the dotted line on this chart is reflecting them. That's a reminder that Medicare's average benefit is rising pretty quickly too. But for many beneficiaries Part D may actually reduce what they now spend out-of-pocket on prescription drugs and insurance premiums. This chart does not reflect that, so let me be clear about that. It just shows their Medicare related premiums and cost sharing.

The overarching point of this chart, however, is the same other that we talked about in the previous slide. Health care spending, including Medicare premiums and cost sharing, is growing faster than income and is likely to

pinch beneficiaries.

So the combination of the warning system and financial pressure on beneficiaries could lead to some debate about significant changes to Medicare in the near future. Last month we talked about how improving the efficiency with which providers use Medicare's resources was a preferred policy approach compared with other options such as limiting benefits or increasing financing.

We also talked about how the effectiveness of policy changes could vary across health care sectors, and depends on other broad trends in health care delivery and in Medicare's market power. For example, if policymakers wanted to constrain fee-for-service updates over a relatively long period of time and other payers weren't doing the same thing, that could backfire and lead to access problems for Medicare beneficiaries.

The back end of this draft chapter has some examples of policy directions for Medicare. These include tools for trying to improve the efficiency with which Medicare's resources are used. Some of these examples include comparative effective analysis, to help define when it is most appropriate for providers to use technologies.

Other tools might include pay-for-performance strategies, competitive bidding and better coordination of Medicare and Medicaid benefits for dual eligibles.

In most of these examples, Medicare would need to collaborate with other payers, public and/or private, in order to ensure that the policy changes would be effective. This could involve facilitating some technical expertise to develop certain methodologies and build consensus among stakeholders on how to use those methodologies.

But the overarching issue here is the degree to which Medicare can collaborate with other payers in order to ensure that this is broader in the entire U.S. health care system.

Just to follow up with a few of your other questions from last time. In the draft chapter I added more of a discussion about how our tax policy subsidizes private health insurance in the United States. Employer contributions to their workers' health insurance premiums are not considered taxable income. Just to give you a sense of the magnitude, CBO estimates that in 2004 this amounted to $145 billion in foregone federal tax revenues.

You also asked about the U.S. approach to direct-

to-consumer advertising for drugs and other services such as imaging. It turns out that the United States is currently the own only country that allows such advertising of specific products. Other countries allow ads that raise awareness about certain health conditions and ask you to go talk to your doctor, but they don't advertise specific products.

Officials with the FDA have testified that it would be counter to the First Amendment to prohibit such advertising in the United States. The FDA monitors DTC ads once they're out there to make sure they're not false or misleading, and they require advertisers to disclose the risk of their products.

You asked about literature on whether individuals really want to be able to choose their own provider in the United States and their relative price sensitivity. There are a number of studies out there that show that people are sensitive to the price of premiums. In other words, they might be willing to live with tighter constraints on their choice of providers if the price of premiums for greater choices too high. But the backlash against managed care in the 1990s suggest that there may be limits to this price

sensitivity.

There's also some literature that shows that there's less price sensitivity among older people, and there's a correlation between the desire for fee-for-service coverage and age. This may be that because older people have more health conditions and more interaction with their health care providers they believe that the non-monetary costs of not being able to choose their own provider are high. It could also be true that the current cohort of elderly is simply used to fee-for-service and the preference for fee-for-service could change as different cohorts enter into the Medicare program.

Finally, you also asked about international comparisons of health outcomes, whether the additional money that we spend per person in the United States corresponds to better outcomes.

For at least some measures the answer is no. We have higher rates of infant mortality, highest standardized rates of all-cause mortality, and similar life expectancy is other industrialized nations. Our higher level of spending may buy some people in the U.S. access to specialized care. But not everyone has that access. Some of our measures of

health outcomes for our population are no better, and sometimes some are worse. As we talked about last time, this reflects our society's preferences among competing policy goals for health care.

That concludes my presentation. I'm happy to take questions and comments.

DR. MILSTEIN: Just a couple of suggestions. One is that I'd like to be sure that the list of considerations, the list of pathways to efficiency capture that our report addresses would include induction of a faster rate of productivity gain via industrial or systems reengineering, which is what enabled so many other consumer-facing industries such as retail to gain a much higher rate of productivity per year than has historically been the case in the health care system. I'll call it the summary of the body of thinking in this direction was in the IOM's August report on systems engineering in health care delivery.

Secondly, I would hope that our report would discuss optional frames of reference for likely rates of spending growth going forward in the future, appreciating that there are at least three options: the 1 percent which is currently the recommendation of the Office of the

Actuary; the 2 percent historical; and the more recent technology pipeline informed estimates, for example, from recent RAND and Stanford reports which suggest that historical rates of 2.5 percent may be substantial underestimates of what actually the biotechnology pipeline has in store for us over the next 25 years.

MR. HACKBARTH: All those numbers, the 1 and 2.5 percent are above GDP growth per capita.

DR. MILSTEIN: Correct.

MR. MULLER: Rachel, thank you for this. To go back to your slide, or page 4, are we going to be able to do some on these, especially the items under the first topic, addressing the long-term sustainability, are we going to make some orders of magnitude estimates as to what we get from these various measures?

For example, in '97 with the Balanced Budget Act at that time we saw some of the effects of option three there, and there have been estimates made obviously on the other categories as well. But is it your plan to include some rough -- you know, to the nearest billions estimates on these kind of matters?

DR. SCHMIDT: In last year's chapter we actually

did discusses this in more detail and that included available estimates that others had done on the order of magnitude. The current thinking was not to repeat that information, but I'm open to your suggestions.

MR. HACKBARTH: Could you just remind me a little bit more about last year's, what sort of --

DR. SCHMIDT: We listed a number of different options that I don't think that we necessarily have talked about much in the past. For example, increasing the age of eligibility to the Medicare program. So we talked about the pros and cons of that and available estimates on savings associated with that.

What else did we cover? Limiting provider updates. We did not, I don't think, provide an order of magnitude estimate, but you're right, one is available from looking at the example of the BBA.

What else did we cover, Mark? I'm drawing a blank.

DR. MILLER: So am I. I know we did some of this but I can't remember --

DR. SCHMIDT: There were things among all of these different options.

MR. HACKBARTH: We can look at that and see if we --

MR. MULLER: Especially in light of the point that Arnie just made and we've been making as well on option number one. There's many heroic efforts going on in that direction. What the track record is and how much that has affected costs would be useful to repeat that, because sometimes it's just good to see what orders of magnitude one can get on that vis-a-vis some of the other steps.

MS. BURKE: As I recall, and I may be recalling incorrectly, in the context of last year's discussion around exactly this issue I think we mentioned the fact that CBO does every year the litany of ways one might address aspects of Medicare or a variety of other programs. And these options are options that have come up every year. So query whether or not -- I don't recall whether we did last year, that is reflect on or look to that in part for some of the estimates of what the impact would be if you increased cost sharing, if you do certain numbers of things.

The one thing I would note in that context, and I do think things like eligibility age, these are things have been around for a long time. With respect to things like

premiums and cost sharing, one of the things that I think ought not get lost in the scheme of things is, as we look at that, rather than simply reference what the cost might be or the reduction in expenditures might be, is what the impact is.

I think reflecting on what the income range is for this population, I think we need to, when we look at those issues, look at the full range of impact, not -- and certainly including reminding people that this is not necessarily a group that spends the winter in Palm Beach, that we really are looking for a group of people that are, as a cohort, better off than some other cohorts but are in fact not a wealthy group of people, so increasing cost sharing, increasing premiums has a disproportionate effect on some of these individuals.

So I just want to be sure, to the extent we do the list, we certainly should look at the CBO list which is available every year. But we ought to be sure that we reflect the wide range of impacts and not simply that you would save X by doing Y. I think that would be important.

MR. HACKBARTH: I agree, Sheila, that is an important point. Another point though is that the taxpayers

that foot the bill are, in many instances, struggling themselves. We see many of them losing employer-based coverage for themselves and their families and their children. It's a tough issue on many a different fronts.

MR. BERTKO: Just a point here. I think Rachel's draft is in good shape. On the Medicare market power slide here I might suggest that in addition to market power, per se, there's the leadership part which we've talked about a little bit. And also what I would call an implicit collaboration with the private sector in that many of the private insurers use Medicare fee schedules for physicians and DRGS and as Medicare makes changes there they are almost automatically swept forward into the much broader private insured sector.

DR. CROSSON: I thought the chapter is coming along very well also. I'd like to argue though on one area and that's on page 25, the paragraph on cost-effectiveness. I think I'd like to argue for a little bit stronger position there. Again, I think perhaps some clarity about comparative effectiveness versus cost effectiveness. So it starts out, I think suggesting that Medicare could help facilitate greater methodological consensus and capacity for

conducting comparative effectiveness analysis, and I would agree with that.

A little further down it says, it seems unlikely that policymakers could begin to incorporate cost or comparative effectiveness analysis in Medicare's coverage or payment policies if other payers are not doing the same. I think we could take a stronger posture than that. I would agree with that with respect to cost effectiveness. I think that's probably beyond what our culture would like to do right now in this country.

But comparative effectiveness, to say that Medicare could not lead in the area of comparative effectiveness either with coverage or payment policies, is probably too timid. I would suggest perhaps saying the opposite, that with respect to comparative effectiveness policymakers could consider analysis to promote Medicare looking at coverage or payment policies, alone without other payers.

MR. DURENBERGER: Thank you. My comment or my question is something I raise each year as I recall, but it's sort of like putting the context chapter in the context of Medicare policy as well as financing.

My first suggestion goes back to what you said earlier about two-pagers, we're now going to publish two-pagers, and for members you publish one-pagers. All I'm arguing for is the introduction be really clear, focused because the rest of the -- I just went back and reread last year's chapter and it's really well done. Quite a bit of progress gets made through this process to the final chapter. I'm merely arguing for the fact that the first couple of pages, or the summary pages, captures the essence of what we want to say, is we say it really well thereafter.

I think also the entire chapter needs, going back to what you said earlier, Glenn, needs to take on just a little bit more of a sense of urgency and less of it's another annual analytical trip through health care spending in America compared with the rest of the world. It almost leave you with a business as usual, but here are the trends. I know that's basically what we're supposed to do, so I'm only saying perhaps in the introduction or the summary or the executive summary of the chapter that would be helpful.

My third a comment is, I had difficulty understanding the interchangeability of words like

efficiency, effectiveness, productivity. I bring this up every year, somebody gives me an explanation and I still don't get it. However, when I read the nice little paper that we're going to talk about tonight at dinner, I got it. All my lights went on.

So with all due respect, I think it will be helpful to readers of this chapter after March if the general approach that we use to words like quality, efficiency, productivity and so forth in tonight's paper got translated into the way we use those same words in this paper.

If I may just one last -- this is a question basically. The context in which we do this is aimed at the seven provider or provider settings, I'm sure. But it's done in the context of new, clear Medicare policy. Last year we began the context chapter by saying in December 2003 the Congress enacted a different major Medicare reform bill. It will address major gaps in the benefit package by establishing a prescription drug benefit, et cetera.

We didn't say, unless we don't believe it, that the MMA has set the Medicare program on a very different course from the one that it has been on since 1965, from

financing providers to financing health insurance plans. That is the overall policy. While it might be posited as giving people choices, the reality is that is a new sense of direction, which means that looking at what's going on in the private sector today is even more important than looking at what might be going on in the single-payer system traditionally.

Also, the policy would at least appear to be moving from a traditional cost or charge-based payment system to more of a defined contribution. Whether anybody will admit that or not I think we can see that built into the policy challenges in the future is that, which gets me to the third point, which is the general direction of running a program which is largely third-party financed to one which is consumer financed is a reality.

So it isn't only the fact that we see an increasing burden on beneficiaries, as well illustrated by the research and analysis, it is also reality that our new Medicare policy is to move the burden of financing Medicare in the future to consumers. Therefore, as a consequence, we ought to look at what's the current impact? What is the structure of sharing costs with the consumer? The premium

level, copay level, things like that. And just raising those kinds of issues in the context of affordability, accessibility, and more importantly, equity.

There was a beautiful section last year on poverty, that kind of a context. So I think we ought to keep doing that in the name of accessibility, affordability and equity. I know that's a load to think about when this is the last time we're going to see it publicly. But it strikes me that that's, from my standpoint, that seems to be what's missing from the chapter.

MR. HACKBARTH: I want to pick up on one of your first points about urgency. I would like to go a step beyond just a dry presentation of the statistics to convey some sense of urgency about this. For me personally, I think I see signs that this is becoming a more urgent matter from the perspective of the users of the health care system and the people who pay for it, individual Americans. For a long time it's been a staple of our debate, we're a rich country. Americans value health care. We get a lot of benefits from it and they like freedom of choice. I think those have, in broad strokes, largely been true statements in the past.

But I wonder whether we're starting to see signs of a shift in that consensus, as evidenced by what I fear is maybe the beginning of the unraveling of the employer-based system of insurance coverage, both for active workers and for retirees.

In a lot of ways, as a country we concealed from the American people, how much all of this really costs, both in our public programs and through the employer-based setting. Now it's starting to come home in various ways more directly and we see people rejecting insurance even when it's offered because they simply can't afford it in the case of many low income workers and families.

I wonder whether we're not seeing the beginning of some different market signals from the American people about what they value and their trade-offs that will add to our collective sense of urgency about doing something on this front.

DR. KANE: Also we seem to not mention Medicaid at all, and yet a lot of what happens, especially on the low income side, does affect the Medicaid program even for the Medicare program as we increase the copay pay. So the whole Medicaid problem is somehow silent here, but I think we

should talk about the impact on Medicaid, even though I know it's not in our direct jurisdiction.

Also the meltdown in the private sector is being picked up increasingly by Medicaid. You can see where the private sector drops and the Medicaid program picks up, and that's coming to a head I think. So ignoring Medicaid altogether in the context I think is maybe not -- we need to start maybe mentioning what's happening on the Medicaid side too because that's been the safety valve for the meltdown, but I don't think it's going to last much longer from what you hear on the Medicaid side.

MR. SMITH: Glenn, I'd be little bit careful and reluctant I think to suggest the there's been some sort of fundamental value shift away from believing that a rich country ought to be able to provide broadly accessible and high quality health care. Evidence for that is not that someone who's working in a low-income job can't afford to pick up an expensive offered health insurance premium.

We have a lot of evidence, and Nancy pointed to Medicaid, but we've also got states now trying to figure out how to provide something approaching universal coverage. It's going on in Vermont, it's going on in Massachusetts,

it's going on in a half a dozen other states. So seems to me the value evidence here is mixed.

What is true and what I think is missing, and I think Dave got to it, what is true is that the old delivery system is melting down and that the employer-based system is revealing itself to be unsustainable. We can debate and we will be wrong, whatever conclusion we reach, about at what rate it will unravel. But the direction is clear.

Something in the context chapter which made that point and suggested that one of the challenges that the context will create is for the public sector to expand its role, as it is already trying in fits and starts to do with state Medicaid programs and with various other efforts, some of the pay-or-play stuff that states are experimenting, getting that on the table rather than suggesting that we may have ended our willingness to pay for high-quality universal health care I think would be both more accurate and more appropriate in setting the context.

MR. HACKBARTH: Just to be clear, I wasn't suggesting a conclusion that there has been a definitive shift in the consensus. Rather I think that there are some signs that may indicate that the consensus is changing.

I think that the old consensus, we want lots of health care and we want lots of free choice, was founded on the experience of a lot of people. This is a free good. So much of what we've done as a society in terms of our public policies and our private policies has been to hide the cost of health care. As people start seeing it revealed in various ways in different settings, then what they value, the expression of their values changes.

MR. SMITH: I guess that's exactly what I was quarreling with. It seems to me there is as much evidence in the current context that as the old systems of delivering the good prove themselves to be more and more inadequate, we collectively, not individually, but collectively are looking for other ways to pay for and deliver the good that we continue to value.

I think we need to be careful in moving from the stress that the collapse of the system puts on an individual household or worker, and concluding that that worker's reluctance to reach deeper into her pocket, is evidence that we are collectively unwilling to pay for health care.

I think we don't know how we're going to do it, but there's as much effort going on today to figure out how

to expand the capacity of the health care system to deliver services to people who are falling through the cracks of the old employer-based system as it deteriorates, as there is throwing up the hands saying, we've reached our limit to pay for it, we're not going to do it anymore. I don't think that's what the evidence tells us.

MR. MULLER: I would second that. I agree that the employer system is unraveling. We are trying to figure out how to collectivize it. At the same time we have enormous problems to figure out how to fund the Medicaid program, so we have this dichotomous debate going on at the state level of how do you pay for the long-term care costs that drive the Medicaid program at the same time you're trying to expand the coverage of those people who are getting thrown out of employer-based.

So exactly how that will wind up I'm not going to predict either. It's too hard. But it is interesting how many states are looking for collective solutions on this, at the same time on the other side of the newspaper article they're saying we can't afford Medicaid. So those both are going on.

MR. HACKBARTH: And if you're substituting

Medicaid for employer-based coverage you're substituting a very different sort of coverage on a variety of different dimensions.

To stay on schedule we're going to have to move ahead. Thank you, Rachel.

Next up is -- is this our last time looking at the oncology report also?

DR. SOKOLOVSKY: We hope we'll bring it back to you in December

MR. HACKBARTH: That's right, this is due in January so we do come back one more time. But we enjoy it each time.

DR. SOKOLOVSKY: As you will recall, the MMA changed the way Medicare pays for both covered outpatient drugs and drug administration services in a series of changes that began in 2004 and are still not complete. Payment rates for drugs which were paid at rates far above acquisition costs were lowered. Payments for drug administration services were increased.

Because of the importance of these drugs for the treatment of cancer the Congress directed MedPAC to study the effect of these payment changes on patient access to

chemotherapy services and quality of care. At this meeting I'll be presenting draft recommendations for your consideration.

Before I do I'd like to acknowledge Sarah Friedman who has done tremendous great work with our drug databases. I also want to note that the data are still preliminary and we have not yet spoken to CBO about spending implications for any of the draft recommendations, so the spending implications are also subject to change.

This slide is to remind you of what the Congress directed us to study, findings for some of the issues I have presented in previous sessions and they are discussed in the draft chapter. In this presentation I'm not going to talk much about beneficiary satisfaction, regional differences, and physician practices, but I'll be happy to answer any questions you might have. In the presentation I'll be focusing on the results of our analysis of partial year 2005 Medicare claims data and discuss changes in drug pricing and issues relating to quality of care.

Medicare beneficiaries make up about one-half of all oncology patients. Our analysis of part-year 2005 Medicare claims data and our site visits found that Medicare

beneficiaries continue to have access to chemotherapy services. Oncology practices continue to treat beneficiaries and patterns of care remain largely the same. Neither beneficiaries nor physicians reported any change in quality of care, however, going back to least 2004, some practices were sending beneficiaries without supplemental coverage to hospitals for chemotherapy administration.

Before I go through the results of the 2005 claims analysis I'd like to remind you briefly of the ongoing payment changes. As you recall, payments for drugs were somewhat reduced in 2004, although Medicare was still paying above acquisition costs in most cases. Payments for drug administration services were increased sharply. On top of the new rates, the Congress added transition payments of 32 percent. As a result, payments for drug administration services increased 217 percent from 2003 to 2004.

In 2005, Medicare began paying for drugs based on the average sales price methodology. Although the average the sales price is not an actual price, it is based on real transaction prices and resulted in Medicare payments that were much closer to physician acquisition costs. Transition payments for drug administration services were reduced 29

percent, but CMS introduced 14 new drug administration codes and the impact of the changes was to reduce fees for drug administration services from 2004 levels, but they remain well above 2003 rates, and physicians were able to bill codes more for each chemotherapy administration.

The agency also introduced a one-year demonstration project that involved surveying patients on the side effects of chemotherapy. I'll talk more about that later.

Here we are focusing on changes from 2003, the year before the payment changes went into effect, to 2005 after the most significant changes had been implemented. For all three years these are partial year claims data. You can see, looking at the table, that payment trends changed in 2005. While the volume of chemotherapy services and chemotherapy drugs provided to beneficiaries continue to rise in physician offices, Medicare payments for chemotherapy drugs, as intended by the legislation, fell by 19 percent despite a volume increase of 120 percent. Note this is really important, when we talk about volumes in relationship to drugs we're not only talking about more drugs but also, and much more importantly in this case,

we're talking about the replacement of older drugs by more expensive, new products.

The volume of chemotherapy drug administration services also increased, and while payments remained constant from 2004 to 2005, they increased about 182 percent from 2003 to 2005.

Most Medicare payments to medical oncologists are for drugs. The high margins that physicians received on drugs before the payment changes subsidized their offices. The MMA changes were meant to end this cross-subsidy and have Medicare pay accurately for both drugs and drug administration services.

In 2004, which is the last year for which we have full data, 72 percent of oncologists' Medicare revenue was for drugs. Although payments for drug administration services in that year increased by more than 200 percent, they continued to make up 12 percent of Medicare revenue. In 2006, CMS estimates that drug revenue will continue to make up about 70 percent of oncologists' Medicare payments, but much of the margin on these drugs is gone.

Continuing a trend, the mix of chemotherapy drugs shifted towards newer and more expensive medications. This

slide estimates the average cost per dose of chemotherapy agents used in 2004 and 2005. As you can see, the use of drugs with average costs of more than $1,000 -- and this is all in 2005 prices -- increased by 18 percent in 2005. On the other hand, use of drugs with dosages costing under $100 decreased by 12 percent. Despite the shift to a higher cost from lower cost drugs the overall number of doses that patients received declined by 4 percent.

The newer cancer drugs that have entered the market in the past few years are considerably more expensive than older drugs. For example, a round of treatment with Avastin, which is one of the most effective of the new drugs, costs about $12,000 every two weeks. Coinsurance for beneficiaries for this drug alone -- and it's not given alone, it's given with other drugs -- would be about $2,400 twice a month.

MedPAC estimates that 9 percent of beneficiaries do not have a supplemental coverage. We do not know how many beneficiaries receiving chemotherapy are fee-for-service only, but practices that we've talked to have estimated between 5 and 20 percent of their patients fit in this category. Before the payment changes, the Medicare

payment rates for drugs were more than 30 percent higher than average physician acquisition costs. If beneficiaries could not pay their 20 percent coinsurance physicians generally could continue to treat them without losing money on the drugs. Now that Medicare is paying more accurately for drugs and margins are lower, physicians may lose money in many cases if they do not collect the beneficiaries' coinsurance.

During our site visits, a number of physicians who were sending beneficiaries to hospital outpatient departments said that they could donate their services but could not afford to donate the drugs patients needed. Because the payment system has changed so much in both physician offices in hospital outpatient departments in recent years I can't quantify the difference in cost for the Medicare program and beneficiaries if they are sent to the hospital. However, historically cost for both beneficiaries and the Medicare program are higher in hospitals, and private payers told us that they paid between two and three times more when physicians sent their patient to the hospital outpatient department for chemotherapy.

This leads to draft recommendation one. The

Congress should establish an interim fund to help beneficiaries afford copayments for Part B drugs. Financing would be provided by voluntary contributions from pharmaceutical manufacturers. We estimate no spending implications but it would be helpful to both beneficiaries and physicians.

There is limited help available for Medicare beneficiaries who need assistance paying for out-of-pocket expenses, and unlike Part D there is no catastrophic cap for beneficiaries with very high drug costs. The American Kidney Fund administers a health insurance premium program to help dialysis patients with both Medigap premiums and other payment assistance. It's funded primarily through donations from dialysis providers, but administered through the foundation to ensure that aid is not linked to receiving services from any specific fund donor.

While pharmaceutical companies have patient assistant funds, the help from these programs usually goes to the uninsured and covers patients needing a specific drug from a specific manufacturer. Recent guidance from the Office of the Inspector General raised questions about conflict of interest with these programs for Medicare Part

D.

Help administered through an independent fund could provide aid more efficiently and without conflict of interest issues for Part B drugs. However, we recommend this only as an interim solution. Next year as I work on our second mandated report on Part B drugs we will look at more long-term solutions to this problem.

Based on a sample of 39 drugs which represented over 90 percent oncology billed drugs, a recent report by the Inspector General found that most physicians could purchase most drugs at the Medicare payment rate. For 32 of the drugs, the average purchase price was within 15 percent of the Medicare payment rate. Five drugs had positive margins ranging from 39 to 87 percent. Two drugs had negative margins of between 25 and 29 percent.

Practices seem to get the best buy when there was competition between name brand drugs that were considered more or less clinically equivalent. In those cases competition allowed physicians to negotiate better prices. They also has the highest margins in cases where a generic competitor became available during the year.

What we found when we added to the IG report --

tracked what happened to Medicare payment rates in the following quarters, we found that payment rates for drugs with the large margins fell sharply in the following quarters. So the Medicare payment rate went down when there was a big gap between what physicians were actually paying and the Medicare rate.

The average sales price is an average and not an actual price. It can result from all purchasers paying the same price or it could hide a wide variation in price between purchasers getting discounts and those paying much more. If the variation is wide then many physicians will not be able to purchase drugs at the Medicare rate. ASP methodology, however, could result in diminishing the margin between best price and worst price if manufacturers sought to maximize their customer base.

MedPAC, in order to test this, purchased sales data for 25 drugs used by oncologists, including both chemotherapy drugs and drugs used to treat the side effects of chemotherapy. We analyze variation in prices paid by physicians from the first quarter of 2005 to the third quarter of this year. Variation was measured by differences between the price of the 75th percentile and the 25th

percentile.

We found that the difference between the best price and the worst price declined throughout the year. The biggest change was in the spread for drugs used to treat the side effects of chemotherapy. The variation in prices for the new single source chemotherapy drugs, which were always small, changed the least. Manufacturers do appear to be narrowing the range of discounts offered to purchasers.

This leads to draft recommendation two. The Secretary should conduct a study of prices paid by the physicians in 2006 to compare payment rates and acquisition costs.

Although such a study would have no immediate effect on beneficiaries or providers it can ensure that payments for drugs are accurate.

Congress mandated that the IG analyze acquisition costs for oncology drugs during the first quarter of 2005. In that quarter ASP was calculated based on manufacturers' prices in effect before the payment system changed. The report provided an early indication that Medicare payment rates would be adequate.

A second analysis is warranted to evaluate how the

system is working following a year of experience. The IG should analyze 2006 physician acquisition costs to see how accurate Medicare drug payments are now.

Recall that in 2006 Medicare is scheduled to implement a new payment system, the competitive acquisition program or CAP. The goal of this program is to increase competition for Part B drugs. CAP vendors who would purchase large quantities of drugs could negotiate lower prices with manufacturers and produce Medicare savings. They would also eliminate financial incentives for physicians to prefer one drug over another. And thirdly, small practices that were unable to purchase drugs at the Medicare payment rate would have an alternative way of acquiring drugs.

Under this program entities like wholesalers would compete to become designated Medicare vendors for Part B drugs and each year physicians would choose whether they wanted to continue buying drugs and billing Medicare or participate in this new program.

Last month I described some of the issues raised by physicians about the CAP program and you can see them on the screen. I won't go over them now, but vendors also

questioned the viability of a business model based on the CAP regulations. In the physician final rules CMS announced changes in the CAP model and many of them are similar to those in your mailing materials. For example, they have permitted vendors to subcontract with physicians to collect coinsurance from beneficiaries. Some additional changes, however, may be warranted.

CAP rules require that drugs be delivered to the facility in which they will be delivered. Oncologists in rural areas point out that they will not be able to participate in the program because of this rule. Beneficiaries in rural areas tend to receive chemotherapy in satellite clinics.

A group practice in a central area provides chemotherapy services once or twice a week in small satellite clinics either owned by the physician or in cooperation with a local hospital. In some cases, physicians and nurses may travel up to four hours to see patients at these clinics. Sometimes they have to mix the drug at the main facility and take the drugs with them to the clinic because the clinic may not have equipment necessary to mix the drugs on-site at the satellite.

This leads to draft recommendation three, which is that the Secretary should allow an exception to the CAP delivery rules for satellite offices of rural providers.

Although this would have no spending implications it would help preserve access for beneficiaries in rural areas and allow rural providers to participate in the CAP program.

Last month we discussed the quality of the demonstration project initiated by CMS in 2005. CMS has developed a new demonstration project for 2006. These demonstration projects as a whole make it hard for MedPAC to evaluate the effects of the MMA mandated changes. In addition, there doesn't seem to be a plan for evaluating these projects.

In the 2005 project, recall practices received $130 for asking questions about nausea, pain and fatigue following chemotherapy. Our analysis of part-year claims suggest it will cost about $200 million; less than CMS had estimated.

As you recall, oncologists during our site visits said that the payments were important in helping them continue to serve Medicare beneficiaries, but they didn't

believe they would lead to improved quality or provide useful research results.

In the 2006 physician final rule CMS announced a new demonstration project. Practices must report on the reason for the patient visit, the patient's condition, and their use of clinical guidelines in treating the patient. Reporting will be through newly developed G-codes. But since these codes have not yet been released I can't really tell you exactly what they'll be reporting. Payments would be tied to a Level 2 and above E&M visits by beneficiaries with one of 13 different cancers. Only hematologists and medical oncologists would be eligible to participate. The payment would be $23, including beneficiary copayment. CMS estimates that this project would cost $150 million.

Aside from the more general concerns about these demonstration projects, this particular one raises two additional concerns, that only two specialties can bill for this project even though there are a number of other specialties that treat these same cancer patients. Also, practices that send patients to the hospital for chemotherapy can still get the benefit of these payments.

Draft recommendation four is, the Secretary should

design future demonstration projects following the standards of evaluation research, including a strategy for project evaluation.

Although this would have no direct effect on beneficiaries and providers, but if a demonstration project was designed to test care delivery options and carefully evaluated, it could lead to improved quality and delivery of care for beneficiaries and possibly program savings.

We found no indication the quality of care has been affected by the Medicare payment changes. However, there are very few consensus quality indicators for chemotherapy related services. Problems in developing them include the number of physicians that cancer patients see, the many varieties of cancer, each requiring its own treatment protocols and drug regimens, and the pace of technological change. However, there are a number of public and private initiatives to define and measure quality of cancer care and these initiatives could provide a framework for a pay-for-performance chemotherapy oncology initiative.

Let me described just two briefly. The National Quality Forum, with federal funding, has established the Quality of Cancer Measures Project bringing together panels

of experts to develop and review measures for breast cancer, colorectal cancer, and end-of-life cancer care. In addition, ASCO has developed a quality oncology practice initiative. It's based on voluntary reporting by practices on quality measures that have been developed from clinical guidelines and consensus indicators. Most of the measures are cross-cutting.

In a pilot study they found wide variation in the use of many of these measures. Currently, NCQA is in preliminary talks with ASCO to conduct an independent assessment of cancer care quality using this instrument. They would establish performance thresholds and physician practices who met the standards could get recognition as quality providers.

There is one measure that meets many of the standards that MedPAC has been looking at as a quality measure. Erythroid growth factors, which are used to treat anemia, which is a common side effect of chemotherapy. Erythropoietin has long been the product that Medicare pays the most for. Since a new product came on the market in 2002, use has increased rapidly. Expenditures by oncologists increased 33 percent from 2001 to 2002, and then

51 percent from 2002 to 2003. At the same time, safety questions have been raised about the potential underuse and overuse of these products.

ASCO has developed clinical guidelines for its use and the FDA in 2004 also changed label requirements, worrying about overuse. The ASCO project found wide variations among practitioners in the use of these products according to clinical guidelines. The guidelines set a target hemoglobin level for cancer patients and say that the private should be withheld if the hemoglobin level exceeds this level. Some local carriers have attempted to apply these guidelines, but they're hampered by lack of easy access to all relevant clinical data.

In the case of dialysis patients who also use these growth factors, providers just enter hematocrit levels on the claims form. Last week in fact CMS set a national policy for the use of growth factor for ESRD patients which is based on clinical guidelines and measuring this level.

Draft recommendation five is that the Secretary should require providers to enter patients' hemoglobin level on all claims for erythroid growth factors.

We don't measure any spending implications here,

but it could increase quality of care for beneficiaries and would create minimal additional provider burden. It meets, again, many of MedPAC criteria for a quality measure. Clinical guidelines exist, significant variation and use of the product according to the clinical guidelines exist, and it's cross-cutting measure in chemotherapy. It could reduce program spending if the data show that the products are overused.

That concludes my presentation.

MR. HACKBARTH: Just as a reminder, the votes on the recommendations will occur next month, but in addition to hearing comments on the whole of the chapter, in particular we'd like to hear any questions or issues you have with the draft recommendations so we can factor that into our preparation.

MR. MULLER: Thank you for a heroic attempt at a very difficult topic. This is one of the more complex chapters we've had in hears.

Glenn, I have comments on a couple of recommendations. Do you want me to offer them at once or do you want to do it by recommendation?

MR. HACKBARTH: My guess is that probably

recommendation one, which has to do with the creation of the fund, is probably the most controversial of the batch. So what I'd like to do is have a separate discussion on that. I'm thinking as I talk. Why don't you just go ahead. If you have issues about other recommendations just like flag those and get them all out on the table.

MR. MULLER: Let me do one and then I'll flag the other ones.

While you discuss in the chapter and in your presentation here not looking at the PhRMA assistance funds; they're largely devoted towards lower income folks, it strikes me that what we're recommending here is a pretty complex and bureaucratic mechanism to set up. The PhRMA assistance funds at least I think would have the attraction of the PhRMA companies basically give that assistance at their marginal cost. Whereas when they contribute to a general fund my guess is they think of that as a kind an average cost contribution that then may have to, as it's used to procure products may be used elsewhere and you point out the necessity for keeping some distance.

So I would think given the magnitude of the needs of the beneficiaries that are going to need assistance,

trying to get it to them, in the sense, as cheaply as possible from the point of view of PhRMA providing it would be a good thing. So I understand the problems -- and you perhaps want to elaborate on the legal issues. Who is it, the IG?

But it strikes me that with the price of the drugs going up considerably, as you pointed out, and the substitution with the proliferation of the more biologic drugs that are coming on and likely to keep coming on based on PhRMA's plans, the expense of these is only going to keep going up. Whether you have a $12,000 per regimen drug or $100,000 per regimen drug, we're going to have more of those rather than the less expensive. So thinking about how to get those to beneficiaries at marginal cost rather than average cost strikes me as a good thing.

So I would urge us to look at that one more fully and perhaps ask why the IG is problems with that. The recommendation that we have just doesn't strike me as we're going to get a lot of contributions towards that, and the bureaucracy in setting it up may not be worth the gain by a long shot. That's my comment there.

Related to that, I think it's recommendation three

-- I'm sorry, recommendation two, where we look at the pricing under the new payment system. From what the chapter says, I take it in this calculation the rebates we get off purchase are not calculated into the cost, right?

DR. SOKOLOVSKY: ASP does include rebates and the IG does include, to the best it can, rebates. We couldn't get that but they have that.

MR. MULLER: My sense is and my question in part is, to what extent to the physician practices have access to some of those rebates? Obviously, most hospitals now by and have been buying for 10, 15 years through large GPOs, so there's a big consolidation of GPOs, and I know the managed care entities do the same. Part of pricing there is the rebate after the fact based on utilization. So hospitals and health plans have access through their GPOs to those rebates, and those are significant in terms of the price. So if that is captured then that answers my question.

If physicians don't have equal access to that because they don't purchase as much in common -- and that's my hypothesis and I think -- is that accurate?

DR. SOKOLOVSKY: I think where oncologists are concerned, because drugs are so much what they do, I never

ran across an oncologist who doesn't purchase through a GPO. When we talk about other specialties who also use Part B drugs then they don't.

MR. MULLER: Do they roughly get, in percentage terms, the same kind of pricing power that Jay gets or John gets or big hospitals get? My guess is it would be less, unless they do it as some kind of a larger grouping.

DR. SOKOLOVSKY: Nobody is going to tell me what kind of rebates they get. And if they told me --

MR. MULLER: You'd be more valuable as a MedPAC analyst.

[Laughter.]

MR. MULLER: I can understand why they have some concerns about what you call the CAP, the acronym, because they don't want to get into that. But I would just think that the rebate question is the biggest part of the pricing question, and how we get a handle on that and whether they get access to that or not. I'm hypothesizing they get much less access to rebates than larger purchasing organizations do just by market power.

But if they get close, then in fact the rates that they're getting who would allow for some of that cross-

subsidy that we're concerned about has been eroded as a result of going to this pricing system. Because my guess is that on some of these drugs the beneficiaries are just going to lose access. To the extent to which -- and my guess is also that the hospitals will continue to keep, through cross-subsidies, the access to beneficiaries going.

If the physicians can't and people drop out then we're going to have a real access problem. If in fact they have good access to rebates, and therefore the price that they're getting is more of a margin that we're now reporting, they may have room to cross-subsidize. So that's the kind of extended question that I'm asking is, to what extent is that capacity to cross-subsidize patients that was built into the old system still available in the new system, because as your results indicate, the prices went down a bit from the first to the last quarter. So the intent of the policy seems to -- being secured. But there may still be margins in there that we don't know about.

DR. MILLER: I think that's the objective of this recommendation, is to ask the IG to look behind it a second time here and see how much spread there is still left in there. Is that about right, Joan?

DR. SOKOLOVSKY: Yes, because they do have the power to get at the rebates.

DR. MILLER: Your line of reasoning is, I think well taken. I think the question is, how much is in there and are they getting closer to the larger discounts or smaller discounts?

MR. MULLER: I'll come back later on recommendation five. It's of much less importance so let's have this conversation first.

MR. HACKBARTH: Having thought about how to proceed here, I think it would be useful if we could maybe focus on recommendation one for a second, the creation of the fund. So let me ask, is there anybody else who wants to speak to that?

MS. DePARLE: I felt this section was interesting because you noted in your description of it that there are other funds that have been established for other conditions. I know in the last year for macular degeneration, the companies who are offering those drugs got together and worked with -- what's the name of the group?

DR. SCHMIDT: Patient Advocacy.

MS. DePARLE: Yes. I guess that makes me curious

and I think you said you don't know exactly how big of a problem this is. I certainly have no objection to Congress establishing a fund. But I guess I'm curious as to how big a problem it really is for the beneficiaries. What's really happening out there?

Secondly, I'm not sure it's necessary for Congress to do this. I think there is a safe harbor under which the ESRD companies operate and also the others who have done it with this patient forum, patient group, so I'm not sure it really is necessary for Congress to do this. I'm just interested, have you talked to any of the manufacturers to see if they have considered this? I'd be surprised if they haven't.

DR. SOKOLOVSKY: I have not yet spoken to manufacturers. They do contribute about $4 billion to patient assistance funds, but the IG guidance came out last week saying that there is some question about the individual assistance programs. That's mainly about Part D, but some of the same issues could arise with Part B because it is drug by drug.

MS. DePARLE: I understand that, but they could all go together and put it in a fund. I guess I'm just

wondering, do you really need Congress to do this? Or couldn't they themselves go together and put together a fund? Maybe that's too much but --

Again, it just leads me to be curious about how big an issue is this? And if it isn't, then how are they paying the copays, because they do seem on some of these drugs that they would be huge. I just find myself with more questions than answers here I guess.

DR. SCANLON: I guess I may be in the same position as Nancy-Ann and I do more about the Congress addressing this specific issue because I think there's the broader issue of the potential copayment liability that beneficiaries have under Part B. That it can be unlimited and cancer patients are one potential group that are going to have high costs. But there are others too.

If we were to get the Congress's attention to this issue I would hope that they would think about it in the broader context in providing relief for anybody that has a catastrophic expense, and maybe at the same time, in our context of the Medicare cost for the long run, thinking about rationalizing cost sharing more. We've got the standardized Medigap policies. Maybe we need to think about

changing them so there is less first dollar coverage. In fact this is one of the CBO's suggestions in terms of their budget options is to change that. That would be one concern.

The second is the issue of, does this reduce again some of the pressure to keep costs down? If drug manufacturers are making contributions to cover the only group of people that are going to have trouble paying their bill, does that take away some of the pressure from them raising prices even higher?

When Ralph was talking about average costs and marginal costs and cross-subsidization, to an extent I would agree with what he said. But I also worry about that in the context of drugs, do those terms really apply as much as they do with respect to other services? Because we may have average costs, but we also have the potential rents that are added to the prices that drug manufacturers charge.

It's been very clear, looking internationally, that drug manufacturers charge what the market will bear. Our market has been more tolerant than any other market in the world. This fund potentially would make it even more tolerant so I worry about it from that perspective.

The last thing I would say is, as an interim solution in terms of that we're going to come back in a year and talk about this in a broader context, nothing's going to happen in the interim. The Congress has finished this year. This would be something that would be the end of next year. It would take a while for it to be implemented. I would say, let us focus on the bigger picture before we go ahead with something.

MR. HACKBARTH: Bob Reischauer can't be here today because of a board meeting conflict but Mark did have a chance yesterday to talk to Bob about this issue and he has some thoughts.

DR. MILLER: He also has major problems with this recommendation. Most of the arguments I think have been mentioned one way or the other, but very quickly: why this particular service or this particular disease and not others? Should we be thinking about a bigger fix along the lines that you're talking about having something either supplemental coverage or catastrophic coverage, that type of thing? Why the manufactures would contribute to something like this? Some of the kind of marginal price, average price issue. Does it change their pressures for lowering

their prices as opposed to getting this assistance?

So there was a whole range of arguments there and I don't think he was comfortable with this recommendation.

MR. HACKBARTH: Any other comments on recommendation one?

DR. NELSON: Only if we don't like it, we ought to come up with some other alternative solution, other than just we're price tolerant in this country. We ought to put ourselves in the position of a patient who has cancer who has a possible life-sustaining treatment that they forego because it's impoverishing their family and whether the solution is for us to recommend that copayments for chemotherapy not be required.

There are a variety of solutions: price controls. There are a whole host of things, none of which I like. But among the alternatives that would protect the beneficiary who has to choose between life and death this seemed to me to be the most acceptable.

MR. HACKBARTH: Although as Bill points out, unfortunately the issue is not unique to cancer patients, and it's a much broader issue of how we share the responsibilities for financing care.

DR. NELSON: To some degree it is unique. In end-stage renal disease it's pretty hard to think where the choice between a treatment that will very likely help is not as direct and proximate, and where the financial consequences can be so overwhelming.

MR. HACKBARTH: Other comments on recommendation one?

Okay, now will return to the original list.

DR. CROSSON: Thank you.

Joan, I just had a clarification question between slides six and eight. It has to do with what has happened to the volume of services. On slides six, in the second line, the number of drug administration services between '04 and '05 rose 30 percent, from 2.3 million to 2.9 million. The number of drug units rose from 19 million to 24 million.

On slide eight, at the bottom there, between '04 and '05, the number of doses fell from 2.1 million to 2 million. So we're obviously measuring three different things. Could you help me understand what those are?

DR. SOKOLOVSKY: Yes, I think I can. You're right, this is wildly complicated. What the problem here is on slide six, we talked about units. Units are in Medicare

payment units, so that Medicare pays on the basis of certain units. But you may need 100 of those units for one dose. So these are payment units.

On slide eight we had to figure out what to call them because what they actually are are lines on claims. So it's the quantity plus the cost of the dose. It's how much was given each time.

So the first one is measuring Medicare in terms of Medicare payment units. This one is measuring in terms of the total amount that people are receiving based on their price. Remember, volume for drugs includes, if it's a more expensive drug it doesn't count as price, it counts as volume.

DR. MILLER: Since I asked Joan to change the slide from lines to dose because we didn't think anybody would understand what lines meant, doses could be going down while the units per dose could be going up. That may be part of the explanation. And to the extent that you're providing a more expensive or newer drug, its value is higher and that would look like an increase in units.

Joan, I apologize for making you change it.

DR. SOKOLOVSKY: It's true, but using an entire

month I can come up with some way to make this actually explainable to people.

DR. CROSSON: The term unit is defined in dollars not in milligrams or something? Unit means what exactly?

DR. SOKOLOVSKY: Unit on the first slide is the Medicare payment unit. So Medicare pays for say drug A in terms of 6 milligrams is one payment unit.

Over here it's about how many payment units does it take to make a dose?

DR. CROSSON: That would imply that the milligrams are increasing. But that could be a function of changing from one basket of drugs to another basket of drugs?

DR. SOKOLOVSKY: Yes.

DR. CROSSON: Thanks.

MR. BERTKO: Can I ask a related question?

I understand the claim line part. The question now would be wouldn't drug administrative services be closely correlated with the number of claim lines? Or is that yet something quite different?

DR. MILLER: I think that's true. Both of those are going up, although the percentage increases are not as -- so if I'm understanding your question, I thought what you

just said is row two and row four should be related?

MR. BERTKO: No. Page six, row two with page eight total. Claim lines being administration of the drug and administrative services, I would think with an administration of a drug.

DR. SOKOLOVSKY: I can explain this one, too.

You can get drug administration payments for giving the drugs that are for the side effects of chemotherapy. The drugs we are looking at are just the chemotherapy drugs.

MS. BURKE: I want to go back to the discussion. First let me ask a question and then I want to talk about the demonstration Project issue.

In looking at the pricing issues going forward, what percentage of these drugs -- certainly the ones that are most frequently utilized, the actual cancer drugs not the drugs that are used to treat the other conditions that are present -- what percentage of them actually have competitors? In how many cases are they essentially largely singular, in terms of their availability?

DR. SOKOLOVSKY: The older ones have competitors. The newer ones have no competitors. One of the things that

happened, and one of the reasons why there are, I think, pretty big savings this year in drugs is that two of the most common chemotherapy drugs this year got competitors.

MS. BURKE: Let me ask one other question, I'm sorry.

With respect to the requirement that the actual delivery of the drugs occur in the same place as they're prepared or the reverse, that they're prepared in the same place that they're actually delivered, what is the background to that particular issue? I know in the recommendation with respect to rural areas, the recommendation certainly makes sense to me. What I want to make sure I fully understand what the reasoning was behind the original requirement? Was it a safety issue? Was it a quality issue? What was it?

DR. SOKOLOVSKY: My understanding was that it was a problem about possible fraud.

MS. BURKE: Fraud in terms of --

DR. SOKOLOVSKY: That you could be collecting these drugs and then reselling them perhaps, or using them in other places. But I don't know this for sure. I really don't know for certain.

MS. BURKE: It would be helpful to understand a little more behind the concern. I guess I could certainly understand that there might be a question of fraud, although it's hard to imagine that they'd be used for things other than what they were intended, but perhaps they might.

That would be helpful to know. I certainly think there are rural issues that ought to be dealt with and I'm certainly not uncomfortable with the recommendation. But before we go down the road of exception, it would be helpful to understand what the fundamental question was so we knew whether or not it had to be dealt with by exception or whether or not the fundamental rule perhaps wasn't entirely necessary.

The last issue that I wanted to raise, and I think I raised this last time, but I continue to be very concerned about it, is this whole issue of what appear to be an attempt through a demonstration to essentially replace income. And that the demonstrations really are not designed nor likely to lead to behavioral changes that ultimately are to the benefit of the program or the beneficiary.

I wonder whether or not there isn't a stronger statement to be made. I certainly agree that we ought to

suggest that demonstrations ought to be based and designed so that there are evaluation criteria in place that makes sense. But it is really this more fundamental question which is what are we really try to achieve here?

I think that demonstrations that really are designed to encourage certain kinds of behaviors, that are based on certain expectations in terms of the presence of certain conditions or the follow up by physicians of certain kinds of behaviors make absolutely sense, that encourage certain kinds of things.

But we seem to be continuing down the road here where they are really just an attempt to fill in a certain amount of money. And I am really troubled by the suggestion that they be limited to only two groups of physicians when, in fact, there are large number of other physicians potentially involved here.

So there are a whole host of things that I'm concerned about, in terms of the design. But I wonder if it isn't time to make a much stronger statement because we seem to see these things -- I mean this is not new, that is the demonstration that sort of seems to not have a point and not likely to give us much information. But this one seems to

be particularly egregious to me.

MR. HACKBARTH: In particular in the case of the original version, with the large payment for just asking several questions, part of what concerned me about that was that it basically made it impossible for us to determine whether the changes in Medicare payment policy, changes in how we pay for drugs and the increase in payments for administration, what the effect would be on access to quality care because they basically filled in the hole that was created, the financial hole.

And so now we're a couple of years into this and we still really can't say what the long-run steady state effect of these policy changes would be on access to quality care because it's all been confounded by the demo dollars.

I share your concerns about how this was done.

DR. MILLER: On this point, you are right that the recommendation as drafted is the Secretary should use demonstrations for these kinds of things. It's very analytical and dry and all of that.

We could think about changing the words of the recommendation. Or in the rationale that always follows the recommendation we can make this point of you asked us to

study it, then you get in the way. You're using demonstrations -- the Commission could find the words here -- feel strongly this is not what a demonstration should be used -- or even more strong language than that.

And we could draft a rationale, bring that to the next meeting, and rather than vote on the words just have it follow the recommendation.

MS. BURKE: I think I would, in fact, lean in that direction, Mark. I think you're right. I think it is not simply the wording of the recommendation but it is a much shorter statement that surrounds it, in terms of what our concerns are. It's not just specific to this particular demo, it is the broader policy.

I mean $150 million may not seem like a lot of money to be throwing at this, but in the scheme of things it's a lot of money that could be used for a whole lot of other things.

It is the broad question about how they design them. It is the particular question in this instance that I think is troubling and has, in fact, clouded this fundamental question that we were asked. But it is this broader question of every time we do this we cloud the

broader question of let's use demonstration money to really encourage certain kinds of behaviors and then measure what, in fact, occurs.

So I think your suggestion that we do a recommendation and perhaps change the terminology a bit, also there's a very strong statement that surrounds that I think would be something that I would like us to be able to look at.

DR. SCANLON: Actually, it's on the same two points that Sheila raised.

With respect to the rural satellite offices, I too would like to know more about what is really behind it because it implied some knowledge that CMS would have of what's happening with physicians' practices that I never believe that they ever had in the past.

We dealt with home health agencies and tried to deal with branches versus satellite offices and nobody had a clue as to what was going on.

There's a question here of what they worried about and would they actually be able to manage it if they went forward with this particular approach.

The second thing is with respect to the

demonstrations, and I think that our language right now is probably too polite. Talking about it in terms of evaluations, I think, doesn't also capture the fact that we have a tradition in both Medicare and Medicaid with respect to demonstrations, that they're meant to improve the efficiency and the quality of the program, that they always by tradition had a budget neutrality requirement which this clearly did not satisfy that, that there's issues of beneficiary protections. There appears to be no informed consent here, in the sense that I'm going to ask you these questions and then you're going to have to do the copay. I mean, that's not something that has been a part of this.

And then fundamentally there's a question of what are we waiving here? In part of this we're paying for something that may not be medically necessary. That's a pretty fundamental thing to waive in terms of Medicare payment.

I think maybe a little bit more in the wording of the recommendation itself, but I think your idea that a very strong rationale will help a lot.

DR. WOLTER: I just had a couple of observations that are maybe for future thought. But it's very striking

to me what percentage of oncologist revenues come from drug and administration. I mean 84 percent, which is extremely at one end of the Bell curve for how physician payment works.

I think inevitably that creates some issues in terms of focus and how people look at their overall book of business that does concern me.

And somehow related to the conversation we just had, just to connect some dots, I think that there are some underlying problems in the E&M codes for oncologists in terms of practice and work expense. I know when we look at oncology income, this whole drug profitability distorts so much how we compare what our oncologists expect to make because they compare themselves to private practices and the way physicians are paid in academic centers or group practices is quite a bit different than what might occur in private practices.

So if you have a fundamental undervaluing of some kind in the E&M code area there's the natural tendency to capitalize on the opportunities you might have in terms of drug pricing. So those are issues where we might connect the dots.

I know we are going to looking at the RVU process and also at issues around practice expense, and that's a good thing. But these things are very related if you look at the big picture of how the total budget for an oncology program is put together.

Then I was also just thinking about the issue of how complex the whole oncology drug situation is becoming, how many drugs there are, how important the side effects are, how important the drug interactions are.

One of the major focus of the 100,000 lives campaign that was launched by HI has to do with medication reconciliation. It just seems to me that inevitably the more places in which these types of drugs are administered when we don't have any monitoring system whatsoever, the more we don't know about what kinds of side effects and medication problems we're having because we really don't have a way to monitor, I think, in these many, many hundreds of places where these drugs are now administered. I think that's a quality problem about which we really don't have any information.

So we've done a great job, and Joan has done a wonderful job, analyzing a complex issue which is privately

around drug pricing. But the connection to these other issues, I think, is very important as well.

DR. STOWERS: My thoughts kind of go back to what Sheila and Bill were saying about the recommendation number four and the demonstration project. To me, even though it's under the guise or umbrella of research, it seems like to me the collection of quality data, no matter what field it's in, is essentially a type of research where we're trying to come back and affect quality.

So I don't really see that as being different or have a hard time understanding why we're going down a policy path here. I think not so much demonstrating research but demonstrating a different payment methodology for collection of data that's entirely different pathway, as Bill mentioned it's not budget neutral. It's not coming out of a pool. It's an add-on payment per visit.

I think it's been stated many times, even the particular individuals who are using it are not endorsing it as a good way to change quality. If it really is needed as an increased payment because of what Nick's talking about of a problem with the RVUs for E&M then I think we ought to be coming out and saying that. But going down this pathway of

a different way of paying for quality and quality data, and us endorsing that at this point, I think is a very risky path that I think we need to make very clear in this chapter that we're not endorsing at this point, unless we're going to endorse it for medicine as a whole.

I think there's a lot of specialties out there that would like to have guaranteed $20 add-on payment per visit, which would be a 50 percent increase in their E&M, to provide that amount of data.

I just think I agree that that whole thing needs to be dealt with a lot stronger back to Congress than what I think maybe what we've been doing. We're just getting behind this and continuing to endorse this kind of separate demonstration project, I think is a mistake for the Commission to do.

DR. KANE: I am kind of picking up on something Alan said, so I may be a little out of sync because I may be going back to recommendation one but I'm not so sure.

Do we know if people are choosing between life and death? And do we know what happens with the beneficiaries without supplemental coverage? And maybe we should recommend that we should find out.

I think we have something of an obligation in that they are unique in that this is the result of a change in a payment method that may put them at higher financial risk. That people without supplemental coverage are now, because they've changed the way you're paying for drugs, they're now at a higher financial risk than they were before.

And would that merit a special opportunity to see how are they adapting to that change, those who don't have supplemental coverage? Are they choosing to die? Are they choosing to go into bankruptcy? Are they putting pressure on the hospitals to absorb it as bad debt or free care? Are the hospitals going to the PhRMA companies and getting them to donate the drugs in the situations that occur?

Do we know anything about that? And can we find out?

If you're going to change the payment policy, this seems like one of the things you really do need to look into in some greater detail and not just say Part B people are high risk of financial -- we changed the policy and therefore these people are facing a much higher financial risk than when physicians felt they had drugs -- were subsidizing the provision of these services with profits

from other drugs. And maybe I'm mixing up when you've gone to the average sales -- the doctors are saying we used to be able to handle this and now we can't because we don't have the profits from the drugs.

DR. SCANLON: I think that the last point you made, in part, is where the people without supplementary insurance may end up being better off if the physician actually was waiving the copay.

But other than that, people with supplemental coverage could be better off because of the policy change because average sales price is so much lower than what average wholesale price was. It was true in the past that beneficiaries were paying, through the 20 percent co-pay, more than the cost of the drug in some instances.

But there's another part of the problem here, too, which is what Joan has talked about, which is the newer drugs coming in that are much more expensive creating a new problem which is not related to Medicare policy but a new problem for people without supplementary insurance.

MR. HACKBARTH: Thank you, Joan.

DR. CROSSON: Separate the administration costs and what the physician can underwrite from the enormously

expensive new drugs that have come online since the pricing thing went in. It's not a matter of whether the physician is willing to accept waiving the copay. It's whether or not the physician can afford to buy the drug.

MR. HACKBARTH: The next topic is care coordination.

MS. MILGATE: We know that beneficiaries see multiple physicians and we know that seeing multiple physicians could increase the need for care coordination. So in our analysis of strategies to better coordinate care, we wanted to know how many physicians beneficiaries see and whether this varies by different types of beneficiaries.

This information will help us identify who is most in need of care coordination and develop strategies that best support both beneficiaries and physicians to better coordinate care. This information will also help us in considering the best attribution methods for pay for performance and specifically for our resource use analysis.

Seeing multiple physicians could increase the need for coordination because it increases the need for communication across the various providers that beneficiaries see. It also puts beneficiaries at greater

risk for duplication of services. It could also increase health care costs as beneficiaries see more providers and increase the potential for adverse events potentially.

A recent Commonwealth survey found when they surveyed patients, that patients who saw multiple physicians were more likely to say that they experienced adverse events.

So what we did was take a 5 percent sample of inpatient, outpatient and physician supplier file 2003 claims. We looked at all beneficiaries except those outside the United States. And then we grouped them into mutually exclusive categories of beneficiaries with various combinations of diabetes, coronary artery disease and congestive heart failure.

What we did was then combine the groupings so we had those with all three of those conditions, those with various combinations of two of those conditions and those beneficiaries with only one of those conditions and neither of the other. And then we observed the prevalence of those conditions in the Medicare population, the amount of dollars that went for different types of services and the number of physicians seen by various indicators.

Some caveats before I go any further are that this analysis did depend fairly highly on the use of the unique identifier on claims and some physicians use a group UPIN at various point in time and use an individual at other points. So it could either be an overcount or an undercount, depending upon those practices.

In addition, we're also relying on the accuracy of the diagnosis codes on claims. And there is some concern over whether those diagnoses are always accurately coded.

Here this is just a descriptive table of what we found. Down the left-hand side you can see our various categories of groups. Again, this is a 5 percent sample. The first row there is the total beneficiaries in the file. The second is the no condition assigned. So you can see that 68 percent of those in the file were not assigned to any of those conditioned groupings.

The next row down, you see that 32 percent actually were assigned to either having one of those conditions, two of those conditions. or there were some beneficiaries with all three of those conditions.

Just to look at that in relationship to the payments, you want to look at the middle row there that's

total in groups for diabetes, CAD and CHF. You see that 61 percent of all payments were for these 32 percent of beneficiaries. If you just look at inpatient payments, it ends up being 70 percent of those payments. And then if you look at the physician supplier file payments it's 51 percent.

I should note, just to make sure it's clear on the physician supplier file payments, those include fee scheduled payments as well as labs, tests, ASC payments. So it's more than just a fee schedule dollars there.

The reason it says draft number is subject to change on the bottom, just to note, is there's a piece of the physician fee schedule payment around 4 percent that we're trying to track down. There was a discrepancy between our members and the Trustees on like 4 percent of the physician fee schedule payments. So there may be some change but nothing major.

So when we looked at the number of physicians seen, we found that on average beneficiaries see five physicians. Those in our chronic condition groupings, on average, saw seven physicians. And then, when we looked at those with all three conditions on average they saw 13

physicians in that one year.

We wanted to get behind those averages a little bit to look at exactly how many physicians were beneficiaries seeing. so we broke them into two categories here on this slide. The blue line is beneficiaries who saw five or fewer physicians in 2003. The yellow-green part of the bars are beneficiaries who saw more than 10 physicians in 2003.

You can see the bar on the left that is the group of beneficiaries had none of these conditions, 76 percent of them saw five or fewer physicians. And then you go down to those that were in our groupings, that's compared to 48 percent of those. And then you can see then with all three conditions that number goes down quite a bit.

On the other end of the spectrum, those beneficiaries with three conditions, 61 percent of them saw 10 or more physicians in 2003. Of course, the light green goes up, depending upon how many physicians.

We took another metric by looking at the actual percentage of an individual's physician care that was billed to one physician. Just a reminder, this is still physician supplier file dollars, so I'm going to use the term

physician payments but it really includes a little more than that.

So here we looked at the proportion of all spending billed by one physician by number of conditions and found that for those who had no condition assigned, so that's the second green bar there, 65 percent of those beneficiaries with none of these conditions had 50 to 100 percent of their care billed to one physician. So a fairly relatively high number. That's compared to 47 percent, which is the number for the total in groups.

And then for those with three conditions, that number of beneficiaries goes down to 25 percent. So 25 percent of those with the three conditions had 50 to 100 percent billed by one physician, which of course means that they're seeing multiple physicians.

An even finer breakdown is on this slide because we found that while we wanted to look at how many dollars were actually for care associated with the condition that put them in the grouping, so here we looked at the line item diagnoses that was associated with certain CPT codes that was, say if it was diabetes only, those line item diagnosis claims that were related to diabetes care, or for those with

three conditions those that were for any of those three conditions, and found much more concentration, meaning that beneficiaries seemed to be seeing generally fewer physicians for care for their particular condition.

So here you see the green bar on the left is the total in all the groups. So that's the average for anyone who had any of those combinations of chronic conditions. 83 percent of those people had 50 to 100 percent of their physician care with one physician. You see it's higher if you have just one condition. And it goes down to 49 percent if beneficiaries had those three conditions, which relatively speaking is still a fairly high number, 49 percent of them had 50 to 100 percent of their care billed with one physician.

Just to give you some sense of how much other care they're getting with the other physicians they're seeing, we found that when we compared the physician fee schedule spending overall two the physician fee schedule spending for just their conditions that the condition spending was about 20 to 30 percent of their spending. So they're getting a lot of other services for other things that just their conditions.

In summary, beneficiaries see multiple physicians. Those with multiple conditions see more physicians. Some physicians are more central than others to any individual beneficiary's care. And beneficiaries with chronic conditions tend to see relatively few for care related to those conditions.

The implications are, I think, that it shows that there is a need for care coordination. It also gives us some information on which beneficiaries might be most in need of those services and could help us consider strategies for beneficiary care coordination.

We'd appreciate your thoughts on what you think these data tell us about those strategies.

MR. BERTKO: Just a quick maybe suggestion, Karen, for a follow-up here. One of the things that I think a number of us who use these attribution rules do in the private sector is to lower the threshold perhaps to 30 percent down from 50 percent to get what I might term a dominant physician. Because when you get to 10 or more physicians cutting them up into pieces makes it increasingly difficult for any single physician to move up. I'd look to my colleagues here to say would a 30 percent threshold still

be a pretty good identifier of that dominant physician? And showing that just maybe in addition to what you've shown us today might be useful.

MR. MULLER: I assume that this sample is off the fee-for-service beneficiaries?

MS. MILGATE: We pulled anyone in who had a claim. So if you were in Medicare Advantage for even part of the year, you could have a claim here. But we did find, in analyzing our enrollment file and who got pulled in, that very few Medicare Advantage did get pulled in. But it is going to be mostly fee-for-service, yes.

MR. MULLER: I was wondering -- I'm trying to remember what period you're looking at -- whether you had enough of -- if there was comparative evidence on what would happen on M+C compared to this population in terms of coordination of care. Because I think one of the assumptions in the whole managed care strategy is that you get better coordination of care than one does in the fee-for-service system, and whether we -- I understand the difficulty in getting data on that, so maybe some of our colleagues could speak to it. But that would be something that would be interesting to look at prospectively, as well.

Secondly, when you look at those kind of conditions, given the specialty nature of America in world medicine these days, you expect people to go to different physicians for these different conditions. So it doesn't surprise me so much that you have that kind of multiplication of physicians with these conditions.

Thinking about how one coordinates across those specialties, aside from signing back to primary care physicians, is going to be a real challenge in terms of policy recommendations here. Because by and large they don't coordinate -- as your data indicates, coordination is not done that well across those specialty ranks. So I think we've got a real challenge here in front of us as to who exactly we are hypothesizing is going to provide the service, unless we go back to some of the thinking of 10 or 12 years ago when we were trying to have the primary care physician be more of the coordinator of care.

A lot of that went the way of -- along with capitation, it kind of went out the door.

MS. BURKE: Glenn, can I follow up on that just for a moment?

One of the things, and I was just going back to see if I can find it. One of the things that concerns me a little bit about looking at this without some real understanding of what we're seeing, is that on the face of it when you say someone's seeing 15 physicians, it's sort of a stunning number. And I understand that we're looking at concentration. To what extent are they seeing -- within that group who do they see and to what extent?

But there is an understanding of what that pattern really tells us, to Ralph's point.

There is some aspect of this, arguably, that we would believe to be appropriate. That in fact, they're being referred to people for very appropriate reasons, the assumption being that not any one physician can deal with every single thing.

MR. MULLER: If you're having a surgery, my guess is you're going to count the surgeon, the anesthesiologist, the pathologist, the radiologist. That's four docs; right?

MS. BURKE: That's at least four.

MR. MULLER: That's at least four. So I mean in that sense, as we've discussed in other chapters and I don't want to go into it too much, the clustering around episodes

and so forth, it would be helpful in this because obviously like any major outpatient or inpatient procedure, you're up to four doctors just like that.

MS. BURKE: Right. And so I think this is a fascinating thing to begin to look at and to look at what the implications are for coordination. But I worry about not taking it too literally without looking at what it's really telling us, in terms of what behaviors are appropriate and what are not appropriate, and what kinds of referral patterns exist.

Because again, I think there's a lot of this that you would assume. If you're having surgery, then you've got everybody that you walk past on your way in the door and everybody you walk past on the way out is billing for some piece of the action.

And so I just want us to be sure to really understand it before we raise suddenly we're concerned that people are seeing 15 docs routinely. I think some better understanding of that would be helpful.

MS. MILGATE: I want to say, I don't think we were trying to imply at all that the numbers are inappropriate because they may very well be necessary. But they do show

that there is a need for there to be some coordination among. It makes you feel like there is unnecessary care, but that wasn't it.

DR. WOLTER: Well, the comments I would make are, when I look at what I would consider some of the better provider groups in terms of how they tackle coordinating care, there's a lot of emphasis on nursing, a lot of emphasis on pharmacy. And the real issue is once you look at all of these numbers, what's happening underneath that?

Certainly, the importance of a medical home and a physician, maybe a primary care physician, who feels they're the champion of this is there. But really I think where the action is is at that level of whose educating? Whose doing medication reconciliation? Who's making sure that the follow up instructions, et cetera, are done. There are certainly many other issues. In most of the fragmented models of health care we have around the country, all of these different offices are not sharing information systems, et cetera. So I suspect there are real issues of coordination.

But how do we get beyond this information and then tackle the issue of how we utilize nursing and pharmacy and

others who oftentimes are really where the action is?

And then the other area where I think there's a lot of potential is the importance of the family themselves in helping to coordinate care. That's quite helpful in some cases and not really available in others.

DR. MILLER: Nick, could you just give me one more pass? I understood the family point, but could you just give me one more pass on the nursing, pharmacy, what you're thinking is behind it?

DR. WOLTER: For example, if you take a complex patient with diabetes in our particular organization, the way that patient really has their care coordinated between visits to a physician is through the diabetic educators, in many cases through a nurse case manager. In our oncology program, and of course most of our oncology patients are seeing a medical oncologist, a radiation oncologist, a surgeon, in some cases other specialists as well. We actually have a number of nursing oncology case managers now who really are there to be the patient advocate in terms of coordinating their care across all of those visits.

We have other advantages in terms of common information systems and that kind of thing.

But if you don't tackle it at that level, it's very hard to create the coordination because for the most part the physicians are very busy. They're the champions. They're directing the care. But the systematic tactics underneath that that have to be in place to really allow the coordination of care to occur are quite significant.

Of course, there are issues in the reimbursement system too in that more often than not there's not reimbursement that covers that kind of systematic infrastructure build. Does that help?

DR. MILLER: I now follow what you said.

MR. HACKBARTH: So in your situation, where there are physicians in the same practice with shared information systems, you still have the additional resource of nurse case managers and other people to help. Obviously, the problems of coordination are multiplied when you're not talking about physicians in the same practice on shared information systems and they don't have any nurse coordinators to help. It's a big issue.

DR. STOWERS: I thought it was a great chapter. It opened a lot of questions. Even that total number, until you really stop and think about it, takes you back into how

many physicians they're seeing.

But to me it raised a lot of curious questions. One of them would be if we couldn't break the data down a little further and maybe look at urban versus rural. Is there a difference in the number of physicians that they see as related to the lower cost per beneficiary in some regions?

And also, something we've talked about for a long time is how does the size of the practice affect the cost of care and the referral patterns? Is this solo, one or two physician practice, a lot less likely to have them seeing a larger number of physicians, as opposed to a large group practice that might refer around within that group?

And then that would have to be broken down a little bit, I think, to see whether it's increased actual referrals or, in a large group there tends to be a lot more shared coverage. So it might be that I'm the primary physician but I'm not available in certain hours, so other people in the group are just seeing them. So there's a difference, I think, in the coverage of the number of physician that are on the list as versus to increased referrals, which might lead to increased testing and other

increased costs to that.

And then the third point, to me, would be interesting would be to break it down geographically a little bit into certain areas of the country. And geographically, you might want to break it down into those areas where the costs per beneficiary is high as opposed to those where the costs per beneficiaries is a lot lower and try to see some correlation between referral patterns and the costs overall.

And then in the end, we say that increased spending doesn't necessarily improve the quality of care and we're probably not there to demonstrate this. But does increased number of physicians that the patient is seeing with increased costs really relate to the increased outcome in the end? Because it may be worth paying to see more physicians in the end. But if in the end it's not increasing the quality, then maybe it's something we need to be looking at.

Those are just some thoughts that I think we can really expand this on further.

MS. MILGATE: I think all three, the urban versus rural, the geographic and the quality relationship, either

separate analysis or through our resource use analysis, we can certainly begin to look at that.

The problem with the size of the practice is one outstanding question we still have is whether we can even identify if a physician is billing as part of a group or on their own is one question. And then looking at the size underneath that, I don't think that we have the data to actually look at that.

DR. STOWERS: I think that would have to be done on a smaller scale where you actually analyze X number of groups.

MS. MILGATE: So actually just ask the groups if we could look at their data?

DR. STOWERS: Exactly. Or you can separate out the -- you know the names of the physicians that are in large groups and that kind of thing, as opposed to those that are not. And then you could run the number of visits related to those physicians or whatever.

I know it would be harder but I think it would give us a lot of insight into referral patterns.

MS. MILGATE: Okay, we can think about it.

MS. HANSEN: My comments are probably going to be

very parallel, Nick, to some of the things that you brought up with the comorbidities of individuals that perhaps the subtext of the care coordination is with pharmacists and geropharmacists in particular, as well as nurses and nurse practitioners dealing with the care coordination.

It's interesting, I have students right now in hospitals that are taking care of older individuals with multiple diagnoses who are actually being prescribed 25 to 30 medications each daily. The whole aspect of cost and quality really does need to be drilled down differently in addition to the description of the physician side.

It raises to me the question of looking at total costs, the concept of care coordination, whether it can be expanded to use other practitioners such as nurses or nurse practitioners to be able to do this.

And then also, the cost of bringing in the specialties of pharmacy, in particular geropharmacists who would understand this because it's so -- what comes about to what I would say the unintended consequences sometimes when you have somebody on 30 medications a day, which does happen now. The whole issue of quality really gets raised in terms of the outcome of the patient.

So it raises something. It doesn't really address this particular aspect, but I would say care coordination is a much more encompassing aspect if we're looking at the quality of impact at the patient level.

MR. SMITH: Ray anticipated a lot of what I wanted to day, so I won't repeat it.

I found myself more struck than most of my colleagues have by the degree of coordination that these numbers seem to reveal, rather than the degree of dispersion. 50 percent of the entire file get 50 percent of their care from one doc. I never would have concluded that. Certainly, if you went back and looked at our discussion of the absence of coordination in the system, we wouldn't have guessed at that number.

I think the question that Ray raises is what are we getting in terms of outcomes with various patterns of physician intensity or physician dispersion? I suspect that the 10 or 12 physicians tells us a lot less because of the number of physicians associated with a particular acute episode then the numbers of folks who get half of their care from one doc or 70 percent of Medicare from one doc.

Does that produce the care coordination outcome

that we have speculated that it should? Or is there no difference?

I think the other important question here, and Karen I don't know if you can get at what this data file, is the geography question. Does this line up with the Dartmouth data? If so, that begins to answer the quantity/quality question in a way that we could guess at from this but we really don't know very much.

DR. CROSSON: I think a lot has already been said. I just wanted to make a couple of comments.

When I looked at it, as has already been said, the large numbers didn't mean anything particularly to me. I didn't think that actually the intention was to indicate that patients seeing a large number of doctors, 12 or 15 or 13, was a bad thing. It was probably just an appropriate thing.

It did indicate, though, I think, that those with complex conditions see more physicians. And therefore, those individuals with those situations probably are at more need of care coordination than others.

So then I started thinking okay, where are we going to go with this?

If you have a 2 x 2 table in your head of important, not important, easy, hard in terms of analysis, this seems to fall into the important hard.

MS. DePARLE: And what do you do then, Jay?

DR. CROSSON: So I think my insight right now would be just simply that it's important and hard, and that we probably need to think about what we're going to go to it. We might end up, as Ralph was suggesting, we might end up with an analysis that looked at this issue with respect to Medicare Advantage versus fee-for-service. And there some issues there.

But I actually think it takes is down more the delivery system line. And as we've talked about at other times, the issue of whether or not there are differences here in how care is delivered at the delivery system design issue level that this is going to take us into.

DR. MILLER: Just to make the linkage, I think you may be having the same -- okay, let's see.

That's kind of where we're headed. Several of you have been making a point since you've been here that we need to look at delivery systems and payment incentives that might help build some of these delivery systems. We're just

kind of dipping our toe in the pool, walking out the front door, whichever way you want to think about it, and taking a first cut at this and trying to drive this into those directions in much more detail.

MS. BURKE: Mark, just in follow up, I think Jay's opening point was an important one and an interesting one. He read it and wasn't particularly troubled on the face of it.

But I think we always have to keep in mind the audience that views the material that we prepare. I can see the headline in tomorrow's newsletter. I think a cautionary note as we do these things in any document that states this isn't inherently bad, that essentially we're asking the question what implications does it have for payment, for delivery systems, for quality indicators. Because of the top, someone who is perhaps not as informed or not as engaged would look at that and go oh my God, where are we going?

So I think we have to think about all of the audiences that we serve in terms of as we go into these very tough, hard issues, getting right out front what we're trying to do here so nobody's confused about us and what

we're identifying as real problems. I just think we need to be careful about that.

MR. HACKBARTH: Good point.

Arnie, the final word on this?

DR. MILSTEIN: Building upon a number of the suggestions made, and I think Jay's observation that it's an important cell for us to shed light if we can. And therefore trying to ask is there not a cell that equals important and not so hard. Not easy, but not so hard.

I wonder if one thing we might explore would be to link with Catherine Baker and her pre-groomed and cleaned Medicare database which I believe, if I understand how that analysis has been prepared, would allow us to look at the relationship between number of physicians seen for chronic illness or the last 24 months of life and adherence to quality of care indicators, either at the state level or at some smaller geographic -- I think that database is sort of set up and ready to run it.

In her publication, she didn't examine these two particular variables but I believe that -- she didn't show this precise relationship but she did, I think, already have preorganized these two values. And I think I'm going to

anticipate that a regression could be run without a lot of incremental work and begin to get it the question multiple people have raised of can we get at a better signal of trouble rather than just a lot of physicians seen, which as we all intuit is not really documentation of much trouble inherently.

MS. MILGATE: Arnie, I'm not aware of who Catherine Baker is. What organization is she with?

DR. MILSTEIN: There was article that was -- she's a researcher. One of her piece of research was distributed to all of us I think about three months ago. It showed that wonderful regression line between amount of Medicare spending in the last 24 months of life by state and adherence to quality standards, basically showing a counterintuitive reverse relationship. The more you spent, the worse the quality. It's her research and I'm pretty sure it was distributed in our packets.

MS. MILGATE: Okay, I'll look up the article.

The other thing to say is one of the reasons we picked these conditions besides they're prevalent and they might indicate that they would need more care coordination is that in the set we're about to use with the physician

resource use analysis, we have quality measures for them. So we could also do a separate analysis ourselves or else include it as a part of our resource use question.

So I think that we should be able to do something akin to what different people were talking about geographically and by number of physicians seen.

MR. HACKBARTH: Thanks, Karen.

We'll now have a brief public comment period.

Okay, we will reconvene at 1:30.

[Whereupon, at 12:17 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION [1:35 p.m.]

MR. HACKBARTH: We're going to now have a series of presentations on payment adequacy preparing us for next month. The first one is on physicians.

MS. BOCCUTI: Welcome back.

Physicians are often the most important link between Medicare beneficiaries and health care. Some 80 percent of non-institutionalized beneficiaries report that their doctor's office is their usual source of care. So as in other provider sectors, MedPAC's framework for assessing payment adequacy for physician services relies on a number of indicators. Today we'll examine findings on several of them, specifically beneficiary access to physicians, physician acceptance of Medicare patients, physician supply and a fee comparison between Medicare and private insurers.

As you recall, MedPAC sponsors a phone survey to obtain the most current data possible on beneficiary access to physician services. We completed this year's survey just this past September. In our last two rounds, we surveyed both Medicare and privately insured individuals age 50 to 64 to assess the extent to which any access problems are unique to the Medicare population.

We'll first look at the ability for people to schedule doctor appointments. This year's survey found that most Medicare beneficiaries and privately insured people did not have to delay getting an appointment due to scheduling issues. Rates across survey years have remained steady and Medicare beneficiaries report that they experience delays a little less often than their privately insured counterparts.

On the chart on the slide you can see that in 2005, among those who tried to schedule a routine care appointment, 74 percent of Medicare beneficiaries and 67 percent of privately insured individuals reported that they never experienced delays.

As expected, for illness or injury, timely appointments were more common for both groups.

We also asked respondents about their ability to find new physicians when needed. We're a bit statistically challenged in this line of questions because the share of people actually looking for new physicians is considerably smaller than those that make doctor appointments. So the differences we see between groups and between years does not have statistical power.

We can say, however, that for the categories that

hold the large majority they are, by themselves, significant in that their certainly statistically different than say chance. So with that said, we turn to the chart.

Among those looking for a new primary care physician the same share of Medicare beneficiaries and privately insured individual, and that is 75 percent, reported that they experienced no problems. Although access appears good for most, some concerns are worth noting on the chart.

Among the subset of people who reported any problems, Medicare beneficiaries were somewhat more likely in 2005 to characterize their problem as big versus small than their privately insured counterparts.

Also, in looking across years, we see this share is growing. So it's going in the wrong direction.

Some subpopulations of beneficiaries may be experiencing more difficulty accessing primary care physicians in recent years, and perhaps to a greater degree than privately insured people. So MedPAC will continue to track this question closely in future surveys and perhaps will develop additional questions to try and dig a little deeper on this finding.

If you move on to specialists, you see that access to new specialists was generally better than access to new primary care physicians. As you can see, it's still been steady over the three years that we've surveyed.

I'll also note that I've broken it down, it's not shown on this table, but I have broken it down for Medicare beneficiaries that are 75 and younger to compare them to the 52 to 64 group of privately insured people. And the findings really aren't different.

MR. HACKBARTH: Can I just ask a question about this one? The people answering these survey questions are beneficiaries who have answered yes to the question, something like have you had to search for a new physician in the past year?

MS. BOCCUTI: Correct, and divided by primary care and specialists. So that really takes out a large share of the people. Whereas most people have appointments, few are looking for new doctors.

When you do look at a much larger survey you do get the statistical significance. And the CAHPS fee-for-service survey shows also that a large majority of Medicare beneficiaries report good access to physicians. These are

consistent with the responses from the MedPAC sponsored survey we were just talking about. Specifically, more than 90 percent of beneficiaries reported either no problem or a small problem accessing a specialist.

Also, the majority of beneficiaries reported that they were able to schedule timely appointments for routine care, either always or usually. These rates have remained quite stable over the last several years.

Another survey we examined comes from the National Ambulatory Medical Care Survey or NAMCS. Findings from this survey indicate that the large majority of physicians in the U.S. are willing to accept new Medicare beneficiaries, and this share remains steady.

Preliminary results from the 2004 round indicate that among physicians with at least 10 percent of their revenue coming from Medicare, 94 percent accepted some or all new Medicare patients. In comparison, the left-hand bars shows that 96 percent reported that they had open practices and thus were accepting some or all new patients. Most importantly, you'll note that these shares did not change between 2003 and 2004.

MR. HACKBARTH: Just one clarification about that

one. In the past, I recall that we have seen data that splits out accepting some new Medicare patients versus accepting all new Medicare patients. What happened to that split?

MS. BOCCUTI: There was a MedPAC sponsored survey that wanted to get at that question, and it asked physicians. And so that was done in 2002. I didn't report it because it is starting to get to be old.

But if you want me to report some of that in the chapter, I can do that.

MR. HACKBARTH: Not if it's 2002.

MS. BOCCUTI: The difficulty is the ability to survey physicians. And so when MedPAC did that a few years ago, that's a key question. So perhaps in other future years it's something to investigate further.

This slide is just an extension from the one you saw previously and it shows that a larger share of physicians accept some or all new Medicare patients than private patients. That's both capitated and non-capitated.

Our analysis of Medicare fee-for-service claims data shows that the number physicians providing services to Medicare beneficiaries has kept pace with growth in the

beneficiary population in recent years. When counting physicians that see Medicare patients, we conservatively only include those physicians who bill Medicare for at least 15 patients in the year. We do this to get what I would say is a realistic sense of physician availability for Medicare patients.

So looking at this table, we see that between 1999 and 2004 the number of physicians who regularly saw Medicare fee-for-service patients grew more than Part B enrollment. So that contributed to the growth in the number of physicians per 1,000 beneficiaries, which is seen in the right-hand column.

Looking at supply trends in the past decade, GAO also found increases in physician supply trends across the United States. GAO found that between 1991 and 2001 the number physicians in the U.S. increased by 26 percent, which is twice the rate of the total population growth during that study period. Other data we looked at this year are residency position fill rates. These rates measure the share of residency positions filled to those that were offered. Nationally, the fill rate has increased slightly, from 89 percent to 92 percent over the last several years.

Among the specialties with the highest fill rates are radiation oncology, dermatology and general surgery. Among the specialties with the lowest fill rates are family practice and neurology.

Although there does not appear to be an overall physician supply problem currently, the expected growth in the Medicare population raises questions regarding the size and mix of the U.S. physician work force.

Research that projects long-term physician supply trends draws varying conclusions however. Some predict future shortages but others note that there's complications with estimating the right supply and demand for physicians.

Another measure we examine to assess payment adequacy is a comparison of Medicare's physician fees to private insurer fees. As shown on this chart, Medicare payments for physician services have historically been below private insurer rates, but the difference between the two has narrowed by the late '90s and remained relatively steady really in the last several years.

Average across all services and areas in 2004 Medicare rates were 83 percent of private rates, which is up from 81 percent in 2003. So Medicare rates increased a

little more than private rates in 2004.

The increase in Medicare's rates stem from several provisions in the MMA. In addition to a 1.5 percent increase in the conversion factor, the law also imposed a floor on the work GPCI through 2006, increased all GPCIs in Alaska through 2005, and provided bonus payments through 2007 for services provided in newly established physician scarcity areas. While those were directed to certain physicians, this analysis is really on average across all services and physicians, keep that in mind.

DR. NELSON: Out of 7,000 CPT codes, which ones did they use to derive the sample?

MS. BOCCUTI: It's across all physician service codes. It's across all services across all areas, so it's very much an average. So in some services the difference would be smaller and in other services it might be larger.

MR. HACKBARTH: Cristina, my recollection -- and correct me if I'm recalling wrong -- is that the narrowing of the gap between Medicare and private fees is attributable, at least in part, to shifting enrollment patterns in the private sector as people have moved out of traditional fee-for-service arrangements into more PPOs,

that has tended to hold down relatively speaking the private fees. And that's part of what explains the narrowing. Am I correct?

MS. BOCCUTI: That's correct for the trend that you saw the narrowing in the earlier years. For the most recent year we studied, for 2004 --

MR. HACKBARTH: No, I'm talking about the sweep of the whole --

MS. BOCCUTI: That is a major component of how it narrowed, yes. But it hasn't been as much of a factor over the last several years.

MR. BERTKO: Glenn, I was going to add that with the consolidation here what's probably happening is much smaller insurers who would have paid at higher rates because of lack of market power are now having members move to much larger insurers who are paying at closer to Medicare rates. And so as that happens. then the overall average of non-Medicare is held down a bit, but it's a migration and it's not a payment change. It's the same store problem in some ways.

DR. WOLTER: I was kind of wondering on this slide whether there might be any value in looking at any

geographic variation, and is there a difference in some parts of the country to others, rural, urban, et cetera, in terms of these ratios? It might be of interest.

MS. BOCCUTI: The Center for Studying Health System Change has looked a little bit at that. They go to specific areas.

For the purposes of the payment adequacy analysis, if we're going to be talking about thinking of payment adequacy across all physicians and an update factor that would go towards all physicians, then we want to kind of nationalize the assessment.

But I think the geographic variation in differences in pricing may be something that we want to look at for other reasons, too.

But I might include some of the work that HSC has done in some of the chapters that shows what happens when there is variation.

MR. HACKBARTH: I guess it was HSC's work that I saw probably a couple of years ago now that said actually the geographic variation in this relationship is quite substantial. As I recall, they said there were some markets where Medicare actually paid more than private payers, and

then others were, of course, paid substantially less.

MS. BOCCUTI: That's true, it does vary. The other piece to that is that access hasn't really reflected the gap -- HSC's finding has been that even when the gap is bigger, the access indicators don't fall in the same direction that you might expect. So the payment is maybe perhaps not the issue that's going on. So it's important to put those two pieces together.

MR. HACKBARTH: Yes, I think that is important.

DR. SCANLON: The GAO issued a report, I think in August, looking at geographic variation in prices paid to both hospitals and physicians by metropolitan area by some of the bigger FEHBP plans. And it does show this incredible variation. It's so large that, given that this is the average relationship between Medicare fees and private fees, you know that there some below and some way above.

MR. HACKBARTH: My recollection was in the HSC thing it was from like 1.2 -- the Medicare was 20 percent higher in some markets to 20 and 30 percent lower in others.

MS. BOCCUTI: And by service it differs, too.

DR. MILSTEIN: Appreciating that it opens up an avenue of inquiry that's a little bit off center, I know

that historically the weakest -- the performance measure of physician availability that's historically performed the least well through the Medicare Beneficiary Survey has been physician availability for phone contact evenings and weekends.

If you already know the answer to this, otherwise maybe the next we revisit this it would be helpful to kind of track what's happening with respect to that particular signal of physician availability because it's historically a weak spot and maybe a little bit more sensitive to adequacy of the payment system than some of the other indicators.

MS. BOCCUTI: Just to clarify, did you mean specifically a Medicare patient having that availability problem? Or is this for physicians, in general, for all types of patients?

DR. MILSTEIN: It was historically on the so-called Medicare Beneficiary Survey. I don't know whether there's a counterpart statistic outside of Medicare.

MS. BOCCUTI: I'll look into that.

We just have one more. Just to sum up real quickly, we are fighting that the majority of Medicare patients are able to access care, make appointments, find

new doctors. But some small share are reporting some problems.

Also, that the number of physicians is growing and is keeping pace with the beneficiary population. And that finally Medicare fees for physician services are stable and they grew a little bit faster in 2004.

In the next meeting, which seems right around the corner actually, we'll be discussing two additional measures from the 2004 Medicare claims: changes in volume by type of service and changes in quality for some new measures. We'll also examine input price changes expected in 2007 from the Medicare Economic Index and review draft recommendations for the physician update.

Also, we'll keep in mind that in December we may also be discussing some legislative changes that may arise regarding Medicare payment updates for physician services.

More questions?

DR. CROSSON: Could we return to slide three?

So the issue here has to do with reimbursement to primary care physicians versus specialists. And the question is whether the change over two years from seven percent to 13 percent identifying it as a big problem is a

real number because these are not -- I guess the n's here are small.

But it would be interesting to know whether or not it's a real number or not because at least -- there's also the difference, which looks significant, between 75 percent and 89 percent of people identifying it as no problem between the primary care and a specialist.

It would be interesting to know whether that difference is significant or it isn't? Or is it the assumption is that it isn't?

MR. SMITH: On that point, I was struck, as Jay was, by the seven to 13. But then I realized that if you added small and big it was 25 to 25. I wonder what we know about the difference between small and big and whether or not that washes out the apparent significance of the seven to 13.

DR. CROSSON: And it might, assuming that the questions were asked the same way. It's just a clue.

But what is different consistently is the difference between individuals identifying no problem in finding new physicians in the specialists column versus primary care. So one question would be is that

statistically significant? Or wasn't that analyzed?

But the larger question, which we've been touching on here, is is there something or some set of things with respect to physician payment policy that have the effect and perhaps an increasing effect of making it more difficult for people to get access to primary care than to specialty care? It would be interesting to know whether this supports that contention or it doesn't, simply because the size of the analysis is not large enough.

DR. MILLER: If I could say a couple of things, and Cristina obviously make sure all of this is correct.

One thing that's interesting on the point that you're raising is -- and I can't remember whether we said this or not. But when you look at those fee comparisons between the public and the private sector, the comparisons -- and of course there's all the variation that everybody has already pointed to.

But on average, the fee comparisons are less favorable for specialty and much more favorable for primary care. In other words, Medicare pays much closer to the private sector for primary care. I believe that's correct, Cristina, on average?

MS. BOCCUTI: I think so.

DR. MILLER: If I could get a nod from Kevin. Kevin is saying yes, so I'm going to stay on yes.

And I think it is right. We have done a couple of disaggregations on this fee stuff in the past to look at a couple of things that people have said on it, and I just couldn't dredge it up fast enough to comment on it.

The other thing I would say about this is you're asking about the statistical significance between specialty and primary care. The n's here are small. We won't be able to tease that out, per se, from this past. And we may try other ways to get out your question.

One thing to keep in mind here is the reason we do this is the key thing about this table, relative to some of the other ones, is it says 2005 on it. We go out and we survey the beneficiaries and it is our fastest way of finding out how things are going, because concerns by commissioners in other settings were these big surveys, which are robust and statistically significant, are a year out of date.

So we sort of have the big robust ones a year out of date. And then we try and hit these ones to get a little

better sense.

We might be able to boost some of the n here. These are not incredibly expensive surveys. We might be able to boost some of the n here and try and explore this a little bit. But obviously, doing it for this round in a month is pretty much out of the question.

The last thing I'll say, and Cristina I want some back here. When you look at people unable to get to primary care physicians, other people, I believe other research outfits have shown -- I'm thinking HSC here -- have said when you find those kind of problems, it's for both Medicare and privately insured, that type of circumstance.

MR. HACKBARTH: Let's just assume for the sake of argument that that's a real increase, the seven to 13. Then the next question would be is that influenced by Medicare fee levels? Or is the increased difficulty in getting a new primary care physician attributable to other things that are going on in the broader physician marketplace?

I know in my own community, Bend, which is a very rapidly growing community, it's very difficult I'm told by a lot of people for a Medicare beneficiary new to town to get a primary care physician. But I'm not sure that that has

anything to do with Medicare's fee levels, but rather an imbalance that exists between population growth and physician supply in a community that's just growing by leaps and bounds. The same sort of difficulties may exist for non-Medicare patients, as well.

MS. BOCCUTI: We try to get at that with the comparative private population but it doesn't -- you know, 4 percentage points, 5 percentage points, their trend is a little bit down. So that's the question we're trying to answer, too, if it's more than just a Medicare payment. It could be about many other factors.

DR. CROSSON: Just one point on the other side. In the short-term analysis I would agree with you. But longer term the fact that both Medicare and private payers may be "underpaying" primary care compared with specialty care would, in fact, create the problem you describe.

MR. HACKBARTH: You know I'm there on that issue.

DR. CROSSON: Just to make the point.

MS. BURKE: But I think, just on this same point, to the point that there are broader questions here, you also note in the report and on the slide that, in terms of residency fill rates, that there are clearly issues in terms

of the choices being made by medical school graduates in terms of the residency programs, all of which are influenced by everything from payment rates to lifestyle choices to a variety of other things.

As a general matter, we don't engage ourselves in health manpower policy traditionally. But in fact, the question that has arisen in the past is whether or not one can encourage specialty choices based on a variety of factors including payment rates.

And so over time, the decision not to go into the primary care specialties, which leads to fewer physicians in those areas, which leads to the likely shortage and the difficulty of gaining access, the linkage between payment policy and manpower policy is one that will continue to come.

I think it is a variety of issues and that's certainly one of them. Payment policy is clearly a part of those decisions that are being made.

MR. HACKBARTH: I think we're in agreement on that. Let's just tie it to our normal way of thinking of things.

Some things are update issues. Some things are

distributive issues. The question of whether we're paying primary care well enough relative to specialists is a distributive question. It really doesn't help us answer what the right update is on the conversion factor for next year or the year after.

If we want to increase relative payment for primary care versus specialists, we need to use other mechanisms like looking at direct process or maybe having different conversion factors. I don't know what all the policy options are.

But the update isn't the best way to solve a primary care shortage problem.

DR. KANE: Quick question. Wasn't 2002 the year that the fees were actually reduced? They don't seem to have any -- there's no measurable noticeable effects. I just wanted to be sure I understood.

MS. BOCCUTI: We've talked about that in the last few years when we've been looking at 2002 data. In fact, the survey that Glenn was thinking about was instigated a bit in part because of that. So it was put in the field right after the pay cuts in 2002 in order to look a little bit at that.

It was a one-year, it was even a little less than one year actually. But it was a one-year pay cut that didn't happen the following year.

DR. KANE: It was never reinstated. In other words, they didn't gain back anything and it's been held down since then to 1 or 2 percent a year?

MS. BOCCUTI: That's correct.

MS. HANSEN: Relative to the payment system, currently do primary care physicians get risk adjusters for more complex patients that they take?

MS. BOCCUTI: There are some modifiers that you put on a claim for the complexity of the patient. Is that your question?

MS. HANSEN: That's part of the question, relative to whether or not when we have the Medicare population broken out just to 65 and older, I wonder if there is the possibility when we do the next study to have an oversampling of the 85 and older, just because the access issues, I think, oftentimes for more complex people, unless they are being paid for, whether or not there's an access issue for primary care.

MS. BOCCUTI: We can look into that. It's going

to be hard to oversample non-institutionalized people, 85 and older. But we'll see what we can do.

DR. STOWERS: I had a couple of questions. Good chapter.

I wanted to go to slide number seven, where we talk about number of physicians billing Medicare. I'm concerned about this 15 patients per year because I think that greatly inflates the number of physicians. I saw 15 patients per day that were Medicare and had somewhere around 500 to 600 Medicare patients that we saw on an annual basis in the practice.

So I would be more concerned with those that maybe were seeing 50 percent of their practice and now they're down to 25 or whatever. But it seems when you say 15 patients per day, that's barely one patient per month that's Medicare. So it seems like that's just seeing one relative that you agreed to see for the family.

MS. BOCCUTI: I just want to clarify the question. It's 15 a year, the cut off. Are you arguing for making the cut off higher?

DR. STOWERS: I think we ought to be looking in the 30 to 40 percent range or 25 percent of their practice

which -- instead of 15, I'm seeing 200 different Medicare patients per year, and not 15. Because those that are seeing like 15 a year are really irrelevant to the system.

MR. HACKBARTH: We don't know the percentages, though, because we don't know their private volume. We just know their Medicare volume. So it needs to be expressed in terms of Medicare volume.

DR. STOWERS: But I'm saying that volume number should be 200 instead of 15 if we're really looking at physician supply. And putting it all the way down at 15 just includes virtually everybody.

MS. BOCCUTI: We used to include everybody. it was just last year and this year that we started --

DR. STOWERS: How much did it change it from including everybody to just 15 patients per year?

MS. BOCCUTI: The ratio didn't change that much.

DR. STOWERS: It was probably insignificant.

MS. BOCCUTI: The ratio didn't change. But why don't I do sort of a sensitivity analysis on that and see what happens when we change.

DR. STOWERS: I think these numbers are going to look a lot different when we don't include every physician

in the country in those numbers.

MS. BOCCUTI: I can do that.

DR. STOWERS: My other thing on this percentage, and I'm not sure we made the point in the chapter, is that if I'm a physician -- and I'm talking about the ratio between private payers and Medicare. And what's causing in my practice for that ratio to stay stable is a decreasing in the payment from my private payers but they're still 20 percent or whatever above what Medicare's paying, there is considerable pressure in my practice to decrease the number of Medicare. Because 20 percent is still a big swing. And if the overall income of the practice is taking a hit, that's still a big number. And even though it's stable, the causes of it are very important.

I think we need to make that point maybe a little bit more clear. I think the ratio can be very misleading in the incentive or the push for physicians to quit seeing Medicare patients and go to those that are 20 percent higher or whatever, as the practice feels more pressure.

MS. BOCCUTI: Okay.

MR. DURENBERGER: This is like having the last word on Sheila's point.

When I reread that language that's in their now about supply, and I'm thinking about where else can we address supply other than here or GME or something which we're not going to visit for a while.

This is although there does not appear to be an overall physician supply problem, currently the precipitous growth in the Medicare population in the next five years or 10 years raises questions regarding the size. Research draws varying conclusions period. That's all it says.

With all due respect, because those are the realities.

You could have pointed to other things like the cost of medical education going up and potentially being a discouragement and so forth.

But more importantly, what I hear from physician leaders and groups is that there is a shortage. And they can feel it and they can see it coming. I guess you can't prove that by 1996 or 2002 data but it feels like it's important for us, in some way, not to let it go at this -- even though we don't do anything about it -- but to make a slightly stronger statement in this context about the

future.

And I don't mean internal medicine versus something else. I mean general supply.

MR. HACKBARTH: Sheila's right. Historically MedPAC has stayed away from issues about manpower, arguing, believing the those are not principally Medicare issues alone. They are broader health care system issues and are not best addressed through Medicare payment policy, which is the name of our commission. So that's been the thinking.

In addition to that, I don't follow this field carefully, but I think I've read studies with diametrically opposed results about whether we've got a future manpower problem or not with experts pointing in opposite directions almost.

So I don't know what the truth is. It would take a substantial investment of our resources to add to that conversation. I'm not sure we'd be successful.

MR. DURENBERGER: I'm not advocating that.

MR. HACKBARTH: My inclination has been to --

MS. BURKE: Glenn, two things in that respect. One is I think we -- the royal we -- the Commission has historically said we don't play in manpower politics. The

reality is of course we do, by the way we pay. We don't in a conscious deliberate way say this, that or the other. But essentially we are a player in that world.

In fact in the past, there have been decisions made in terms of updates that differentiate among specialists and other kinds of decisions that were made at the time. I mean way back.

And so I agree with you that as a general matter, it is not part of our purview to look at it. And I wonder however, having said that, I think there are differences of opinion as to what the totality of the physician population is and whether it is adequate or not.

I don't believe, although I may be wrong, and Jay may know this or others may know this. I don't believe there's a lot of dispute about the concern about the absence of primary care physicians or the specialists that are viewed as primary care, whether it's in family practice or internal medicine. I think that is clearly documented with little dispute, that there is, in fact, a decline in those populations and it is an issue.

And it is a particular issue for this population because of the presentation of these patients and how they

can best be managed.

I don't know that there's much we can do other than affirmatively state that there is a concern here, that our policies are a part of a broader picture. I don't know what else we can do about it. But I think we ought to acknowledge there is an issue. We ought to acknowledge that there is, in fact, this question of specialists, particularly those that relate to the elderly, and whether or not there are going to be an adequate number of those and whether there ought to be a conversation about what are the factors that play into this, I guess.

MR. HACKBARTH: Perhaps I'm slicing this too fine, Sheila. I agree with that, and witness our initial review of the RUC process and whether we are paying appropriately. I think that those issues are fair game for MedPAC, and they're issues I personally feel strongly about.

But I see that as a little bit different than the overall physician supply for the year 2020 because -- and the distinction I see is one, we're addressing Medicare payment policy. Are we appropriately rewarding primary care versus specialty care? Whereas the other is a much bigger issue of our enough people going to medical school or

nursing school or whatever the profession might be?

So I think we get to a similar place. I just want to narrow the terrain that we cover as much as possible.

MR. DURENBERGER: The question I was raising is why put the section in at all? I mean, if you're going to put the section in and say there's no problem when the consensus is there is some problem but it doesn't happen to be our purview, why put in the section? That's kind of the way I was presenting it.

MR. HACKBARTH: Let me take a look at that passage. I don't think we ought to say there's no problem on the aggregate. I think we ought to be agnostic on that and let others investigate it.

DR. STOWERS: I don't mean to muddy the water but I think relative to Congress right now, and in the mindset that we ought to be looking at current policy, and understanding that MedPAC stands behind getting rid of the SGR and going to a different system, the fact of the matter is that we have predicted under current law 26 percent cut over the next five years or so in physician payments.

Like I said, I know we don't have a crystal ball but I don't see the reserves in these numbers in access that

could withstand that kind of a cut in physician payments.

I think if we're going to talk a chapter about access to care for Medicare patients, I just can't imagine that we would do that without making some kind of comment, either out of our past chapter on the SGR or whatever on bringing that into this that, at least in my personal opinion, that these numbers would significantly change with that kind of a cut.

So if we're talking access to care, I really also worry about a chapter that comes out saying things are great when such a huge change is in law right now.

MR. HACKBARTH: Of course, we will directly address the update because we need to make a recommendation on that. So the question before us will be whether we should even do one of those cuts, let alone six or seven consecutively.

DR. STOWERS: I just think it ought to be brought into this chapter that we're okay where we are but we maybe couldn't sustain big change.

MR. MULLER: In conjunction with what Ray, Dave and Sheila have said, I think this chapter indicates that there's not that much of a problem, obviously that

primary/specialty differential. Whereas I think the field feels there's, at least in certain parts of the country there are some real problems out there. Whether in some parts of the country where there's malpractice issues, there's shortages of OBs and neurosurgeons. In other parts of the country there are shortages of primary care, and so forth. And again, I agree with you, how much we can shave from Medicare. We've said at other times, a lot of the payment policies in the private sector are add-ons or mirrors or reflections of what happens inside the Medicare system.

Just two facts that I pay attention to, or at least two trends I pay attention to. One is for a number of years now, of the physicians that we produce each year, only about two-thirds of them come out of American schools. That's very much affected by GME policy. I'll concede that.

Secondly, that if you like at what medical students, the specialties they're picking now compared to 10 years ago, there's not just a primary care differential between 10 years ago that people have mentioned. But there's a very substantial change in the specialties they're

choosing, as well.

Like the rest of you, I'm not quite sure what the 10-year implication of that is. But there's certainly a big import that happens if that keeps accumulating another five or 10 years.

So perhaps if we could put some data in there that just looks at those choices compared to 10 years ago as just evidence of a change in where the distribution of physicians is going. Again, it takes a cohort of about 10 years running to really make a substantial change.

But still, the fact that it's changed -- when I look at the literature 10 years ago in the heyday of managed care in California and capitation, everybody's going to be primary care, 50-50 primary care specialty, and see how much that has shifted just in a short 10 years. That is a very consequential change in how young people coming out of medical school right now are making choices about where they want to go. I think that's a very significant change.

I think that data is pretty easy to get. Just look at where the 2005 crop of graduating group compares to the 1995 or 1994 group. But I think having that out there is going to cause us, over the next four or five years, to

start seeing some consequence in these choices.

MR. HACKBARTH: Thank you, Cristina.

Next is payment adequacy for home health.

MS. CHENG: All right. In my segment of this afternoon, I'm going to give everybody some information on the home health sector just to get everyone up to speed. And then I've got four pieces of the payment adequacy framework to talk with you about today: beneficiary access to care, quality of care, the supply of agencies, and some information on the influence of overuse on costs.

In the past two meetings, I've been here talking to you about home health and we've been working on a mandated study for Congress. You gave me your conclusions. And that study is on its way to the printer.

We're shifting gears a little bit. Today's analysis is starting to move us ahead into the March report and decisions about the update for 2007.

Current spending on this sector from Medicare is about $12 billion. Spending has grown nearly 40 percent since the inception of the PPS in 2000 and spending is projected to grow another 16 percent between 2005 and 2010.

There was a 5 percent rural add-on that was put in

place April of 2004. That expired in April of this year and currently there is no rural add-on.

The base payment in this sector was increased to 2.8 percent over the 2005 level. Under current law, that is to say if Congress makes no policy in this sector, this sector will receive a full market basket update in 2007.

The first piece of the payment adequacy framework that I have this afternoon, and I'd like to thank Sarah Kwon and Sarah Friedman for doing the data analysis on this piece, is an access to care.

What we find here is that beneficiaries' ability to access home care is unchanged from last year. Nearly 90 percent of the beneficiaries surveyed reported little or no problem with getting the services that they needed. 11 percent reported a big problem. That's the green bar on your screen there with no problem. The dark blue, small problem and the light blue, big problem.

These results are based on CMS's survey of about 100,000 fee-for-service beneficiaries across the country. The survey includes beneficiaries who could have had problems accessing home care because they were not eligible for the benefit. The survey didn't distinguish between

eligible and ineligible beneficiaries.

We took a little time to look behind these numbers this year, at the experience of these beneficiaries elsewhere in the Medicare program. And what we found started to suggest to us that the access problems of some of these beneficiaries might not be unique to the home care setting. We found that the beneficiaries in that light blue bar that had a big problem with home health access constituted 25 to 30 percent of beneficiaries who had big problems accessing prescription drugs, physician generalists or specialists even know the people in that blue bar only represented about 10 percent of the population seeking those services.

Thus, those who had home health access problems were more than proportionally represented among those beneficiaries who had access difficulties in other areas of health care.

The second piece of the framework that I have for you is quality. Your mailing materials included three quality indicators in addition to the ones that I've noted on the screen. Those in your mailing materials and the ones that we have on the screen both tell the same story. The

maintenance or gradual improvement in the proportions of patients who increased their ability to function, decreased their pain, or decreased their use of the hospital ER all suggest that the quality of home health care has improved or stayed the same over the past year.

These quality indicators are risk adjusted, so to the extent that we have risk adjustment models we're not measuring a change in the age or the comorbidity or the functional capacity of beneficiaries. What we're trying to get at is differences in the quality of care that's delivered by the home health agencies.

The third piece of the framework that I have for you is agency entry and exit. We find that there are over 8,000 home health agencies currently participating in the Medicare program and that's 14 percent growth since the year 2000.

Home health agencies continue to have a wide range in size. We have some that provide 100 episodes annually and some that provide 5,000 annual episodes. So we look at the number of home health agencies to tell us about providers' decision to enter or exit the program. But what it doesn't give us much information about is the capacity of

the system because we have such a wide variation in the size of these agencies.

The final piece of information that I have for your consideration in the policy analysis for payment adequacy is some evidence of overuse from the Office of Inspector General. Some agencies may be overusing home health therapy visits to generate higher payments. What I'm referring to is a trio of reports that the OIG has published over the past year in which they selected an agency each from Florida, California and Connecticut.

What they did was they reviewed episodes at those agencies that just met that ten therapy visit threshold. That is to say the episode had 11 therapy visits or 12 therapy visits, they just met the threshold over which you get a substantially higher payment for the care delivered during that episode.

And two agencies, the therapy provided failed a medical record review for medical necessity for services 64 times of 74 times at one agency and 19 out of 40 claims at a second agency.

In the third case, all 100 claims sampled met the test for medical necessity.

The OIG did not target these agencies because they were particularly bad actors or that they had some kind of history. What they were trying to do is get a sense of the typical agencies' experience in the Medicare program.

The third case proves that overuse of therapy is not universal. The first two cases suggest, however, that overuse of therapy may be prevalent.

The failure of these additional therapy visits to meet tests of medical necessity suggest that the same quality of care could have been achieved with the use of fewer resources. So the Commission may wish to take into account this indication about payments and costs as we move into the numbers on the payments and costs next month.

With that, I'm going to wrap up. So we had four pieces of information to take into next month's consideration. Most beneficiaries had little or no problem accessing care, the share of patients with positive quality outcomes has increased very slightly over the past year, agencies are entering the program, and we have a little bit of information on payments and costs that you may wish to consider.

Next month I'll bring you additional information

on payments and costs, some information on geographic access to care, changes in the volume of care, and access to capital.

So with that, I'm looking for your input on how to use the findings that we have so far in the payment adequacy framework.

MS. BURKE: I'm going to assume in the course of your anticipating next month's discussion that because there seems to be some consistency and difficulty in access of certain patients to a whole variety of things, that there are clearly going to be some geographic indicators. I'm assuming that. It may not prove to be the case. But I've got to believe, if you look at urban versus rural, that people that run into repeated difficulties accessing a broad array of services may or may not be located in particular geographic locations.

MS. CHENG: Actually, we did do a quick pass at our access survey and we compared the rate of having problems for rural beneficiaries and urban beneficiaries. And we found again this year, which is also what we found last year that, in fact, rural beneficiaries report having fewer problems. 82 percent of rural beneficiaries reported

no problem accessing care.

MS. BURKE: So do we know what the common element is that would lead to difficulties across the broad array of services for a particular economic -- I mean, do we have a sense of what the common denominator is?

MS. CHENG: We're a little restricted in our ability to dig very far into CAHPS. It's a wonderful survey that CMS does. It's got a big n. But it doesn't have much in the way of demographics.

So you might wonder could we find patterns along the lines of income? Could we find patterns along dual eligibles, perhaps? And we can't actually tease that out of CAHPS. We gave that a shot but we couldn't get that out of the data.

MR. HACKBARTH: Continuing on this for just a second, my recollection is that there is some overlap between the sort of patients that have difficulty getting access to SNF care and those that have difficulty getting access to home health care. In both cases we're talking about a relatively small percentage of the patients.

We have, in each case, each payment system case-mix design issues so that there may be systematic

underpayment for certain types of patients. It's not necessarily an update issue or the overall level of payment, but it's how the systems adjust payment for patients with different characteristics.

Is that true, Sharon?

MS. CHENG: Again, probably if we had -- if we could grab the CAHPS folks and get some bene clinical characteristics we could test that out. But I don't know from CAHPS what level of ADL impairment they had. I don't know about their primary diagnosis and comorbidities, things that you would think might be the commonalities I can't get at directly here.

MR. MULLER: To follow up, I think we tend to advantage in both systems, rehab-type patients versus medically complex patients. So to the extent to which you have medically complex patients and therefore have these difficulties, the system doesn't case-mix adjust as well for them as they do for rehab. That's my memory, as well, for those two populations.

DR. MILLER: If I could just take a shot at parsing through some of this, I think it's true that through our deliberations over the last couple of years we have come

to this point on SNF and home health and said we think there are things in the payment system, just like Ralph said, that may encourage or discourage -- you want to take rehab but you don't necessarily want to take complex care patients. We've talked about the notion of getting into the guts of the system and trying to balance some of those distributional issues out.

I also thought that you might have been on a slightly different point when you were asking your question, but if I'm off then just dismiss it.

We don't find a lot of access problems in home health. And to the extent that we find them, people have access problems much more broadly. And that almost gets back to some of the other conversation about trying to find somebody in a fast-growing area, certain populations, poor health status, those types of things which have traditionally had problems.

I think that was more part of the exchange, too, if I understood what you were asking, but I'm not sure.

MS. BURKE: You do. I mean, there are odd patterns here and it's trying to understand what the right intervention -- query whether they are people who are

cognitively impaired and can't navigate? Are they people who do have no family support so they don't have a system that allows them to navigate all of the providers? And then what are the interventions? What would the solution to that be?

It is all of that, in terms trying to understand who these folks are. If it's not a geographic issue, and I'm glad you reminded me of that, in fact Sharon, that we didn't see this. I remember asking this question last year about the overall issue.

so there's some indicator here and the question is what's the right fix among all of these sort of issues.

MS. HANSEN: I think that the case-mix discussion and the complexity and the choice of my comment earlier about are we paying differentially for these medically complex so that the incentive would be still to serve this population.

So the ability to delve into that, I think, would be something I would certainly like to see so that we can start looking at this not as one homogenous cohort but the ability to look at the subsets and what impact that has.

And that correlates actually, not on the deck

here, but on the material that we received, Sharon. It was on page six of the report that speaks of the positive outcomes, looking at it year-over-year. But there are a couple at the very bottom that relate not to the payment but to the quality of care aspect that has to do with readmission to the hospital as well as unplanned ER use.

I know that it was benchmarked at a certain percentage and that percentage is held steady. I guess my question is more, going backward a little bit, to say should that be looked at a little bit more separately again for the more medically complex? Are there kinds of things that should be expected outcomes so that three out of 10 people don't automatically perhaps go back into the hospital. Or that one out of five people don't have an unplanned ER use. In other words, is 21 percent an acceptable number for quality for unplanned ER use?

And I don't have any answers about that, but I don't know whether there's a way to ask those questions or take a look at the data differently but for a subset of the more medically complex.

DR. NELSON: The OIG did a sample of three out of 7,000. Do they have plans to more systematically take a

look at that, is my first question?

The second question is who is responsible for medical necessity verification in home health care?

And I guess my third observation is you end your chapter saying that some evidence of overuse of resources is present and we ought to take that into account when we're taking a look at payments and costs next month.

But I would suggest that to ratchet down the payments and further stimulate gaming of resources isn't the solution. I think what we want to do is try and find incentives to pay for the supplemental therapy for those patients that need it and pay the home health agencies enough so they provide reasonable care to those who don't need it without playing games.

Who does the medical necessity? And is the OIG doing more on this?

MS. CHENG: There is some shared responsibility A physician signs off on a plan of care for a home health beneficiary. And then, generally speaking, the home health agency follows that plan of care unless they see a substantial change in the patient's condition or for some reason goes back to the physician, who could then modify

that plan of care. But there's joint decision making there as the home health agency develops a plan of care, the physician signs off on it and then the home health agency implements that plan.

DR. NELSON: Would that one fall within the purview of the contractors?

MS. CHENG: The FIs, or the RHHIs in this case, can review claims for medical necessity and can upcode or downcode the claims based on what they see in medical records. This was not done by the FIs though. This review was done by the OIG. My impression of this review was that it was a fairly intensive task. They took the records from this and rather than just look at the evidence that was submitted on the claim, they actually went back and did a medical record review, which is a fairly substantial undertaking.

I don't know how many more agencies they would want to review. They did indicate that they picked three but they wanted to get sort of a typical three. They wanted to look at something that that would be representative of the typical behavior.

MR. HACKBARTH: Such a small number of agencies

might be useful in suggesting new paths for analysis and research. I agree with Alan, it seems like a thin read to use in a payment adequacy analysis for a whole industry. Maybe it feeds into questions about design of the case-mix system and the like, which incidentally we have been working on.

But it's utility in addressing what the right update factor is seems pretty limited to me.

DR. SCANLON: I wouldn't carry it to the point of saying that this should be used to update the update factor. I think it goes more to the point of the design of the classifications and the fact that we have -- instead of classifying people on the basis of their needs, we're using a service measure, and that there's the potential that if you move from nine therapy treatments to 10 or 11 that you can change your payment dramatically.

But it is telling that if the OIG did this study of three agencies and found nothing, that would problem be a whole lot less indicative of an issue than doing three agencies and finding the share of services that were medically unnecessary, that we found. We only had one agency that turned out to turn in only claims that were

medically necessary.

The problem here for the IG as well as for the intermediaries is this is expensive. And only about 2 percent of claims are getting reviewed. So we're relying on the good faith of the providers in terms of compliance and this is clear that we may have a problem here that we need to be concerned about.

MR. DeBUSK: Taking off on Alan's comment that he made about adequate payment, I remember in 2000 when they put in the prospective payment system, the OASIS, one of the major concerns was the diabetic patient because it was felt at that time that there was a gross underpayment for that patient. And I'm beginning to wonder what happened to that patient? Is that patient being handed off? That patient is going somewhere, because that payment at that time seemed to be very, very inadequate. That would be interesting to know if there's information available on that.

The second, reaching out a little bit, the second point I want to bring up is the LUPA. At that time we felt like this would be an excellent opportunity. We were talking about preventive prophylactic medicine at that time. And with the use of the LUPA, maybe that would be an

opportunity to install, an opportunity to take and address preventive medicine.

Of course, that's a long time ago. But that's something else I think certainly could be thought about to improve the overall system.

MS. CHENG: I think I can probably bring you both those pieces of information when I come back to you next month with volume. I can see what I can find out about share of patients with diabetes as a primary diagnosis. And also preliminary results suggest that LUPAs are still -- I think I counted 13 percent of episodes, which has been pretty much steady state from the beginning of this system. CMS thought that there would be about 15 percent and it stayed 12, 14, 13 since we started.

MR. SMITH: Very briefly, Sheila anticipated much of what I wanted to say.

Sharon, as Sheila was, I was struck by the 25 percent having trouble accessing other services. And maybe just coming off, as most of us have in one way or another, spending time on Part D and try to help folks figure out how to navigate it, I assume the navigation issue is a real one and wonder if we can't get at that, whether it's patient

characteristics, as Mark speculated, whether or not it's support at home, access to some other interlocutor.

If we've got this kind of difference between those having difficulty finding care in multiple settings, maybe it's geography. But boy, I bet we're much more likely, if we can mine the patient characteristic data, I suspect we're more likely to find an answer than figuring out whether or not it's rural or urban.

MS. CHENG: I can bring you a piece of research -- I can't quote the authors off the top of my head -- that looked a little bit at navigation issues specifically. They were asking folks that had gotten to home care, SNF and maybe one other setting, how did you get here? And so they had a little bit of -- it was a state-based study. But it had some interesting information about who used family members, who got navigation help from a physician and that kind of thing. I'll bring you that.

MR. HACKBARTH: Thank you, Sharon. Good job.

Next up is hospital.

MR. ASHBY: We do have our gang of thousands here ready to go.

This session we'll deal with payment adequacy for

hospitals. Each year the Commission makes update recommendations for outpatient and acute inpatient services. But because of joint costs among hospital services and uncertainty about allocation of those costs in the Medicare cost report, we assess the adequacy of payments for the hospital as a whole.

Just a bit of background, the spending on services covered by the acute inpatient prospective payment was $93 billion in 2004 and $17 million for the outpatient PPS.

We have information for you today on four of the factors that we consider in assessing payment adequacy, the four that you see listed here, and we will follow in December with information on payments and costs in 2006 and on the appropriateness of hospitals' cost growth.

I'll begin with access to care where our measures address the service capacity of hospitals and facility openings and closings. Focusing in this first chart on outpatient service capacity, you see that the share of hospitals offering outpatient services, specifically outpatient department or clinic services, outpatient surgery and ER services, has remained stable from 1990 through 2004. Outpatient surgery, in fact, has increased from 81 to 86

percent.

Next we look at a set of specialized inpatient and outpatient services. Here all five services that we're looking at have risen in proportion at least two percentage points from 1998 through 2003, with a larger increase, from 26 to 33 percent, for trauma centers despite the fact that this service is generally considered to be unprofitable.

Next we have a set of specialized ancillary services. Once again we find that the proportion of hospitals offering the service has risen in every case except psychiatric services, which have fallen from 50 to 46 percent of hospitals.

At this point, I turn the presentation over to Tim.

MR. GREENE: In each year since 2002 more hospitals have joined the Medicare program than have ceased participating, generally closing as acute care hospitals. In 2004, 61 hospitals joined the Medicare program and 44 dropped out for a net gain of 17. One-third of new participants identified themselves by name as specialty hospitals, orthopedic, heart, women's, and so on.

The annual number of hospitals ceasing

participation in the Medicare program dropped from 93 percent in 1999 to 44 in 2004.

In addition to those leaving Medicare entirely, approximately 1,000 rural hospitals converted to critical access hospital status between 1998 and 2004. These hospitals are no longer paid under the acute inpatient or outpatient prospective payment systems. However, they are still available to provide care to Medicare beneficiaries. In 2004 145 hospitals became CAHs. We expect that conversions will essentially cease after 2005.

Turning now to changes in the quality of care, we analyze risk adjusted mortality indicators developed by the Agency for Health Care Policy and Research. AHRQ chose these indicators based on evidence that their rates are related to the quality of inpatient care. It reports great variations among hospitals in performance on these measures. Both in-hospital and 30-day mortality declined from 1998 to 2004 for each of the eight conditions and procedures we measured.

I should also add that all rates declined from 2003 to 2004, as well.

I'll turn to our second outcome measure. Adverse

events reflect another dimension of quality of care, patient safety. We examined changes in AHRQ patient safety indicators, PSIs, to identify potentially preventable adverse events resulting from hospital care. The rate of adverse events increased for six of the eight most common measures from 1998 to 2004. In addition, four increased and four decreased between 2003 and 2004.

Although these are rare events, often with rates under 100 per 10,000 eligible beneficiaries, collectively they affected approximately 386,000 cases in 2004.

We now turn to examination of processes of care. Data from the quality improvement organization, QIO, program on the clinical effectiveness and appropriateness of care in hospitals show improvement for 22 of 25 measures from 2002 to 2005. Nine out of 10 AMI indicators improved, as did three of four heart failure indicators, seven of eight pneumonia indicators, and all three surgical infection prevention indicators.

Despite the widespread improvement in indicators, the three I've discussed so far, many beneficiaries are not receiving clinically indicated services. Looking at the QIO data, prophylactic antibiotics are discontinued within 24

hours after surgery only half the time. In general, many quality measures show improvement but we're concerned about the trend for some measures, especially the patient safety indicators that I reviewed a moment ago.

Turning now to inpatient volume change, the number of discharges, whether calculated from Medicare or all payers which includes Medicare, increased every year from 1999 through 2004. In 2001 and 2002, a substantial portion of the increase in Medicare discharges resulted from beneficiaries leaving the Medicare+Choice program and returning to traditional Medicare. Since this fee-for-service discharges alone, that leads to an increase in the fee-for-service discharge total in these years. From 2000 to 2003, the annual increase in Medicare discharges exceeded those for all payers. But the two measures show identical growth rates of 2.1 percent in 2004.

Turning to our second inpatient use measure, the average length of stay for Medicare patients fell more than 30 percent during the 1990s with annual declines exceeding five percentage points from 1993 through 1996. After that, the rate of decline slowed. The rate of decline slowed to 1.1 percent in 2004. The drop in length of stay has been

greater for Medicare than for all payers, which again includes Medicare, in every year since 1999. But in 2004 the gap in rate of decline narrowed to only a tenth of a percentage point.

Finally, we look at the case-mix index, the inpatient case-mix index. The CMI, or case-mix index, for Medicare inpatient services provided by acute care hospitals decreased slightly from 1998 through 2001. Since then the CMI has registered increased of 1 percent, 0.6 percent and 0.4 percent. This has a direct implication for Medicare inpatient hospital payment.

In Medicare's per case payment system, case-mix increases result in proportionate increase in inpatient PPS payments.

Now Dan will be discussing outpatient volume.

DR. ZABINSKI: This diagram illustrates the cumulative growth rate in the volume of hospital outpatient services since the first full year of the outpatient PPS in 2001. What the diagram illustrates is that the annual growth rate in the volume of services has been quite strong every year but the rate of growth has been decreasing from a level of 12.7 percent in 2002 down to 8.3 percent in 2003

and then finally 5.3 percent in 2004.

MR. BERTKO: Is that, like Tim's, not adjusted for the shift back from Med Advantage in membership? Is that a pure number basis on rate of growth? So the fact that more people, a million more folks are covered, contributes to this growth?

DR. ZABINSKI: Yes.

MR. BERTKO: In the next round, could you maybe give us one with that taken out?

DR. ZABINSKI: Subtract about two percentage points off and you've got the ballpark.

On this diagram we illustrate the cumulative percentage growth in the service-mix index for outpatient services in every year. The service-mix index is similar to the case-mix index that Tim talked about on the outpatient side.

Unlike volume, the service-mix index has been increasing every year. But a little bit different from volume, the service-mix index has been increasing at quite a steady rate rather than showing a little bit of a decline over time. For example, it increased by 1.3 percent in 2002, 1.7 percent in 2003, and then 1.5 percent in 2004.

I'll turn it over to David Glass and he's going to discuss hospitals' access to capital.

MR. GLASS: Hospitals need access to capital to build facilities and buy equipment. They're certainly building facilities, as you can see from this graph. It's gone from about $10 million in 1998 to over $20 billion for hospital construction in 2005. So it's a big number, steady growth. But is it enough in itself to replace outdated equipment and facilities?

One indicator of that is the capital spending ratio, which is over 1.3, which says they're more than replacing the depreciation and amortization.

As we said, construction spending is strong. Other indicators are that issuances for tax-exempt hospitals continue to increase. They were about 15 billion in 2000. They're now over $26 billion through October of 2005.

Upgrades have also exceeded downgrades for the first time since 1998. In dollar terms the upgrades far exceed the downgrades. In other words, the credit of these hospitals has risen. And in fact, all key ratios that they look at have improved.

The reason they can do that while still borrowing

even more money is that, as the AHA reported, profit margins for hospitals reached a six-year high in 2004.

Hospitals expect access to remain good. They expect capital spending to increase. They're reporting access is the same or better than it was five years ago, according to a recent survey.

The for-profits also have access to capital. One of those indicators is stock buybacks. One large chain is buying back $2.5 billion of stock.

Also, there continue to be acquisitions by for-profits and new players are entering the game. In fact, some new private companies are entering and buying rural hospitals.

In conclusion, for the hospital industry as a whole, evidence is that access to capital is good.

Some people are concerned that there are some hospitals that cannot access capital. However, for the update we're interested in the aggregate of the industry. And also, the ratings agencies point out that hospitals that can't access capital tend to either be acquired or they merge with another hospital and that wouldn't affect access for Medicare beneficiaries.

MR. ASHBY: Just to summarize for a moment, we found that hospitals' capacity has remained stable for outpatient services and has expanded for almost all specialized services. We found that the number of closures is significantly down -- in fact, it's dropped by half -- while closings are more than offset by openings. Quality of care is generally improving except that we have some concern about mixed results for safety measures.

Both inpatient and outpatient volume are increasing along with case-mix index on the inpatient side and service-mix index on the outpatient side. And finally, hospitals' access to capital is quite good.

We will again be back next month to present our financial analyses.

DR. MILSTEIN: Perhaps my comment is more referable to the upcoming report but could you just let us know if there are ways in which the next month's report will segment the analysis to respect Congress's expressed intent in the Medicare Modernization Act that our payment should be adequate to what's necessary to cover the costs of efficient hospitals as opposed to average hospitals?

MR. ASHBY: We're definitely going to take that

one fairly directly in next month's analysis and I think it's probably just best to wait for that discussion.

DR. MILSTEIN: If there are ways of segmenting the analysis so that our definition of efficiency might not only encompass efficiency defined over the course of a hospitalization but also to think about hospital efficiency with respect to managing chronic illness care over the course of a whole episode.

MR. ASHBY: That we're going to deal with tomorrow on the inpatient resource use session. We don't anticipate having a direct measure of that for our payment adequacy work just yet. But we are moving on that front, as you'll hear tomorrow.

MR. BERTKO: Two questions for Tim. The first one, I'm going to couch this as passing along a secondhand rumor on critical access hospitals that one of the people I work with said that she had heard at some meeting, that perhaps as many as 2,000 hospitals had now applied -- in total -- to be CAH's. And I recall, at least from one of our earlier meetings, that the top end was thought to be only adding 100 or so hospitals. Have you heard anything about that?

MR. ASHBY: I had not heard that number. 2,000 would be very hard to understand how that could happen because there are only about 2,000 or I think 2,200 rural hospitals period. And the door is closing and we're at a count of about 1,150 at the moment.

We did anticipate maybe 100-ish or something along that line.

MR. BERTKO: You're confirming what I recalled from the prior meeting.

MR. ASHBY: Yes.

MR. BERTKO: The second one is on the intensity graph that you showed.

DR. MILLER: Can I just ask one thing? Is there a source in CMS that if those applications have, in fact, arrived would know this?

MR. ASHBY: We could report on the actual latest number. They report rather regularly so we can come back with the latest and greatest number.

DR. MILLER: This is an amazing program and so it might be interesting to see if there's another source.

MR. BERTKO: That's the only reason I pass it on.

DR. MILLER: That's why I'm asking would CMS know

because I know some of these decisions, at least prior to the sunsetting or whatever if the right way to describe it, these decisions were pitched by the governor. But I still think CMS had to be involved in the actual finalizing of all of that. So I'm thinking somebody should know the answer to that.

I'd like to know for sure that that's just a rumor.

MR. ASHBY: So we'll get both the number approved and the number of applications in the pipeline for next time.

MR. BERTKO: Great.

From this slide my question really is is there any evidence of code creep here on DRGs? And I know that in some portion of that period we had the intensity creep by one of the for-profit chains. And whether you could even look at some of these, perhaps in a few selected DRGs to see whether something's been going on there and whether that, in fact, is an important factor. Is that something you guys can look at?

MR. GREENE: We're intending to. We coded data that will be analyzed and we'll be presenting it at a future

meeting.

MR. BERTKO: Thanks.

DR. CROSSON: Just a question about the access to capital criteria and sort of the philosophy behind that.

The building boom that is on the chart is likely also a product of the favorable interest rate environment that we've had over the last number of years. So the question is as we think about that over time, because presumably that's going through another cyclical change, when we look at the access to capital criteria do we take that into consideration? Do we, in fact, just view the cost of borrowing as another operating cost that contributes to a favorable margin or not? Or is this consideration held independent of capital access costs?

Is that clear what I'm saying?

MR. GLASS: We're not looking so much at the cost of capital as whether they're accessing it. But obviously, it's easier to access when it costs less.

DR. CROSSON: I guess what I'm saying is does Medicare then take on the burden in the end of paying for the higher cost of capital? Is that what we think Medicare is supposed to do or not?

MR. ASHBY: There's a different answer to that. That's considered in the capital market basket which goes into the update every year. So a rise in interest rates will produce a higher update, all else being equal.

DR. MILLER: Just to sort some of this out a little bit further, so there's an update for the capital part of the prospective payment system, which is a separate update. And there's a separate market basket for that that would capture this component. That was one answer.

Go on. You seem to have another question. But I was also wondering whether you were asking how are those costs captured in the cost report? Was that part of your question or not? Maybe not.

DR. CROSSON: I guess what I'm thinking is if we're heading into a higher interest rate environment, and if we find -- let's say we have this discussion three or four years from now, and we find that the access to capital criteria is problematic, does that then sort of get built in as a consideration in this update, in addition?

MR. HACKBARTH: There is a cyclical component to this, as Ralph has pointed out in the past. And conditions have been relatively favorable in the financial markets,

interest rates.

And so in addition to profit margins, that's one of the factors that causes the decision about to invest now and build new capacity.

At some point the interest rate cycle will switch and then the investment will fall way off. I think what Jay is asking is when that happens, do we say oh, that's a factor that argues for a higher update? Do we play the game both directions? Or do we just play it one direction?

DR. CROSSON: That's correct.

DR. MILLER: Since nobody seems to be offering an answer to that, although they could if they wanted, I think what I would say about this is all of these things are incredibly imperfect and we look at four or five different factors. And none of them alone is dispositive. And even together it requires -- and I think in some ways it's the very existence of this group, one of the very reasons for a group like this to exist, where you look at a set of things like this and say I see all of these indicators and I bring a judgment to it.

I think we do consider all of this stuff in both directions.

Some of the other sectors are even much more on point on this in saying that Medicare's payments may have nothing to do with what the capital trends are because Medicare is such a small player in this particular market. Whereas here Medicare is larger and so you think we ought to be keeping an eye on this.

So I think it's really, in the end, a judgment that we put numbers in front of you and try and talk you through them. But collectively you're looking at a number of things and then making a judgment.

DR. KANE: I'm wondering if not interest rates but payment rates for specific DRGs and illnesses might be the cause for some of this ramp up. My question was actually do you have a sense of what proportion of this study is for specialty care, either orthopedic centers or cardiac centers or hospitals that are being built in response to the physician joint ventures? Can we break this out at all by the type of capital spending, the type of service or whether it's a specialty hospital or not?

MR. GLASS: The HSC, Center for Health Systems Change, has looked at this. And they find evidence that a lot of the money is going into some particular specialized

service like cardiac and catheterization.

DR. MILLER: Tim, didn't you report on the number of new hospitals entering and what number of them characterized themselves as specialty hospitals?

MR. GREENE: One-third characterize themselves as specialty by name. It doesn't tell you very much but it's a start.

DR. MILLER: Could you just hit the microphone and give us that number again?

MR. GREENE: About one-third of the 61 new hospitals identified themselves as specialty, orthopedic, heart hospital, things like that.

MR. HACKBARTH: Part of it may be specialty specific institutions. But even in general hospitals they know, as we know, that certain services are more profitable than others. And they to tend to want to invest in those things for understandable reasons.

DR. KANE: Again, in thinking about what do you do with this information then, are we talking about payment adequacy or are we talking about sort of a capital competition spiral that's going on because our inpatient rates are out of whack? I guess how to interpret this is my

question? Especially if it does look like it's the specialty arms race going here and not necessarily --

How should we interpret this?

MR. HACKBARTH: Maybe Ralph has the answer to that.

MR. MULLER: I do have an opinion on that.

Remember last year the margin was a about minus 1.9. So it may be out of whack but it may be in that direction.

If we look at the mortality and the safety numbers on page nine and 10, as you've pointed out, the mortality rates have gone down while some of the safety indicators have shown some increase. Now we probably defined death the same in 1994 as we did in 2004, but some of the other safety indicators may be a function of more reporting, better reporting, especially with the focus on safety and quality since the IOM report in 1999. My guess would be that people are just a lot more focused on reporting these things than we were then.

So is it fair to hypothesize that we could just be reporting this more accurately than we did then?

MR. GREENE: It's possible but it comes basically

from administrative data, claims data filed for billing purposes. This is not quality data submitted for quality purposes. It may be influenced by those interests, but it's not directly reported quality data in this chart.

MR. HACKBARTH: Could I get Karen also to address that question. I remember when we first wrote the chapter on hospital quality trends this was one of the issues that we discussed within this group. And we also consulted some outside experts about whether these particular safety measures would be biased by the sort of factors you're talking about.

MS. MILGATE: I think Tim's answer is the first line answer to that, is that it is administrative data. So it's probably not reporting of errors to any particular database for reporting of errors sake. But there are some questions about whether coding practices have changed and whether they're just coding in more codes, so you would tend to see more of these happening over time.

However, when we did talk to some coding experts they didn't seem to think that that would be certainly the only driver or the primary driver of this from having looked at coding practices. But that's as much as we knew about

it.

MR. MULLER: My second question deals a little bit off of Nancy's comment or question. Last year we started migrating from looking at total Medicare margins towards looking at total margin because on the theory that the higher payment rates in the private market were allowing Medicare expansion of services to go on.

As I responded to Nancy there, we had seen in the last four or five years a decline in total Medicare margin and inpatient margins and so fort. I think last year it was minus 1.9 and minus 1.5. My guess is that that number will be even more negative when we get your numbers next month. I'll bet a cheeseburger on that. And my guess is, as you said, the total margins are probably going up. I think you just said that they had gone up in the last year.

So I suppose I can anticipate therefore that we'll probably keep looking at the total margin issue more than the Medicare margin.

MR. HACKBARTH: I was going to let you go until the last part.

Just to the record straight, Ralph, what we're looking at is the rate of increase of Medicare costs per

case. And as a long-standing part of our analysis one of the things that we look at is the appropriateness of that increase. So, in trying to determine that, we said what's driving this?

We concluded that a major factor driving it was the relatively liberal payment policy on the private side. We've been through this cycle before in the Medicare programs. We've documented the three phases of the PPS history and we're in a phase that's not too dissimilar from what happened in the late 1980s where private payment and margins went up, helped drive an increase in Medicare costs per case and Medicare margins fell. What is the appropriate policy response to that situation was the question on the table last year.

I'm not going to bet you a cheeseburger about this year because I'm pretty sure that you're going to be right, that Medicare margins will continue to be negative because this force is still in place. Generous payment on the private side has been driving substantial increases in costs per case.

So from my vantage point I see that as being a little bit different than what you said, which is we're

going to look at total margins. We're looking at why Medicare costs are going up and whether Medicare policy should accommodate that increase.

MS. HANSEN: This is a question for slide 10 relative to the patient safety indicators, and it was helpful to realize that this is the administrative billings per se, not the safety aspect.

I'm still quite taken aback by the decubitus ulcer issue and I imagine that many of the patients who show up in the hospital from another facility actually the reason the treatments are done. But are the decubitus ulcer billings separated out as to ones that are acquired in the hospital as compared to prior to coming in? That's one question.

Just the second question was the finding of failure to rescue. Does that mean that this was a preventable death?

MR. GREENE: The latter, basically yes, it's related to mortality. On the former, the decubitus ulcer is an area of concern because it's common. These rates are defined per member of an eligible population. Eligible population for decubitus ulcer would exclude those who are transferred in from long-term care facilities and other

restrictions like that.

MS. HANSEN: I'm sorry, so these are in-hospital acquired?

MR. GREENE: Yes, there are intended to be that and they're defined that way..

MS. HANSEN: That just poses a broader question. Since lengths of stay have been decreasing so dramatically and the fact that this is still -- even though there's an improvement it appears. But the length of stay of a Medicare stay seems to be dropping? Was that correct from a previous presentation? But that in the meantime we still have this number of decubitus ulcers occurring in-hospital.

Does this have consequences for payment, as well? Or is that kind of just the description of what is happening in quality right now? Is it only at that level?

MR. GREENE: It's the latter, to the extent that the diagnosis would affect DRG assignment and payment, yes. But I doubt it would.

MR. GLASS: The rate is increasing, by the way.

MR. GREENE: The rate is increasing. This is an increase in decubitus ulcer.

MS. HANSEN: It means -- I thought --

MR. GREENE: The rate is increasing, not getting better.

MS. HANSEN: It's getting worse. Excuse me, I misread the footnote here.

So this, at this moment, is just a descriptive factor entirely?

MR. GREENE: Yes.

MS. HANSEN: This is a public reportable number in terms of say hospital-to-hospital comparison of performance of decubitus ulcers as a quality measure?

MR. GREENE: It wouldn't be included in the process measures that CMS collects, no. It would not be. It's publicly available data, just as we are able to make use of it but it's not published data in general, as far as I know.

MS. HANSEN: Thank you.

DR. STOWERS: Would this not include decubitus that a patient came from home with?

MR. GREENE: I'm not sure about that.

DR. STOWERS: I'm saying they're seen in the hospital and they're admitted to the hospital.

MR. GREENE: I think it's designed not to, but I

can't tell you for sure.

DR. STOWERS: I didn't think, back in these older data times, that we had a mandated diagnosis as when they came in and when they left. Didn't we just require that in recent history? So this could actually say that more people are coming into the hospital from home or from the practices with decubitus? So it could be a lack of access out of the outpatient setting.

MR. GREENE: Yes.

MS. MILGATE: The only exclusion is those that came from the nursing home. And there's even some question about whether source of admission is even that accurate.

A couple of other points, from Jenny's question. The failure to rescue is death, but these are potentially preventable. So it's not clear that these definitely were -- well, the category could have been avoided. But they don't look at the specific event and say this definitely could have been avoided.

So it's important to make sure -- these are sort of indicators but not clear measures. We look at this at the overall hospital industry level. We're not sure that, because of coding practices that may differ, that this would

even be something you would want to use at the individual hospital level. We may need a little bit more information on the type of patients that enter the hospital before they can be used.

DR. STOWERS: So this could mean that there's more people coming into the hospital with decubiti?

MS. MILGATE: Actually, I suppose it could mean that.

DR. STOWERS: So it could mean lack of access out somewhere else. Because with the shorter and shorter stay in hospitals, the odds of a decubitus developing in the hospital gets less and less.

MR. GLASS: But Karen, for the eligibility to be in this class, don't they have to have a certain length of stay in the hospital?

MS. MILGATE: For decubitus -- is that right, Sharon? What is the length? Five? Yes, there is some length of time that you have to be in hospital to be eligible for the decubitus ulcer.

MR. GREENE: Which still doesn't rule out the patient arriving with a decubitus ulcer.

MS. MILGATE: Right, you still could've gotten it

somewhere else.

DR. MILLER: Why don't we run this down, the definition, and be sure that we're clear next time.

DR. MILSTEIN: There is a way that we can get at Ray's question and that is that there are multiple states that for a while have had in place present on admission indicators for secondary diagnoses and will allow a separate analysis purely for Medicare patients, Pennsylvania, California, et cetera.

And so we could, between now and the next meeting, those are public databases. A lot of the analyses are already run. We could, for this complication codes, which are built off of hospital discharge databases, we could home in on the Medicare experience in the states for which present on admission codes are collected.

MR. HACKBARTH: Just a reminder, this is something that we've recommended, that we collect this data so that we can discriminate between those conditions that were the result of hospital care and those that were present on admission.

We need to keep rolling here.

MS. BURKE: Mine was really just -- I think I'm

not understanding something and I just wanted to try and clarify it. If you look on slide 10 and slide 11, on slide 10 there is an indication that post-op sepsis has increased, the frequency has increased? On page 11, the last bullet says surgical infection prevention, all three indicators improved.

Is this not -- I mean, those aren't necessarily related?

MR. GREENE: The first is an outcome indicator. The second are various CMS processes. The QIO measures or process of care measures. So we're saying that for three process of care measures, care has gotten better by a different measure of the outcome, sepsis outcome has gotten worse.

MS. BURKE: So the process is better but the patient died.

MR. GREENE: Slightly different time periods.

MS. BURKE: They seem counterintuitive.

MR. HACKBARTH: And slightly different periods. One is 2002 to 2004. The other is 1998 to 2004. So that may be a factor. It could be a trend that peaked and declined.

DR. MILLER: This won't make you happy or anything, but it's been pretty systematic for the last couple of years when we started looking at quality measures related to the hospital setting. We'd look at process, we'd look at safety. To the extent that we had outcome, we would look at that.

And these babies were moving in different directions and it was pretty confusing. And I think that's still sort of the circumstance.

MS. BURKE: Confusing.

DR. MILLER: Confusing, right.

MR. GREENE: Census has been a problem. It's been in the published literature.

MS. BURKE: Exactly. So it would be helpful to understand how we could improve the process but still fail to address the problem. So perhaps, in the course of going forward, it would be helpful to understand -- if in fact it's a timing issue or if there is really this disconnect where the check marks are getting made but the patient is still getting sick. It would help me to understand what the disconnect is.

MR. GLASS: We can also look at what the actual

rate is.

MS. BURKE: That would be great. Thank you.

DR. WOLTER: I continue to be concerned about not at least taking a run at looking at outpatient versus inpatient margins. The reason I say that is the longer we let a situation go, where in fact outpatient margins may be considerably more negative than inpatient margins, the more incentives remain in place for investment in certain parts of care and not in other parts of care.

In my view, there's absolutely no evidence right now that hospital accounting practices are accounting for those margins.

We may not have the evidence the other way either but I think that we could criticize how much fixed overhead hospitals carry. It's unlikely, in my view, that they're allocating that differently to outpatient versus inpatient care.

A little bit along the line of what Nancy was asking about where the investment goes, and that's a new payment system, outpatient prospective payment, the longer that runs negative the more incentive there's going to be to put your investment on the inpatient side, particularly in

those areas where there's profitability, which we all know what those are, cardiac, ortho, neuro, et cetera. And that's where all this capital is going.

I think if we just let this go without being a little bit more serious about trying to understand it, people will follow the dollars. So I really worry about that.

I don't know how we get at it, because we've tried I know in the past and we haven't had good cooperation in those kind of things.

MR. ASHBY: We do have one more analytical line in mind and planned for right after the holidays, to take that question on. How successful we'll be remains to be seen.

DR. WOLTER: But when we have these kind of imbalances, just like we've talked about the DRG imbalances within say the impatient system, it does create behavior that sometimes we don't catch up to until the cat is out of the -- the cow is out of the barn or whatever.

Also, I just want to put a pitch in. We went away from a 0.5 percent add for technology last year. I worry about that because I don't think the current technology pass-through or whatever it's called, which is really aimed

at very specific technologies or procedures, I don't think it picks up some of the other larger system technology needs that are being addressed. The obvious one is clinical information systems.

But there is some interesting technology in telephony now evolving in chronic disease management, for example, that can really help us stabilize people and keep them out of hospital and that sort of thing.

I think that add had some value, although I know we're really looking at ways to control the rise in cost. But just to put a pitch in for that.

MS. DePARLE: I had an observation about our comments about access to capital. I guess it's slide 18 or 16 here, we talk about access to capital is good. And with respect to the not-for-profits, one thing I think we need to bear in mind and maybe look at a little bit further is in the last two or three months I've seen two different reports from rating agencies. I guess the text of our draft here implies that the rating agencies have, in general, said things are more favorable or better.

I don't know if there have been more upgrades than downgrades this year. Last year we had some data about

that.

But I've seen two reports that indicate the rating agencies are going to start to take into account whether or not hospitals have clinical information systems and how robust they are in doing their ratings.

And also even more recently, a couple weeks ago, I saw one where they said they're going to start requiring not-for-profit hospitals -- well, all hospitals, but not-for-profit hospitals -- to meet the requirements of Sarbanes-Oxley which, for any of you here who have gone through that process of going through every system in your hospital or entity and making sure that it is up to standards and that you can back up everything you have, it may very well be quite a signal of progress but it will be quite expensive for hospitals as well.

I'm saying that's access to capital. It may also relate to the point that Nick made, at least on the clinical information systems, that there are input costs here that I'm not sure are adequately taken into account.

The other one is we make the point that for-profits have access. And one of the bullets underneath that is stock buybacks. I just want to note, I'm aware of one

major for-profit company that's doing a stock buy back. I'm not sure that they would argue or that anyone else would view that as a sign of strength in the capital markets. I think what that perhaps is is a sign that -- I mean, they're using shareholders' equity because their stock, they believe, is not adequately valued by the market.

I suppose you can look at that as that they have access to it. But it's not necessarily a sign that they are feeling strong right now.

MR. GLASS: They're doing it with borrowed money, I guess was the point. They're borrowing quite a bit of money to buy back $2.5 billion. So they have access to the --

MS. DePARLE: They have access to that, but well...

DR. KANE: [Inaudible.]

MS. DePARLE: I'm not sure how much Medicare payment has to do with that either, but I question that a little bit as a sign of strength or of health.

MR. HACKBARTH: Okay, thank you very much.

MS. HANSEN: One small comment.

Glenn, you mentioned that the patient safety

factors on page 10, that the elements that we're looking at and measuring over time, one of the indicators is also people who break their hips while in the hospital. I wonder if that's something as a variable that we could add on as a measurement? Because that has huge cost and quality implications from a Medicare prospective, whether it's both acute, nursing home, and home health costs later on.

MR. GLASS: I think that may have been on the original list and was extremely small incidents but we can look at it.

MR. GREENE: It had a very small n. I think we excluded that from final analysis because the numbers were too small.

MS. HANSEN: So they still are very small right now?

MR. GREENE: No, I'm just saying this is not the complete set of safety indicators. We focused on ones that had adequate numbers of cases to analyze. If it was the hip fracture PSI, I think we ignored it because it was a very small n and we didn't trust the results.

MS. HANSEN: If I could then just see a list of the ones that we do follow, that would be helpful.

MR. GREENE: Of course.

MS. HANSEN: Thank you.

MR. HACKBARTH: There's actually, Jenny, I can't remember if the full list was in the chapter.

MR. GREENE: Maybe in the data book.

MR. HACKBARTH: It may be useful, Jenny, for you to look at the chapter. What year was that?

UNIDENTIFIED VOICE: March of 2004.

MR. HACKBARTH: March of 2004. There's a chapter going through all of the hospital quality statistics. That would give you some additional background on that.

MR. GREENE: We also have a table in the July 2005 data book.

MR. HACKBARTH: Thank you.

Okay, moving ahead, we're now switching gears away from payment adequacy analysis to look specifically at rural hospitals and outpatient PPS.

DR. ZABINSKI: Since CMS started using the outpatient prospective payment system in August of 2000, the financial performance of rural hospitals under the outpatient PPS has been only slightly worse than that of their urban counterparts.

However, many rural hospitals receive what are referred to as hold harmless payments. The idea of the hold harmless payments is that they are additional payments that hospitals receive at the end of the year to increase their outpatient PPS payments to the level they would have received under the cost-based system that preceded the outpatient PPS.

We know that without the hold harmless payments the financial performance of rural hospitals would be much worse than what it is. For example, we estimate that the outpatient margin for rural hospitals would be about three percentage points lower than what it actually is.

The bad news for rural hospitals is that the hold harmless payments expire at the end of this year. Without a new policy to replace it, rural beneficiaries may have problems accessing necessary hospital outpatient care.

In March 2005 we recommended extending the hold harmless payments for one year through calendar year 2006. The idea was to give us time to answer the following question: why do rural hospitals have relatively poor financial performance under the outpatient PPS in the absence of hold harmless payments?

We've identified two possibilities. The first possibility is that rural hospitals have high costs per outpatient service because they tend to be low volume. And we make that statement supported by two facts. First, that costs per service are higher among low volume hospitals. And second, we know that rural hospitals are disproportionately low volume hospitals.

The second possibility explaining the relatively poor performance of the rural hospitals, at least financially, is that the payments relative to costs are lower for services that require relatively few resources than what the payment relative to costs is for more complex services. And rural hospitals furnish a disproportionately high share of these low-resource basic services.

What this signifies perhaps is the need to recalibrate the outpatient PPS so that payments and costs line up more accurately. What this would do is it would move money around the outpatient PPS but it would not add anymore costs to the outpatient PPS nor to the Medicare program.

For the remainder of my discussion, I'm going to discuss these two possibilities in more detail starting with

our analysis of the relationship between the costs per outpatient service and volume of services.

Using a regression analysis we found that the cost per outpatient services clearly declines as hospital volume of outpatient services increases. We also found that the rate of decrease is higher among low volume hospitals than it is among high-volume hospitals. This diagram illustrates that finding. Along the X axis we have the number of outpatient services that hospitals furnish. On the Y axis is the cost per outpatient service relative to mean value of outpatient costs per service.

The idea is that if a hospital has a positive value, their costs per service are above the mean. If they have a negative value, their costs per service or below the mean. The curve illustrates the relationship between costs per service and volume. As you can see at relatively low volume levels that the cost per service is high, and then it decreases slowly as volume increases.

And then, at about 78,000 services, cost per service falls below the mean. For a lack of better term, we refer to the hospitals that are below the 78,000 service threshold as low volume hospitals and these encompass about

32 percent of all hospitals

For rural hospitals the issue is that they are disproportionately low-volume hospitals. For example, 55 percent of rural hospitals are low volume, where as I just said only 32 percent of all hospitals are low volume. Also, 64 percent of low-volume hospitals are rural hospitals whereas only 37 percent of all hospitals are rural.

MR. HACKBARTH: Dan, could you just pause for a second and explain the unit of measure services? So we're not talking about outpatient department visits here. We're talking about the very small units. So any one visit could have multiple service.

DR. ZABINSKI: Primarily, it's like a procedure, a diagnostic test or an imaging service. Most of them are going to fall in that category. It can be very simple things such as setting a broken bone or a very complex thing such as inserting a pacemaker but it's a single service, right.

The key underlying point here is that many of the low-volume rural hospitals are isolated. For example, we know that about 25 percent of the low-volume rural hospitals are at least 25 miles from another hospital that provides

outpatient services including critical access hospitals. These isolated hospitals are likely very important to beneficiaries' access to hospital outpatient services.

In considering all the results I've talked about, we conclude that making additional payments to low-volume hospitals would be an appropriate replacement of the hold harmless payments that expire at the end of this year.

But if you implement a low-volume adjustment, it should have the following three characteristics. First, the volume used as the basis for adjustment should be the volume averaged over several years rather than a single year. That helps smooth out annual variations in volume that a hospital can experience.

Second, the volume used as the basis for adjustment should be the volume that occurs when furnishing services to all patients, not just Medicare beneficiaries, because the volume of services furnished to all patients can affect the cost per service for outpatient PPS services.

And then finally, there should be some distance requirement. That is a hospital should be at least some minimum distance from any other hospital in order to receive a low-volume adjustment. First of all, this helps avoid

making additional payments to hospitals that are low volume because of poor performance in relation to nearby competitors rather than being low volume because they are isolated. Also, it helps avoid creating potential problems of excess capacity.

One thing I want to emphasize though is that we must be very careful in how large we set the distance requirement because it can strongly affect how many hospitals can qualify. For example, under a 25 mile distance requirement about 17 percent of low volume hospitals would qualify for an adjustment. But if we use a larger 35 mile distance requirement only 6 percent of low-volume hospitals would qualify for an adjustment.

I'm going to move on to the second possibility I mentioned earlier for explaining that relatively poor financial performance of rural hospitals, that being a different service mix between urban and rural hospitals.

In particular, we know that rural hospitals have a lower service-mix index meaning that they provide services that are more basic and tend to require fewer resources. Now I want to emphasize that this difference in service-mix index will affect the financial performance of rural

hospitals only if the payments relative to costs, in other words the payment-to-cost ratio, is lower for these lower resource services than it is for more complex services.

That said, it does appear that the difference in service mix between urban and rural hospitals is an issue. For example, regression results by us and CMS indicate that outpatient PPS payments relative to costs are lower for these lower resource basic services.

I want to say, though, that these results are not definitive proof of rural hospitals being at a competitive disadvantage. What we really need to do is make a comparison of the payment and the costs for individual services to determine whether the payment-to-cost ratio is lower for the services provided by rural hospitals. But if results of such an analysis do indicate that the outpatient PPS is not paying as precisely as it should for individual services, what we would need to do is take a step back and recalibrate the payments in the outpatient PPS so that payments do accurately match the costs at the individual service level.

And then to summarize, I want to review three key points of my discussion. First, that the financial

performance of rural hospitals under the outpatient PPS will decline if no policy replaces the hold harmless payments that expire at the end of this year.

Second, we view a low-volume adjustment with a distance requirement as a viable replacement for the hold harmless payments. One thing I want to point out is that CMS intends to begin using a policy in 2006 that will provide additional payments to rural sole community hospitals that are located in rural areas. But we believe a low-volume adjustment with a distance requirement has advantages over CMS's intended policy and that the low-volume adjustment should be used in place of rather than in addition to CMS's intended policy.

And then finally, an investigation should be made into whether the outpatient PPS pays precisely for the payment and costs of individual services. And when I say that, that would be quite an undertaking and require quite a few resources.

Now I turn things over to the Commission for discussion and I'm most interested in hearing your thoughts on any recommendations that we should pursue.

MR. HACKBARTH: Would you go to slide eight for

just a second, Dan?

This is parallel, analogous to the inpatient low-volume adjustment that we recommended a number of years ago. And as I recall, it's been enacted into law; right?

DR. ZABINSKI: Very similar, yes.

MR. HACKBARTH: The issues about the service-mix index are basically analogous to the issues we've been wrestling through with the DRG weights and whether they create uneven levels of profitability across services. So there are clear parallels to our inpatient work in both of these; right?

DR. ZABINSKI: I agree with that, yes.

MR. HACKBARTH: To address the service-mix index issue, you said that's not something that's easy to do or quick to do. Could you just elaborate on that?

DR. ZABINSKI: We have started work on that sort of thing. It started sometime ago. It's been going in fits and starts. Largely what it requires is digging very deep into the claims data and that looking at the costs and the payments for the individual services.

Having done some work on that I'm just speaking from first-hand experience, it's very tough sledding to go

through all of that.

DR. MILLER: To put it a little bit differently, when we did the inpatient work the big challenge was everybody's view was these DRGs are more profitable than those DRGs. Everybody carried that around in their head from their experience.

The real difficult issue was could you actually quantify that from the existing data? And it took us about 15 months to actually derive the actual cost and payments for individual DRGs.

It would be a similar exercise here to do for the -- the numbers escaping me -- however many APCs are out there.

DR. ZABINSKI: 700 to 800. It varies from year to year.

MR. HACKBARTH: The question that this leads me to is we did this last year because we were concerned that the system discriminated against rural hospitals and was a big contributor to their overall negative margins. We can pretty easily recommend a fix to part of it, the piece of the low margin that's attributable to low volume. But the piece that's attributable to case-mix inaccuracies takes a

longer time.

How much of the problem are we addressing if we just do the low-volume piece in the short run and not the other?

DR. ZABINSKI: From the numbers that I have, it looks like about a 50-50 split. It's probably about half of each. As I said, if you take away the hold harmless payments, the rural hospitals are about three percentage points below their urban counterparts. I guess a low volume adjustment could take about half of that difference away.

DR. MILLER: [off microphone] That assumes that the other half is attributable to it, which we have a hunch but we don't actually have that.

DR. STOWERS: I'm back to page eight again just to go over the three points.

I wonder what we mean by several years and averaging. The majority of the hospitals that we're talking about here are critical access, or at least a lot of them.

DR. ZABINSKI: They're exempt from the outpatient PPS.

DR. STOWERS: Right now, but I'm saying here we might not be.

DR. MILLER: Unless I'm missing something here Dan, this policy would be directed at rural hospitals paid under PPS --

DR. ZABINSKI: Exactly.

DR. MILLER: -- because critical access are paid cost plus --

DR. STOWERS: So the critical access are out of this specifically?

DR. MILLER: Right.

DR. STOWERS: That changes things a little bit.

So even on item number three, with the distance requirement, we're not talking about critical access at all where that distance has been determined?

DR. ZABINSKI: My feeling on that is you look at the distance requirement. If you have a hospital that is within -- my belief is that the critical access hospitals should be included when considering the distance requirement because most critical access hospitals furnish outpatient services.

DR. STOWERS: But isn't this opening the whole can of worms that we went through last year where, for whatever mechanism, through either their state or through CMS, they

were certified?

MS. THOMAS: Can I help to clarify here? This policy would not affect critical access hospitals. The 25 would only affect the calculation for PPS hospitals if they're near a CAH. So it doesn't affect CAHs at all.

DR. STOWERS: It's a one-way thing.

MS. THOMAS: Yes.

DR. STOWERS: Okay.

DR. KANE: Actually, that was my question in a way, too. What's left after you take out the critical access hospitals in this analysis? Were they in here to begin with? Are they affecting the volume?

And then I guess if you take them out, how many hospitals do you have left that are rural, low volume, 25 miles away from -- how big a pot are we dealing with here? Is it worth going to this much -- I know they're valuable hospitals. I'm just trying to find out what happens when you take CAHs out.

MR. HACKBARTH: Is it 2,000 total rural hospitals, 1,000 of which are critical access. So that leaves 1,000 others.

DR. KANE: Another thousand may have applications

into CMS.

DR. ZABINSKI: You'd end up with about somewhere in the neighborhood of 200 hospitals, 170 to 200 hospitals, I figure, with the 25 mile distance requirement.

MR. SMITH: 200 that would be affected?

DR. ZABINSKI: That would get an additional payment.

MR. SMITH: 200 out of the 1,000?

DR. ZABINSKI: Yes. Now if you move that up to -- let me make sure I've got my numbers right in my head.

MR. HACKBARTH: Your point is an important one, Nancy, in terms of it's a lot of work for a relatively small number of relatively small institutions.

On the other hand, if you don't address clear problems, that's what fuels everybody to say well, I want to be a critical access hospital. So we don't address issues like this, it won't be long before we have 2,000 critical access hospitals.

DR. ZABINSKI: I'll modify what I said earlier. Under a 25 mile distance requirement, you'd have about 150 rural hospitals getting a low-volume adjustment. If you drop that to a 15 mile requirement, you would move somewhere

closer to 450 to 500 hospitals.

DR. KANE: Maybe the numbers might influence our judgment perhaps more on whether it's worth pursuing the payment to cost than it is the volume adjustment. In other words, if there's a lot of work to coming out, that maybe it's not worth it for 200 hospitals. I don't know.

MR. SMITH: [off microphone.] It's the other way around. Let me make sure I understand what you said. If 150 would qualify for your low-volume adjustment, that would suggest that 850 wouldn't.

DR. ZABINSKI: Right.

MR. SMITH: [off microphone.] Your presentation again suggesting that absent the hold harmless, all 850 [inaudible].

DR. ZABINSKI: No. I mean they're rural hospitals and they're not all in trouble to start out with. Some are in quite fine financial situations.

MR. SMITH: [off microphone.] But of that 800 of that population, are there any that wouldn't qualify for the low-income adjustment? Which I assume would [inaudible] the hold harmless quantitatively? How many of the 850 would be in trouble?

DR. ZABINSKI: Not off the cuff, no.

DR. MILLER: I thought Nancy's point was a little bit different. Do you want to move with this policy and help 150 to 200-some-odd hospitals? Or do you want to spend the time to develop the payment system adjustments which might affect all hospitals and all of the 1,000 rurals that we have in conversation here?

DR. KANE: What I was saying was that if we really only have about 200 hospitals -- how many hospitals -- after you take out critical access, how many hospitals are disadvantaged A, by the volume; and B, by the payment-to-cost issues? And then, if that's only 200 or less, is it worth going through the payment-to-cost analysis?

MR. HACKBARTH: Potentially it's the full universe of PPS hospitals that could be hurt by accuracies in the adjustments for different types of cases. That's not just rural hospitals. That could be urban hospitals, depending on their distribution of cases.

So that's a systemwide outpatient PPS issue, as opposed to just an issue for 200 or 500 rural hospitals. This is potentially much bigger

And we're actually a little bit ahead of ourselves

because we really don't know that there's a problem there. As I heard the presentation, there was some suggestive evidence but not a conclusion. So I think we ought to look at it a little bit more.

DR. KANE: The other piece of the low payment-to-cost for low weight things is is the reason that rural hospitals provide relatively more of those related to the fact that those are provided in the non-hospital sector in other environments? And maybe that would be better in the rural environment, as well? ASCs or freestanding?

Is the rural hospital the most efficient place to provide a low payment, low case weight service? And is that being provided, in fact, in physicians offices or other places in the non-rural environment? I'm just trying to get at where is this --

MR. HACKBARTH: Good questions, all of them. I think that you're further ahead than our analysis and thinking of the issue is.

Also, I appreciate your thinking about efficient use of scarce resources, not just ours but CMS's. Those are the right questions to be asking. We just can't give definitive answers at this point.

Ray.

DR. STOWERS: I just had one more question.

Are we setting up -- because I'm really not sure on it. Are we setting up a whole situation where a hospital that is not a critical access who maybe in the past helped the establishment of a critical access hospital over the mountain or whatever, who now could be in some way penalized because they have someone within that distance from them? Because now they don't meet a mileage requirement?

DR. MILLER: Would the critical access hospital be penalized?

DR. STOWERS: No, would it prevent increased payments to the other hospital that happens to be within 15 miles of the critical access hospital? What we doing to the relationship between those 150 hospitals and critical access hospitals who well, in a very cooperative market, working together, may have agreed and not fought having the critical access. Now all of a sudden they don't meet some distance requirement.

I just think we need to think on through that a little bit, because I'm not sure it's going to be to their advantage to -- if I'm understanding it right, if they have

someone within this mileage requirement, then they're not going to be eligible?

DR. ZABINSKI: Right.

DR. STOWERS: To stay on the --

DR. ZABINSKI: There's nothing to stay on. There's something to quality for but there's nothing to stay on.

DR. STOWERS: Because somebody happens to be within a distance to them, of which they may have had no control, or may even have helped, now they're disadvantaged because they have someone within that.

It seems like a reversal. I could see it back when the critical access was being set up. But to have the larger hospital be penalized because there's a critical access within a certain distance of them, I'm not sure that all makes sense in there. We can talk about it more later.

MR. HACKBARTH: We'll think through that some more. We need to keep moving here.

MR. BERTKO: I just have one short question that's an addendum to Nancy's group question, which is are you thinking about this as a budget neutral adjuster rather than just a one-way payment?

DR. ZABINSKI: You could do it either way. For example, the hold harmless payments are not budget neutral. But CMS's -- that intended policy I talked about for CMS, that is going to be budget neutral. You could do this either way. No reason why you have to do it one way or the other.

MR. MULLER: Just a clarification on our consideration here. In terms of the lower volume, therefore higher costs hospitals, in the urban settings that don't qualify because obviously they, almost by definition, don't meet the distance criterion. They may serve an equal number of people, just given urban populations versus rural populations.

What's our policy reason for excluding them versus the rurals?

DR. MILLER: Because they don't have an access issue. You can go to another hospital nearby.

MR. MULLER: But they may serve the same number of people as the rural ones. So is it just because there's a hospital nearby? Or is it based on the number of beneficiaries?

DR. MILLER: If I'm understanding your question,

the line of reasoning works like this -- and it's the same line of reasoning on the inpatient side. If you have two hospitals across the street from one another, and one is low volume and the other isn't, it might be because people are sorting themselves do "the better hospital".

In that instance, would you really want to go in and reward low volume in that instance? Then you're just sort of maintaining capacity.

Whereas in a rural area, you get further out, that may be the only source of care. But I think it's also a legitimate point. You still may be supporting a hospital that people do or don't want to go to. But it becomes more of an access issue the further out that you are. I think that's the line of reasoning.

MR. DURENBERGER: Could I ask Ralph's question just a little bit differently, which is maybe three questions. First, what is a hospital? Two, are patients portable? And three, if so, for what distance? I mean, I hate to be simplistic about this, but...

DR. KANE: There's a fourth one, which says that rural hospitals may have substitutes that just aren't hospitals, which is the physicians' office and the

ambulatory surgery center. And we're missing those completely by having it be hospital definition only, especially on these low intensity services.

MR. DURENBERGER: A different way of asking the question, is this really basically a political measure distance? Or is there actually some foundation in high-quality effective medical care and access represented in that numbers 15, 25, et cetera?

DR. MILLER: Dan, you want to answer this?

DR. ZABINSKI: You go first.

DR. MILLER: I would be hard-pressed to argue that there is an analytical framework for 15, 25 or 35 miles. I think this comes down to -- just like in response to Ralph's question, where do you think you actually have an access issue?

I think Nancy, your point about but could there be other substitutes out there is a really good one and it could very well be that you can say 15, 25, 30 miles of a hospital and an emergency clinic and make that as part of your requirements.

But I don't know that there's an analytical argument for 35 miles. I think for us, we're benchmarking

it to what it was on the inpatient side.

DR. WOLTER: I was just remembering, or trying to remember some of the data way back when the whole critical access program was being discussed. If I'm remembering right many, if not most, of the institutions that have become critical access had margins that were positive or break even under the inpatient part of their payment but really felt that where they were getting in trouble was under outpatient.

Then I was thinking about last year, when we discussed the rapid growth of the critical access program and had quite a discussion about whether or not we should go back to more consistent rules about who's in and who's out.

I was just asking Sarah, I guess there's a report due next December on the whole rural payment package. And I don't know whether we'd be looking at the critical access piece in that or not.

But where I'm going with that is it's possible that had we had a low-volume adjuster earlier, we might have had fewer critical access hospitals develop. I really don't know that, but it's maybe an alternative for us to think about going forward as a policy alternative, although it's

always hard to go back again, I suppose.

MR. HACKBARTH: Okay, we're going to have to move on for right now and go from outpatient PPS for rural hospitals to valuing services under the physician fee schedule.

DR. HAYES: Good afternoon. During this session and the next one we will be talking about some topics on physician services and we thought it would be wise to just kind of locate these topics in MedPAC's overall agenda on physician services just to provide some context.

And so when we think about that agenda, the items kind of sort themselves into a couple of different themes. The first has to do with mispricing. This is a topic that we raised in the June 2005 report. It's some evidence of errors in the physician fee schedule, possibilities that Medicare is paying too much or too little for some services. And within that we have the two topics for today, valuing physician services and then practice expense.

In addition, there are some issues of geography in the area of mispricing. One of them has to do with the boundaries of the payment localities in the physician fee schedule and the fact that they have not been revisited

since 1997.

The other has to do with the way the practice expense adjuster works and a possibility that it's overadjusting payments for services where there is a disproportionate use of equipment and supplies.

The geography topics are not for today, of course, and you'll be hearing more about those at future meetings.

The other theme that comes through in our agenda has to do with what we might call resource use and quality. You'll be talking about measuring resource use tomorrow morning. Some of that agenda involves physician services. I talked about care coordination earlier today.

The third topic here has what we call managing volume growth. This kind of ripples throughout the other topics. It's worth observing that the Congress remains interested in ways to reform the SGR.

That's kind of where we are with the agenda.

I'll also note that there are some other more cross-cutting issues here involving other sectors. So for example, we are focusing during this report cycle on this matter of the choices that beneficiaries have about the settings where they receive care. So in the case of

outpatient services we have choices among hospital outpatient departments, physicians' offices and ambulatory surgical centers. So you'll be hearing more about that issue at a future meeting.

And finally, I just would point out that a lot of this implicates some of the broader issues, some of which came up earlier today and at previous meetings, having to do with things like physician incomes and how the relative incomes vary among physician specialties. Also, the term was used at an earlier discussion, entrepreneurial behavior on the part of physicians, self-referral and all that.

So these are wide range of issues involved here with physician services. But today we want to focus on a couple of the mispricing issues.

So Dana will talk more about the process for establishing values in the physician fee schedule, how they are reviewed periodically and some problems we see and some ways that we might address those problems.

MS. KELLEY: In September we presented to you information about this process of the relative values of physician services. As we talked about, making sure services are accurately valued is important in order for

Medicare to be a prudent purchaser. This valuation means that Medicare is paying too much for some services and not enough for others. As a result, the market for physician services can become distorted with physician decisions influenced by financial considerations rather than solely by clinical necessity.

Over time, as some of you noted in September, misvaluation can make certain specialties more financially attractive than others, which can have implications for the supply of physicians. We also discussed the fact that evaluation and management services as a group may be coming undervalued relative to other services.

Routine review of the fee schedules relative values is necessary because the resources required to perform a service can change over time. When that happens, the value of a service must be changed accordingly otherwise Medicare's payments will be too high or too low.

By law CMS is required to review the work RVUs every five years to determine if any services have become misvalued and if revisions are necessary. The work RVUs, as you'll remember, account for a little more than half of total payments.

This process is known as the five-year review and the third five-year review is currently underway.

In conducting its five-year reviews, CMS relies heavily on the assistance of the AMA's RVS update committee or RUC. The five-year review process begins with CMS requesting public comments on potentially misvalued work RVUs. All of the codes in the fee schedules are open for comment.

In addition, CMS staff themselves may identify codes that they believe are in need of review. Identified codes are then forwarded to the RUC for evaluation.

The RUC relies on specialty societies do field surveys on the work required to perform the services in question. The RUC then evaluates the survey data and other evidence and develops recommendations for consideration by CMS. CMS makes the final decisions regarding relative value changes. In the two previous five-year reviews, the Agency accepted more than 90 percent of RUC recommendations.

It seems clear that the process of valuing physician work is not working as well as it should. We know that the factors that can lead to a service becoming misvalued, such as learning by doing and technology

substitution, suggest that both undervalued and overvalued services are an issue. But as you can see here, previous five-year reviews led to substantially more increases in RVUs than decreases. During the first five-year review, the RUC recommended that the relative values be increased for 296 codes, maintained for 650 codes and decreased for 107 codes.

The second five-year review produced an even more lopsided outcome, with the RUC recommending that the relative values be increase for 469 codes, maintained for 311 codes and decreased for 27 codes. As I mentioned, the vast majority of these recommendations were excepted by CMS.

In both the first and second five-year reviews, the growth in the RVUs for so many codes would have increased total payments so CMS was required to reduce payments for all services to maintain budget neutrality.

The results of previous reviews point to a tendency to ignore overvalued services. There are a number of reasons why a bias in favor of these services exists. I'm going to focus on the role CMS plays in the five-year review process as it's currently designed and how it might act to reduce the bias in the process.

CMS's major role in the process comes at the beginning, when it identifies the codes that the RUC is going to consider. Most services that CMS submits to the RUC for review are identified in public comments from specialty societies. The vast majority of these comments are related to services that specialty societies believe are undervalued. During the second five-year review CMS, then HCFA, received comments on approximately 900 codes. The relative values for all but a handful of these codes were considered by commenters to be too low.

The same is true of the 540 codes submitted to CMS for the current review. This is not surprising, given that specialty societies and their members have a financial stake in the outcome of the process. Indeed, the chair of the RUC stated, in a letter to the Commission, that physician specialty societies cannot be relied upon to nominate potentially overvalued codes.

Since physician specialties are unlikely to submit codes that are overvalued, the burden of doing so must fall on others. CMS has sometimes identified codes that it believes are misvalued and asked that the RUC evaluate them. However, during the second five-year review, CMS did not

themselves identify any codes for RUC review, but instead just took the ones that the specialty societies and others had submitted.

And for the current five-year review, CMS did identify 168 codes that they felt needed review. But the Agency doesn't appear to have focused on services that appeared to be overvalued. CMS submitted 149 codes because they had never before been reviewed, one low-volume that was initially valued as being performed in the inpatient setting but that is now believed to be provided primarily in the outpatient setting, and 19 codes that CMS believes have experienced advances in technology that are likely to have changed the amount of work required to perform them.

But CMS did not indicate to the RUC whether it thought the submitted codes were under our overvalued, nor did the Agency provide any evidence for the RUC to consider.

So the services that are reviewed by the RUC are substantially more likely to be undervalued than overvalued and the services that are not reviewed are assumed to be accurate. But as we have discussed, there's no reason to think that over time services are more likely to become

undervalued than overvalued. In fact, the RVUs for many relatively new services are almost certainly too high.

New services entering the physician fee schedule may be assigned relatively high work values because of the additional time, mental effort, technical skill, psychological stress and risk associated with performing a new service. For such services, we would expect physician work to go down over time as physicians gain familiarity with the services and become more efficient in furnishing them.

Other changes in medical practice may also result in changes in physician work. Thus, starting from the premise that RVUs are accurate probably results in some services becoming and remaining systematically overvalued over time.

Reducing CMS's reliance on specialty societies to identify codes that need review could go a long way towards reducing bias in the process of valuing physician work. One way to do this would be for CMS to solicit nominations from carrier medical directors, as HCFA did during the first five-year review. Private plans might also be a source of information. Tapping these sources may result in greater

identification of overvalued services than currently occurs.

Another way to reduce bias might be to put in place triggers for automatic reviews. For example, CMS could require automatic reviews for all recently introduced services. New services could be scheduled for review within some period of time, such as three years, or for repeated review over a longer period of time to ensure that the natural decline in the work associated with many new services is reflected in the RVUs.

CMS could also institute automatic decreases of some specified percentage amount unless evidence suggested a different relative value was more accurate.

CMS could also require automatic reviews when services experience large changes in practice expense. A large increase in practice expense signals the need to evaluate work RVUs because changes might reflect substitution of nonphysician clinical staff or other inputs for work previously done by physicians.

For example, use of digital storage of radiographic and other images may increase practice expense but can reduce physician work by reducing interpretation time.

Data analysis could also help in the identification of services and could be used to trigger automatic reviews, as well. Kevin's going to discuss the types of data analysis that could be useful to the process.

DR. HAYES: Some of this would entail use of claims data to look for signs that perhaps the amount of work required to furnish services has changed. So CMS could go through the claims data and look for changes in hospital length of stay, shifts in the site of service from one setting to another, the mix of specialties that are furnishing physician services, growth in the volume of services. All of these things could be evidence that the resources used to provide services has changed.

Another possibility would be to look through the claims data and look for combinations of services that are typically furnished during a single encounter. The thought here would be that perhaps there is some efficiencies associated with providing more than one service during a single encounter and that that should be reflected in the RVUs, and therefore how the payments work.

One final example of a data analysis would be to just look at alternative data sources to see if, for some

services at least, there might be data say from operating room logs on the amount of time it takes to perform a surgical procedure, the amount of time that anesthesiologists report it takes to provide their services during procedures, that kind of thing.

So this is kind of an overview of what we see here on this issue. Clearly there's a need for review of the RVUs in the fee schedule. At the same time, we see a process in place to do so but some evidence of problems with it. But we've tried to provide you with some ideas for how those problems might be at least minimized.

Before we turn things over to you, I just would go over one more slide here which talks about some potential policy options. We're at the point now where we really, as staff, need some guidance from you about where you would like to go next on this topic. When we think about the discussion that happened in September, where the focus was mostly on the RUC's role in the review process, combine that with what we reviewed today, more focusing on CMS's role, the question is what do we do next? And are you in a position at this point to start talking about some policy options? Would you want to be making some recommendations

in this area?

In thinking about topics you might want to consider, they're listed here. The first one would have to do with the composition of the RUC. Back in September you talked about some different ideas, the mix of specialties represented on the RUC, should there be some other interests represented there, retired physicians. We talked today about private payers and so on.

What's emerged, as we've worked on this issue, is the importance of changes in RVUs for new services. Does that mean that technology diffusion and some people with expertise in that need to be represented? These are just some ideas of things you might want to consider in that area.

The other has to do with the structure of the review process. As we've heard, this idea that there's a presumption that the existing RVUs are accurate, maybe that's not appropriate for things like new services or services where we've seen an increase in either practice expense or work RVUs, suggesting that maybe there's some substitution going on within a service.

And finally, as we discussed today, there's some

opportunities here for further data analyses on the part of CMS to flag services that are potentially misvalued.

So that's pretty much where we are and we look forward to your comments.

DR. NELSON: I wonder if the term bias implies intent? And if so, it may be not the most appropriate term if indeed, the results of the deliberations of the RUC, for example, are a product of the rules that they follow. It may be that we'll agree that bias doesn't imply intent. But I raise that as a question.

If it's possible to pick a term that may be viewed by some as less pejorative, it might not be a bad idea.

On page 13, it notes that RVUs for services can become too high when the volume of services grows because the requirements for nonphysician clinical staff time and so forth may lessen and you get economies of scale as the volume goes up.

I would suggest that for E&M services, where work is most closely correlated with time, that's not the case. As a matter of fact, to the degree that adding additional office calls in a day may involve paying overtime for staff time, it could even be the reverse.

With respect to the composition of the RUC. I think that there could be some consideration of altering composition away from a senate model which is currently a possible example of the composition, toward a model that might include considerations of the number of practitioners or the volume of claims. It being the case, it may be that the RUC doesn't have proceduralists overrepresented but that primary care physicians might be underrepresented if one considers some of those other attributes that might be involved.

MR. BERTKO: I guess is a question. I wrote down some words Dana used which was not working well as a process, and it seems like the two of you have made a pretty strong case for that. Is there time to fix it for this five-year review? If not, is there anything that we should say on a more urgent basis?

DR. HAYES: I can take a stab at that, which would be that we know that the RUC advises CMS but that ultimately the decision-making involved here is the responsibility of CMS. So one could imagine that the RUC is still a ways away from actually making those recommendations to CMS and then CMS will go through a process.

Perhaps some of the data analyses that we have identified here could be used as part of their rationale for either adhering to the RUC's recommendations or not. But either way, there is some merit, I think, in looking at some of that. It's just a possibility.

MR. BERTKO: I guess the follow-up question would be do we want to do anything? And if so, how soon?

DR. MILLER: The reason that I asked Kevin and Dana to conclude the way that we did here, to try and conceptually organize the boxes where one might develop recommendations out of, is I think that -- to Kevin's point -- I think, first of all, we have some momentum on this. We have the Commission understanding this. I think we have people who feel that this feeds off into a lot of different directions, just straight pricing, accuracy within the system, some of the incentives on where people choose to practice medicine and all of that.

There's two things we could do here. But the reason that I asked them to bring this conclusion to the meeting this time was one, would be to try and get some process changes that we think we could agree with now. We'll come back in December, give you draft recommendations,

discuss and vote in January, put it in the March report. And by the way, put it alongside some of this. We've been talking update issues and some of these issues bleed over into those kinds of conversations, and have it there.

On the other hand, we have a lot of things, as Kevin pointed out at the beginning of his presentation, we have a lot of other physician stuff coming online. And if you wanted to sort of -- all right, well maybe there's some other work to be done here, you could house it in the June report.

The whole point, which I think you've probably picked up on is we wanted to bring it to this meeting because if we want to make a run at March, this would be the time to do it.

I'll stop there.

DR. CROSSON: This is just a feasibility question and maybe Ray could answer this. It seems like the solution here might be a combination of things, something along the lines that Alan was proposing. But then would it be feasible to have essentially all services evaluated for revaluation on a rolling basis every five years? Is that a body of work that's doable within the framework of this?

DR. HAYES: It's a lot of work to review these RVUs in terms of surveying physicians about the amount of work involved, the specialty societies essentially kind of gear up to do this and spend some months working on the effort. And then there's the staff work and the work of the RUC itself. The RUC meets once a quarter and spends four days, Thursday through Sunday, going through a very long agenda.

So it sounds like it would be a lot of work to just kind of go through big blocks of codes using a process like that. And that's part of the reason why we identified these tools here, these data analyses, as a way to set priorities, to flag services that are particularly in need of review.

Just thinking out loud, but a way to operationalize what you propose would be to maybe -- rather than trying to do whole segments of the fee schedule on a regular basis, would be instead to do some kind of sampling maybe with an alternative process to see if it's possible to validate codes, the RVUs. That's just an idea, an alternative to a way to look at this.

DR. MILLER: There is one other thought on Jay's

idea, and actually to encompass a lot of the ideas that people have said here. But the thought is triggered by Jay's last comment.

You could keep the existing RUC and have it continue to do kind of the year-to-year changes, and then look for a different entity, RUC Prime or RUC-II or whatever it is, that says your composition will be a little bit different and your job will also be a little bit different, that we're going to be looking for you -- and I'm making all this up here -- every two or three years to try and have this rolling look through more aggressively all of the codes. I'm telling you this is just off the top of my head.

DR. NELSON: But you have to bear in mind that it costs the specialty societies substantial amounts of money to collect the data and do a fairly decent analytic job of just the codes that they're doing. So if you had RUC Prime, either there would have to be some administrative entity that gets a ton of money, or there would have to be some way of altering payments to the specialty society.

DR. STOWERS: I was just going to answer to Jay, too. I think it maybe isn't efficient because of the

tremendous cost and time and effort that goes into reviewing, to trying every five years to review every code. I like the idea of trying to select out those. But I do think there is some rolling way that would be efficient not to hit everybody with everything once every five years, which I think really cuts into the rest of the RUC process and everything. So I think it's well worth reexamining that.

But I'm not sure just a get them all type attitude is either the right way to go.

MR. DeBUSK: Are we propping up a broken system?

DR. MILSTEIN: Given the sheer duration and magnitude of this problem, this is not a new problem, I'm wondering if we should put on the table -- I'll just put them more robust, and perhaps -- solutions that are quite different than some of the things we've considered before. This is not an exhaustive list and it's not necessarily in any particular order of "robustness".

But as I think back on the report we heard from Urban Institute in the spring, I think one minor fix that I didn't hear discussed would be some kind of a much more proactive and shortened interval between when a new code is

established and when it's reviewed. Because I'm sure part of the problem is that the rate of productivity increase post new codes being established.

Secondly, is it possible for us to get a little closer to the -- given the imperfection of the information by which we're trying to infer, in essence, net practice income, are there ways we might get a different window on that?

I'm thinking, in particular, there is quite good public transparency with respect to payable salaries for different specialties that come from the state -- I'll call it from public delivery systems. For example, last week in the California papers, due to the transparency of what folks at the University of California were paid, there was clarity as to who was paid the most within the UC system. The number one salary earner were to dermatologic pathologists.

Are there alternative sources of information on the -- I'll call it the derived salary, after you've paid your practice expenses, that we might examine?

And also, in terms of quality of information flow, one of the things that I think enables us to have more confidence in, for example, the flow of hospital cost

information by which we ascertain the reasonableness of what we're paying hospitals, is because -- as I understand it -- false reporting by a hospital becomes problematic in terms of -- is it the Federal False Claims Act? Is that the relevant legislation?

Whereas the somewhat less precise reporting that may occur through the RUC surveys is not subject to that same kind of what I'll call discipline.

And last but not least, and I throw this out as again an example of something very different than we've thought about before. In the IRS code, there's something called the alternative minimum tax where you sort of say we understand that we're trying to establish all these fair deductions. But at the end of the day there's an all things considered clause where you go back and, in this case, look at the ratio between what specialists are taking home and what primary care physicians are taking home.

Should we consider some kind of a ratio between those two things with respect to effort devoted to Medicare patients so that there is a little bit more of a balance in the kind of I'll call it both talent flow and proceed fairness issues are a little bit better addressed than they

have been for quite a long time.

DR. MILLER: Can I say two things about your comments? One is the first idea that you said, about a short-term review of the code, you did hear that idea. That is on the table. And they actually had an even more aggressive version of it as the value of the code would begin to decline unless it was reviewed and showed to be that it shouldn't. So that's on the table.

I have to say, I didn't understand the false claims point.

DR. MILSTEIN: It has to do with the quality of the information on which we are ascertaining what -- in this case, how much time it's taking to provide various services.

I was contrasting that with what we use to judge hospitals, which is the Medicare cost reports, for which inaccuracies I think are associated with penalties in terms of inaccurate reporting. Whereas, that inaccuracies in, for example, the surveys that are done of how much time things might take for a physician, as I remember the Urban Institute report is a process in which there is much less confidence.

DR. SCANLON: This is kind of a follow up to Jay

and Arnie and Ray, as well.

Perhaps doing it every five years is too much. But the idea of letting it go 15 or 20 years without having everything looked at becomes incredibly problematic. I think that we need to -- given that we've already passed this amount of time and it would be a big job, think about these strategies that Kevin has talked about in terms of trying to target, including some random sampling, and saying has this ever been reviewed? And if not, it may be time to review it. And over a period of time that we really do accomplish a rather comprehensive review.

But in terms of what Arnie was talking about, I would love to have an independent external data source that will allow us to set these values. But the problem we have potentially is the Medicare fee schedule has already contaminated the world so much that there isn't that kind of independent experience.

So then we're back to we're going to have to rely upon, in some respects, the expert opinion and input from the people that actually provide the services. But more so in the practice expense, which we're going to talk about in a minute, than in the work area, we used in the past

something to try and calibrate their responses.

We know that even if they're doing their best job, in terms of trying to tell you what it takes to do something, that it's hard from a human perspective to quantify all kinds of different activities, to divide your day up, to be able to talk about how when you move from this task to another task, what's involved.

And so you end up, when you do the sum, it's not equal to the whole. It's equal to something else. And you need something to bring it back into line.

It's different problems for the work side than it is for the practice expense side. But it's a problem for both sides. And it's something that if there was a better way, we should be thinking about pursuing it. But at this point, I have no idea what that better way is.

MR. HACKBARTH: I've been thinking about Alan's initial question, does the use of bias imply that people are not acting in good faith in some fashion. I don't have any reason to believe that. A lot of good people have worked very hard and put a lot of hours in to try and do this.

I do believe that there is a tendency built into the system from just how it operates and the rules. I think

that some or all of the options that Dana and Kevin have proposed for how you might change the process could alter that tendency somewhat, and perhaps significantly

In answer to Pete's question, are we tinkering with a broken system, I honestly don't know the answer to that but it's my sense that we're probably likely to get results more quickly if we work within this framework and suggest reasonable modifications to it, as opposed to blowing it up and saying let's start from a completely different direction. But we could be pretty well back here five years from now saying we made all of these changes and we're not achieving the goal.

Which brings me to my last point. As I've said several times, I'm very concerned about how we pay physicians and what we're rewarding through our payment systems, the signals that medical students get about what society values. I think that we need to change the signals if we're going to have a better health care system.

And because Medicare is looked to on many of these things, I think that Medicare ought to help lead the way on it. So I'm sort of left with a mixed set of feelings. I don't know that these sort of modifications will get us to

nirvana. I think that we can go through the list that Kevin and Dana have presented and I think probably find consensus that a significant number of these might be worth trying.

At the end of the day though, there may still be another step that needs to happen to rebalance our system. So independent of the analytic process, if you will, that we're talking about here, policy judgments may need to be made that we're not getting the sort of physicians in health care that we want. I don't know if it's a different conversion factor for primary care or something to send the sort of signals that we want to send.

It's a hard issue but let me reiterate. My intent here is not to impugn the integrity or the effort of anybody who's worked on this process. I think they're, as far as I can tell, making their absolute best effort within the framework that they've been given. But I don't like the results. I don't think that they're the right results for the program.

MR. DURENBERGER: I think everyone here agrees with what you've just said. And I think at the time we did this, in the mid-80s and enacted it into law in 1989 and implemented thereafter, the word value as in relative value

had a very different meaning from what it has today. We're living in another era today.

What was helpful to me, in thinking about that, was the reference to the work of Health Economics Research. I suppose you could have brought in some other people to talk about this.

This whole issue of how do you examine the changes in each of these areas, particularly those that have the infusion of information technology, medical technology, whole lots of other kinds of technology, which as we all know has been incredible over the last 15 years, what does that mean in terms of the amount of time, effort, stress, skill? And where should the financial benefit of the result from time to time lie? With whom? How much of it should lie with the individual, the surgeon in this case, or somebody else?

I can't imagine, skilled as these 23 groups of professionals are at their particular professions, they could ever get to that issue. Nobody's ever asked them to do that. But somebody on behalf of Medicare beneficiaries and the Trust Fund ought to ask someone to inject that part of the sort of value process into this.

We obviously aren't going to get it done by March or by June next year. But I think if that side of it were presented to these 23 professions, and perhaps all of the professions, in some understandable way, a better way than I can do it, it might be very helpful to the process.

MR. HACKBARTH: Other comments?

Mark let me turn to you. You earlier tried to give us the feedback that you and the staff need to advance this work. Push us some more.

DR. MILLER: This is what we could do.

Under the notion of the composition of the RUC, we could try and come back to you with recommendations of the kind, and we're just talking here, of changing the composition of the RUC in terms of its specialty mix. There have been a couple of comments from either a session ago or two sessions ago, I can't remember, would want to include -- a couple of commissioners said this -- people other than the specialties, more people who are outside the specialties, carrier medical directors, people who aren't directly -- you know, more academic types of people who wouldn't be as tied as directly to the outcomes of the decisions.

I'm not being very articulate. It's getting late.

So we could come to you with a set of recommendations along those lines.

Another set of recommendations, and I think I'm following your scheme here guys, and if I'm missing it let me know, the structure of the process. This is the notion of triggers. So a new service comes in, it comes down unless -- those types of things. The other idea, if there's a large change on PE, maybe that's a signal, and on practice expense, maybe that's a signal that the work unit might want to change.

The third category would be things like the list of services that Kevin went through, that CMS would need to do this, present the information and drive some of the codes that go into the RUC process and ask for those codes to be reviewed. Here again, there could be consultations with -- I believe we said this in some of our internal conversations. It might be that carrier medical directors, even in that process, could make a contribution in addition to the data analysis if you didn't want to put them right onto the RUC. Those types of things.

And then there was this last set of ideas, which I

don't have anything coherent to say about, the notion of more timely review and potentially are we restructuring the RUC or talking about a different RUC? But I think the notion more was timely review sampling sets of codes.

We could try and take all of those sets of comments and somehow craft a set of recommendations, roll them in in December, put them up in front of you, and see how much of it hangs.

MR. SMITH: I think, Mark, you got most of that list. I think we shouldn't neglect Bill's idea that no code should go forever without being reviewed. That there ought to be sort of a reverse trigger. We ought to look at new procedures relatively rapidly. We ought to look at things that haven't been reviewed relatively rapidly.

I would look, Mark, to invite other big stakeholders. Carrier medical directors are proximate, but they wouldn't seem to me as good as a plan medical director or somebody representing the insurance industry. Folks who piggyback on Medicare or take signals from Medicare a fair amount, it would seem to me would add a richer mix than someone who may know a lot but is one step removed.

I have the same feeling about the notion that

retired specialists are better than active specialists. I'm not sure that parses. They may not be quite as directly self-interested but they probably also are less in touch with what's going on in the specialty. I think the agenda may be more important here than the composition of the RUC itself. The budget neutrality of the process is powerful. And if you've got to deal with the agenda you don't get to both shape the agenda and deal with it, but you have to deal with the agenda that is presented to you by some of the triggers that have been suggested.

It probably isn't nirvana, Glenn, but a lot better than what we have now.

DR. CROSSON: Just a design thought that occurred to me as you were finishing, Mark. And that is that a sampling process could then lead to a targeted review process. You could have a sequence like that where you did sampling regularly and then you used that information to target areas subsequently.

DR. MILSTEIN: I also wanted to support Glenn's suggestion that we at least consider a perhaps less quantitatively intricate, sort of all things considered judgment, that might translate into a different conversion

factor for service groups that we -- based on a broader set of less objective evidence, we judge to comply a certain direction. In this case, I guess, we're talking about a more favorable conversion factor for the services that we think, all things considered, are consistently undervalued.

DR. WOLTER: As I was listening to all of this, I think I heard two buckets of things being discussed. Most of it was refinements around a current process and around a current reimbursement system. A little bit of it was do we want to be thinking about more fundamental reform issues in physician payment?

So a question, Glenn, would be do you want us to think about that? That might be a longer-term discussion, over the next year or longer, as opposed to these refinements of the current process.

I ask that because I see in many organizations, where physicians are in the organization, a movement to look beyond the RVU payment system. For example, we use it and it has a lot of positives. It's what we would call piecework. It's very incentivizing of productivity.

However, if you don't find a way to carve out 10 or 20 percent of dollars that maybe get paid in a totally

different manner around participation and quality, patient safety, sort of other system activities, it's very hard for physicians to free themselves up to find time to do that because the RVU incentive is so totally focused on productivity, which is about sort of individual patient activity or procedures rather than about these larger system issues that we're dealing with.

And so that's a complex conversation that isn't going to get us anywhere in the short run but it could have some long-term value. But I don't know whether that's our role to be wrestling with that or not.

MR. HACKBARTH: Having been through sort of a similar experience, I can relate to what you're saying and trying to find that balance between the productivity and other types of compensation.

But isn't the emphasis on productivity inherent in a fee-for-service payment system? The advantage that you have is that you're pooling the revenues and then saying within our group what sort of behavior best rewards patient care, as opposed to a fee-for-service insurance system where the money, by definition, is flowing for service rendered to patients.

It's a dramatic shift in orientation to say we ought to be paying for something other than service rendered to patients.

DR. WOLTER: Although largely in my particular market we're paid fee-for-service. And so we have the same schizophrenia, as an organization, about how much in productivity do we want to incentive versus how do we want to tackle some of these larger issues.

My question really is do we, as a Commission, want to think about where we might want to be with all of this over five or 10 years in terms of the incentives we put in place for the whole delivery system, maybe to move over time in a different direction, not just about how we incentivize today?

MR. HACKBARTH: I, for one, would be open to that. As I said earlier, I think that the sort of changes we're talking about here could be constructive improvements on the system now in place but may fall well short of where we ultimately want to be. So yes, I'd be open to that.

DR. MILLER: This isn't perhaps as grand a scheme as you're referring to in our work. But remember, we have this other work going on which we're looking at trying to

look at the development of episodes of care. You can imagine taking that work, looking at a spin off of that work, saying you know, a way to pay for diabetic care is to give a payment for the management of that care for six months, a year, whatever the case may be, and fundamentally structure it. From our coordinated care work and the episode analysis, which we're going to hear a little bit about tomorrow, that all could coalesce into those kinds of proposals.

That's little different than I think what you're asking, which is should we step back and ask ourselves what we would like to see in five or 10 years, I think is maybe the difference. But we do have things that I think go in the direction that you might be thinking of.

DR. KANE: I have a quick comment. I noticed you dropped Arnie's suggestion of looking at high-income specialties or high and low-income specialties as a trigger for reviewing codes. But it's just as good as some of the other methods you've got out there. I wouldn't drop it. If you know the top earning specialties and the lowest earning specialties, if there isn't an effort to start there and sort of figure out whether there's miscoding going on that

creates that distribution of income.

DR. NELSON: I have the sense that there's a feeling that if you put together the right body of people they can somehow invoke enormous wisdom and correct the mispricing. I think it's important to recognize that the RUC requires a fair amount of evidentiary base when specialty goes in and wants some review of their service values. They really collect as much information as they can. It isn't just folks arm wrestling each other.

Whatever we were to see as replacing that, whether it's an administrative process or whatever, they're going to have to invest in collecting data in order to support their case.

MR. HACKBARTH: Okay, having successfully answered all of those questions, we'll move on for right now and obviously come back to this again next month. Or will it not be next month?

DR. MILLER: We're going to try and put together some draft recommendations for December. I mean, for us this is weeks away.

MR. HACKBARTH: It's so close. Good luck to you all. We'll see you then.

DR. MILLER: I don't think we can stay for this session.

MR. HACKBARTH: We're down to our last presentation now, which is on practice expense.

MS. RAY: Good evening.

MR. DURENBERGER: You had to remind us, didn't you?

MS. RAY: I did. It's getting late.

I'm here to also discuss another issue regarding how Medicare pays for physician services. Recall the physician fee schedule consists of payments for physician work, practice expenses, and expenses for professional liability insurance. Last session you discussed issues surrounding payments for physician work. This session we're going to start to discuss issues surrounding practice expense payments.

In particular, we would like to get your input on future work in this area.

I just wanted to give you a little bit of context here. Payments for practice expenses are not trivial. They account for a little less than half of the $53 billion paid to physicians in 2003. Payments for physician practice

expense have been resource-based beginning in 1999. Before that practice expense payments were based on physicians' historical charges.

So what is so important about practice expense payments and how we derive their relative value units? Given the magnitude of the dollars involved, inaccurate payments can boost volume for certain services inappropriately and undermine access to care. Some of you have expressed concern that inaccurate payments can make some specialties more financially attractive than others. These are all points that you just heard from Kevin and Dana.

I just wanted to briefly remind you that this is not the first we have looked at this topic. The MMA required us to assess the impact of phasing in resource-based practice expense payments. In this 2004 report we also began to raise some issues concerning the data and the methods used to derive resource-based practice expense relative value units or RVUs.

So what are practice expenses? They are the costs involved in running a practice. CMS divides them into two categories. Direct practice costs include the costs for

nonphysician clinical labor, like nurses, medical equipment and medical supplies. Indirect practice costs include the costs of administrative labor like receptionist, office supplies and other equipment. Indirect costs account for more than half of the practice costs incurred by most specialties.

So how are practice expense RVUs derived? I'm not going to trouble you with the details, which are included in your mailing materials and I'm happy to take questions at the end of this presentation if you have questions about the method.

Suffice it to say that the current method, called the top-down method, is complex. Under the top-down method, CMS estimates total practice costs for each specialty group. CMS then allocates these total costs down to the service level to specific CPT codes. CMS allocates a share of the total practice costs to an individual service based on the ratio of the service's individual cost to the total specialty-specific costs. When more than one specialty performs a service, CMS averages the practice cost as a final step.

Thus, providers who perform a service frequently

have more influence over the payment than specialties that rarely perform it.

So let's talk about some concerns of the data sources used to derive practice expenses. On this slide we're going to talk about data sources used to estimate the total practice costs. First, one of the data sources, the SMS survey data, is old. It's from the 1990s. CMS uses this source to derive specialty-specific total practice cost pools. This survey, the SMS survey, was last conducted by the AMA in 1999. The AMA has no plans to update the survey at this time. Thus, this data source probably does not do a great job of capturing current practice patterns, current equipment and supplies.

Second, through March 1, 2005, specialty groups could submit to CMS updated total practice cost data. Few specialties have done so. Using the new data raises potential equity problems since not all groups have submitted data. For example, among the recent submissions that CMS approved, the practice expense per hour increased by at least 70 percent. In most instances, CMS incorporates this data budget neutral.

Let's turn to the second data source that CMS uses

to derive practice expense RVUs. This data source estimates the resources required to perform each of the 7,000 services, or nearly all of the services in the physician fee schedule. For example, in this database, it estimates the direct costs in 2005 for an EEG are $74 for clinical staff, $31 for medical supplies and $19 for medical equipment. This data source is used to allocate direct practice expense costs to individual services.

So what are the issues here? The data on the estimates of clinical labor, time and types of equipment and supplies, the direct resources, was refined by a subcommittee of the AMA using a process that is similar to the RUC's method for updating the work RVUs in which specialties step forward to provide data. Of concern is the process used to maintain and update these data in the future, specialties coming forward to provide information to a subcommittee of the AMA. This process might have some of the same limitations as the process that CMS uses to maintain the work RVUs.

In response to a question that Jay brought up in the last session, these direct resource data were originally developed by 15 panels. The AMA subcommittee went through

the 7,000 codes and reviewed them. It took them, they started in 1999 and they completed that process in 2005, just to give you an idea of how long it took at least to review the direct resource imports for practice expenses.

Another issue I'd like to raise here is concerning the estimates of the labor costs and equipment use. That data comes from CMS. CMS may be underestimating the use of certain types of medical equipment, including department used for imaging purposes, which could result in medical equipment costs that are too high.

When estimating the cost per minute of each type of service, CMS assumes that equipment is used 50 percent of the time. Rapid growth in the volume of diagnostic imaging services, along with evidence we have seen that most imaging centers operate at least 40 hours per week, suggests that imaging equipment may be used at greater than 50 percent capacity.

Let's move to concerns about the current methods used to derive practice expense RVUs. The top-down method is complex. For example, CMS uses different allocation methods for direct and indirect costs and for services provided by physicians and services not provided by

physicians, that is nonphysician services. There are multiple steps involved in allocating the dollars to a specific service. Certain specialties contend their practice expense payments are underestimated when CMS averages the practice cost of a service across all the specialties that perform it. Some stakeholders are concerned that indirect costs for nonphysician services may not be accurate.

Finally, a more theoretical concern. The fee schedule was not designed to be specialty-specific, yet the way we are deriving practice expense RVU starts with specialty-specific cost pools.

I guess the takeaway point here is that it is not clear whether we are allocating costs in individual services accurately.

One alternative to the top-down method is determining the practice cost of a service by summing the resources necessary to furnish the service. That is the clinical labor, medical equipment and medical supplies. We already have a data source, the resource input data I just spoke about. CMS proposed implementing this bottom-up method in the 2006 proposed physician fee schedule. CMS

ultimately did not implement the bottom-up method for 2006 because the impact of the new method published in the proposed rule was incorrect. CMS explained that stakeholders would not have sufficient opportunity to submit meaningful comments about the proposal if the Agency had implemented the change in the final rule.

This is not the first time CMS proposed a bottom-up method. The Agency originally proposed a bottom-up method in 1997 when proposing to derive resource-based RVUs but did not implement it in part because of concerns about the accuracy of the direct resource data.

So let's talk about possible research questions you might want to pursue. The first one would be to look at ways to gain new data to derive practice expense RVUs. As we just discussed, the SMS survey data is old. Permitting specialties to submit newer data raises equity problems. We could look at issues such as who would sponsor it, how would data be collected and verified.

In the final rule, I want to point out, CMS noted that a multispecialty survey done for a uniform time period would be most helpful. And the Agency also pointed out that they are planning on working with the AMA and the medical

community to discuss issues surrounding such a survey, including funding issues.

The second item that we're planning to look at is to assess the process by which the AMA will maintain and update the direct resource data. This will parallel our work RUC analysis.

The third item here would be for us to learn more about the prices CMS uses and assumptions made regarding equipment use and depreciation life. And here Ariel will be coming back to you later in the cycle on this, we expect.

And finally, we could look at estimating the impact of a bottom-up method by specialty and type of service and think about some of the issue surrounding a bottom-up process. On the one hand, it would greatly simplify how direct practice expense RVUs would be derived. In addition, it would probably eliminate the need for a nonphysician work pool. It would increase the reliance on the resource input data that has been refined by the AMA.

And lastly, a point on our research agenda that we could take on would be to estimate the impact of different ways to allocate indirect costs. Indirect costs, like I said, account for more than half of most specialties' costs.

Ideally, we would want to use the same way to allocate cost to individual services for both physician and nonphysician services. And we would also want a method that is easily understandable and transparent.

That concludes my presentation. And again I'd like to get your input on our work agenda.

MR. HACKBARTH: Comments? Questions?

DR. SCANLON: I guess I have to confess I'm confused by the bottom-up and the top-down methods because actually when CMS, then HCFA, was going through this back in the late '90s and they did the bottom-up first, they were still doing a calibration using the SMS data. And then when they turned around and said we're now going to do the top-down, starting with the SMS data, and instead of using it to calibrate things they used to the CPEP data, the panels, to allocate the SMS data.

I guess yes, there are always the devils in the details, but for me they always were essentially the same method. You were taking these estimates that you got from the CPEP and you were taking the total amount spent or checks that were written for practice expense from the SMS and you were using the two to come up with a set of relative

values.

Now I'm not sure if I understand whether the new bottom-up method is different and how it's going to be different because we're still talking about how can we re-create the SMS.

MS. RAY: The new bottom-up would rely on the refined CPEP data only. So to calculate the cost of an EEG, you would simply sum the nonphysician clinical time plus the medical equipment plus the medical supplies. There would no longer be a need for SMS.

However, under CMS's proposed rule, you would still need some way to derive those total practice cost pools for the indirect which would, of course, right now be the SMS data.

DR. SCANLON: I think I understand it now. I guess the reaction to that is there is the issue that the review panel, the PEAC, had the advantage of the SMS, as well as the CPEP information. As we move further out from that, those values become more problematic. And the need for a full-scale calibration becomes something that we would have to address again.

We would be able to do this for a while but we

would then reach a point where we're concerned about how good are we in terms of the accuracy of that kind of information? So that puts us back into the bind of where do we get the data to keep practice expense up to date? Because we need to know what physicians spent in aggregate and we need to know how much individual procedures use.

MS. RAY: I think, regarding your first point about how would you maintain the CPEP refined data over time, I think that's precisely the point that the second bullet under our future work is trying to address there. Again, I think that faces the same challenge as on the work RVUs.

I think your point about what to do on the indirect and how do we update SMS, that's of course another issue that we can explore.

DR. SCANLON: I guess I was actually arguing that you need to SMS-like data to keep your CPEP estimates accurate over time. That if you're constantly making your estimates based upon well, this is what we think it takes to do this service, which is what the PEAC would do and what the CPEP panels did, eventually you're going to be out of kilter. You're not going to replicate what real practice

expenses are in the aggregate. And that is potentially a problem.

DR. MILLER: Nancy, I'm listening to this and I'm not hearing a real huge disconnect. In some of our own conversations we have made the point, and I think even here in front of this group more than once, but certainly in our internal conversations. You have to have something to replace -- either have a new SMS or replace the SMS so that you have kind of a uniform collection of the data that you need. And then I think there are the issues of how you get into calibrating -- go ahead.

MS. RAY: Right. I agree. But I think the issue is whether or not you can rely solely on this RUC process to update the CPEP estimates over time, or whether you need to go out and collect total practice cost data for both direct and indirect and to keep that up to date. I think that that's an issue that we can explore.

DR. CROSSON: Nancy, in the section on using supplemental data, I was a little bit confused. This process is mandated by BBRA but then it says that in the 2006 final rule CMS did not extend the deadline. Does that mean permanently? What does that mean? Is this process

moot, or what?

MS. RAY: At least for the next calendar year, yes. CMS explored interest in looking at new ways to collect information on total practice costs and would like to go down that avenue. At least that's how I interpret their final rule.

DR. KANE: Is CPEPs cost or is it units of time and minutes of machine time? Because you also have the units -- has there ever been an effort to develop a standard cost per unit? I remember working on this 10 years ago and I've kind of lost track of it. But it seems to me at one point we were trying to develop standard costs per unit and you could upgrade the standard costs but keep the units over some reasonable period of time.

MS. RAY: The CPEP is composed of both. It takes five minutes of a nurse to take your history and the nurse's time is X dollars per hour.

I think that's the other aspect that we could learn more about is how the cost data is included and how it's updated over time to reflect efficiencies and productivity gains, et cetera.

DR. KANE: Because if you have both, then you can

pull the cost piece out, use the minutes and utilization data -- it would probably be valid for at least a few years. What's not valid is the standard cost piece and you can come up with indicators to keep upgrading your standard -- and I think we were working on that 10 years ago but it got blown up. I've got all my notes at home and I can pull it out.

But maybe we should go back to looking at whether you can do standard costing around the practice expenses so that you don't need to update as regularly as you would if you had to use the costs that the CPEPs is on.

MS. RAY: The spreadsheets do allow you to -- they have the spreadsheets out there with a minute and the costs.

DR. WOLTER: I know some people have raised the issue that there's more geographic variation in the practice expense the way it's been calculated in the past and that maybe in truth there's less variation geographically than the current system seems to have put in place. Would this process at all deal with some of those questions about geographic variation?

MS. RAY: I know that's an area that we are also going to be taking on. I didn't explicitly talk about it in this presentation. But I think the notion here is that

certain services within the practice expense payment, like for medical equipment, are purchased on a national market. And so I think we're going to be coming back to you later this season with work on that, yes.

MR. HACKBARTH: Others?

Okay, thanks Nancy.

We'll now have a brief public comment period, and the usual ground rules apply, which you know well. Please keep your comments brief. And if somebody in front of has made the same comment, just get up there and say I agree with so-and-so.

MR. RICH: Mr. Chairman, Bill Rich. I'm Chair of the RUC.

Thank you for the opportunity to address you and I'd like Ms. Kelley for her excellent and thorough review of the valuation of physician services.

A lot of the discussion seems to be based on the premise that there's been a devaluation of EM services over the last 15 years since RBRVS. So I think it's important that we look to see how RBRVS has addressed the public policy goals of the 1989 legislation and what role the RUC has played in that.

We just went back and we looked at over the last three five-year reviews, assuming our recommendation on EM are accepted, what's happened to EM services? And EM services were only out -- we looked at the 150 top volume services in Medicare and only 10 of those had increased relatively or increased value over their starting value in 1993. So through the five-year reviews, EM has indeed kept up its relatively.

Secondly, what's happened to the public policy goal of changing and switching reimbursement? If you look what's happened to surgical services, the top four services in total RVUs have gone down 42, 40, 32 and 32. And we look at Bob Berenson's work in the Urban Institute this spring, Mr. Chairman, you will remember that indeed, if you look at total relative value units, EM has gone up. Surgery has gone down. And that was part of our initial public policy goal.

But what's happened in the middle? Imaging and diagnostic services have exploded. So there hasn't been enough revenue shift to EM.

But I would like to emphasize I think the assumption is that we have not maintained relatively. But

actually, if you look at the data, we really have.

My second point is what's the value of the RUC in this and how do we function? We're not a consensus or a representative panel. We're an expert panel. You're not allowed to debate when an issue involving your specialty comes on the floor. There's 10 medical specialties, 10 surgical specialties and six others, like radiology and anesthesiology, et cetera.

Can we lower values? We certainly do. When we're given the opportunity to lower values, if we look at the practice expense issues. And the value of using an independent expert panel is borne out. Because initially the PEAC data -- we're all trying to dredge up those memories. It's kind of funny listening to the discussion.

When the RUC took over that function and created the PEAC, the original data was done by an outside contractor with Abt and CMS. We lowered those values 160 percent.

As far as valuations of services, we do have look-back provisions. We, as the commissioners, have a great deal of concern about mispricing services, especially on the practice expense side. We've advocated to CMS for three

years there be a look-back provision for any supply over $200. They've just adopted that in this rule.

We also have an earlier look-back on the valuation of work. If we feel that the description of the service involves technology and/or clinical staff that could be substituted, we now have a look-back provision. We do not have to wait five years to look at a service.

In addition, if you look at the volume of services that have been reviewed in the three five-year reviews, any service of any volume and any impact has been reviewed. In the current five-year review, 65 percent of the Medicare fee schedule underwent review.

I'm also the guy that wrote you the honest letter that said most specialties aren't going to recommend decreases to their services. So we agree with the panel, there has to be a mechanism for identifying overvalued services.

We have the assumption that the current value is correct unless the specialty has compelling evidence to change it. So there is strength in assuming that the current value is correct. Most of the codes that are brought to the RUC in the five-year review, if you look at

the data, do not go up because of our assumption that it is correct unless you present compelling evidence that the patient population has changed or there is an inaccurate assumption made in the initial valuation.

So I think there is some strength in making the assumption that the values are correct.

We welcome the Commission's input on any other mechanisms for identifying overvalued codes. CMS has wonderful medical people that work for them. They are overworked. They have the ability but they have not had the time and the resources to really identify these codes. And that's a failure in the system. We agree with that. And we would support and work with the Commissioners and really look very carefully at any suggestions you have to CMS to really identify codes.

We've had some suggestions ourselves on change in volume site of service, as Ms. Kelley has pointed out.

So I think basically, I think that I wouldn't blow up the process now. It's something that I don't think the depth of our review is really understood by the Commission.

I'd be glad to bring a group of men and women here to explain the processes. But I think it is a fair process.

It's a deliberative process. It's not a political process. And frankly, it's not a representative process. It's truly an expert panel. It tries to husband the societies' resources and how they're allocated fairly.

Thank you, sir.

MR. MAY: My name is Don May and I'm with the American Hospital Association. Just two comments today, one on adequacy and the adequacy discussion.

I thought the discussion raised a lot of good questions about cost growth and the drivers of hospital costs.

I think, based on the discussions last year on the historical trends that we saw in payment-to-cost ratios for private payers and for the Medicare program and Medicaid program, in relationship to the change in cost per year, and when you look at those historical trends and those cycles, one of the things I think we need to be cautious of is looking at the causation that's implied here. Whether private payers are -- hospitals are driving up costs because private payers are doing one thing or another, or really what's driving costs being those things that hospitals are doing to provide care.

Hopefully everyone received a copy of the document we sent, Taking the Pulse on Hospitals. It highlighted a lot of those challenges. But you talked about them today. The pressures on hospitals to develop electronic health records, clinical information systems, all of the new reporting that's being required of hospitals and asked of hospitals on quality of care, work force shortages, all of these different types of pressures really are the cause of hospital growth. And this is a concern that we have as well.

I think we have to be cautious in implying causation when we look at some of those historical trends.

The second issue is on the outpatient hold harmless discussion in the rural hospitals. We really appreciate the Commission taking a look at this. It's a very important issue for rural hospitals and for the survival of rural hospitals.

The hold harmless provision was put in place both to address payment adequacy and access to care in rural areas. Both of those functions are critical in the rural hold harmless system, first because the outpatient system is pegged to pay less than costs.

I think the most current numbers show that the Medicare program pays 87 cents for every dollar of cost. So we know payment adequacy is an issue. And we need to be concerned about that when we talk about rural hospitals and access in rural areas.

I think Dr. Wolter mentioned that the key reason that a lot of CAHs, I think a lot of the majority of the CAHs, have switched to become CAHs is the outpatient scenario. Outpatient is such a large part of rural hospitals' business. And almost every hospital in the country loses money providing care to Medicare patients in the outpatient setting.

In terms of a low-volume adjustment as a replacement to the hold harmless, I'd just like to offer one insight. On the low-volume adjustment for inpatient services, which the Commission recommended in its rural report a while back and was implemented by CMS, I want to highlight that their implementation allows 10 hospitals in the country to receive a low-volume adjustment.

I don't believe that any of the analysis that MedPAC did only included 10 hospitals in receiving this analysis. I think that as you talk about low-volume

adjustments and mileage requirements and what determines low volume, really be cautious about how your recommendation can be used later on because of the way we've seen some things get implemented. It's not always the way they were intended.

One last point to address the concern about whether outpatient service settings, other outpatient service settings should be considered, things like ASCs or physician offices. What we're trying to do with this hold harmless is to protect access to outpatient hospital services. ASCs and physician offices are not open 24 hours a day for the most part. They're not providing emergency care or charity care. They're not necessarily the hub of care in rural settings. The hospital is the hub of care in the rural community.

And losing access to the outpatient setting or losing access to outpatient hospital care can oftentimes mean losing access to all hospital care in a community when you lose that outpatient care.

So we really encourage you to continue discussions on this important provision and would encourage you to look at the option of extending the hold harmless as an

alternative to a low-volume adjustment. It's something that's already in the Senate bill. It's something that people have done in the past to continue this protection for the outpatient program in the rural hospitals, and would encourage you to look at that option, as well.

Thank you.

MS. COLGAN: I'm Corinne Colgan, here representing the American College of Surgeons.

As RUC participants, we would just like to support the comments made by Dr. Rich. In particular, the reference regarding the question as to whether E&M services have kept pace relative to other services in the Medicare fee schedule, the College has done some extensive analysis of Medicare and NAMCS data looking at that. And we believe that that assumption is simply incorrect.

In a dynamic related to that, there was discussion at length at the last meeting, and it was touched upon at this meeting, that there is a passive devaluation of services when certain services are increased in terms of work values and others are not. It seemed to be the focus that it was the E&M services alone that suffered that sort of passive devaluation. If that is across the board, and

particularly for lower volume services such as surgery, it can really take the brunt of increases to any other services.

We saw this in the first five-year review when E&M services received an average increase of 16 percent. 1,000 codes were reviewed. As the Commissioners know, approximately 300 codes received increases.

In order to achieve budget neutrality, CMS had to apply a negative 8.3 percent reduction across all procedures and a full two-thirds of that reduction was simply as a result of the E&M increases.

So we can see what happens when large volume procedures are increased, that it does impact sort of disproportionately all procedures.

MR. REGAN: My name is Jim Reagan. I'm a urologist down the street here at Georgetown.

I was a member of the PEAC almost from the beginning, so I had the good fortune of reviewing almost 7,000 of the practice expense inputs -- of the 7,000 codes, almost all of the practice expense inputs. I can tell you how many tissues you're allowed when you go see your psychiatrist, how many Q-tips you're allowed when you go see

your ENT doctor.

The PEAC itself got very granular in dealing with direct practice inputs. And I would just urge the Commission, definitely don't lose that process. It worked extremely well. Our sniff test was very good amongst each other. That's number one.

Number two, I wanted to echo also Dr. Rich's comments.

Number three, just a word of caution. Please don't assume that money is the only thing that drives medical students into a given specialty. Especially in this day and age when more than 50 percent of our medical school classes are women, a lot of other things go into the mix, including lifestyle and time for family, et cetera.

The third thing, just a question, a rhetorical question. We found in the RUC and in the PEAC that having somebody from CMS at the table all the time was a great resource. They weren't always an active participant.

But I was struck by the fact that there's nobody from CMS at the table now. Admittedly, this is my first meeting by I'd just throw that out. We find it to be extremely helpful. And I don't know whether MedPAC has ever

crossed that bridge or not.

Thank you very much, Mr. Chairman.

MR. HACKBARTH: Okay. We will reconvene at 9:00 a.m. tomorrow morning.

[Whereupon, at 5:29 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Wednesday, November 16, 2005.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Wednesday, November 16, 2006
10:07 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

P R O C E E D I N G S

MR. HACKBARTH: We're ready to start.

We begin this morning with two presentations about measuring resource use. The first is on physicians. Niall.

MR. BRENNAN: Thanks Glenn.

I'm here today to give you an update on our ongoing work in the area of physician resource use. We have a fairly short presentation for you today, so I'm the only one presenting but Karen and Anne have both played a large role in getting us to this point.

You'll remember that in March of 2005 the Commission recommended that CMS should monitor physician resource use and report back to physicians on a confidential basis. With this in mind, we're undertaking a series of analyses that will hopefully lead to a better understanding of physician resource use in Medicare and the feasibility of existing grouping tools for this process.

We're going to be analyzing two samples of Medicare claims, a 5 percent sample and a 100 percent sample, using two commercially available groupers, the Symmetry Episode Treatment Groups or ETGs and MedSTAT Episode Groups or MEGs. The 5 percent claims analysis is

underway and we'll begin the 100 percent claims analysis in five smaller geographic areas early next year.

For the 5 percent analysis, we assembled a data set of 140 million claims from calendar years 2002 and 2003 from the physician, hospital outpatient, home health, hospital inpatient, and SNF settings. When we ran these claims through the groupers both groupers were able to assign approximately 95 percent of claims to episodes which compares quite well to commercial benchmarks or commercial data that has been run through the groupers. As part of the grouping process, the claims are assigned to one of 500 or more episode types.

Now we don't plan on looking at all 500 of these episode types in detail. Instead, we're going to try and focus on a subset that we feel are relevant to the Medicare population, have the appropriate mix of prevalence or frequency, resource use and variation because obviously a variation in resource use is one of the central focuses of the project.

These conditions were also selected with a mix of acute and chronic conditions in mind, and also the availability of quality indicators.

There were a full list of these possible conditions in your mailing materials and we'll look at some of them in the next two tables.

For these tables, we took some of the select conditions and looked at how they ranked on certain measures after claims have been run through both groupers. If you look at the table going from left to right, the left-hand column lists the condition. And there's a lot of abbreviation in the first list of conditions, coronary artery disease, urinary tract infection, et cetera.

The second column lists frequency, defined as whether or not the condition ranked in the top decile in either grouper. The total cost column also represents a top decile concept. If the condition ranked in the top decile in either grouper, it featured in the table.

The last two columns show the quartile of variation in the two groupers, where the condition ranked. So here a higher number indicates more variation than a lower number.

I'd just also like to note that the list of conditions is not in any particular order.

Going across, if we look at coronary artery

disease, it ranked in the top decile for frequency in both the MedSTAT and the ETG grouper. It ranked in the top decile for total costs in both groupers. And it ranked in the third quartile for variation in the ETG grouper and the second quartile for variation in the MEG grouper.

Table two lists some more conditions. There's slightly less overlap in terms of frequency but I do want to note here that if we relax the requirements to the top quartile, most of these conditions would again rank in both groupers.

The blank for breast cancer under frequency means that it didn't rank in the top decile for either grouper.

On variation in this table there's a little more difference between the two groupers. For example, diabetes only ranks in the first quartile for variation for ETGs where it's in the third quartile for variation in MEGs. We're obviously going to explore in a little more detail why these things are occurring.

Where do we go from here? In many ways, the act of physically grouping the data is the easy part. I was actually just at a conference in Phoenix with the makers of the ETG software and they have lots of quite expensive post-

grouping solutions for people, because it's all a question of maximizing the data that you have.

What we're going to do is that we're going to evaluate the grouping process in conjunction with an expert panel that we've assembled and also in conjunction with some of outside consultants. As you know, we've contracted the MEG analysis out to MedSTAT. And for the ETG analysis, we have retained the services of some folks at Symmetry on a consulting basis, just to talk through technical issues and generally point us in the right direction.

Once that's done, we can begin the post-grouping analysis. We'll finalize the list of selected conditions. We'll evaluate several outlier or attribution methods. And when I say attribution, it's a means of assigning an episode to a particular physician.

There's a parallel project going on side by side with the grouping, which has been standardizing the dollars on all these claims to make sure we're comparing like with like. So we're almost at the stage where we can merge the standardized dollars onto the claims in order to make that comparison better. Then we'll begin to examine variation in physician resource use by MSA, examine variation in

physician resource use by specialty for certain conditions, and then finally we will also look at linking resource use measures to quality indications. And then we'll move on to the 100 percent analysis in the five selected geographic regions.

I know your mailing materials also contains some extra information and I'd be happy to answer any questions on either the mailing materials or the presentation.

MR. HACKBARTH: Niall, could you go back to the second table of conditions?

On this one, the two groupers seem to be coming up with fairly different results, even on something as basic as frequency. Does that concern you? What do you make of that?

MR. BRENNAN: It doesn't concern me that much, partially because when you use a decile approach, the cutoff is fairly strict and you're either in or you're out. We did do some runs looking at the top quartile and a lot of those conditions then featured in both groupers.

Also, the two groupers do employ slightly different clinical logic. In particular, I think MEGs employs more of a disease progression logic that may draw in

some complications or comorbidities that might, under ETGs, group to a separate episode. These are some of the things that we're going to explore and hopefully find answers to.

MR. BERTKO: First, let me say, Niall and for your colleagues, this is a ton of work. So I appreciate this. And on behalf of the Commissioners here I guess I'd make a comment that I would say this is a really good starting point at a very granular level to find an understanding of how these things work, which I think is very useful for us.

The point I guess I would like to make and for you guys to consider, adding to your work list, is to look at what I think is more commonly done at near a final stage which is market baskets of what specialists usually do and then potentially stepwise variation by specialty.

So in this case, specialists, you find a group of conditions that might cover 80 percent or 90 percent of what cardiologists actually bill for or what dermatologists actually bill for and then get to the comparisons across that.

Perhaps you're on the way to doing that. It didn't show up in these materials. But I think when we get ultimately to the point of assigning accountability and

measuring efficiency that gets closer to how the real world works, as opposed to this stage, which I think is the understanding stage.

MR. BRENNAN: Absolutely and I think the market basket concept particularly relates to what Doug Cabe is doing with his grouper. And even though we're not using his grouper, I think we understand the general approach and will be trying to do something along those lines.

Thanks, John.

DR. CROSSON: Now I wonder if, without getting too technical, you could give us a sense of the clinical logic between the two groups, just so we can get a feeling for that?

MR. BRENNAN: I guess I would describe the main differences in the clinical logic is that ETGs are more procedure driven than MEGs, so for coronary artery disease you'll have acute myocardial infarction with or without a certain procedure. Whereas for MEGs you have just a single coronary artery disease episode but what MEGs do is they stratify it by varying disease stages and disease progression.

To my mind, at a very top line level, that's the

biggest difference. Each grouper also -- these are proprietary tools so we can't get into the exact nuts and bolts of the clinical logic because that's what they sell to people. But we'd certainly be happy to look more into that.

In the mailing materials we did you give you a sample of claims that showed how the MEG grouper grouped a particular series of claims into three different episodes. It arrived too late for your mailing materials. But we did send a similar set of claims to ETGs. And for that particular example, they essentially both grouped in the same ways, although there are other examples where I think they might group in slightly different ways.

DR. CROSSON: But collectively do they both sweep in the same information, although they're aggregated differently?

MR. BRENNAN: They're both working off the exact same claims data, yes.

MR. HACKBARTH: Can I just follow up on Jay's question?

So they have different clinical logic. Could you describe how, at some point down the road, you decide which clinical logic is the best to use?

DR. MILLER: I'll take that, Niall.

I think, just to be very direct about it, I think part of this exercise is to see the different properties and frankly, for a group like this to look at this kind of stuff and say what makes more inherent logic or even face validity types of logic. I think there will be certain things where mechanically or analytically when you see how the data turns out, it will be this seems to make more sense. But I think there will still be, in the end of all of this, some degree of judgment.

I think this exercise is we're saying that the program needs to move in this direction. And I think some of what we're up to here is trying to understand a little more mechanically how realistic or how far we have to go to get to that point. .

MR. BERTKO: Let me agree with what Mark said and since Bob's not here I'll pick the metaphor of the day, which is bicycles. One might be a mountain bike that you use for stump jumping and another is a road bike. They both work, they both do similar kinds of things. But one may have an application that fits a certain use better than others.

The only other comment I'd make is that Symmetry ETGs are probably the de facto industry standard today. But there are MedSTAT, there's the Doug Cabe one. And I think there may even be one from 3M out there that are usable.

DR. MILSTEIN: I have a couple questions. One relates to the last interchange. And that is one of the struggles of researchers who have focused on comparatively evaluating these tools have not yet resolved is that there is no gold standard by which you can judge the two different tools.

I think as David Eddy I think mentioned when he was here last spring, we've mapped about 20 percent of clinical activity to any kind of outcomes research. So for 80 percent of clinical activity, including dollars billed, there's no way of judging whether something is so-called evidence based or not.

That always will put you in a very -- until we have more outcomes research you will never be able to come up with a gold standard that will tell you whether or not -- even for a specific uses, stump jumping versus road bikes -- one is better than the other. We just have to realize going into it that we don't have a gold standard and no researcher

has yet to formulate a gold standard for comparing such tools. It's related to absence of knowledge with respect to outcomes.

My other brief technical comment, and then I want to move on to my question, is that in deciding which application of ETGs we pursue this issue of whether or not you do or do not use the use of a procedure as a basis for splitting an ETG is a decision to be made by the user. It's not an inherent property of the ETG grouping system. So as we proceed, we may want to test it both ways. There are obviously people who believe that the presence of a procedure is de facto evidence of greater severity. There are others who believe that that's extremely flawed logic.

The question I had is the following: John mentioned that one way of moving this analysis to an additional phase, where you're not making a judgment about how a physician's relative resource use with respect to a particular condition, making a judgment sort of all things considered across all types of treatments that a physician provides, how relatively resource efficient is that physician?

And John suggested one way, which I very much

endorse, by which we might test that. That is form for whatever is the physician's predominate specialty a market basket of the most common activities of that specialty and then compare physicians using that standardized market basket.

A second quite prevalent approach that's used in the industry that I would hope we would also test as we move to this all-case portrait of physician resource use is a pure empirical examination in which you use the full mix of whatever the physician is treating as your unit of analysis rather than a standardized market basket for whatever might be that physician's predominant specialty.

MR. BRENNAN: Thanks.

MR. MULLER: Is this being used in any real-time concurrent basis or mostly for retrospective?

MR. BRENNAN: Our use of it is retrospective. It's for calendar years 2003 and 2002.

MR. MULLER: But I mean the users out there in the world.

MR. BRENNAN: And the "real world" by nature it sort of has to be retrospective even though it's about as close to real-time as you can get with retrospective data.

A lot of managed care companies -- and John can probably answer better than I can -- are running it on three month lags and things like that. And so every quarter they'll feed a new quarter's worth of data into the groupers and look to see if things have changed.

Have I gotten that?

MR. BERTKO: Yes, you have with the one restriction that depending on how you use it, if you use it for network analysis, typically you don't keep shifting and cutting and chipping and pasting your network every three months. But rather it's perhaps a year-to-year change with data updates, as Niall said, perhaps every quarter.

MR. MULLER: We'll be discussing this in the next topic, as well, in terms of shaping the behavior and modifying it, you need it fairly current, especially around individual physician behavior. I think three months is reasonably current for that. In our usual world of one or two years lag is not going to be as helpful as kind of three month old data.

MR. BERTKO: Let me add to this, and I think Niall you can nod whether you're doing this or not. We suggested earlier that looking at the longitudinal stability of these

is pretty important. From our much smaller database it looks like they're pretty stable. That has a doctor's practice pattern, as measured this way against the community, tends to remain in place over year-to-year. But this would be one of the important findings here.

I think you guys are looking at three years, perhaps?

MR. BRENNAN: We are going to look at that, John. And just to follow up a little bit more, Ralph, in the commercial sector -- and we are going to be touching a little on this by trying to link to quality indicators -- but a lot of companies now are trying to target specific things like testing or eye exams for diabetes.

And it is kind of real-time because they'll be spinning it through. And if there's no need HbA1c test or eye exam for a diabetic in the previous nine or 10 months, they will often generate an automated letter to the beneficiary and to the doctor, telling the beneficiary you might want to get this test and also saying to the doctor is this a mistake? Could you have a quick look at the patient's case records?

A lot of companies are actually doing that. So

that's again, essentially a real-time intervention based on these groupers in conjunction with certain quality indicators.

MR. MULLER: I'll address this to both of you, to John as well. In terms of the cohorts that the people who have been using this for a while use, essentially are these regional cohorts? Are they subgroupings? When you try to go to a individual physician instead of physicians what cohort do you show that physician?

MR. BERTKO: Let me speak to what I think is common practice in the under-65 commercial industry, and that is to look at within specialty, within market. So in Arnie's case it would be the people that he practices with and comparison in the San Francisco Bay area but not in Idaho or Pennsylvania.

DR. MILLER: On that point, that's something that I think we'll crank through here and give a set of different reference points that then you can think through.

Can I also ask just one technical point? To Arnie's question, isn't some of what he was talking about on the procedure contemplated by this difference between ETGs and Super ETGs? Or am I completely off on that?

MR. BRENNAN: Yes, Super ETGs eliminate -- combine ETGs with some of that surgery.

DR. NELSON: Help me understand what the first and the third quartile variations for diabetes, for example, implies and whether the being in the fourth quartile implies such a broad distribution that it ceases to have much value in discriminatory terms? Or whether indeed the fourth quartile variation still has substantial value?

MR. BRENNAN: If you're in the fourth quartile, clearly there's a lot of observed variation in the data. We can look at a specific condition in more detail to see what's driving that variation. And if we feel that the things that are driving the variation are things that are worth looking at, then I think it's worthwhile to look at it.

DR. MILLER: Can I also take a shot at that? When Niall was setting up the beginning of his presentation, he was talking about the notion of looking at its relevance to the Medicare population, its prevalence, its resource use and its variation.

One way to think about this, and this is for the Commissioners to think about, the fourth quartile is most

variation; right? I've got that right?

MR. BRENNAN: Yes.

DR. MILLER: The thing you want to look is conditions that are common in the Medicare population, they account for a lot of dollars, and there is a lot of variation sort of triggering the question is this the place where you could get some more consensus among medical practice patterns? You could sort of argue that the fourth quartile is the one you want to focus on. I don't want to say that real strongly, but that's some of the thought here.

MR. HACKBARTH: I think part of what Alan was getting at is that it could be that that's where the opportunity is. We've got widely varying practice and we want to narrow that. But could it also be a symptom that the grouping is that you're grouping very dissimilar patients?

DR. MILLER: Absolutely. And I think some of this exercise is to look at how these groupers work and see what the underlying structure is. Absolutely. But if you end up believing that they've put them together in a way that's clinically credible, that may be your opportunity.

MR. BERTKO: Let me only add to what Mark said.

That is while things in the fourth quartile of variation are probably clearly important, even the third quartile may be important because you could have -- think of an long right-tailed distribution. The end of the tail might be driving it into the fourth quartile. But the third quartile variation might actually have lots of dollars and lots of people in it. It's just got a bunch of people that are just a little off the median.

MR. BRENNAN: Exactly, John. There are some low-frequency conditions that have very high variation that are still -- and you know, as part of the outlier process and just generally looking at things in more detail we'll try and account for that. So some of the things in the third quartile might move to the fourth after some trimming.

DR. WOLTER: As I'm listening to this, I was thinking it might be quite useful for us to learn more about what is being done in the under-65 age group specifically. Are there physicians being moved in and out of networks based on this information? What percentage of physicians? What kind of data is being fed back to physicians to try to get them to look at their practice decisions? There would be a whole host of questions really, in terms of practical

decisions you have been making about how the data is used. And it might give us a little framework for discussion about how we might want to proceed with this data for Medicare beneficiaries.

MR. BRENNAN: It is being used to make decisions like that, telling physicians about their efficiency relative to their peers. It is used to make tier determinations and the like.

MR. HACKBARTH: I think that's a good point, Nick, and we could look at maybe getting a panel of people to come and talk about their experience with it and answer some of those questions.

MS. BURKE: Can I ask a factual question? When you chose these particular conditions you looked, as I recall from the materials, you looked at frequency. I mean, the sort of high frequency.

How much relevance is that to outliers? To what extent are the large majority of outliers tend to be in those conditions?

MR. BRENNAN: Outliers based on cost? To be honest, I couldn't answer your question right now. I can check into it. The conditions weren't just picked based on

frequency. This is sort of the greatest hits of elderly conditions so by definition they're going to show up. There probably will be outliers for each condition. So we can test various approaches. If we trim off the bottom and top 1 percent what effect does that have on the stability of our results, et cetera.

MS. BURKE: Just as looking -- I think John is right, it isn't just about the fourth quartile. You might see a tremendous value in looking at the third quartile. It also seems to me there may be some relevance in looking at what we know about outliers, as well, in terms of what we decide to look at and where there is that kind of enormous variance and whether this has largely picked up those sort of categories would be interesting to know, as well.

MR. BRENNAN: Absolutely.

MR. BERTKO: I was going to just reply to Sheila.

There are only three or four or five algorithms to look at that. The one that I suggested stepwise by specialty combines both the prevalence --

MS. BURKE: We'll pick some of that up.

MR. BERTKO: -- and the amount of people over the threshold to see what might be the affect. Could you move

those outliers back to the median. But the way that Niall is doing it is another perfectly good way and that's probably what we can talk about later.

MR. BRENNAN: Those are excellent points, Sheila.

Just to draw your attention back to the last slide, we will hopefully, in a couple of months, come back with precisely that kind of information, outlier method A led to this, outlier method B, and the same with the attribution method.

MS. BURKE: Great. Thank you.

DR. KANE: Nick, most of my question is how is the private sector using this? And I guess one other corollary to that it how are the physicians responding? And what kinds of issues do they have with it? Especially if you're giving them information on their resource use. How credible is what they're seeing? How does it go over?

Shifting people among networks, maybe they don't have much say. But if you're trying to train physicians to practice differently, what's the reception?

I guess if we do have a group of people -- this is from Dave Durenberger. If you do have a group of people come to present, perhaps we should get some who aren't the

Kaisers of the world but some of the more normal market, the more U.S. mainstream market types, to come in and talk up about their experiences with this kind of information and how it's used and how the reactions are.

MR. BERTKO: If I can, just to give you a generic industry response: one, the doctors that we have had some experience with are okay as long as you explain it to them and don't say it's a black box, trust us. And so, we've used one Ph.D. that's working on it to stand up in front of a bunch of docs and say here's how it works.

In the second case, where some physicians have complained about being excluded, we have in some cases, and I think others have, produced a very short what I'll call a report card that says this. In one case, a president of a county medical association complained about being excluded. We handed him his report card and he looked over and said 200 percent of community average in my specialty? Okay, I'll be back.

MR. SMITH: Nancy raised one of the questions. It would be very useful to sort of look back through the feedback loop here, not simply ask the technicians how they're using it but try to figure out how this really

affects practice.

I just wanted to make sure I understood. The quartile distribution of variation tells us the difference between the top and the bottom more or less, but it doesn't actually tell us -- this could be a very narrow variation within a disease category.

MR. BRENNAN: It could.

MR. SMITH: So in terms of the low hanging fruit, John, it wouldn't simply be looking for big -- we'd want to look at the difference between quartile four and quartile one before we figured out that quartile four was a particularly rich one to try to mine.

MR. BRENNAN: Actually, Dave, I misspoke. We calculated coefficients of variation for each condition and those with the highest coefficients of variation for that condition were reported as being in the fourth quartile.

MR. SMITH: Good. Thank you.

MR. HACKBARTH: Any others?

DR. MILSTEIN: Per Nancy's question, if you look it what's happened in the private sector over the next 10 year with respect to use of these resource use profilers, what we will find is the full range of spectrum in terms of

the diplomacy and success with which these are used. And if we want, I can identify three locations where the physicians will come in and tell us that this was ridiculous and completely unfair.

I can also, on the other side of the spectrum, mobilize circumstances where three physicians will come in and say the scales fell from their eyes, they had no idea, and that once they made the changes to bring their pattern in greater alignment with the community standard, resource use dropped substantially with no change in quality, and thank you very much, I had the idea.

And so we can sprinkle reports across that whole spectrum and points in between. The issue is not the groupers, it's the use of common sense and interpersonal intelligence in how they're used.

DR. KANE: Just to follow up, I think in particular I'd be interested in knowing how it gets used in the fee-for-service market that isn't in some kind of a medical infrastructure where they're kind of used to this kind of oversight and information.

DR. MILSTEIN: There are many such examples.

MR. BERTKO: Let me only add in a different way to

Arnie, one of the industry players did something in one market that was incredibly stupid, got everybody in an uproar, and in my opinion just did it all backwards because they tried to overreach in terms of what could actually be done using the data in hand.

So when Arnie talks about diplomacy, it's got to be from all sectors, both receptivity as well as an appropriate use of the technology.

MR. HACKBARTH: We will try to put together a panel or opportunity to have some interaction with people on both sides who have experience with this so we can talk about some of these questions. Obviously, we can't get a representative sample of all of the people in the world but we may be able to get a few very intelligent ones.

Anything else for Niall? If not, you are done, sir. Thank you.

Next we are moving on to hospital resource use.

MS. MUTTI: One of the goals of the Commission is to improve Medicare's ability to hold providers accountable for the quality of their care and the resources to provide that care. Over the last couple of years the Commission has focused on quality of care and pay for performance. More

recently, as Niall just talked about, we focused on physician resource use.

Today, in this presentation, we begin consideration of hospitals' resource use both during the admission as well as surrounding the admission.

In part, we're motivated to look at this topic because of the sheer costliness of this sector. Inpatient hospitalization accounts for 35 percent of Medicare spending. That's about $100 billion in 2005, and that comes out to about $275 million a day.

Ultimately, we are hoping to measure hospital efficiency so we can encourage greater efficiency. As we've discussed before, efficiency is a function of two things: quality and resource use, as you can see on the slide.

Today, we'll focus on three possible dimensions of hospital inpatient resource use. We've derived these from looking at a preliminary look at the literature and talking with some health care experts. It's a preliminary look, so we're interested in your thoughts on the appropriateness of these. I'll mention each first and then we'll spend some time going through each, and we'd love to get your comments at the end.

The first is the hospital's costs during an inpatient stay. These are the costs the hospital incurs that are ultimately paid for by Medicare as part of PPS.

The second is the volume of care around the inpatient stay, and that refers to physician visits during the stay as well as a range of services after discharge.

The third is the resource use of admitting physicians. These are the physician on the hospital's medical staff. Here we're trying to get at their propensity to admit.

So we'll go through each of those and another aspect of this presentation is a slight digression that Sharon will talk about as getting at the link of quality and resource use and some thoughts we have on some initial research in that area.

So with that, I'll turn it over to Jack.

MR. ASHBY: The first and narrowest dimension of inpatient resource use is the cost of an inpatient stay. Medicare's inpatient PPS, of course, already provides an incentive for hospitals to control their costs. But Medicare's goal is to set payment rates that cover the costs of efficient providers.

To gauge the efficiency of hospitals, whether for individual institutions or for the industry as a whole, the Medicare program and MedPAC need appropriate measures of resource use and hospital quality. So I'm going to talk briefly about cost measures and their use to date in payment policy, and then Sharon will come on and discuss the quality measures that are most appropriately linked to a measure -- a cost-based measure of the inpatient stay.

The Medicare cost reports provide the data for a measure of each hospital's Medicare allowable costs per discharge. But to fairly compare hospitals on their average costs per discharge, we need to make two general types of adjustments to this base measure. These would control for factors that are largely outside of hospital control but that do influence their costs and to control for differences in the product of different hospitals.

To the best of our knowledge, none of the private insurers that have experimented with measuring hospital resource use has employed a measure of standardized cost per discharge. Insurers generally use their own payment rates for this purpose. For example, one approach has been to measure resource use for an inpatient stay by summing the

hospital's per diem payment rate times the number of patient days and then rewarding hospitals with the lowest average value on that measure. Obviously, this approach is heavily influenced by a hospital's performance in controlling length of stay.

The Maryland rate setting system however, as we talked about a bit in September, has used a standardized cost per discharge measure for many years. Each year hospitals in that system are compared on the cost measure within peer groups that are organized on the basis of teaching status and urban/suburban/rural location. Hospitals with the lowest costs in their group have an increment added to the payment rates that they would otherwise be allowed to charge, and those with the highest costs have an increment taken away.

A similar approach could be taken for Medicare. A small payment add-on for hospitals with the lowest resource use in the previous one or more years, based on a measure of standardized costs per discharge and possibly administered within broadly defined groups of hospitals.

And of course, the resource use measure could be paired with appropriate quality measures so that the payment

add-ons reflect overall hospital efficiency rather than resource use alone.

That provides a good point of transition into Sharon's discussing quality measures.

MS. CHENG: So we've all got Anne's picture in our head. We had resource use on one side and quality on the other and then there were a couple of boxes under the resource use.

What I'm going to try to sketch for you briefly is what we're going to start off with on quality and the quality measure that we're starting off with best relates to that first box, the resource use the Jack just described. So a fairly narrow measure of resource use. And we're going to start steps toward bringing those two things together and getting an efficiency measure.

What we've got up on the screen then is a summary of the materials that you had in your packet. It outlines our proposal for this starting off launching point for the hospital quality measure to pair with the resource use. We propose to gather and calculate 36 indicators of hospital quality for inpatient care that seem to fit the Commission's criteria for a good measure set.

We've got six domains. And within each domain there are several types of indicators. So for example, surgery would be one of the domains. Within that domain we've got some mortality indicators that relate to surgical procedures such as mortality following a CABG procedure. We've got an other outcome, which would be failure to rescue.

We've got process measures that relate directly to surgery such as antibiotic timing before surgery and discontinuing antibiotics after surgery. And we've also got safety measures. For example, in this domain it would be postoperative complications.

Another domain then that has a similar concept is CHF. But rather than being driven by the surgery procedure, it's driven by all patients who are admitted with a CHF primary diagnosis. And in that dimension, then we would have mortality for those patients and we would have process measures that relate to CHF patients being treated in the hospital.

And then another example would be all patient measures. And primarily we're thinking about safety measures that could apply to all patients. They wouldn't

have to have a particular condition. They wouldn't have to have surgery. This would be things like a decubitus ulcer or a hospital acquired infection.

And then we would also try to look at a readmission rate. We're trying to get a readmission rate that would apply to as many patients as possible, rather than do just a particular surgery readmission or just a particular condition readmission. That's probably the one where we need the most to focus our thinking a little bit.

As we collect and calculate these measures, then we're going to start seeing how they behave. What's the covariation, hopefully, between measures in the same domain, among measures across domains. As we start getting a picture of that, we'll also start thinking about how you could start to bring some of these measures together.

Since we'd like to take our quality score and marry it to a resource use, we want to try to get some summary on the quality side so that we can compare it to this resource use measure for the hospitals in a way that's a good apples-to-apples comparison.

After we get those two together, if they start fitting, then we'll see whether or not we can distinguish

hospitals based on their efficiency on this dimension. And then, if differences emerge, we can test whether certain hospital characteristics are related to those differences.

With that plan in our first box, we'll get back to the mainstream of the presentation on resource use and Anne will take us to the second dimension of resource use.

MS. MUTTI: The second dimension of hospital resource use concerns the volume of care around an inpatient stay. Jack has talked about the hospital's costs to provide the care during a stay. And that can be represented by the hospital stay box.

In this second dimension, we're suggesting that the hospital can also influence other costs around the stay and that include physician visits during the stay as well as the range of other services after the stay, physician visits, outpatient care, post-acute care, readmissions.

The fundamental question here is whether it's appropriate to measure such an episode and hold the hospital accountable for it. We've identified two questions that seem like first-order questions to begin to analyze the fundamental question. That is can and does the hospital influence costs, other provider's costs, around the stay?

We'll look at some evidence on that.

The second question is is there evidence of variation in Medicare spending around the hospital stay? We'll look at the evidence we have on that.

On the first question about the hospital's influence, I think it's important to bear in mind that certainly physicians have a lot of the control over patient care, and therefore costs. They're the ones that admit and discharge patients, that order and perform surgery, that write prescriptions, a whole host of things that directs a lot of the care. But in talking to experts and also looking at the literature, we did find evidence that the hospitals can also influence the costs across an episode.

For example, we found that a high quality, well managed nursing staff can put in place processes that both improve quality and save resources. For example, one California hospital found that by hosting an hour long education session and putting preprinted cardiac orders in place they reduced the incidence of atrial fibrillation which is a complication associated with cardiac surgery that tends to increase costs. So if we could avoid that, we both improve quality and save costs both during the admission and

after the admission.

Nurses also educate patients about self-care upon discharge. And if that's not done well, it could result in readmissions or certainly more expensive outpatient care.

Another example is in terms of a hospital's approach to and competence in discharge planning, that is arranging care after the patient is discharged. If that is not done well, that could lead to more services used after discharge or readmission, also.

Hospitals are also often able to influence the practice style of their physicians practicing in the hospital. When hospitals first hire or award admitting privileges for a physicians, they can review that physician's track record on their admission patterns and make a decision based on that.

On an ongoing basis, a hospital can set performance goals that affect physicians pay and decisions about whether they retain that employee or whether they want to renew a contract.

For physicians with admitting privileges, hospitals can offer rewards such as preferred or more operating room time, office space and research support.

On the question of variation, research shows there is wide variation across hospitals in the number of services provided around a given type of hospital stay. Again, this is important because variation in caring for similar patients with no quality differences suggests the possibility that resources could be safely conserved.

Some researchers have focused on variation in the volume of services provided just during the hospital stay. They found that after adjusting for price and case mix, payments to physicians for inpatient care ranged twofold among MSAs. So that's looking across all MSAs, the highest to lowest, the variation in spending for a similar type of the stay was twofold different.

Other research has looked at variation in resource use six months to five years after the hospitalization in some 300 hospitals. This study found that Medicare spending on hospital and physician services in high intensity hospitals was 11 to 16 percent higher than in low intensity hospitals. After the initial six months wider variation was found, 49 to 58 percent higher in some hospitals than others. This study also looked at the quality of care and used a couple of measures, several measures, and found that

there was no difference among the intensity of hospitals in terms of their quality.

Another study found that patients in the last six months of life getting care from the seven best hospitals for geriatric care as rated by U.S. News and World Report, received very different amounts of care. For example, the number of physician visits was more than twice as high at Mount Sinai Hospital and UCLA Hospital than at Duke University Hospital.

There are a number of design issues to consider in measuring this dimension and I'll focus just on one here. We've mentioned several others in the paper.

One of the key issues is the length of time or the window during which you would hold the hospitals accountable for the services delivered. The window could be a fixed, relatively short period of time, 15 to 30 days, or it could be variable based on condition, maybe not to exceed one year. We have spoken to a few plans that have used this approach. It basically mirrors the episode approach that Niall just spoke about. Instead of assigning episodes to physicians, they assign the episode to hospitals, or maybe they do both.

A third alternative is to consider a longer period, one to five years. This mirrors some of the research I just mentioned and gets at more of a longitudinal measure.

One question that arises is whether the hospital can be reasonably held accountable for care delivered six months, a year, or more after the initial hospitalization. The longer the window, the more likely it is that the physician is to be far more responsible for the costs of the care, the volume of the care.

The significance of this concern may depend on how one conceives of the role of the hospital, though. If the role is narrowly defined, that is the hospital should be responsible only for the direct care it provided and its effectiveness in its discharge plan, a hospital may not be reasonably held accountable or responsible for the volume of care provided to patients who haven't been hospitalized in months.

On the other hand, a more broadly defined role for hospitals could focus on the pivotal role that hospitals play in convening physicians. This view recognizes that while the hospital itself is not directly responsible for

the care, it is in the position to and should influence physicians both in their hospital-based care and beyond.

This brings us to the final of the three dimensions of resource use. It seeks to measure the propensity of the hospital's affiliated physicians to admit their patients for inpatient care. The other two measures have focused on the costs and the volume once an admission occurs. This measure hopes to reflect something about the appropriateness of the admission.

We know that rates of admission vary geographically. One study found again that there was a twofold difference looking across MSAs around the country in the rate at which they admitted patients. Another study found that patients living in Boston were rehospitalized 60 percent were often than patients in New Haven. Research also shows that higher rates of admission are not necessarily associated with higher quality.

We understand that hospitals can and do influence physicians' admitting practices. First. they affiliate, whether by salary, contract or admitting privileges, with physicians who often have a track record on their volume of admissions.

Second, hospitals may invest in outpatient clinics and chronic care management initiatives that mitigate the need to hospitalize.

And third, hospitals can control the growth and supply in hospital beds. The more beds available, the more admissions there tend to be. Bed supply has been found to influence the threshold for admitting patients with chronic illnesses such as congestive heart failure, COPD and cancer.

The implementation issues on this dimension have given us some pause here. We discussed it in the paper but I won't go into some of our thoughts here. But we're struggling a little bit with how you would calculate an admission rate for a hospital and its medical staff. We'd like to give that some more thought and come back to you, and certainly welcome any thought that you may have here.

That brings us to our next steps. As Jack discussed, we plan to measure standardized hospital costs. And as Sharon discussed, we plan to examine the relationship of costs and quality. We hope to come back to you with an installment on both of those in time for you to be considered in the context of hospital payment adequacy.

And then we hope to give it some deeper thought,

both of those issues, and analysis in time for a June report chapter.

We will also further explore the hospitals influence on the volume of services around the stay and the variation in spending by length of episode. And as I mentioned a moment ago, we want to give more thought to how you would measure the propensity to admit.

With that, we'd love your comments.

MR. HACKBARTH: Good job by all of you.

This question of whether hospitals influence the care delivered within the admission or outside the admission obviously is a critical one. The answer to do they is it varies. It varies from institution to institution and certainly within the inpatient admission some influence more than others. As you get further away from that, the influence probably diminishes everywhere.

I think the policy question is not whether they do today but whether they should in the future and whether we can design payment systems that overcome what is now a very diffuse accountability for performance and get physicians and hospitals collaborating to improve performance not just in the inpatient stay but in the care surrounding it.

So how things work today is interesting and important because it tells us what we've got to overcome. But it ought not decide the future of the policy. Does that make sense?

DR. MILSTEIN: I just wanted to reinforce Glenn's last point and also say this was a beautifully formulated presentation of a very tricky topic.

And with respect to your last question, I think my suggestion would be to speak to Elliott Fisher and Jack Wennberg. They have begun developing methods built on Medicare program data to begin to calculate at the individual physician level propensity to admit measures.

MR. MULLER: I second that. This is well done and very important work and I think it ties to a lot of themes that we have on our schedule and our plate.

Obviously, tying resource use and quality measures is critical in the whole P4P process because that comes down to having those things tied together. So I think the work this Commission and the rest of the world is doing on for P4P will be advanced by this work. I think you've got good quality measures there. One can nitpick one or two of them, but I think those are the right set of measures. By and

large they're evidence based. Increasingly I think the quality community is coming together on a more standardized set of measures. Three or four years ago we were all over the map. I think by and large there's been more congruence in coming together. So I think the whole P4P process -- and I agree with what Arnie they just said. The work we've seen from Fisher and the whole Wennberg Dartmouth School is critical to this.

I want to make a couple of comments on how we look at this. I think the resource classifications by hospital, I think the Maryland ones are little not granular enough. For example, just the urban/suburban rule is not sufficient. I mean, yesterday we had a long discussion on the critical access hospitals. Obviously some of us have had long discussions about teaching hospitals.

So I think one has to figure out how some of the categories that we have inside the program or should have inside the program are not just in urban/large urban/small urban/suburban rule. Obviously, we don't use suburban inside of Medicare the way Maryland does. But I think we have to use those categories of analysis that we have used.

I think also, in terms of a critical question,

this comes back to the previous discussion on physicians as well as on hospitals, is what is the account unit that goes both to your central question about inside the hospital and after the hospital and Glenn's point on that.

I think we're a long ways away from having a lot of accountability for after the hospital stay. My advice is to try to focus first on getting the right kind of accountability inside the hospital in terms of how one uses one's analytical energy and how one thinks about policy. For example, we've seen the very small and halting steps on gainsharing inside the hospital. Some of us would argue that one needs to go far more fully into gainsharing to get some kind of joint accountability between physician and hospital inside the hospital setting. So again, that's one of the themes we've discussed inside the Commission.

As somebody said earlier, we're not all Kaisers in the world. There are a few of them. But there are more and more settings in which the physicians are employed inside a hospital setting. Whether it's the academic kind of hospitals where they're employed by the medical school. But there's more and more. I think a critical distinct there is the extent to which what I'll call the admitting physicians

rather than the hospital-based physicians, that is the cardiologist rather than the pathologist, are employed in a common way. Because they have, in many ways, the most important shaping of utilization. They're more influential in utilization than the hospital-based physician.

So I think having this Commission be more and more recommending that these accountable units be established, and obviously the hospital is a natural setting for that given its legal structure in the American system. But as we all know, having the physician community in general feel comfortable with that, it's one thing to say that. It's another thing to actually execute it in many parts of the country.

There are some places that are natural for that, again the Kaisers, the big teaching hospitals. But there are many places in the country where that kind of congruence of interest is not as well established.

But I think we need to keep focusing on what those accountable units are if we are to kind to secure this kind of management of the process that we're looking for. I think we've all said the individual physician that is kind of sitting out there by himself or herself is not a good

unit of analysis or unit of accountability. And so to keep moving in that direction I think is important.

The last point is the one I made on the physician point, as well. Having data that's reasonably current is important. I agree with John's point earlier that maybe a year at the last year is possible. I think going back to physicians with three-year-old data or hospitals with three-year-old data is difficult. It's important to keep tying the resource utilization data to the quality data. The example that John referred to of where one insurer tried to use this in a very heavy-handed way in one Metropolitan area, they used the words quality and did it only on costs. They excluded all of the physicians of one of the four or five leading academic medical centers in the country. They said not one physician from that medical center would qualify.

And that, on the fact of it, just strains credulity, that there's not one quality physician out of 1500 at this leading academic medical center. So I think it's important that the resource data and the quality data be tied very closely and we don't use the words quality and then just do it on the basis of costs, because those

physicians were all excluded on the fact that they were at a higher cost medical center and teaching hospital.

So therefore, both having current data and using cost and quality in concert is of critical importance.

The last point I would just make on that is the extent to which the physician community can be involved in representing and using this data is critical. I think, unfortunately, the managed care plans of the world don't have the same kind of credibility with the physician community that physicians have with each other. It's just a lot easier to have physician communities kind of using this information and presenting it to each other than having it come from either the government or the insurer.

Obviously, Medicare can take a lead in causing this information to be created. But I think it's important to then get it down to the level of accountable units in which physicians can be involved, because the kind of conduct that we're really trying to shape over a long period of time does work I think best when it's kind of a physician-to-physician communication. Obviously aided and accelerated by what CMS or the Humanas of the world can do because they have databases that the local accountable unit;

e.g. the hospital, the physician group may not have. But still, I think bringing it down to that kind of level where physicians can be champions of this data to other physicians is of critical importance.

MS. BURKE: I also want to compliment you on helping us frame and begin to discuss this enormously complicated question. I think you did just a spectacular job.

There are really just a couple of things that I wanted to mention, which I suspect in the course of us going forward it will occur to you to think of.

One is just a simple thing and that is also tracking what's happening on a state-by-state basis and the statutory changes regarding nursing and the requirement for nursing services and the nurse-to-patient bed requirements. As you know, California has gone through this. There are other states that are looking at it. It will have some impact. It will be an issue that the hospitals can't control. It's an external force but will have a direct impact in terms of their staffing issues.

Just as sort of a side note, there are those kinds of activities that are going on as well that will have some

influence. I think it will be interesting to note how wide-ranging that is.

Obviously, this whole range of issues has a clear relationship to the whole question of gainsharing and how we encourage relationships between physicians and patients or physicians and hospitals. Clearly, in the course of our work on that, it will also have an impact on what we think to be appropriate relationships and appropriate incentives going forward in terms of the kind of behavioral changes that you want to see in terms of physicians and how they relate to hospitals and to others.

The other I guess not cautionary note but the other thing that I think will be important for us to understand -- and Ralph touched on this a little bit -- is that I think we have to continue to remind ourselves that the capacity to influence or the relationships will vary by type of hospital. There are hospitals that will have more or less ability to sort of influence their physicians, depending upon the kinds of things that they do, their size, their location, whether they're the only game in town, how easily either party can take a walk. We don't need you on our staff or I don't need to be on your staff, I'm the only

guy in town that does cardiology, whatever it happens to be.

And I think we have to be sensitive to that in terms of the kinds of relationships we want to encourage. So the type of hospital that it is and an understanding of that. I think the Maryland system is a crude system in so many ways. So I just think that as we go forward and look at these things, I think we need to be realistic about what can we expect, depending on the kind of institution, the kind of relationship, the kind of physician practice in the community.

I think it will be very important for us, as it was in the prior discussion, to get folks before us in the course of conversation who have begun to think about these relationships. How physicians are experiencing them. And it will also vary by type of physician. And also the prevalence of hospitalists, which are not widespread but they are a pattern that are increasing in some areas and not in others. It will have an impact in terms of what that relationship looks like.

I mean the sort of old relationships of the percentage-based contracts and the hospital-based docs, radiologists, pathologists, anesthesiologists, as compared

to folks whose practices are largely outside of the hospital, how people approach these things.

So I think having people talk with us about that, it will vary by specialty, it will vary by geographic location, it will vary by type of hospital. So I think all of the work that you've laid out here suggests to me that you're sensitive to those issues. But I think we need to continue to remind ourselves that there may not be a simple one answer to this. It will, in fact, vary. And I think we ought to make sure the system is sensitive enough to accommodate those variations, some of which are, in fact, appropriate and some of which are not, but some of which are clearly appropriate.

DR. KANE: I think this is great and I would like to encourage you to actually go one more step when you have nothing else to do, which is to get up to the geographic level and even though there may be multiple players in a geographic area. I think that's where some accountability needs to be started to be placed. And often I think you'll find that there are geographic areas, particularly sometimes hospital service areas, that can be defined that way in which there is a hospital that calls itself a system and

then actually dominates the care in that area. There's a lot of areas like that.

Those systems, they do have parents, they have maybe one or two hospitals. They often own physician practices. They own labs. They own skilled nursing facilities, assisted living. There are places in the country, increasingly I think, where you could get to a geographic area and find one or maybe two dominant systems and start suggesting that they take under consideration, working as a team or whatever, collaborating over the measures that you see at a geographic area.

I'm getting a little bit at your propensity to admit but I'm taking it a little bit higher.

And also, I think you can take it across time and certainly look at chronic care disease management across these geographic areas.

If you start measuring it, you might well find there can be accountable units. And you can find accountable units. If you can't find them right away, you might start creating the interest in having accountable units by something doing the measurement and putting out that kind of information and asking the right questions and

encouraging collaborative responses.

MR. DURENBERGER: I agree with everybody, this is a great design. Are you familiar with the Wisconsin Quality Collaborative? This is on the geographic point. It really also gets to the point made in the beginning about accountable and the key role that physicians play.

They haven't advanced in Wisconsin from six groups to now 70 percent of the docs in the state. They started the first three years on the quality, in the quality box. They disclosed everything. They got all the right reaction, except from the public. But I mean, they got it from their docs, they got it from the specialists. It was beautiful. It was really encouraging to them. Now they're moving to the efficiency side.

So even the pressure geographically of this going on in most of the state on the largest group, which is Aurora, and the most expensive one -- right, John -- in the eastern part of the state, even Aurora has been forced to join.

The physician power in this, as it relates to their hospitals as well, is strong enough to start poking into the how much does it cost to do this issue, as well,

which health plans have a lot of difficulty getting at because it's perceptively self-serving. But if the physicians and the hospitals are driving that part of the efficiency agenda as well, it's got a huge amount of potential.

So if you come to Minnesota you know the Institute for Clinical Systems Improvement, community measurement. Again, these are the beginnings of tools that have been employed for a while but now converted to the same agenda.

And so I'm just endorsing Nancy's point about there is some geography that can give us some clues to the role that physicians can play when they're presented with the appropriate amount of information by the appropriate party.

MS. HANSEN: This has been just a fascinating structure to read. One of the things I'm looking at from the quality and resource use side, on slide number eight about what the hospital does influence. I'd like to pick up on some things that I think Sheila said about the nursing staff, mainly because that's probably what I know best, and that's the largest work force, of course, that's involved, whether to take a look at also some things that do exist as

a backdrop that right now not only the staffing ratios that I certainly feel in California, but that kind of nurses who are in practice from the level of preparation of their associate degrees compared to baccalaureate type of nurses.

Increasingly, the use of foreign-trained nurses has another factor of communication and safety that have elements. And kind of the proportionality of using travelers nurses, which also is another phenomenon that hospitals are experiencing right now.

And then moving on to the whole aspect of looking at discharge planning as to what people can control there. You can have a wonderfully smart and efficient discharge planner, but if you have no resources in your community you don't have control over those elements.

So it's one thing to have a very vertical system where you have a panoply of nursing homes and subacute systems and what not that you can refer to. But to be able to take a look at what's controllable as to how do you measure effective discharge planning, it's not just person-centric, but it's resource possible.

Finally, on the whole aspect in the future more of gainsharing in a larger sense, when I hear about the study

of if the nurses had this card and the hospital employed this kind of training to make sure everybody used it, my question is more a futuristic one for whether or not -- even though that was found to be effective -- when we think about the length of stay that I brought up yesterday that tend to be fairly short, whether or not that's the most effective teaching time for most patients when they're in hospitals. And whether the gainsharing feature look of hospitals and doctors coming together, whether some of that pre-teaching occurs prior to the episode, especially if it's a planned surgery or something like that, to the post-episode as well, too, the immediacy of when that information is both digestible and important for behavioral change so that to take a look at that impact on readmission rates in the first 30 days.

Some of these things of looking at it as an episode of care relative to what happens and piecing the physician and the hospital together for consideration on that.

Anyway, these are just some of the areas of how to take a look at quality of care and resource use and the readmit rate in the future.

DR. CROSSON: Again, kudos here, because I have to admit when I first picked up the chapter and I looked at the title and it said inpatient hospital resource use, I said hospitals have DRGs, end of story. And it's clearly not.

I think dividing the resource use in this way, which I sort of read as inside the DRG number one, outside the DRG number two, and no DRG in the first place number three, adds a lot. I also think that they're nicely ordered in terms of the difficulty as we go along in coming up with ideas and potential solutions, the hardest one being the issue of how to structure incentives that would actually push against inappropriate hospitalizations in the first place, since in the paper it was well laid out that, of course, that's the revenue for hospitals.

So I think I end up in the same pace as Ralph in the end that if that third area, which I think is potentially productive, is going to turn out to be so, it's really going to involve the issue of trying to get incentives for hospitals and physicians to work more closely. Because I think in the end, to imagine that somehow hospitals would be incented to push against patients being admitted, the fee-for-service hospitals, it's hard to

imagine how that would work unless there was something pretty robust created and allowed and created between doctors and hospitals.

But since that exists in my kind of abnormal situation in Kaiser Permanente, I obviously think it can work and that it's a fruitful area.

MR. HACKBARTH: Okay. Thank you very much. Good job.

We now move to two presentations about the implementation of MMA. First, a look at Part D implementation and plan and benefit designs, and then we turn to Medicare Advantage.

MR. BRENNAN: Thanks everybody.

As you all know, the Part D program represents the largest expansion of Medicare since its inception and it's going to significantly increase Medicare outlays over the next couple of years.

As most of you probably also know, while it seems as if we've been talking about the benefit for a very long time, we took one of the major concrete steps on the road to reality when open enrollment started yesterday. John said there were hundreds of Medicare beneficiaries camped out on

his front lawn.

It also represents a fundamental change in the way Medicare does business. Beneficiaries will only be able to get prescription drug coverage from stand-alone PDP plans or Medicare Advantage prescription drug plans.

From bene prospective, the implementation of the benefit represents a significant coverage expansion. Because the initiative is on the beneficiary to select among, in some cases, many competing plans depending on your outlook you can either see that as a triumph of competition or a potential burden on beneficiaries as they attempt to differentiate between all these different choices.

Today we're going to present you with some information on our work plan for analysis of the Part D program and some preliminary data on plan offerings, premiums and benefit packages. Just to note also that Cristina is also heavily involved in this Part D work plan and research process.

The next two slides go into a little more detail on some of the questions that we hope to address in the coming months. Part D is different from fee-for-service Medicare because premiums can vary not only across

geographic areas but within geographic areas, whereas the Part B premium is the same nationwide. Part D benefits can also differ within defined actuarial boundaries, whereas the fee-for-service benefit is the same nationwide.

With this in mind, we're going to look at variation, differences in benefit packages, premiums and formularies. We have some basic info later in the presentation regarding benefit packages and premiums and we'll expect have more details in future presentations.

We'll also be looking at differences between PDP and MA-PD benefit designs. The MMA permitted MA plans to apply a portion of the difference between their bids and the benchmarks to enhance their plan offerings which could include extra benefits or lower premiums. So we'll be looking for evidence of this and the extent to which MA plans have more generous Part D benefits or lower Part D premiums. We'll be looking to see whether it's had an impact on MA enrollment and ultimately drug utilization.

We'll also be paying particular attention to the web-based tools that are being made available to beneficiaries and State Health Insurance Programs to provide assistance in the enrollment process. Tools such as these

are important because beneficiaries are going to need a way to distinguish between these multiple competing plans and to see the information on these plans displayed in a standardized format.

I'd also like to note that Joan is leading a separate study that's going to examine the types of information and modes of communication that most Medicare beneficiaries are using to learn about their Part D options.

The MMA also included subsidies that cover some or all of the premiums and cost-sharing for individuals with low levels of income and assets. However, these subsidies are only applicable to Part D plans with premiums that are at or below a certain threshold level calculated for each region. This threshold amount is designed to keep enrollment of beneficiaries who qualify for low-income subsidies in lower priced plans while ensuring that at least one stand-alone PDP is available to them. Plans that are below this threshold qualify for auto enrollment of dual eligibles into the benefit, which has the potential to save them money on marketing costs.

CMS is auto enrolling these 6 million or so duals this fall so that they will have Part D coverage on January

1, 2006 and that's the date under which their prescription drug coverage through Medicaid will officially end.

An interesting thing about the auto enrollment process, and something that we'll be tracking on, is that duals can switch plans after they've been auto enrolled and we will be monitoring to see how often they are exercising this option to switch plans.

Finally, both CBO and CMS projected high enrollment in the Part D benefit and we'll be comparing actual enrollment to these enrollment estimates. Although I'd like to note that open enrollment, which as I said began yesterday, runs through May of 2006 which means that final final enrollment numbers will be too late for inclusion in our June report.

Just a quick bird's eye view of a plan entry, and some of you may know these numbers already. But based on the data released by CMS, it's clear that there's been a lot of plan entry. There are 82 PDP sponsors nationwide with 10 of them offering products in all 34 regions. The total number of PDP plans is approximately 1,400 and the total number of MA-PDs is a little over 1,600. Because of all of this plan entry there was no need to exercise the fallback

option which is provided for in the legislation.

As described earlier, PDPs with premiums below a certain threshold are eligible for auto enrollment of dual eligibles and there are at least six such plans available in every region. Rachel is going to walk you through some more data pertaining to Part D plan entry and premiums.

DR. SCHMIDT: I should mention that some of the slides that Niall and I are presenting to you may differ a little bit or be entirely new to you relative to the mailing materials. And that's because we received some more information from CMS after the mailing materials went out. We will come to you in the future again with more information as we get it.

The MMA included a defined standard benefit that I'm sure you're familiar with, with a $250 deductible and then a range of spending with 25 percent coinsurance and then the notorious coverage gap, and then some catastrophic coverage. But it also gave plans flexibility to provide different benefit structures provided they meet certain tests of actuarial equivalence.

For example, you could use tiered copayments instead of 25 percent coinsurance so long as the cost-

sharing amount was actuarially equivalent. Both the standard benefit and ones that are actuarially equivalent to it are called basic plans. In addition, once an organization offers a basic plan, it may also offer what's called enhanced coverage which is a combination of basic coverage plus some supplemental coverage.

So for example, an enhanced plan might have a higher actuarial value than the basic plan because, for example, it might fill in the coverage gap to some extent.

These pie charts up on the slide now, let me give you the lay of the landscape here, will have stand-alone PDPs on the left and Medicare Advantage PDs on the right. These pie charts are showing you the distribution of the standard benefit in the red. Yellow shows you actuarially equivalent basic benefits in yellow, and then enhanced benefits in the light blue.

You can see that relatively few plans have just the standard defined benefit. They're taking advantage of the opportunity to use actuarial equivalence or enhancing the benefits. You can see about 9 percent of the stand-alone PDPs have a standard benefit, 15 percent among MA-PDs. It also looks as though the MA-PDs tend to be offering a

larger portion of enhanced benefits relative to the stand-alone plans.

Next we wanted to give you a sense of the distribution of premiums for Part D. We've got the number of stand-alone PDP plans again on the left-hand side and MA-PDs on the right. For this slide, we're not yet able to separate out the premiums for basic versus enhanced plans, so this slide combines those two types of plans together in these distributional graphs. However, you can pretty much assume that the enhanced benefits tend to be on the right-hand tail of both of these distributions.

So among the stand-alone PDPs you can see that the median and the average is in the $30 to $40 range and there's a minimum among all of these plan offerings of about $2 a month and the maximum premium out there is about $105 per month.

Among the Medicare Advantage plans there's the same width of distribution but you can see that it's much more skewed to the left, that there are many zero or very low premium plans out there.

I should note, though, that when we say that an MA plan says that they have no premium for their Part D benefit

it still may be the case that a beneficiary would have to pay some premium for the Part A and Part B side offering in that MA plan.

DR. MILLER: Can I just would reinforce one point, just in particular for anybody. I think the Commission gets it, but even also for the public.

The variation that we see here, it's important to bear in mind we haven't yet be able to parse between basic and enhanced plan. So some of the variation that's going to be driven here is by the fact that you have rich with less rich plans side-by-side.

I just want to be sure that the listeners in the public also understand that this variation needs to be parsed further to get a real comparison there.

DR. SCHMIDT: Thanks.

I mentioned that one of the features of this defined standard benefit includes a $250 deductible. So we wanted to take a look at the extent to which plans are using that $250 deductible or some other sort of structure. Again, the lay of the landscape here is stand-alone PDPs are in the two left-hand side columns and Medicare Advantage PDs are on the right-hand side.

We classified plan offerings here into basic plans, which means both the red and yellow chunks of the pie charts that we saw a moment ago. So ones that are the standard benefit or actually equivalent to it versus enhanced plans, the ones that includes a little more generous coverage in there. That's why we have four columns in this slide.

You can see, if you look on the bottom row, the $250 deductible row, nearly 60 percent of basic plans, both among stand-alone PDPs and Medicare Advantage PDs, are using the $250 deductible. Almost all of the enhanced plans have basically no deductible or a reduced deductible.

We plan to take a more detailed look at the structure of plan's formularies and their cost-sharing when we get more detailed data from CMS. But here's a preliminary look, just to give you a sense of things. Remember one of the ways in which plans have some flexibility is that they could either use the 25 percent coinsurance or they might, for example, want to use tiered copayments in lieu of that coinsurance, which is something that's probably more familiar to a lot of people out there who have benefits through former employers and that sort of

thing.

Some organizations may be out there testing the waters, doing some of each type of plan to see what beneficiaries prefer. So we're going to see a variety of things out there.

Coinsurance, if you think about it, can tend to put a little bit more risk on the beneficiary in the sense that if the price of a drug goes up then the beneficiary is paying a bit more. So a plan might like it in that respect. But on the other hand, tiered copayments are more familiar to beneficiaries. You may also be able to steer beneficiaries to use certain types of drugs by looking at the differences between copayments. So it's not entirely clear which one they prefer.

Again here, we're distinguishing between basic plans and enhanced plans and we've got stand-alone PDPs and Medicare Advantage ones. You can see in most plans are not using to choose the 25 percent coinsurance. 82 percent of basic stand-alone PDPs are using tiered copayments and 67 percent of basic Medicare Advantage PDs are using tiered copayments, and virtually all enhanced plans are using tiered copayments.

If we look at the distribution of copayment structures for those that are using tiers, we see in the entire distribution that the number of tiers varies between two and eight, and most plans seem to be using three to four tiers. This might be a structure where you have one copay for a generic, one for a preferred brand, one for a non-preferred brand and perhaps another for specialty drugs. But it differs in our data from plan to plan.

Because of the complexity of this cost-sharing structure and these tiered copayments, that really reinforces how important is to display information well to the beneficiaries. Distinctions among plans can be very important and difficult to understand. For example, if you had a web tool that just focused solely on whether or not a particular drug was covered by a plan, a beneficiary might not be able to understand the important differences in cost-sharing that apply across those plans.

So for that reason, we're going to be paying close attention to the web tools that are available to try and see if a typical beneficiary can figure these things out well or not.

So to summarize here, we're seeing that most plans

have decided to use tiered copayments rather than the 25 percent coinsurance and it looks like most are using three to four tiers.

Finally, we want to give you a sense of how many plans are providing coverage in the coverage gap. Once again, this slide is combining plans that have basic coverage along with ones that have more generous supplemental coverage. We weren't able to distinguish between the two yet, but we will come back to you with that. Stand-alone PDPs are on the left, Medicare Advantage on the right.

The vast majority of plans are not providing coverage in the gap, as you can see, 84 percent among stand-alone PDPs and 76 percent among MA-PDs.

When they do provide coverage in the gap, it tends to be generic only coverage. A very small number of plans are providing both generic and brand coverage in the coverage gap. And even among those plans, it's really just a handful of organizations that are doing so. Those tend to be major players that are operating in a large number of regions.

So these slides that I've just gone through are

here to give you a sense, just a taste, of some of the data we're starting to see about the variation in plans available to beneficiaries for 2006. We'll be back to you to show you more dimensions of that variation in the future.

Niall has outlined some of the research questions we have and we're happy to take your comments and suggestions for how to advance this research.

MS. DePARLE: Thanks.

This last slide is an example, I guess, that relates to one of my questions which is this is based on CMS data you say. But did you take some actual submissions by the plans and go through them and then group them into these areas? Or did you give them the areas and they told you which ones fell into which categories?

DR. SCHMIDT: Our slides have a combination of both approaches, to be honest with you. For this particular slide, this is based on CMS's groupings of who has which kind of coverage. Some of the more recent data that we just received, the reason that we had some new slides for you, have more of the plan submissions and we're still combing through those.

MS. DePARLE: Because I had heard anecdotally at a

conference I was at a couple of weeks ago from a number of plans that the data on the web site I think was still not correct for them and didn't describe their Part B premium quickly or Part D premium correctly. It's anecdotal but I heard it enough that it made me wonder where could one go to get the correct information.

So you didn't just take this off the web site? You took it from them but you didn't necessarily look at the plan submissions?

DR. SCHMIDT: It's information that was available on their web site but not the information that I think you're referring to. I think that CMS had some difficulty getting their web-based tool up because there were some problems both with the -- as I understand it, problems with the software pulling up the correct information that a plan had submitted. Plus there were some inaccuracies in what plans had submitted.

There's a separate set of data that CMS has made available to organizations and researchers on their web site that does this sort of summary. So they've already combed through it.

MS. DePARLE: Maybe the kind of inaccuracies that

were being mentioned would be more granular and wouldn't affect these categories anyway. I just wondered.

Is the plan finder -- I guess I'm interested in what tools are available to a beneficiary who wants to approach this by saying okay, here are the 10 drugs I use. Let's see which plans are in my area that would be best for me. Is the plan finder up and running?

MR. BRENNAN: Yes and beneficiaries can input the specific drugs that they use and see whether or not they're on various plan formularies and what the copayments would be.

MS. DePARLE: Have you guys actually tried to use it?

MR. BRENNAN: We attended a demo of the plan finder a couple of weeks ago -- weeks, months -- in Baltimore. I personally haven't used it since it went live but we intend to test it and see.

MS. DePARLE: Have you called the 1-800 number?

DR. SCHMIDT: No, not yet.

MR. BRENNAN: No.

MS. DePARLE: I have and some other people have. And if you tell them about drugs they seem very -- at least

the people that I got seemed very hazy about trying to figure out which drugs were where. So it seems like the web-based tools are going to be the most important -- if they're accurate -- the most important resource.

DR. SCHMIDT: I think the people at the other end of the 1-800 line are actually using the web-based tools.

MS. DePARLE: Maybe when I called it was before that was maybe set up because I think it didn't come online until last week. That may be what it was.

DR. MILLER: Just to make another point on this, these guys and other staff did go up to see what CMS had and test drive it before it all got out. And we really haven't had time since it's been out to look at it.

But also just to remind you, and I think this was mentioned earlier, Joan is going to be looking behind the education process and sort of what decisions they made and what tools that they used to actually make those decisions.

I think I'm describing that right. And Joan is nodding, so I'm going stay with yes again.

MR. SMITH: We sort of have a synthetic focus group around this table. All of us have, either with mothers-in-law or mothers or fathers or aging relatives --

played with this a little bit. I have used plan finder. I did it at a community center in a small New England town and actually found it relatively easy to use. It was not hard to get it.

But what was almost impossible, Nancy-Ann, was helping folks who were not comfortable get it.

So this evening with 15 people trying to figure out what to do with a couple of us who were comfortable with plan finder, it actually worked pretty well. But when I shifted gears and tried to say okay, now you do it, it was a miserable failure, as it was with my mother-in-law, which has other consequences.

[Laughter.]

MR. SMITH: One other observation and Rachel, it speaks to the way you tried to discriminate among the plans. The first dollar aversion is a big deal. It's sort irrationally a big deal. And the tools don't help people think about -- the first dollar aversion is a magnet in a way that trumps more rational decision-making and the tools don't help. Unless you've got an interlocutor, it's very hard to get past the attraction of getting rid of the deductible.

And the gap terrifies people. They don't know what to make about it. They don't know how to think about the probability that they will or won't or are facing it.

And my guess, and this is a tiny sample of relatives and 15 folks, but my guess is that the admission numbers are going to terrify us, the registration numbers are going to terrify us on January 1. We're going to have to figure out, or CMS is going on to figure out -- fortunately it won't be us -- about how to talk to people whose reaction is to step back and say I don't get it, it's too complicated, I'm too scared, I'm too nervous about what I don't understand and I'm going to wait.

MR. MULLER: Just on that same point, the bulk of the media coverage in Philadelphia and New York, et cetera, where I am a lot, is dealing with its complexity. So could you remind us again what the kind of estimates were of take up rates and so forth, and when we'll know what they'll be? Because insofar as they're so complex people will step back for a while with the kind of consequences that David -- so could you remind us again what the estimates were?

MR. BRENNAN: Depending on the denominator, be it Part A and Part B, 85 to 90 percent of enrollees.

DR. SCHMIDT: But that was including people who have coverage through an employer.

MR. MULLER: Was that discriminated is to January 1st or June 1st? Those are long-term?

First year.

Because I think, especially seeing about 85 percent or so of all of the coverage basically had three or more tiers. I just started thinking. And obviously the number of plans, some areas have 30 or 40 plans to choose from?

As Arnie said, this is consumer directed health care run amok. This is going to be a real problem. I don't know how people think through it. Especially, so many people think -- David was pointing out about the gap. So many beneficiaries think the cost of a drug is their copayment, not the total cost. So when you start thinking through the complexity of understanding how you finance health care in America -- well, I think I'll bet another cheeseburger that the rate is going to be pretty low for a year.

DR. MILLER: Just on the rates, and Rachel and Niall just make sure I've got this right. Let's be clear,

some auto enrollment will occur. And if the employer says okay, I'm moving into this, then that enrollment will occur.

I think the point you're driving it is for those people who have to make a much more proactive decision. That will be the question of how much enrollment you get out of that group, I think, just to narrow the point a little bit.

So you'll get blocks of people who will come in almost automatically, for lack of a better word.

MR. BRENNAN: I would add, most people already in Medicare Advantage organizations will just switch over to a plan with drug coverage. So that's another 13 percent or 14 percent it's already there.

MR. MULLER: That's 13 to 15 percent there. And the duals are what percent?

DR. SCHMIDT: About 16 or 17 percent.

MR. MULLER: So you're up to 30. And then the credibles are --

DR. SCHMIDT: The employers are on the order of 30 percent. So a lot of the chunks of people include those who have Medigap policy now that don't cover any drugs. Those are the ones that are probably really up for open

enrollment.

MR. HACKBARTH: And that group of people, in choosing among Medigap plans, they face difficult decisions of a difficult sort all of the time. Or have and maybe make good choices, maybe make not so good choices.

MS. BURKE: This isn't the question I was going to ask. But one of the things you may want to do is Kaiser has -- Trish has been doing a lot of this work with blend and have just released some numbers, I think within the last few weeks, that indicate that somewhere north of 60 percent of seniors have never used a computer. There is some enormous percentage. And the extent to which they are dependent upon that method for navigating, at least evidence would suggest, that there isn't much history there in terms of their interest, willingness or capacity to do so. So you may just want to touch base with them in terms of some of the stuff they're getting in terms of survey work with seniors that may assist.

I really wanted to ask a question that was more forward thinking and not specifically focused on, in the course of this paper or the research questions you're asking. And that is what our expectation is in terms of the

information that will be produced by CMS in the course of utilization of the new benefit? And how we anticipate using that information going forward in terms of tracking what's occurring with patients, how they're utilizing drugs, whether in fact it's appropriate use, again with an eye towards quality, with an eye towards moving people towards good decisions in terms of appropriate care.

What comfort do we have that CMS has thought ahead to what it is that they need to produce and gather the timeliness of that information and how we can utilize that information in informing physicians about their practice patterns and decisions with respect to prescription drug use.

Given the size of the population that are dependent upon drugs, given the importance of that increasingly in clinical care today, I would hate to have us get too far afield in this new benefit without having thought about what are we going to do with the information that's produced in terms of utilization? What are they producing? Do we have some sense that they have made the right choices about what to track, when we'll get the information, how current it will be, and how we utilize it

in terms of our goals going forward about informing physicians about appropriate practice patterns and essentially prescription drug use.

DR. MILLER: Do you want me to take a shot at that? The first thing I would say is just to answer part of your question, I would like to just answer what we're thinking about doing. I know CMS will engage in analysis and think about this. But I also think, in all honesty, they're also in the midst of trying to implement this. And I think that they're blown out just with that right at the moment.

To be honest, at least for me and any of the analysts should respond, I haven't put the question to them of what's your research? What's your long-run research agenda? So that's one point.

A second point is that we have been engaging them in conversations already to obtain the data that we need to do this. We're just working through it and structuring this is what we need, this is what we're going to need next, the next allotment that we're going to ask for is the enrollment data, and then the data beyond that will be the utilization data. And that's where we'll start to get into things that

I think you're reaching to, which is if you have this kind of plan structure or this kind of tiering structure or this kind of benefit structure, fill the gap, don't fill the gap, deductible, no deductible, whatever the case may be, what kinds of patterns do you see, utilization and otherwise?

And for us, just so you know, not to get your expectations up too fast, that's got to happen before even the data rolls in and then us to analyze it. I think those questions are a bit of a way off for the moment.

MS. BURKE: But Mark, if I could just take that one step further, and I understand that this is not a short-term. My concern is that -- and you're right, I'm sure they are overwhelmed with just the implementation.

But early on, I think we have to make it clear the decisions about prescriptions and the use of prescriptions and the choice of specific medications and their use in treating certain conditions is a huge part of watching best practices. What do people know about the utilization or interventions with certain kinds of conditions? What is current today? What isn't?

I know that is a longer term question but I think it will have a huge impact in terms of resource utilization,

in terms of outcomes, in terms of physicians' understanding what, in fact, are viewed today as best practice as compared to what they may have used in terms of the past in terms of interventions.

So again I think you're right. This is the longer-term question, which is why I preface it by saying this isn't today's conversation. But I think the expectations should be that we're going to want to understand that. We're going to want to use that information in this feedback loop in terms of helping physicians understand what, in fact, is occurring.

I know it's something certainly the private plans are spending a lot of time thinking about and have already begun, in terms of trying to do course correction and dealing with their physicians in terms of patterns of use. And again, I think from Medicare's standpoint, now that we're going to have this information wherein the past we haven't because we haven't covered drugs, I think we too very quickly are going to have to begin to think about how we use this information to inform physicians and to, in fact, affect their behavior going forward.

DR. MILLER: I know other people want to comment

and I'll be very brief here.

I just want to remind everyone that the June chapter, we laid out what should be collected and monitored and viewed over time. And actually, there has been some Hill interest in that in taking a look at it and starting to think about how to structure things.

And I also would say this, I think our process of working with CMS, we want this data for these purposes, will also be a signal to them as they think about how they want to structure their -- okay, sorry.

MR. BERTKO: Can I add something here?

In the drug stuff there's a prescription drug event aggregator that is different from the A/B types of stuff where those things typically take a year and some months to go into the file. And so for certain kinds of data -- not to answer all the question that you raised, Sheila -- there could be stuff that's available in a relatively short run. And we may need to triage some of that, because it's going to be near real-time.

The downloads from the private plans are going to be daily because they have to work to do all of the various

limits in case someone changes from area to area.

DR. CROSSON: My question was basically an extension of Mark's comments a couple of minutes ago about sort of the forward-looking work stream.

We have a rather substantial natural experiment going on here. And one of the issues, in addition to the appropriateness of drug utilization on the part of physicians, is the question of the appropriateness of choices that beneficiaries are making based on the panoply of benefit design, whether those are wise choices or not and the like.

The claims information is not going to be ready until December 31st of 2006, and therefore analysis of that and the thinking here is probably a year-and-a-half away at least.

The question is would there be any value in trying to address this question of the relationship between benefit design choice and the wisdom of choice by actually looking at the risk profile of members who have chosen different plans based on existing claims data from Medicare Part A and Part B, to begin to think about and address that question well in advance of actually looking at the real utilization.

Because it might be something that could be done sooner than a year-and-a-half to two years.

DR. SCHMIDT: That's actually the same information that CMS uses to build risk adjusters for Part D, at least initially. And so, in the process of looking at those initial risk adjusters, we've been looking at some of the same questions.

DR. MILSTEIN: If you begin to think through what kind of a model for ideal choice might look like, the best database to build from would be a cooperating, existing Medigap plan that covers drugs because that would -- sorry, John.

That gives you the information on the specific drugs that somebody is currently on. And knowing their Part A and Part B claims gives you a hint as to what drugs they might be on but not the specific drugs. And given the importance of formulary tiering with respect to distinctions between the plans, if you really wanted a reasonable basis for comparing actual choice with what might be considered to be best value given a person's preferences and prior utilization a cooperating Medigap carrier, in conjunction with the Part A and Part B data, would give us a far more

precise measure of just how suboptimal beneficiary choices are.

MR. BERTKO: I need to reply on this.

The asymmetry of information for the 10 percent of Medigap members who choose HIJ is horrendous. The use is high. I'm sorry, Arnie. It wouldn't provide anything except a sample of really high users.

DR. MILSTEIN: Later.

MR. BERTKO: Later.

DR. KANE: I'm trying to do the math here of 3,000 plans into 25 million people. I'm kind of averaging somewhere around 8,000 or 9,000 --

MR. BERTKO: Wrong math.

DR. KANE: But my real question isn't really the math. My real question is is there a break even volume for these plans? And if there is, and some don't make it, what's the plan? And who's responsible? And what does that do to the beneficiary? I'm just really thinking this can't be all that financially stable with this many players in the market. And if it's going to shake down, it's going to shake down over the next year to two?

What's the plan for how these beneficiaries are

going to be moved around and whether they'll ever reenroll again? How do we deal with that?

MR. HACKBARTH: You're getting more than your fair share of air time here.

MR. BERTKO: Let me say normal market dynamics, I think, will have people enroll in the lower cost plans. Those will be the winners. And 90 percent of people will choose a plan that continues.

Now that's membership. That may be only 25 percent of the plans. And so 75 percent may have, as you were saying, 800 members. And my expectation is they will quickly decide another business is good for them.

DR. KANE: Doesn't that kind of create enormous instability for the beneficiary? Allowing this much play --

MS. BURKE: But Nancy, we've been through this. Been here, done this. This is exactly what happened with the risk plans, where they failed.

DR. KANE: I know and so I'm saying what is in place to protect the beneficiary from that level of chaos? And who's responsible if a plan goes belly up in the middle? Who's going to manage that process for the beneficiary?

MR. BERTKO: Let me, only on that last point,

insolvency. The standards for being there are quite strong. I think 99 percent of the plans are probably state licensed, in terms of the thing. And the last 1 percent had to file -- and I can personally say, we put a bunch of money into New York state because we at the time didn't have a license. And there's no way we'll burn through that money. But it's sitting there as a protection for beneficiaries.

DR. MILLER: And when the circumstances happened in the past, what the Agency does is it steps into the marketplace, deals with the failing plans, and starts going to the other plans in the area and saying will you start to take these? So that's one thought.

The other thing is that there is some expectation, and even beyond the notion of plans leaving from year-to-year, which I assume there will be some shakeout. Beneficiaries may choose other plans next year during open enrollment season just because they want a different benefit structure.

MS. DePARLE: This would happen at open enrollment. I think John's right. It most likely won't be plans in the middle of the year saying gee, what was I doing? It's going to be plans notifying CMS sometime April

-- is that when they have to say? June. Yes, we will be there for next year, or no we won't. And here's what we're filing. And that's what you might see -- I suspect you will see some pulling out.

MS. BURKE: You may also see adjustments in their structure of their plan.

MS. DePARLE: I think you will. You'll see some changes in their pricing, I'm sure.

MR. HACKBARTH: That's one important distinction, plan failure, which I think is going to be a rare event. And then plans departing the market, people having to make different choices.

One difference between this and the Medicare+Choice situation may be that -- in the Medicare+Choice situation the most difficult circumstances involved beneficiaries having to change physicians because a plan went out of the market, chose to leave the market. That won't be the issue here unless we're talking about obviously a Medicare Advantage plan.

MS. BURKE: But they may also --

DR. KANE: Change their prescriptions or their copay.

MS. BURKE: They may have a different formulary. You may have those issues that arise, in terms of having to change plan to plan.

MR. HACKBARTH: Absolutely.

MS. BURKE: Where different drugs are covered or the pricing is different or the tiering is different. So those things could occur.

DR. NELSON: I'll be brief.

Apart from monitoring churn within plans, it will be important for us to keep track of churn within the formulary, even though the plan is stable from two standpoints.

First of all, an unstable formulary is disturbing to both the patient and the physician. There are implications for patient safety. I'll give you two examples.

Thyroid preparations differ in their bioavailability within the same compound, depending on which generic product. And so if a company drops one, in this case thyroxin, preparation and substitutes it for another from a different producer or manufacturer because it's cheaper, the bioavailability of that product may be very

different. That is its effect on the body may be very different. And in order to reequilibrate it, the physician has to order relatively sophisticated tests in order to determine whether a different dosage is required to have the same biological effect.

The same is true if a physician is managing blood lipid and cholesterol problems. If they drop Lipitor from the formulary, for example, and add Mevacor in its stead because it's cheaper, then blood tests will have to be done sequentially to determine whether or not the patient is getting the same effect.

So when a patient has been stable on a blood pressure medicine, a cholesterol medicine, on a thyroid medicine, they're stabilized, the physician has their program so that everybody knows what to expect, and you start changing that because of churn in the formulary, there are costs consequences and there are patient safety consequences.

MS. HANSEN: This may be more of a question for Joan's work in the future. I think one of the things that was noted to be with the Part D that the people who are not dual eligibles and certainly not the population we talked

about, but the people who are perhaps 150 percent above poverty -- I guess the estimates have been 9 million to 11 million people would be qualified.

That whole group is really a new targeted group. And whether or not we're looking at that group in particular, because that's even more difficult of a group to reach just because that is a group that certainly, for the most part, may not be using computers, and again that's a large generalization, but the complexity of choices.

So Sheila, I don't know whether that's where the Kaiser Commission is already focusing on that, but whether to not that's appropriate for one of our areas to really look at since that's a significant Medicare population in terms of access.

And then using other organizations such as the state health insurance counseling programs, which become another source, because these are more voice-to-voice face-to-face kind of counseling sessions, as well as the National Council on Aging, which has it's whole distribution of senior centers where a lot of people who might be in this category may have some interface.

DR. SOKOLOVSKY: Let me just answer a little bit.

I'm going to present more of the work plan in January but just to get an idea, we're doing three projects on this. One of them is a general survey of beneficiaries, looking at where they're getting their information and what kinds of things were important for them if they make choices and things that they can answer in a survey question.

Then to dig down deeper, we're doing focus groups and trying to get a much deeper handle but in obviously a less quantifiable way.

But the third thing we're doing is a series of structured interviews with State Health Insurance Programs, Councils of Aging, different kinds of grass roots organizations, looking at what their experiences are with specific populations and that population in particular.

One of the other things that CMS has determined is that those people who are not dual eligibles but have incomes up to 150 percent of poverty, and who are qualified for some low-income subsidy, if they have applied for the subsidy but have not chosen a plan, In May they will be auto enrolled in the same way that dual eligibles are auto enrolled.

MR. BERTKO: Just a quick question that's a real

question, back to slide three about your research questions.

The top one on that, types of plans available to recipients of low-income subsidies. I guess I'd want you to think about defining that more specifically because from a members point of view, a low-income senior, all the plans are the same from benefit design in terms of copays, of course. And perhaps only the formularies would be the only differential that you would need or want to look at in that case.

And then there's a second somewhat related question on people in long-term care facilities. There's been some talk at least that these facilities may, in fact, want to consolidate carriers so that they perhaps deal with a single carrier or maybe only two inside a facility. It may be worthwhile to investigate the extent to which that goes on to see whether there might be things we learn from it or other types of stuff.

DR. SCHMIDT: I think your point about plans available to low-income subsidy benes is an important one. The formula dimension one is probably the most important, particularly for the dual eligible population where they use

very particular types of drugs. So I think that was kind of under the surface of what we had in mind there.

And yes, we're aware of the long-term care pharmacy issue and we plan to monitor that, as well.

MR. HACKBARTH: Okay, thank you.

Next up is Medicare Advantage.

DR. HARRISON: Today we'll begin looking at changes the Medicare Advantage program will undergo for 2006 and see how those changes may affect the competitive environment.

Let me just review several big challenges that are likely to affect MA plans. First, CMS will no longer pay the plans set rates. Instead, plans will bid to provide Medicare benefits. Their bids will be compared with benchmarks that were established by the MMA at the county payment rates previously used to pay the plans.

I'm not going to go over the formula in detail again unless there are questions but the general idea is that if a plan bids below the benchmark for the basic Medicare Part A and Part B benefits, it receives it's bid plus 75 percent of the savings relative to the benchmark. The plan then must use those savings or rebate to provide

the enrollees with supplemental benefits or lower premiums.

Another change is that new plan types will be allowed. Regional plans will be allowed. They are required to be PPOs and they must serve entire regions built up from states. Other plans are referred to as local plans and they may define their own county-based service areas.

The regional PPOS may be allowed to have looser networks of providers than local plans.

Another new type of plan is the special needs plans. I may lapse into SNPs. We'll see if I can avoid that.

They may restrict their enrollment to one of three types of beneficiaries: Medicare and Medicaid dual eligibles, beneficiaries living in institutions and beneficiaries with chronic conditions.

The third big change is the introduction of the Medicare Part D drug benefit. Part D will provide plans with additional funding and new competitors. Most MA plans provided some drug coverage and indeed research showed that one of the primary drivers of plan enrollment was their provision of drug coverage.

However, plans never received explicit government

payments to provide drug coverage and often the coverage was very limited.

Beginning in 2006, MA plans that include the Part D drug benefit or an equivalent or enhanced version will be paid by Medicare just as if it were a stand-alone PDP. Because many MA plans already offer drug benefits without receiving Medicare reimbursement, the Part D payments will represent a new stream of funding that could increase their payments from Medicare from 10 to 20 percent.

Of course, plans that offer drug benefits that did not reach the actuarial value of the Part D benefit will have to improve their drug coverage and plans will also have to meet new formulary and data requirements.

The stand-alone PDPs will represent a new form of competition for the MA plans. The PDPs will offer a relatively affordable way for beneficiaries to remain in fee-for-service Medicare and obtain prescription drug coverage. We will watch to see how all of these competitive forces play out.

To look at the competition, we will undertake a three-stage process necessitated by the timing of the data, as we talked about for the Part D. This fall we're

examining the plan offerings for 2006. Today I will begin to describe their availability and characterize some of the benefits. We will put a special focus on regional plans today and examine the special needs plan offerings in a coming meeting.

Next spring, once enrollment data become available, we will examine enrollment patterns to see how competition is developing. The key questions are is total enrollment in MA plans growing? Which types of plans are attracting enrollees where? And are special needs plans encouraging dual eligibles to enroll?

Finally, we will analyze the competition in conjunction with analysis of Part D developments. We would like to learn how competition shakes out between the MA plans and stand-alone PDPs and what happens with Medigap enrollment? And how are payments to MA plans comparing with spending in the Medicare fee-for-service program?

I will now begin stage one by providing information on plan availability for 2006.

2006 will be a record year for plan availability. Virtually all Medicare beneficiaries will have a Medicare Advantage plan available to them, compared with 84 percent

availability this year and 77 percent in 2004. In fairness, I will note there are a few counties that will not have plans in Alaska and in New England. The actual availability is 99.6 percent of beneficiaries.

Availability will be significantly higher than in recent years for each type of MA plan shown here. 80 percent of beneficiaries will have a local HMO or PPO available in 2006. The previous high occurred in 1998 just after the inception of the M+C program when 74 percent of beneficiaries had a plan available.

Private fee-for-service plans generally do not coordinate care through a network but instead allow enrollees to see all Medicare providers and the plans reimburse those providers at fee-for-service Medicare rates. Their enrollment has been growing over the last couple of years and they are really expanding for 2006 and will be available to 80 percent of Medicare beneficiaries, up from 45 percent this year.

Combining the local coordinated care plans, the HMOs and PPOs, with the private fee-for-service plans, 99 percent of beneficiaries will have a local plan available.

The new regional plans will be available to 88

percent of beneficiaries. Even though the regional plans can't improve the 99 percent availability measure significantly, regional plans will, however, increase beneficiaries' range of choices. Also, regional plans will expand the availability of coordinated care plans. Not shown on this table is the fact that local or regional coordinated care plans will be available to 98 percent of the Medicare population.

I will go into a little more detail about the regional plan offerings at the end of this session.

Virtually all beneficiaries will have a choice of two or more MA plans. Greater choice will be available not just because MA plans are entering new areas but also because more plans are entering already well-established MA areas, potentially stimulating competition. Overall beneficiaries will have more than twice the number of MA plans to choose from in 2006 than they have now. Half of all beneficiaries will be able to choose from among 16 or more MA plans and 5 percent of beneficiaries will be able to choose from over 40 MA plans.

Beneficiaries in Broward County, Florida will have the most choice, 63 MA plans, which is an increase from 39

this year.

Bear in mind, these plan choices are in addition to the stand-alone PDP offerings. I should note that plan sponsoring organizations often offer more than one plan choice but there's still quite a bit of choice. As a result, some consumer groups have raised concerns about whether there is too much choice for beneficiaries to make informed decisions.

We have established there will be lots of choice. Now let's look at how attractive some of those choices may appear.

We see here that many of the choices will have zero premiums and provide enhanced benefits. By the way, zero premium means no premium in addition to the standard Part B premium that all beneficiaries pay. Zero premium MA plans will be available to 86 percent of Medicare beneficiaries in 2006. That is an increase over 2005 when 58 percent of beneficiaries had access to zero premium plans.

Although premiums for the private fee-for-service plans and the regional PPO plans tend not to be as low as premiums for the local HMOs, about one-third of

beneficiaries will have access to zero premium private fee-for-service plans and a similar share of beneficiaries will have access to zero premium regional plans for 2006.

Zero premium plans that include drug coverage will also be available. 73 percent of beneficiaries will have access to plans that charge no premium in addition to the Part B premium and have a zero premium for the Part D benefits that they offer. 31 percent of beneficiaries will have access to a zero premium plan that offers drug coverage with some coverage in the gap. Not shown on this table, 15 percent of Medicare beneficiaries will have access to zero premium plans that include brand and generic coverage in the gap. All of the zero premium plans that provide coverage in the gap are local HMOs and PPOs.

I would like to highlight one more number on the table. 25 percent of beneficiaries will have access to a zero premium private fee-for-service plan that includes Part D coverage. This means that one quarter of all beneficiaries have access to a plan that is at least actuarially equivalent to Medicare fee-for-service benefit and includes a drug benefit at no extra charge.

Now not all beneficiaries have access to zero

premium MA-PDs. But if you consider those beneficiaries that do with those that have access to plans with a premium of $1 to $20 a month, you will find that 80 percent of beneficiaries will have access to MA-PDs with total premiums of $20 or less per month in 2006.

However, at the other end, about 11 percent of beneficiaries would have to pay at least $40 a month to enroll in an MA-PD and some beneficiaries would even have to pay as much as $116 a month.

Now let's highlight the regional plans. CMS established 26 state-based bidding regions for regional plans. No plans bid in the five white colored regions that include 13 states. But we counted 71 plans in the other 21 regions.

No region has more than six plans and actually the number of plans in a region may give a false impression of plan participation. The five regions with a two on them have plans offered by two organizations. In the other 16 regions that have plans, a single organization offers all of the plans within each region. Over all regions, about 60 percent of all plans are offered by one sponsor, that would be Humana.

We're stressing plan concentration here because the decisions made by one or two sponsors could change the regional plan landscape tremendously.

This map also shows that PPO regions categorized by the average regional bid as a percentage of the regional benchmarks. Remember that the farther below its benchmark a plan bids, the more funding it has to enhance benefits without raising enrollee premiums. Based on the map, regional PPOs plans in the four reddish regions -- Florida, Hawaii, Nevada and New York -- most likely would be able to offer the richest benefit packages. At the other end of the spectrum plans in the three striped regions -- Alabama, Tennessee, Arkansas, Missouri, Kansas and Oklahoma -- are required by law to charge premiums for the basic Medicare benefits because their bids were above the benchmarks in those regions. The enrollees there would also have to pay the full cost of any supplemental benefits offered.

And indeed, this tends to predict things nicely. Only beneficiaries in the four red regions would be able to join a zero premium MA-PD regional plan. The lowest premium regional plan in any of the three striped regions is $66 a month, and all of the plans in those regions that include

drug coverage cost over $100 a month.

The MMA mandated that regional plans have a single deductible for all Part A and Part B services and an out-of-pocket limit on beneficiary cost-sharing liability for Medicare services provided in-network. The law and subsequent regulations did not set specific dollar values for the deductible in the out-of-pocket limit. While many of the regional plans to not have a deductible, the most common regional plan design has a $100 deductible for in-network services and a $300 deductible for out-of-network services. The out-of-pocket limits range from $1000 per year to $5,000 per year and the most common plan design has an out-of-pocket limit of $5,000.

Most local plans have similar deductibles and limits but we have not had the data to do a detailed comparative analysis to see whether the law had changed benefit offerings much. We will do so. And we'll also look at the special needs plans in a future meeting.

For now, we'll go ahead and discuss the plan availability findings and ask me any questions. Also, let me know if there any other analyses you'd like to see, whether just on MA or comparing MA to MA-PD plans.

MS. DePARLE: Thanks, Scott. You've done a lot of analysis already with just the data that's available.

One thing that was striking to me is the growth in the private fee-for-service plans. Page four, I guess you had a chart that showed 80 percent of beneficiaries now have access to a private fee-for-service plan. And then you also said 25 percent, I think, of beneficiaries will have access to a private fee-for-service plan with a zero premium drug benefit. Is that right?

DR. HARRISON: Yes.

MS. DePARLE: I'm interested in what -- I don't have a very articulate question. But what's going on there? Where is that growth coming from? How are they doing it? What seems to be happening there?

You seem to think it's significant that beneficiaries will have that choice. Are you saying that that will be an interesting comparison with fee-for-service PD?

DR. HARRISON: In a sense, they're getting a package that the actuaries have deemed to be at least actuarially equivalent to the Medicare package. In theory, they'd be able to go to their current providers. And they

would get extra things on top of that.

MR. HACKBARTH: What do we know about how the private fee-for-service plans pay providers? Do they just typically pay the Medicare rates? How does that work?

DR. HARRISON: My understanding is that they typically pay Medicare rates.

MR. HACKBARTH: Are they doing anything over and above being a straight fee-for-service provider? Do they have programs for coordinated care, disease management? What do we know what those features?

DR. HARRISON: I've been told that some of them do and maybe wants to elaborate some on that.

MR. BERTKO: Let me again use a different metaphor today, which is the plumbing/air-conditioning/electric system. You can't have incentives but you can run all these things, care coordination, in the background, have nurses. It's more difficult because you can't have, for example, preadmission notification requirements. But you can have preadmission requests. And so to the extent that you find somebody in the hospital and you can set up care coordination for discharge planning, things like we talked about earlier today, all that stuff could happen, transplant

management, disease management types of stuff, because the data comes through.

So as long as it's what I would call nonintrusive, it can happen. In fact, it parallels much of what we do in the commercial sector for the under-65 market in the loosest PPO plans.

MR. HACKBARTH: Are you saying, John, that you know that the existing plans do that? Or are you saying that they could potentially do that?

MR. BERTKO: I can only speak for the big competitors who have been in the private fee-for-service. This year there's several of us. And we all, I believe, do the same things and I'll call it that background mode.

MS. DePARLE: But why would a -- are you in the same markets for private fee-for-service that you're in with an MA-PD plan?

MR. BERTKO: They're all MA-PD plans.

MS. DePARLE: A local MA plan, I guess is what I'm describing.

MR. BERTKO: The attractiveness of an HMO is a much better value typically in the markets in which it can be offered, because it's got the density of membership.

It's gotten fairly intensive and sometimes intrusive management through the physicians, typically. And so that offers greater cost savings.

In the greatest example, you go to Jay's world, which is a separate universe of providers and you can never get out but you're happy when you're in, or you leave.

DR. CROSSON: Sounds like heaven.

[Laughter.]

MS. DePARLE: I'm interested in from a provider -- to follow up on Glenn's question about from a physician or a clinician or a hospital's viewpoint.

So would a hospital that's in your local MA-PD plan also be in your private fee-for-service plan? Or would a clinician? And they'd be getting paid different rates, I take it?

MR. BERTKO: That's a maybe. And yes, they may be getting paid different rates. That's a whole different contracting issue.

More typically, the private fee-for-service are in the areas with low concentration. As a product, their huge attractiveness is the absence of strong network contracting stuff, which is a huge, huge investment. Instead, there's a

provider education aspect which is easier to carry out, although you can't overemphasize the need to do that.

MR. HACKBARTH: Are there any private fee-for-service plans that are offered in non-floor areas?

DR. HARRISON: Oh, yes. 80 percent of beneficiaries will have a private fee-for-service plan available. Now do they look as attractive in the big cities? No.

And in fact, the zero premium with drugs, they tend to be in the Midwest and they have avoided like Chicago and Milwaukee -- I think Milwaukee. But typically, they have avoided the big cities in those areas. And there may be other products in those areas that are more attractive.

DR. CROSSON: But isn't the fact that they can enforce Medicare rates going to make them differentially competitive now with the regional plans? Or at least the regional plan periphery service areas? Is that the competitive dynamic that's beginning?

MR. BERTKO: Yes and no. That's an honest answer.

Yes, they are, because the essence of having to physically contract with docs across a huge geographic area makes it easy.

No, the regional things must be competitive. And so any differential between that has got to be really quite small.

MS. BURKE: Glenn, maybe it's just me, but I am increasingly getting lost in trying to understand what the incentives are in the structures of these variable -- between a private fee-for-service and a regional.

And I wonder, perhaps at our next meeting, if we can do a Dick, Jane and Spot tutorial for the ill-informed on essentially how these are now really structured. Because I really am losing track of why one would go to one versus another and why certain providers would participate in some and not others and where the differential and the incentive is in terms of the payment structure. I may be singular in that but I'm struggling to get it.

MR. BERTKO: Can I give Scott perhaps a lead on this in the way that we've tried to show this to a number of folks?

Broadest network, least constraints, and I'll call it lowest benefit value is private fee-for-service. As you then squeeze constraints down, say to regional PPO out-of-network ability, you get higher network value but some

restrictions. You move all the way over to HMO, you get greatest restriction on network, but highest benefit values.

And that pretty much flows from --

MS. BURKE: I kind of get the big picture but I'd really like to understand at a granular level really how one differentiates among them, how the payment rate structures, what the controls are, and what the contracting relationship is. It would be at least helpful to me.

As I say, I may be singular, in which case I'm willing to do it off line. That's fine. But I'm lost here.

MS. DePARLE: The marketing, too. I'm interested in how the private fee-for-service plans are marketed.

MS. BURKE: And how they market. And whether the sponsors -- I mean, if you've got one sponsor doing four of these different things. I don't get it.

DR. HARRISON: What we don't have yet is the actual bidding information. But I think we might learn something from the bids because there are different reasons why you might bid higher or lower under one program than the other. I'd kind of like to see some data before I go out on a limb like that.

MS. HANSEN: Could I add one more variable to that

is to take it from the beneficiary level? Just really what happens to the person who goes fishing around once they enter into the system?

DR. SCANLON: And what it costs them?

MR. HACKBARTH: Could you go to slide four for just a second? Just one last question about the private fee-for-service.

If you go from 2004 to 2006, there's been a very large increase in the percentage of beneficiaries that have access to a private fee-for-service plan. I think initially the plans, the private fee-for-service plans, tended to be in the floor counties. And now they're expanding the scope of the offering geographically.

Why? What's changed between 2004 and 2006?

DR. HARRISON: I think some of the bigger players have figured out that this may be a good business to be in. So where we started off with maybe a smaller player, we've had some of the biggest MA plans, Humana, United, and PacifiCare, Anthem WellPoint, they've all come in in the last two years.

MR. BERTKO: Glenn, there's actually a much easier answer. Because MMA was passed and changed the forward

looking growth in rates factor, in 2004 you submitted your ACRs at the time, about September. So folks had one perspective on future at that point. By 2005, and going into 2006 of course, you had a completely different one because growth rates are now moving at a different rate and under a different set of laws.

MR. HACKBARTH: Be more concrete about --

MR. BERTKO: I'm sorry. Prior to the MMA, there were restrictions, the 2 percent rule for example, in the large urban areas. And in the MMA among the things it did was to tie the growth in the rate book, the benchmark, to the growth in the overall program as well as establish the fee-for-service rates as a fourth prong in this.

And so the business outlook in terms of what revenue is going to come through became easier to identify on a long-term basis, as opposed to one which looked extremely volatile and perhaps shrinking versus the cost picture of it.

MS. BURKE: May I ask a question on slide six?

Scott, and I may be remembering incorrectly the number, but as I recall from our previous conversation on the drug benefit, there were a very minuscule number of

plans that were essentially going to cover the gap.

Do I read this correctly to suggest that there are 31 percent of Medicare beneficiaries will have available to them a plan that has a zero premium and covers the gap?

DR. HARRISON: Yes.

MS. BURKE: So that seems slightly inconsistent.

DR. HARRISON: And I think they tend to be Southern Florida, New York.

MS. BURKE: Do those numbers compute with the numbers that we just saw on the drug?

DR. HARRISON: The drug analysis was all based on numbers of plans, whereas this is based on population.

MS. BURKE: Thank you.

MR. BERTKO: Sheila, let me make a different point here which I think Rachel or Scott may have mentioned but I'll repeat it differently.

The MA plans bid, they have a difference in savings, the rebates that are then available --

MS. BURKE: This is just a factual question. It's just the numbers.

MR. BERTKO: But it influences the difference in numbers, also. There's more money available.

MS. BURKE: I think the answer was one is plans and one is people. That's the answer. That's why there's a difference.

MR. BERTKO: That's an incomplete answer. There's more money available to MA-PD folks in general, and particularly in these counties, than there is to PDP folks because of the rebate.

MS. BURKE: Okay.

MR. SMITH: Scott, I assume that the language here, Part D coverage in gap doesn't necessarily mean the gap is filled?

DR. HARRISON: It's going to take a lot more -- in some fashion and it's going to be hard to figure out exactly how much that is. But we will get there.

MS. BURKE: Thank you.

MR. DURENBERGER: In terms of a research agenda and so forth, my principal focus and concern -- and this isn't a short-term answer -- is with the equity issue. I think John and I both met on the old Competitive Pricing Commission. The goal of that commission really was, unfortunately it was budget neutral, but the goal was to try to ask the plans to inform the Medicare program through

competition what's the actual cost of delivering a basic benefit package in XYZ community. That was the theory of it.

They could never come to the what we call high-value communities, like the one I live in, because of the budget neutrality factor. So we went to other communities and weren't very successful.

So I guess what all that points out to is number one, we all will admit to cost variations from one community to the other. But we shouldn't admit to the perpetuation of variations that don't have a good rationale, a good reason for existing, particularly if they have an adverse impact on the quality and the value of health care.

So it's hard to articulate this one as an equity argument but you could start with rural America and say oh, you've got one plan or you've got two plans or whatever, to the degree that those plans are not able to finance the maintenance of physicians of high quality in rural communities we have an equity problem. That's a small example of it.

But the larger one will simply be if we can help policymakers understand that just because everybody pays the

same amount into Medicare doesn't mean you always get out the same value as reflected either in payments to plans or payments to doctors. But you ought to be able to get something else in exchange for the difference in value or payment, if it has to exist, which is higher quality or higher investment in something that benefits the beneficiary.

So along the line of the discussions we've had periodically about the role of this Commission, I'd like to accent this issue of equity as we develop the research around Medicare Advantage and the prescription drug plans.

MR. HACKBARTH: You also, I assume, see the same issue in traditional fee-for-service Medicare. The disparity, the geographic disparity in value is not inherently a Medicare Advantage issue. It's a program-wide issue.

MR. HACKBARTH: Others? Okay, thank you, Scott.

We'll now have a brief public comment period.

Okay, thank you very much.

[Whereupon, at 11:39 a.m., the meeting was adjourned.]