MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
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COMMISSIONERS PRESENT:

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MARY K. WAKEFIELD, Ph.D.

NICHOLAS J. WOLTER, M.D.

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Dialysis services: assessing payment adequacy and updating payments -- Nancy Ray 5

MR. HACKBARTH: The first item on our agenda for today is dialysis services. Nancy.

MS. RAY: Thank you, Glenn.

Recall that our update framework first considers the question of whether current Medicare payments are adequate and then considers the second question of whether payments should change in 2005, the next payment year. So let's proceed and try to answer these two questions for outpatient dialysis services.

To assist payment adequacy, your mailing material includes an analysis of six factors. Some are beneficiary focused and some are provider- focused.

The first factor we looked at is beneficiaries' access to care. Here the evidence suggests that beneficiaries are not facing systematic barriers in obtaining needed care. Throughout the year, we monitor the literature, dialysis magazines, and Internet websites to look at any potential access barriers that may be coming along during the year.

For this year we particularly -- some have raised concerns that facilities may be exiting areas that are located -- facilities located in lower income areas. So we took a look at that this year. What we found is that this does not appear to be the case. The two biggest factors that seem to reflect closures are whether the facility is non-profit and whether the facility is hospital-based. We looked at the proportion of facilities remaining open in HPSAs and there was very little difference, in rural areas very little difference, and we also looked at --

DR. NEWHOUSE: [off microphone.] What exactly does this mean? Does this mean that 50 percent of the hospital-based facilities closed in a year?

MS. RAY: No. This means that of the facilities that closed.

DR. NEWHOUSE: All right.

MS. RAY: The fact that we found that the non-

profit and hospital-based are more likely to close is consistent with our analyses that we have conducted last year and the year before last. What makes this analysis different is that we looked at whether or not the facility was located in a HPSA. We've looked at the proportion of facilities in rural areas and that has remained constant. Roughly 25 percent of all facilities are in rural areas over the last five years.

This is the additional new information that we looked at this year, looking at the facilities that opened that remained in business versus those that closed. Again, we see very little difference based for lower income areas and areas based on ethnicity and race.

Moving right along now to the second factor, we looked at providers' capacity to treat patients. And here we conclude that capacity appears to meet demand. This graph compares the growth in the number of in-center dialysis hemodialysis stations to the growth in the patient population.

Our framework, or the third factor that we looked at the growth of the volume of services. Here increasing volume of services could suggest that payments are at least adequate.

With that in mind, total dialysis patients have been increasing by about 6 percent per year between 1996 and 2001. Dialysis payments have also increased by 6 percent per year during this time period, from $2.4 billion to $3.3 billion. Separately billable drugs, erythropoietin has increased roughly about 12 percent from $809 million to $1.4 billion. And other injectable drugs show the greatest growth, growing by about 25 percent per year from $281 million to $877 million.

Moving along now to our fourth factor that we looked at to assess payment adequacy, we looked at quality. It's continuing to improve for some measures. We used CMS's clinical performance measures that show improving dialysis adequacy, improving anemia status. Again, for dialysis adequacy and anemia status as well as nutritional status, we have data now going back from 1993.

There has been little change in beneficiaries nutritional status and this focuses -- this is partly due

to CMS's coverage policy on some of the nutritional interventions. They have a restrictive coverage policy for the use of those interventions.

Finally, CMS is now starting to collect clinical performance measure data on vascular access care. There was some small improvement in vascular access care, and my understanding is that the networks -- that's the QIOs -- for dialysis facilities are engaging in a quality improvement project aimed to improve vascular access care.

Many may be aware of a recent GAO study that discussed dialysis quality. It was released last month. And the GAO study focused on quality assurance; that is how well facilities are meeting Medicare's conditions of coverage. The conditions of coverage are Medicare's baseline standards, quality standards. It also commented on how well CMS and the states are conducting their survey efforts.

GAO raised concerns for all three parties, facilities, the CMS, and the states. And in fact, made six recommendations to improve the quality assurance process, three of which MedPAC made back in June of 2000. Those three were to improve the frequency of inspection, to implement intermediate sanctions, and to publicly release the results of the survey and certification efforts on the publicly available Dialysis Compare website.

At the end of my presentation, I'd like to come back to quality and talk about other ways for Medicare to consider to improve dialysis quality.

This leads us to the fifth factor, access to capital. Access to capital appears to be sufficient. We base this on the reports from financial analysts and we also base this on the growth over the last 10 years of for-profit facilities. It seems to be still an attractive place for for-profit facilities to build facilities as well as acquire existing facilities.

With that in mind, one of the four major chains just announced on Monday their intent to acquire non-profit facilities in the Midwest, picking up about 260 patients.

DR. ROWE: [off microphone.] Nancy, while you're on that point, could you indicate whether this growth in for-

profit facilities has been largely conversion of not-for-profits, or is this establishment of new facilities?

MS. RAY: That's a good question.

DR. ROWE: [off microphone.] Because many hospitals find that it makes more sense for them to basically sell their facility to a for-profit and then management has a lower cost of goods, established management programs, as long as the hospital's patients have access and doctors have access. And then the place has access to capital and it can renovate because the hospital hasn't been able to renovate the dialysis unit because it doesn't have any access to capital, et cetera, et cetera.

So I was just wondering about that conversion.

DR. MILLER: [off microphone.] Nancy, I thought we had some discussion of this at one point when we were talking some of the language in the report. I was asking a question about growth at the expense of.

MS. RAY: Yes, I do remember that discussion. Yes.

DR. MILLER: I don't know if it's was a one for one, but I thought you said at that time that the growth for the non-profits is definitely --

MS. RAY: Right. Clearly, some of the growth of for-profits has been those chains acquiring non-profit, independent non-profit and hospital-based facilities.

DR. ROWE: [off microphone.] Like you said, in the Midwest.

MS. RAY: Right, exactly. What I can't give you right now is the exact number, the exact proportion, whether it's half new facilities and half acquiring old. I'll have to get back to you with that.

DR. ROWE: [off microphone.] I think it would be interesting because one of the measures we use of access is whether there's new entrance into the market place in terms of new facilities and access to capital.

DR. REISCHAUER: But we know that there are new facilities because there's been tremendous growth in the number of facilities.

MS. RAY: And facilities. There has been a net increase.

DR. REISCHAUER: I'm looking at the paper that says facilities and there's been a 76 percent growth over the last decade, so that's not chicken feed.

DR. ROWE: [off microphone.] Right. I accept that. I was thinking over the last couple years is whether it's gotten to steady state or whether it's continuing to increase. That was my question.

DR. REISCHAUER: But if we know that the total number of facilities is growing or stations, or whatever we want to measure it by, is growing along with the demand, then do we care about the composition?

DR. ROWE: [off microphone.] No, I don't think we care from a policy point of view.

DR. REISCHAUER: For business opportunities.

DR. ROWE: [off microphone.] No. No. Sorry to interrupt. More sorry that you know.

MS. RAY: Not a problem.

So moving right along, that was our fifth factor, access to capital. And that leads us to our final factor, payments and costs for 2004.

Let's take a minute and talk about this graph. First of all, you'll see that we have three years of data reported here, 1999, 2000, and 2001. We unfortunately don't have 2002 data to show you, and that is because we had a very small sample, we have a very small sample right now of cost reports in the data that CMS makes available. Roughly we only have 40 percent of facilities cost reports in 2002. That compares to about 91 percent in 2001. So that is why we don't have the more recent year available. Hopefully, there will be one more update to CMS's database on cost reports and who know, maybe we'll get lucky.

Next, you'll notice that there's two lines, red line and a yellow line. As you recall from last year, we analyzed 1996 cost reports. In 1996 the FIs did an extensive audit of the cost reports of freestanding dialysis facilities. Roughly about two-thirds of the cost reports were reopened and settled with an audit.

So the red line reflects adjusting cost to reflect the results of the audit. Overall, what we found in comparing 1996 costs from cost reports before they were audited to after is that reported costs were roughly 96 percent of

allowed cost. So what we did here is we adjusted cost to reflect the 96 percent that was allowable, payment-to-cost ratio. So what you're doing is you're reducing the denominator that will increase your payment-to-cost ratio.

So the red line includes the audit adjustment and the yellow line does not include the audit adjustment for each of the three years that we have presented.

Also recall, we did this audit adjustment last year and ProPAC, many years ago, also did an audit adjustment back in the late '80s. There they found that reported costs were 88 percent of allowable cost back then, from the late '80s.

So here you'll see a payment-to-cost ratio in 2001 of 1.03. That's without the audit adjustment. That's roughly, for you margin people, a 1.8 percent margin. And including the audit adjustment, the payment-to-cost ratio is 1.06, which is a 4.4 percent margin.

I'd like to talk about the downward trend between 1999 and 2001 and what explains this trend. Payment was increased in 2000 and 2001 by 1.2 percent and 2.4 percent. But at the same time, Amgen raised the price of erythropoietin by 3.9 percent in each of those two years.

In addition to that, providers costs spiked, particularly between 2000 and 2001, by 5.5 percent. The two areas that rose were labor costs and the administrative and general costs that are reported on the cost reports.

DR. ROWE: [off microphone.] And labor costs were mainly nursing costs?

MS. RAY: The labor costs reflect nurses, technicians, LPNs, dietitians, as best of my understanding. It includes salaries and it includes benefits.

DR. ROWE: [off microphone.] You don't know where the increase is?

MS. RAY: No, it does not break it out by the specific labor component, no. It's just the one category. Unfortunately, we don't have a break-out for the administrative and general expenses, either. My impression from the industry is that some of that cost growth was due to liability increases and malpractice increases there, as well as utilities.

So estimating from the 2001 point -- I guess I'd like to make the point that I presented payment-to-cost ratios and I'm also presenting margins to be consistent with the other sectors, for example, in the hospitals and SNFs and home health you usually hear margins not payment-to-cost ratios. And a margin, just for the audience's sake, is payments minus cost divided by payments, which is roughly the percent of revenue the provider is keeping, our rough estimate of that.

MS. DePARLE: And it's just Medicare?

MS. RAY: It is just Medicare.

DR. REISCHAUER: Nancy, what was the takeaway from your description of what happened between 1999 and 2001, but looking out into the future? That you think these payment-to-cost ratios are going to level off?

MS. RAY: Okay, that leads me to my next point.

DR. REISCHAUER: Okay, I'm your straight guy.

MS. RAY: Thank you.

So what we did is we took our 2001 point and we proceeded then to estimate 2004 payments and cost. We do that by inflating costs by the market basket. The payment-to-cost ratio then, including the audit adjustment, for 2004 would be 1.02. That would be our estimate. That represents a 0.7 percent margin. So this presumes continued increases in cost based on the market basket, if that answers your question.

MR. MULLER: Along the line of Bob's question, I seem to remember two years ago we were looking at cost estimates that people were saying the costs were going up beyond the marketplace indicators that we had. So this would kind of confirm that the way the costs finally came in, it came in above the estimates that we were making at that time of what the costs would be. Is that fair? That the actual costs, now that we've seen them two years later, are higher than the costs that we had anticipated at that time?

MS. RAY: It's your question are the actual costs higher than the market basket? Than the Commission's market basket estimates in previous years?

MR. MULLER: That's another way of saying that, yes.

MR. HACKBARTH: Another way, perhaps of asking it is if we went back and look at what we projected for this

year, how did our projection for 2001 compare with the actual result? Now that we have real data.

MS. RAY: I would like to get back to you on that, if I could.

MR. HACKBARTH: In rolling forward from the actual data, you said you used market basket or was it market basket minus a productivity factor.

MS. RAY: Market basket less a productivity, yes. Thank you for the clarification.

MS. DePARLE: And when you say market basket, there's a CMS market basket and then --

MS. RAY: Right, exactly.

MS. DePARLE: I've never understood why we have a separate one? Why we don't just agree with CMS.

MS. RAY: We had a separate one because CMS just developed their market basket for dialysis services. It was just released in May of this year.

MS. DePARLE: So we had one before.

MS. RAY: Ours is first.

DR. REISCHAUER: [off microphone.] The question is why did they have one?

MS. DePARLE: They were told to develop one. So what are we going to do? Are we going to use theirs or are we going to use ours?

MS. RAY: I was going to talk about that later but let me go ahead and address it. First of all, if you use CMS's market basket to project out costs to 2004, just to let you know that the payment-to-cost ratio in 2004 would be estimated at 1.01. That's the first thing.

I think the second thing is, of course the Commission can talk about whether or not to just go ahead and adopt the CMS market basket or we can continue to use both and compare the two. BIPA required the Secretary to develop the market basket for dialysis services.

I think over time, as CMS goes to a broader bundle, and then the market basket is going to have to be revised to account for those additional services, that might be one factor in leading us to think about using the CMS market basket.

Your mailing materials included some historical data in how well CMS's market basket compared to MedPAC's. Both

are pretty close, but we can talk about this a little bit later.

DR. REISCHAUER: They aren't as close as the table suggests though, because you have the MedPAC market basket in every year rising faster than the CMS market basket. And yet, averaged over a five year period, they are the same. There must be a typo in the table.

MS. DePARLE: I'd be interested in qualitatively can you describe what the differences are and why we would choose ours versus theirs.

MS. RAY: Sure. The differences are when ProPAC first developed the Commission's market basket, they used indices from the home health, SNF, and hospital PPS market baskets.

So for example, the easiest example I can give you is in the MedPAC market basket there are four main categories: labor, other direct costs, capital, and administrative and general. For the labor component, what is used is they used the home health labor index, they use the SNF labor index, and they use the hospital PPS labor index. And each is weighted by one-third.

So it's a mixture of -- for the other categories it's a little bit more complex, but it's a mix of the use of utilities from SNFs and so forth, to come up with the Commission's market basket.

CMS, on the other hand, uses eight categories, not four, I believe. And they pull out the indices from either using the ECI, the PPI, and I'm sorry, I forget the third one. So they're using, for example, the labor -- to estimate the labor costs for all health care workers from the ECI, for example.

I can get back to you in the January mailing materials with more detail about the comparison of the two, that will help you think about this issue more closely.

DR. NELSON: Nancy, what are the implications of the consistent difference between audited and unaudited?

MS. RAY: Excuse me, I'm sorry?

DR. NELSON: What are the implications of that consistent difference, between audited and unaudited? What does that mean?

MS. RAY: What we did in each year, in 1996 we found that the reported costs that facilities put down on their

cost reports once they were audited, that CMS disallowed basically 4 percent. So reported costs were 96 percent of allowed cost.

So what I've done here is made an adjustment to cost in each of the years, taking roughly 96 percent in each of the years. So that's why between the two lines there's that same three percentage point difference.

DR. ROWE: [off microphone.] It's not a typical accounting audit. It's a revision of what's acceptable.

DR. NELSON: I got it. Was the standard of variation pretty narrow or pretty broad? This is a consistent number that represents the difference. And I guess I would ask whether or not there were a substantial number of outliers in which that difference was much different from the average?

MS. RAY: I can't answer that question for you right now. But what I can answer is that about two-thirds of facilities had a substantial decline from their reported costs to their allowable costs. I'd have to get back to you to answer your more detailed question.

MR. HACKBARTH: We're doing an excellent job of anticipating issues, some of which I think are planned for later parts of Nancy's presentation. Could I suggest that we let her get her presentation out and then we'll take commissioner questions? I think that will be a more efficient way to proceed. So why don't you go ahead, Nancy.

MS. RAY: I think we're finished with this chart.

So just in summary, the analysis, just a gentle reminder of the first five market factors suggest no systematic problems in accessing care, that there is sufficient capacity to treat patients, and services are growing. There is improving quality on some measures and providers seem to have sufficient access to capital.

That leads us to the second part of our update framework, looking at what kind of cost changes can we expect in 2005.

Here again, the one major factor that we consider is the change in input prices between 2004 and 2005. As we've already discussed, we now have two market baskets, Commission's and CMS's. The Commission's market basket

estimates the increase in providers costs at 2.3 percent. CMS estimates that cost growth to be 2.9 percent.

We also look at other factors that may affect providers costs between 2004 and 2005. One of those is cost increasing and quality enhancing medical advances. Here, based on our review of the literature, we believe that most of these advances will come in the way of separately billable drugs.

And then find that the other factor that we do consider is the productivity growth. Our update framework reflects our expectation that, in the aggregate, providers should be able to reduce the quantity of inputs required to produce a unit of service while maintaining service quality. We use a 10-year economy-wide multi-factor productivity growth and that is currently estimated at 0.9 percent.

So putting together the increase in input prices less the adjustment for productivity improvement, that would result, using MedPAC's market basket, in a 1.4 percent increase to the payment rate for the composite rate services. Using CMS's market basket, that would result in a 2 percent increase.

As a reminder, current law increases composite rate payments in calendar year 2005 right in the middle, by 1.6 percent.

So that leads us to our first draft recommendation, that the Congress should maintain current law and update the composite rate by 1.6 percent for calendar year 2005. The spending implications of this are none, because it's already in current law. And for beneficiary and providers it would increase the composite rate for providers. And for beneficiaries, maintain access to quality care.

MR. HACKBARTH: For the benefit of the audience, I should say that although we will discuss draft recommendation at this meeting, the actual voting on recommendations occurs in January.

Any questions or comments?

MR. MULLER: If we can go back to your slopes of the payment of costs. I noticed in the material you sent out ahead of time that it looks like the costs in 2000, which is the last year that we have the costs on, went up about

5.5 percent over the year before. Our market basket index was about 3.8, so about one-half higher.

If that is likely to occur in '02 as well, because a lot of things were going on in '01 in terms of staff shortages, nurses, et cetera, blood costs, those kind of things that were probably still going on in '02.

Does that mean is it likely that as we get the '02 and '03 final estimates, that we're likely to be below 100 percent of payment-to-cost?

MS. RAY: Again, without a larger sample of facilities with cost reports for 2002, I just don't -- you know, at this point can't estimate what the change -- how the slope of costs will go.

MR. HACKBARTH: Can I ask a related question? Earlier you gave us a projection of the margins for '04, and it was less than 1 percent, .7 percent or something like that.

MS. RAY: Right.

MR. HACKBARTH: That involves a projection of costs and revenues out into the future. On the revenue side, is the assumption just the increases in the composite rate? Or how do you factor in the growth and the use of the drugs outside the composite rate? Since that's a big part of the profitability of the business.

MS. RAY: Sure, absolutely. That's a good question.

That's where our estimate, I think, conservatively estimates what the payment-to-cost ratio is in 2004, because we don't adjust for the increasing volume of separately billable services, which as you've already seen has gone up considerably since 1996.

DR. REISCHAUER: That's 40 percent of the total, if I remember your analysis.

MS. RAY: That's 40 percent of the total, that's right.

DR. REISCHAUER: And we're saying that it doesn't change.

MS. RAY: And it doesn't change, that's right. If you think it would change -- if you wanted to increase it between 2001 to 2004 based on the annual growth rate, it would be roughly probably increasing the proportion from 40 to roughly 43 or 44 percent of payments.

DR. REISCHAUER: But there's a huge margin, we think, on that.

MS. RAY: There is a large and positive margin on that, yes.

DR. REISCHAUER: So it affects really the way we view this whole thing but we aren't making a guesstimate of how much.

MS. RAY: I could go back and do that.

DR. REISCHAUER: No, I'm just reflecting on how worried should we be about this downward sloping line. And the answer is not as much as one would think.

MS. RAY: Right, because we hold volume of services constant, this is -- like I said -- a conservative estimate.

MR. HACKBARTH: I think it would be helpful if fore the January discussion we could have a sensitivity analysis or something that shows the revenue side, which might be changing there, as well as the issue raised by Ralph about the trend on the cost side.

MR. MULLER: If we're doing our two-stage test and let's say if the costs, in fact, are accelerating more than our past indices, it's likely that we might be below the payments on this before the drug analysis that Bob has asked for, that we may -- if the payment ratio is less than 100 percent, then the question is does that kind of touch the question of adequacy or not?

MR. HACKBARTH: In fact, if we just look at the composite rate services only, the ones covered by the composite rate, I think we're already below 100 percent.

MS. RAY: Yes, you are.

MR. HACKBARTH: That is offset by the very substantial profits earned on the non-covered, or the services outside the composite rate.

MS. RAY: That's correct.

MR. HACKBARTH: That's the piece that's been growing. So understanding that part of the projection, I think, is as important as understanding the cost trend.

Other questions or comments?

DR. WOLTER: I was just looking at the data on Table 3 that had some things like sessions per station, total treatments per employee, percentage of LPNs, percentage of

RNs. And I'm thinking about this productivity adjustment which I know is a discussion point right now, not only in dialysis but in other sectors.

Those would possibly be some indicators, perhaps not outstanding ones, but some indicators of is there in fact some track record of productivity increases. And I'm wondering if dialysis would be a place to start looking from year to year at some indicators that might help us understand, in fact, are productivity changes from year to year current because I think there's some controversy about that issue and how easy is it to do.

In this particular set of data, if you look from 2000 to 2002, there are a couple of things there that in a high-level way might suggest some productivity improvements although 2001 went in the other direction.

It's just a thought.

MR. MULLER: Triggered by Nick's comment, dialysis is always more of a focused factor than probably other things we look at. So insofar as some people have been touting that as a way of getting more productivity in health care. It would be useful to try to take a crack at Nick's question.

MS. DePARLE: At one of our last sessions, when we talked about this, we spent some time talking about the medical interventions, and I remember specifically nutrition, that were not covered by composite rate. And I was persuaded that we should try to do something about that.

DR. ROWE: I think we're going to get to that.

MS. DePARLE: Am I jumping ahead again?

DR. ROWE: We're going to get to rewarding quality based on these measures in the next presentation.

MS. DePARLE: Good, I hope we will.

DR. REISCHAUER: I think Nick's focus is an interesting one and I glanced at that table and thought whoa, not much productivity here. But then I looked at treatments per employee, which would be a crude measure. And it actually increased by 3.9 percent over the two-year period. In other words, well above -- we're using total factors as opposed to labor factor productivity.

But also, one wonders when we're considering productivity in this sector, what is the appropriate measure of output? And it's quality adjust treatments. And we have some measures that quality has improved.

Of course, we want to reward people for that improvement in quality. We don't want to take away from them, in a sense. So it's a complex issue, I think, for us to grapple with because what we want is to provide the best care that's available at reasonable prices.

MS. RAY: Right.

MR. HACKBARTH: We've had several comments raising, I think, important and very legitimate concerns about are we perhaps being too aggressive here in light of the cost trends and declining margin and the like.

The other piece of the picture, or another piece of the picture, is that when we do our analysis of adequacy we don't look only at margins. Here we have an industry where there seems to be a continuing influx of investment by for-profit companies that presumably see this as a good business opportunity. So it's a complex picture.

Do we want to move on to the other recommendation, Nancy?

MS. RAY: Yes.

I promised earlier that we'd be drilling down a little bit more about quality of care. As I've already discussed, GAO and patient organizations continue to raise concerns about dialysis quality.

Recall that Medicare right now uses I would say three levers to try to maintain and improve quality. One, the quality assurance standards. Two, quality improvement efforts undertaken by the networks. And three, the publicly reporting of data both on the Dialysis Compare website, which is a facility level website that provides outcome information by facility, as well as CMS's clinical performance measure project.

I would suggest that there may be a fourth lever for Medicare to think about to try to improve quality, and that would be using quality incentives to improve outpatient dialysis care. Recall that the Commission expressed an urgent need to improve quality in our June 2003 report and endorsed the idea of the use of linking payments to

quality. The outpatient dialysis sector is a ready environment for doing so.

In the June of 2003 chapter, the Commission included four criteria to think about using quality incentives for a given sector. The first criteria: are there evidence-based measures available. The answer to that for dialysis services is yes. The National Kidney Foundation has spent many years in developing evidence- based measures with providers, facilities, physicians and nephrology nurses, and we have evidence-based measures for, of course, dialysis adequacy, anemia status, vascular access management, nutritional management, as well as a new one related to bone disease.

The second criteria questions whether providers can improve upon these measures. Again, I think the answer to than for outpatient dialysis sector is yes. Since 1993 we've seen that providers can improve upon dialysis adequacy and anemia status. More remains for those two indicators and now there's new indicators related to bone disease as well as nutritional management.

The third question is are there data available to risk adjust measures? Here again, the answer is yes. When a patient first becomes eligible for the ESRD program, the facility is required to fill out a medical enrollment form the 2728 form. Here we have comorbidities at ESRD incidents. And those data are collected electronically and maintained in a nice computer database. We also, of course, have access to all beneficiaries' Part A and Part B claims to supplement the medical evidence data.

And then the fourth question is are there systems in place to collect data? And again, here the answer is yes. Right now CMS collects adequacy of dialysis information and hematocrit status on facilities outpatient dialysis claims, on the claims submitted by outpatient dialysis facilities for dialysis and for Epo. There's also been an ongoing effort to electronically link facilities to the networks and CMS for improved data collection.

So your mailing materials included other key design issues that would need to be considered when implementing quality incentives for this sector. The first question is which providers. And here both facilities and physicians,

it's a partnership and both together work to improve beneficiaries quality. The actions of both parties affect patients quality of care. Recall that physicians caring for dialysis patients receive a monthly capitated payment. So they are seeing -- under the new revision to the fee schedule, physicians seeing dialysis patients will be seeing the patient at least once a month.

The second question is how should provides be rewarded? Here we looked at the new ESRD demonstration project, which rewards providers both based on improvements within the facility as well as whether or not their level exceeded a national target. That, to us, seemed like a reasonable and fair approach to do that. In the demonstration, a small set-aside of payments are used. And here we think that could be roughly 1 to 3 percent of payments.

For dialysis facilities anyway, total payments from dialysis, erythropoietin and other injectable drugs averaged roughly about $2.8 million in 2001.

The next question asks how should quality be measured? Again here, we've discussed some of the measures already, dialysis adequacy, anemia status. CMS does not yet have a clinical performance measure for bone disease, but the National Kidney Foundation, like I said, has developed a clinical guideline and CMS could readily use that to develop a clinical performance measure here.

I raised the issue about the need risk adjust. And I just wanted to mention here that our June 2003 analysis of dialysis quality and providers cost also included many case-mix variables from the medical evidence form and did show that quality is related to case-mix. So that would be a very important factor in implementing quality incentives.

I guess I'd just like to also just reiterate that CMS and its contractors are well versed at developing and measuring dialysis outcomes and, in fact, they are published already on a facility level basis on the compare website. They are reported for dialysis adequacy, anemia status, and survival.

DR. REISCHAUER: But these aren't risk adjusted?

MS. RAY: The dialysis adequacy and anemia, to my knowledge are not. The survival is listed in three

categories so it's as expected, more than expected, or less than expected.

So that leads us to our draft recommendation, that the Congress should establish a quality incentive payment policy for outpatient dialysis services. The spending implications of the recommendation as it's currently crafted is none. And it would maintain access to high quality care for beneficiaries.

MR. HACKBARTH: So we're talking about, you referred earlier, to 1 or 2 percent. So we would set aside 1 or 2 percent of the expected payments in the pool for distribution based on the quality indicators?

MS. RAY: Right.

MR. HACKBARTH: So it's a budget neutral proposal.

MS. RAY: Right. I think my mailing actually had 1 to 3 percent but it's 1 to 2 percent.

MR. HACKBARTH: Just one other clarification. We talk about risk adjustment. Are you saying that there's a risk adjustment method that exists on the shelf that could be applied for this purpose or not?

MS. RAY: There is sufficient data out there, I think, to risk adjust the measures, both with the medical evidence form as well as all the other Part A and Part B claims that CMS's contractors -- that would be the USRDS over at the University of Minnesota and the folks over at the University of Michigan -- who are currently doing CMS's broader bundle. They're actually looking at case-mix adjusting the broader bundle payments using case-mix measures, but there is a lot of work being done in this right now.

MR. HACKBARTH: I have Dave Durenberger, Jack, Joe and David Smith.

MR. DURENBERGER: First, I just want to compliment you on the analysis. I can't get this excited as you can about this, and I'm sure glad you can. It is really, really well done.

But it led me, particularly as you got to the key design issues, it led me to observe that the answer to your second bullet, how should providers be rewarded is with more patients. I've got my health savings account add-on. Providers should be rewarded with more patients.

And the third bullet would be how should quality be measured and reported?

I would just hope that between now and June you might add -- whether it's in the narrative or wherever it is -- some thoughts about the role of the patient, in particular, in judging quality. You well expressed the concern about cherry picking and so forth in the system and it seems to me the degree to which these patients who are going to be patients for a long, long time are well informed about not only the providers and the services they are receiving, but also about their own role. And I'm making some assumptions because I'm not knowledgeable that if nutrition and nutrition management is a critical factor here, then the patient plays a big role. It isn't just the provider's role. The patient plays an important role.

And so from our standpoint, thinking about an ideal way to look at the role that the financing plays in quality improvement and enhancement, we ought to focus or ask somebody to focus sometime on the role of the patient in all the respects. If you think that's a good idea, I hope you would look at it.

MR. HACKBARTH: I think that's an excellent point. I don't see it as mutually exclusive. I think you can both have a financial reward for providers and use the same information to educate patients and potentially shift patient volume over time, as well. I think they're complementary, not mutually exclusive.

Jack Rowe.

DR. ROWE: I have a couple of points here. I agree this is very well done.

I think you gave some examples, Nancy, of the importance of both physicians and facilities in your comments but I think we could have a little more of that in the text itself. I think it's really key here from my point of view, and I've had the opportunity to talk with the staff a little bit about this, that we all recognize that the physician can be incentivized to improve quality very significantly in a number of ways by paying closer attention to issues such as nutrition and hematocrit and KT/V and vascular access and all of that.

But in addition, the facility can. Because if you can imagine that if there was a significant incentive for facilities to enhance nutritional status, and if a facility was big enough, it would be incentive to hire a dietitian to be there. The patients are sitting there on the machine, and give much more advice and counsel and review of dietary habits and diet content and everything else, and do measures of the nutritional status, et cetera. And a variety of those are available beyond albumin. And so I think it's important to emphasize we have to incent both the doctors and the facilities.

With respect to that, there are some places in the document where it's ambiguous. For instance, on page 16, that's one case but there are others, where you talk about CMS as planning to incent providers. And you don't make it clear whether they mean doctors or facilities. It sounds like facilities to me.

MS. RAY: In the new demonstration it is just facility.

DR. ROWE: But I think what I'd like to do is have us adopt an approach here where we don't just talk about providers, like on these slides, but doctors and facilities because I think we have to deal with them separately.

With respect of the quality issues, I think 1 to 2 or 1 to 3 percent doesn't sound like a lot. But then, when you start to look at these margins, it begins to look pretty significant in terms of the proportion of the margin. So I think it is a meaningful number.

MR. HACKBARTH: The other thing on that, my first reaction was that's not very much. But if it's 2 percent and, depending on your distribution formula, only 25 percent qualify there's a lot of leverage there. So you have 2 percent of the total payments going to 25 or 30 or 40 percent of the providers. They're getting a pretty significant bump.

MS. RAY: I'd don't follow your comment about 25 to 40 percent of the provider population.

DR. ROWE: He's saying only one-quarter of them qualify and if it's cost neutral you take 2 percent of the whole thing and you give it all to that quarter, then they're going to get 6 percent.

MS. RAY: I know I mentioned in my mailing materials and I don't know if you're referring to this NCQA threshold of the number of patients to develop a stable -- that's not what you're referring to?

MR. HACKBARTH: No, it's not. What I'm referring to is the design and I'm jumping way ahead so let me go back a couple of steps.

Part of implementing a program such as this is deciding how much money is in the pool and then the second part is what's the distribution formula. A couple comments on that.

One is, in keeping with our past discussions, I think what we're talking about is giving the bulk of the incentive payments to providers who have the absolute highest levels of performance on the pertinent measures but reserving a piece of the pool to reward providers who have shown significant improvement in their performance. I think that's the approach that we've talked about.

And then the next question is okay, if we're talking about the providers with the absolute highest levels of performance, where is that threshold set? Is it set so it's the top 10 percent of providers, the top 25 percent of providers? That's the issue that I was leaping ahead towards.

If you focus the incentive payments on 25 or 30 percent of the providers with the absolute best performance, then the leverage becomes pretty significant.

DR. ROWE: I agree with that and there are a couple of different ways you could do it. I would also suggest that with respect to the quality measurement, with respect to both the physicians and the facilities, you could consider a floor of acceptable quality that we could migrate northward over time, as well as a level of quality or a change in quality that would trigger a payment. And if you did that the floor would be what you would have to reach in order to be an accredited Medicare nephrologist or facility. And if you didn't meet it, you didn't meet the conditions of participation.

Now there are access issues, et cetera, here. But if we're serious about paying for performance what you could say is this is the standard of care that we believe

Medicare beneficiaries deserve. We finally have found an area on medicine that we can measure quality, we think, reliably. And if you don't meet this, then you don't get to have Medicare beneficiaries, either as a doctor or a facility.

So you can use quality two ways. It's not just moving the money around in a cost-neutral way. It's also, perhaps, influencing volume. Because if there are two facilities in the town -- this gets to David's point -- or two nephrologists in the town, and one isn't meeting the minimum quality standards, then the other nephrologist is getting those cases. He doesn't have to get paid any more per case.

Another point on this is risk adjustment. I think that the assumption in your comments was that there are some ways to risk adjust this, that it would be important to risk adjust it, and I agree with that. But the assumption, I think in what I read and heard, is that it would be the entire population.

I think one of the problems with this population is that if you've seen one dialysis patient, you've seen one dialysis patient. They're very different. There's a subset who are diabetic, that may be 40 percent. Then there are patients waiting for transplantation. Then there are patients who are dying of some other disease and they're going to gradually do worse and worse, independent of what the quality of the doctor or the facility is. Their measures are going to go down because, in fact, they have a fatal disease. We shouldn't be penalizing the facility or the doctor because somebody with disseminated cancer is losing their functional status. So we have to be careful about it.

And I would think that one way to do it is to go with it and say okay, we're not necessarily going to use these measures for incentive payments on the entire patient population. We're going to take a subset, as we start, of the patient population. We'll take all of the diabetics and the polycystic kidney disease patients or whatever, and we'll use those, risk adjust those within those categories. It might be half the population to start, walk before we run, and not wind up penalizing facilities because some of

the patients -- because they're willing to take patients who, in fact, are dying or who are very impaired or whatever. Because we don't want people cherry picking and being disadvantaged because they didn't take a patient.

It's mentioned here but I'm just thinking of a way of getting around it, particularly for a small facility that's got 15 stations or something, or a nephrologist with a small population of patients.

So these are just a couple random thoughts about how you might go ahead with this. I think it's very, very interesting. And I would push you further along on the bone disease access ideas, as well, and see if we can find five, not two, measures. Thank you.

DR. NEWHOUSE: I had a couple suggestions, one for research that might change this slide.

Table 4 in our briefing materials has some notable gains in quality of care. The percentage receiving inadequate treatment goes down by half over four years, from 22 to 11, and percentage with low anemia goes down by more than half from 57 to 24.

My suggestion is that you might think about whether you can do any analysis that would look at whether that has had any effect on other Medicare costs for this population. Because if the quality incentives are effective -- and if they're not effective why are we doing it -- and there are effects in other areas, the fact that you're not getting inadequate dialysis means you don't have to be hospitalized at some point. Then the spending implications are actually that this is cost saving.

And it would be nice if we could have some documentation of that. I would think, in principle, that analysis could be done.

The second point I wanted to make was that there was a Ph.D. dissertation done a few years ago on quality of care in the New York cardiac surgeon system that looked at variability over time. In fact, there's quite a bit of variability, and a lot of the variation is just kind of random noise because of inadequate risk adjustment, which suggests -- the student developed some statistical methods for smoothing this over several years.

Which suggests if we go forward with this and probably also beyond the ESRD setting, that if we're going to reward performance, we would do some kind of multi-year average performance, so that you didn't get bounced in or out of your bonus or penalty by some random draw from the patient mix.

MR. SMITH: Thanks, Glenn.

Joe joins Jack and David in raising some of the questions that are in my mind, so I'll be brief.

But it does seem to me that the design issues here are tricky. I have no idea whether or not 1 percent or 2 percent is powerful enough, and whether or not across settings whether or not the same percentages would hold. I think we need to think more carefully about that. But it obviously depends a lot on how the 2 percent is distributed. If you distribute it to 80 percent of the providers, it's not as powerful if you distribute it to 40.

But that connects with another design issue, which is what you hope with a quality payment incentive is not only the folks who win the prize this year improve, but that everybody improves. That this has got a pull effect on the system as a whole. We need to be careful that we don't concentrate so much on the leverage issue that we neglect the pull issue.

Which connects with Jack's question about whether or not there's a facility death penalty. It's an important one, but it has very important access issues and probably access issues not simply quantitatively but distributionally as well. We ought to think about how to link that question. I think Jack's right to raise it, that it becomes a condition of participation to meet a threshold. But maybe in a more subtle way to link it with the issues that Dave raises about can we use this to drive patients to high quality providers, perhaps even thinking about financial incentives to patients, not simply access to high quality information about quality differences.

These are tricky questions that are going to come up again and again over the next two days. They're going to be very important in January. I think we ought to step back and ask ourselves is there a systematic way to try to think about this? And most importantly, how do we make

sure that even though only Nick gets the reward this year, that my incentive to improve is as powerful?

That's how we make the system better, not by figuring out how to distribute 1 or 2 percent around a very small number of already, in most cases, already high quality providers.

MR. HACKBARTH: Those are excellent points.

I think isn't part of the answer a tool for addressing the latter point is by reserving a piece of the incentive pool for improvement, as opposed to just using it all to reward absolute high levels of high performance?

MR. SMITH: I think that's right. Again, the distribution of whatever the incentive pool is among high rates of improvement above whatever the appropriate minimum threshold is, how that compares to how you distribute this to already high quality providers.

To some extent, as we think about the broad beneficiary population, we ought not to be interested in spending as much money to reward high quality as we would to reward high levels of improvement.

On the other hand, who knows what that induces at the high quality providers if they are somehow -- they can't get an increased piece of the action until their performance declines so that it can turn around and improve. That would be obviously a perverse outcome. So this is trickier, I think, then we're yet up to, but critical stuff.

DR. STOWERS: I won't belabor what David said, but I was going to talk about the same thing. I have a little bit of a problem with this high amount of set-aside for the few that reach a real high standard and de-incentivizing the masses of a beneficiaries that we're really trying to get the standard raised, rather than setting some kind of a reasonable standard that a lot more could meet and be incentivized to reach.

The other thing, I think, we've talked about for a long time is whether this set-aside ought to come out of existing payments or whether it ought to come out of updates along the way. There's kind of a de-incentivization along the way if we talk about taking out of their existing payments and then try to fight to get

that back. I think we maybe want to be clear that when we talk about taking set-aside money that it's not coming out of what they're making now.

MR. HACKBARTH: The dollars are fungible. Mathematically I think it works out the same but there may be an important packaging question.

DR. STOWERS: But it's a packaging question because you hear on the street, so to speak, that they're going to take it away from me and I have to fight back for it, so I don't want in this quality thing.

DR. ROWE: Ray, as I recall, we have like 13 years without an update. So if we promise them that we're going to give it to them in the updates, that might not be too incenting, because they're not going to believe there is an update.

DR. STOWERS: I hear you. But instead of an updated we now have this quality money. I'm saying instead of. We now have quality money out there that you could earn.

MS. DePARLE: Is there a recommendation that there be an annual update? I know we're making a recommendation for an update this year, but are we recommending to Congress anything about putting that into law?

DR. ROWE: It's in the bill, isn't it? The Medicare bill.

MS. DePARLE: I don't think so. It's not in the bill. They gave them an update for one year.

MS. RAY: Right. The bill gives them 1.6 percent in 2005. We can, of course, discuss if the Commission wants to go down that road about whether or not --

MS. DePARLE: I think it's the only provider that doesn't have some provision in law, is that right?

MS. RAY: My impression is all the other providers do have that provision in law, yes. I mean hospitals and...

MR. HACKBARTH: Implicit in what we do, and we do review the rates each year, is that within our framework they do have an annual update analysis. But you're right that something the industry has sought is a formal legislative recognition of that.

MS. DePARLE: That wasn't actually my point. It's just Jack reminded me about the 13 years.

I'm excited about the opportunity here to do something to improve quality, but I guess I just want to agree with David that I think it's tricky and so I have some both substantive and practical packaging, I think was the word you used, policy concerns about the way that we go about this and the design of it.

Given what we just saw about the trends and the margins in the industry, I don't feel comfortable saying that what we would do on a quality incentive payment policy should be budgeted neutral. I also think the recent history of these ideas, which is very recent since the one I'm aware of is what's in the current Medicare bill, is to make it on top of whatever the provider is getting.

In an ideal world what Jack and Joe have talked about, where you would have a condition of participation that everyone has to meet that's much higher than people are meeting now. And then you go on beyond that, that's how we'd all choose to operate. But I just don't think that's realistic.

And so I think if we want to move forward here, I would not vote to do this budget neutral at this point.

DR. NEWHOUSE: I just wanted to comment quickly on the issue that both David and Ray raised by doing it on an absolute level of quality versus a change in quality or an improvement.

The reason I would de-emphasize, though not zero the improvement side, which I think it sounds like you would emphasize, is a portion of what you were alluding to were the high performer degrading their performance to improve. But in general, anybody looking at this would say what's going to happen downstream in future years?

Depending on how the payment formula goes for how much payment there is for how much improvement, I may choose to withhold some improvement I could make now to more improvement next year and get my payment next year if I'm looking at something that if I do the best I can this year I get something more this year but then I get nothing more than future.

In general, I think there's serious issues with how the improvement thing plays out over time, which is why I would put more of the money on absolute performance, though

I don't have really well-formed notions of whether absolute means the top 10 percent or the top 70 percent.

MR. SMITH: I think this is exactly the way, Joe, that the question of how do we distribute a quality pot interacts with the question Jack raises about an absolute threshold as a condition of participation. It seems to me that if we could link those two notions, that we've got a part of money somehow divvied up between high performers and improvement, but we've got a threshold which assures us of a minimal level of quality and then are prepared to reward improvement more than absolute performance above that level, my guess -- but it's why I think these are tricky question and not easy ones -- my guess is we'd have a broader impact on a larger beneficiary population, which ought to be one of our objectives.

DR. NEWHOUSE: That's correct.

DR. ROWE: My concern with your thought, Joe, and it's kind of an interesting question about absolute versus change over time, has to do with the clinical reality.

I think that you can have an absolute measure if it's a process measure. Did the patient did Epo? Did the patient get an albumin measured? Did the patient have a dietary consultation? Did the patient do this? Did you do that?

But if you have an outcome measure, a clinical outcome measure, what is the functional status of the patient? What's their weight? What's their muscle mass? What's their blah, blah, blah? It takes a long time to build up bones for people who have renal disease-related osteomalacia. It takes a long time to get people to understand the dietary restrictions and to be compliant with the diet and get back in shape, et cetera, et cetera.

What you want to do is if somebody is going from a relatively low level and is improving and getting toward your standard but not yet there, you want to certainly reward them.

So I think if we had process measures, I'm with you. If we have clinical outcome measures, I'd like to see some consideration for improvement. We can go around and around on this, but I would like to make that distinction.

MR. HACKBARTH: The other thought that raises in my mind, if you're talking about outcome measures and there's imprecision, as there inevitably is, in your risk adjustment, having an improvement payment is perhaps a bit of a hedge against imprecision in your risk adjustment.

If you've got a facility that's consistently attracting caring for patients that are more complicated and higher risk, beyond which you fully account for in your risk adjustment, they may look poor on your absolute values, but if they are improving compared to themselves over time then they would be rewarded.

DR. NEWHOUSE: The improvement may just be because the risk adjustment was incomplete so I got better patients next year. You may be just rewarding noise in the improvement.

MR. HACKBARTH: Yes, and that's an issues with risk adjustment across the board in linking payment.

DR. NEWHOUSE: It's more of an issue in change than in levels.

MR. HACKBARTH: Lots of things to discuss.

Thank you, Nancy.