MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 9, 2004, 10:31 a.m. *

COMMISSIONERS PRESENT:

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1 P R O C E E D I N G S

2 MR. HACKBARTH: Can I get your attention for just
3 a second? We're going to wait a few minutes before we
4 start. We're going to try to get some additional chairs and
5 move staff people on this side so that we have more room for
6 our public guests. And we'll just take a minute to see if
7 we can organize that and get it done quickly. Thanks.

8 We're trying to get the chairs. If we can't get
9 the chairs, our next step is that all of you have a copy of
10 the agenda. I know you're all deeply interested in every
11 facet of the Medicare program, but there might be some
12 issues that you're more interested in than others. So our
13 next step would be to do some triage and have people whose
14 principal interest is not on the agenda this morning, if you
15 could make way for somebody who really is dying to hear and
16 talk about this morning's agenda. That would be our next
17 step.

18 My understanding is the chairs are on the way and
19 it's going to take a little time to get here. So I would

1 ask the staff as they arrive if you could move back here,
2 get one and sit down, I would appreciate that. Because
3 we're already behind, I hate to just sit here and wait an
4 uncertain amount of time. So we're going to try to start
5 and work through the addition of the chairs.
6 Before we turn to our first agenda item, let me
7 just make a few comments to set the stage for the meeting
8 today and tomorrow. As most of our guests know, our process
9 is to consider draft recommendations at the December meeting
10 and then have votes on final recommendations at our January
11 meeting. In fact, that's what we will be doing today.
12 I want to make a couple of points about the draft
13 recommendations that we will be considering. There are a
14 lot of them, number one, 28 in total, which is going to mean
15 that both the staff and the commissioners exercise a lot of
16 discipline about presentation and discussion so we can get
17 through all of the material.
18 It also, let me advise you in advance, could
19 affect the amount of time that we have for public discussion
20 depending on how the schedule goes. I will do my best to
21 allow our usual amount of time for that, but given the
22 volume of work required, it may be compressed a little bit.

1 The second point about the draft recommendations
2 is that they are, in fact, draft recommendations. I would
3 urge you to consider them as such, not over interpret what
4 it is. In the case of the update factors, for example, all
5 of the draft recommendations are, in fact, what we
6 recommended last year. Whether we will end up in the same
7 place or not I don't know. That's why we're having the
8 meeting and having the discussion and that's what we'll
9 figure out over the course of the next month.
10 The third thing to mention about the draft
11 recommendations is when you look at it you may say this
12 isn't a complete set of Medicare issues or even issues on
13 which MedPAC has expressed a deep interest in the past. One
14 notable example of that is Medicare Advantage where we've
15 spent a lot of time in the past analyzing, making
16 recommendations, developing a point of view. It is not
17 included in the recommendations for the January report
18 principally for logistical reasons. Because of the many
19 mandated reports that we have to do, in addition to our
20 normal work on the update factors, we simply did not have
21 enough staff resources or time with commissioners to also
22 process recommendations about Medicare Advantage. That does

1 not mean that we have lost interest and will not come back.
2 In fact, we envision that we will be taking of Medicare
3 Advantage again for our June report with discussions to
4 occur about the issues and possible votes on recommendations
5 to occur in March and April.
6 So the fact that it is not included does not mean
7 lack of interest or lack of concern about the program.
8 That's the context for what we will be doing.
9 First up is pay for performance.
10 MS. MILGATE: In this session we will be
11 discussing draft recommendations that have come out of our
12 past three discussions on pay for performance for hospitals,
13 physicians and home health agencies. The central question
14 of this analysis has been whether it's feasible, given
15 current measures and measurement activities, to link a
16 portion of payment of quality.
17 First, I want to just give a brief overview of how
18 this discussion as evolved. About two years ago we began to
19 consider various incentives Medicare could use to speed the
20 pace of quality improvement. We evaluated a host of private
21 and public sector efforts to incentivize quality
22 improvement, including nonfinancial incentives. The

1 Commission concluded at that time that Medicare must lead
2 efforts to improve quality through the use of financial
3 incentives.
4 This was based on several points. First, that the
5 current Medicare payment system is neutral, that is a high
6 quality provider is paid the same as one who delivers low-
7 quality care, and sometimes even negative towards quality.
8 For example, a hospital that improves quality by reducing
9 complications may, in fact, lose revenue.
10 In addition, Medicare is the largest single
11 purchaser and private sector purchasers told us that their
12 efforts would be much more effective if Medicare were to
13 lead the way.
14 In addition, you have also expressed concern about
15 the cost of patients of not moving forward in terms of
16 unnecessary mortality, morbidity and the missed
17 opportunities that abound in our current system.
18 At that the same time, we developed criteria for
19 determining which settings were ready to tie a portion of
20 payment to quality. I'm not going to go through these
21 because we've talked about them on numerous occasions but
22 these are the criteria we've applied in looking at

1 hospitals, physicians and home health agencies this fall.

2 Last year, using these criteria, the Commission

3 determined in March of 2004 that facilities and physicians

4 who treat dialysis patients and Medicare Advantage plans met

5 the criteria and at that time we recommended that Congress

6 establish a quality incentive program in those settings.

7 At that time, you also laid out some design

8 principles for the program. First, that the program should

9 reward both attainment of a certain thresholds and to

10 encourage the broadest amount of improvement possible to

11 also reward providers that improved over time. In addition,

12 that the program should start by withholding a small

13 percentage, 1 to 2 percent, of total payment and then

14 redistributing it on the basis of quality but that that

15 percent might actually increase over time as a broader set

16 of measures was developed and the measures were improved.

17 In addition, those dollars should all be

18 distributed so there would be none held back for the

19 Medicare program. And that over time, measures must evolve

20 so that, in fact, if we reach high levels of performance on

21 some measures we may need to move on to new and better

22 measures.

1 To evaluate measures for hospitals and physicians,
2 we talked to an inventoried measure sets from CMS,
3 accreditors, the National Quality Forum, purchasers and
4 plans, various hospital organizations, as well as physician
5 organizations, researchers and also state initiatives. For
6 hospitals, we found that a wide variety of measures of
7 clinically appropriate care are common across measure sets
8 but, in fact, found that 10 were found in almost every
9 measure set.

10 These were the initial starter set that was used
11 in the voluntary reporting initiative, which is a
12 public/private partnership of hospital organizations, CMS,
13 JCAHO and others. And then the MMA required hospitals to
14 report on these measures to receive a full update.

15 As a result of this emphasis, as of last week
16 4,000 hospital scores have been reported on the CMS web
17 site, including scores for 200 critical access hospitals,
18 which is interesting because they actually were not subject
19 to the MMA incentive.

20 In addition, the voluntary reporting initiative
21 has another set of measures that they intend on rolling out
22 in the next six months to a year, which would give us a

1 wider variety of measures to look at hospitals on, including
2 such crosscutting measures as surgical infection prevention.
3 We also looked at outcomes measures and also found
4 a wide variety of outcomes measures are used, in particular
5 to look at mortality and complication rates. However, in
6 talking to experts in the area, we found strong consensus
7 only around a few in terms of whether they would be useful
8 for pay for performance but there was a lot of discussion
9 about the ways to actually improve claims information to get
10 better information on outcomes and, in particular, the
11 suggestion was that if we could flag whether secondary
12 diagnoses were present on admission it would be very useful
13 in improving risk adjustment for mortality scores and to
14 help discern complications that were present on admission
15 from complications that may have been the result of hospital
16 care.
17 The next two sets up there are crosscutting
18 measures, crosscutting in the sense that they apply to all
19 types of conditions as well as all types of hospitals, both
20 small and large, including some rural hospitals. These are
21 useful parts of any measure set because we have some
22 limitations in the sense that hospital do have different

1 emphasis on different conditions. So if you were measuring
2 the quality of heart care, for example, it might not apply
3 as broadly as if you included crosscutting measures in your
4 set.
5 There's a survey that has been developed by the
6 Leapfrog Group to measure hospital safe practices. This is
7 based on a set of practices that were identified by the
8 National Quality Forum and endorsed by then, including such
9 practices as hand washing practices and strategies for
10 preventing infections in hospitals. This survey has already
11 been filled out on over 1000 hospitals.
12 In addition to this tool, a standardized tool for
13 measuring patient experience of care, hospital CAHPS, has
14 been researched for years and is expected to be issued in
15 final form later this year.
16 Our experts also told us they felt like
17 accreditation was a good measure of a hospital's basic
18 ability to improve quality.
19 In summary, the analysis shows that measures of
20 clinically appropriate care are well accepted and that a
21 subset are already collected by CMS, that a few outcomes
22 measures are also available and by improving claims the set

1 could be much broader, and that measure sets and tools to
2 collect data are already used or almost ready to be used to
3 evaluate hospital practices to prevent errors and patient
4 experience of care.

5 Therefore, this draft recommendation reflects the
6 conclusion that it is feasible to link a portion of hospital
7 payment to quality and the draft recommendation reads: the
8 Congress should establish a quality incentive payment policy
9 for hospitals and Medicare.

10 We see that there would be no impact on spending,
11 that it would improve the quality of care, and some
12 providers could receive higher or lower payments, depending
13 upon their quality performance.

14 We recognize that some hospitals would experience
15 additional burden of all these sets were used. But we also
16 acknowledge that these efforts might encourage increased
17 alignment of quality improvement measurement efforts across
18 external organizations. Thus, this could minimize hospital
19 burden in the long run.

20 The second recommendation is aimed at
21 significantly expanding the set of outcomes which can be
22 derived from claims. I already describe why this would be

1 useful. Knowing whether any of the secondary diagnoses were
2 present on admission would improve risk adjustment and could
3 help us discern which complications may be the result of
4 hospital care. Coding and quality experts have been
5 discussing this possibly for some time and recently the
6 National Committee on Vital and Health Statistics has
7 supported this recommendation. The Agency for Health Care
8 Research and Quality has supported this recommendation. The
9 Consumer Purchaser Disclosure Project has supported it. And
10 the National Uniform Billing Committee, which develops and
11 maintains the billing forms for hospital over time, has
12 included a field where hospitals can flag this in the UB04.
13 The implication on spending is that there would be
14 no impact and we see no impact on beneficiaries or
15 providers. However, we do acknowledge there may be some
16 increased activity for hospitals but it does not appear this
17 would be any significant increase in the amount of work that
18 coders would need to perform.
19 Physicians guide much of the care beneficiaries
20 receive. Without their participation in pay for performance
21 initiative, any pay for performance initiative will be less
22 effective. Further, use of information technology to

1 manage patient care and assess performance is expected to
2 improve quality and can be measured. Therefore, measures
3 aimed at that goal should be a central part of the program.
4 However, the Commission has told us that you feel strongly
5 that not just the acquisition of information technology
6 should be rewarded, but the actual use of information
7 technology for functions that improve quality should be
8 rewarded.

9 So measures in this set, for example, could
10 include whether a physician had a patient registry and used
11 that patient registry to identify diabetes and then also
12 sent follow-up reminders. In addition, this could be used
13 in the area of specialty care to track whether patients
14 received the appropriate follow-up care and to make sure
15 that the referring physician actually received the
16 information on the specialist assessment. These measures
17 could be met by physicians with information technology or
18 without information technology. But because it would be
19 easier of a physician used information technology, we
20 believe this will be an incentive for physicians to acquire
21 information technology.

22 This measure is crosscutting in the same way I

1 spoke about in the hospital world, in the sense that it cuts
2 across different types of conditions as well as different
3 types of physicians, so it can be used to measure quality in
4 all physician care.
5 In addition to those types of measures, we found
6 that there were a wide variety of clinically appropriate
7 care measures but the question there was whether we would
8 want to require physicians to give additional information
9 through medical record abstraction or flow sheets, or
10 whether we should rely on the information that can be
11 gathered through claims.
12 The Commission felt that to the extent possible we
13 should rely on currently collect information. However, it
14 was uncomfortable with just leaving the claims based
15 information at its current level, and there are a couple of
16 recommendations that the Commission talked about to improve
17 the data, and that would be able to be able to use lab
18 values as well as prescription data to measure the care of
19 physicians.
20 In addition, a patient experience survey is under
21 development at AHRQ and could be used in the future when
22 it's out in final form.

1 In summary, encouraging physicians to use
2 information technology to better manage and assess patient
3 care is of great importance to Medicare, and it is possible
4 to measure physician progress in doing so. some claims
5 based measures of clinically appropriate care are available
6 and could be greatly improved with lab values and
7 prescription data, and eventually a standardized tool for
8 measuring patient experience of care will also be available.
9 Therefore, we conclude it is feasible to tie a
10 portion of physician payment to quality and draft
11 recommendation three reads that Congress should establish a
12 quality incentive payment policy for physicians in Medicare.
13 We see no impact on spending. It would improve
14 the quality of care. Some providers could receive higher or
15 lower payments, depending upon their quality performance.
16 Again, we acknowledge some increased burden on
17 physicians for filling out a survey on their care management
18 practices that could be performed by using information
19 technology. However, no medical record abstraction or flow
20 sheets would be required. Therefore, we believe the
21 increased burden of data collection will be minimal.
22 Draft recommendation four is aimed at improving

1 and expanding the information on patients by including
2 information Medicare can analyze on lab values. For
3 example, without lab values if a test is performed we simply
4 know if the test was performed. We don't know if, in fact,
5 the patient's levels were in normal ranges or not. It's not
6 without precedent that clinical information is included on
7 claims. For example, dialysis facilities already report two
8 types of lab results on their claims.
9 Therefore, draft recommendation four reads: CMS
10 should require those who perform lab tests to submit lab
11 values on claims or separately using common vocabulary and
12 messaging standards. Chantal will speak in more detail this
13 afternoon about the utility of using common standards.
14 We see no impact on spending and the implication
15 for beneficiaries and providers would also be none. Again,
16 however, we would acknowledge there would be some increased
17 burden on those who perform labs and that would include some
18 hospitals and physicians but we believe, again, that this
19 would be a minimal burden.
20 Draft recommendation five is also directed at
21 greatly improving the data by making it possible for
22 Medicare to actually use prescription data to look at

1 physician care. This type of data helps Medicare identify
2 patients who have certain conditions and whether they are
3 receiving appropriate care including whether they actually
4 filled the prescriptions they received. Those who use
5 claims-based measures say these data would greatly enhance
6 the utility of the data sets, the data that we can get from
7 claims.
8 The recommendation reads: CMS should ensure that
9 the prescription claims data from the Part D program be
10 available in enough detail to assess the quality of
11 physician care.
12 The spending implication would be none and the
13 beneficiary and provider implication would also be minimal.
14 Now Sharon's going to go through the summary and
15 recommendations on home health care.
16 MS. CHENG: The third sector we'll discuss this
17 morning is home health care. Because of the relatively weak
18 definition of this benefit, the lack of many clinical
19 standards and the wide variation that we've observed in the
20 services delivered in this benefit, pay for performance
21 could have been especially important role in this sector in
22 aligning what Medicare buys with what Medicare wants to

1 purchase. Rather than paying for visits or episodes, pay
2 for performance in home health would allow Medicare to
3 attach some of its dollars directly to purchasing better
4 outcomes for patients who are cared for under this benefit.
5 When we discussed the available measures with the
6 Commission back in September, we heard support for the
7 functional improvement and stabilization measures and the
8 clinical improvement measures that are based on the OASIS
9 patient care tool. These measures are widely used and
10 already collected by CMS. Risk adjustment is necessary for
11 this set of outcome measures and is adequate for a core set
12 of these measures. Including the prognosis and the length
13 of stay in the risk adjustment are ways to avoid penalizing
14 agencies who care for many longer stay patients whose goals
15 may differ from the shorter stay patients.
16 Adverse event measures, such as rehospitalization
17 or the use of emergency room care, could also be useful
18 measures of the quality of care in this sector. However,
19 more research is needed. We also heard a desire to
20 encourage the development of process measures and patient
21 experience measures for this setting. These measures would
22 enhance the starter set that we're proposing to more fully

1 capture the range of patient's goals from achieving
2 functional outcomes to achieving independence at home to
3 staying safely at home.
4 Based on the analysis that we've done and the
5 input that we received from you in September, we conclude
6 that it is feasible to link payments to quality in home
7 health.
8 Draft recommendation six reads: the Congress
9 should establish a quality incentive payment policy for home
10 health agencies in Medicare.
11 The spending implication of this would be to have
12 no impact. The beneficiary and provider implication would
13 be the improvement of the quality of care and some providers
14 could receive higher or lower payments depending on the
15 quality of their care.
16 We acknowledge, too, in this setting that OASIS
17 assessment of every patient at the beginning of care and
18 their discharge currently requires substantial time and
19 effort. However, since it is currently collected and is a
20 current condition of participation, using these OASIS-
21 derived measures to formulate these quality measures would
22 pose only a minimal new burden.

1 We also bring draft recommendation seven because
2 patient safety is an important aspect of home health care
3 quality, and we'd like to be able to improve our measurement
4 of it. One of the primary goals of home health is to ensure
5 that the patient is able to remain safely at home. And
6 while there are good reasons why a home health provider
7 might send a patient to the hospital or to use the ED, it is
8 also important be able to measure when these
9 hospitalizations or ER use are linked to poor quality care.
10 Therefore, draft recommendation seven reads: the
11 Secretary should develop a valid set of measures of home
12 health adverse events and include adequate risk adjustment.
13 The spending implication is this would have no impact and
14 the beneficiary and provider implication of developing this
15 measure would be none.
16 With that, we wrap up our presentation and open it
17 up for your input.
18 MR. HACKBARTH: Could I start by just addressing a
19 couple issues I think we've discussed before? They are the
20 size of the pool and what it means to say that the measures
21 are well accepted. Let me start with the latter first.
22 At our last discussion, Arnie asked the question

1 well accepted by whom, basically. And I think the agreement
2 was it's well accepted by basically expert opinion, people
3 who have clinical expertise, measurement expertise and can
4 provide some assurance that the measures are valid, reliable
5 and so on, as opposed to just generally accepted by the
6 provider community. I think that's the message that we
7 agreed on there and I just wanted to confirm that that's
8 what we're talking about.
9 Then with regard to the size of the pool, I think
10 where we are -- and please feel free to disagree -- is we've
11 talked about a small amount, 1 to 2 percent, as the starting
12 point and leaving open the possibility if not desirability
13 of that percentage growing over time as we become more
14 confident in the tools, develop broader measures of quality
15 and the like.
16 I see a lot of people nodding and I just want to
17 make sure that's that message that we're conveying.
18 Other questions or comments for Sharon and Karen?
19 DR. NELSON: I take it that you're inviting
20 comments on all of the recommendations?
21 MR. HACKBARTH: Yes, I think that's the best way
22 to do it.

1 DR. NELSON: First, I'll state the obvious, that
2 the impact, a possible worrisome impact on access, would be
3 lessened if there weren't losers who couldn't provide the
4 data or who appeared not to have high quality for whatever
5 reason and yet still may have a fairly large Medicare load.
6 So if it were possible to bring in new money so
7 that high performance could be rewarded without penalizing
8 those whose performance doesn't measure as well, the worries
9 about access to care would be lessened. And certainly that
10 is something that I would advocate.
11 With respect to an issue that's not quite as
12 obvious, having to do with submitting the results of lab
13 tests, I'd be more comfortable if we called for
14 demonstrations to assess better the feasibility of that, not
15 so much because of the ability of large commercial labs to
16 provide those data, but an awful lot of Medicare laboratory
17 tests are done in physician's offices. It's one thing to be
18 able to record that a lab test was ordered or done and
19 submit that as a bill. It's quite another matter to collect
20 the results of that, those laboratory tests, downstream.
21 Some of the lab tests may require a period of
22 time, such as cultures and things of that sort. The

1 practical impediments to collect those data and submit the
2 results may be much greater than we are recognizing.
3 So rather than jump right into that at this point,
4 I think it would be healthy for us to have more information
5 about the impact with respect to the administrative burden.
6 MR. HACKBARTH: Any response on that issue, Karen?
7 MS. MILGATE: Just that in talking to people that
8 are more familiar with how lab results are done, we did hear
9 the comment that they did think it would be much easier for
10 the large labs to do this. One of the pieces is not just to
11 record the value and report the value, but also to
12 standardize the messaging standards. That was another piece
13 that they said the larger labs would more easily do. So it
14 might be something we would need to look at in more detail
15 on how easy or hard it would be for physician offices.
16 MR. HACKBARTH: We'll take a further look at that
17 and consider how to address it.
18 DR. CROSSON: Thank you. This is the beginning
19 of, I think, a very good direction. And I think it's a
20 little bit historic on some level, even for a newcomer it
21 feels that way to me. I'd like to compliment Karen and the
22 rest of the staff for the work that's been done here.

1 I'd like to address one specific comment to
2 recommendation three, which is the recommendation for
3 payment policy for physicians. There is a strong
4 relationship between the whole pay for performance idea and
5 the use of clinical information technology. They are
6 linked. They have been linked in the discussions we've had
7 and in the analyses. If you go back and forth between the
8 two papers that we are going to review today, they are
9 there.
10 My own sense is that they are justly linked
11 because in the end, in order to really get depth,
12 consistency and reproducibility of information, clinical
13 information, that's broad enough to involve enough
14 physicians and enough care and enough patients, you're going
15 to have to have the information flowing from clinical
16 information systems.
17 Of course, the barrier is simply in many cases
18 that the business case isn't there, at least for some.
19 My sense has always been that if there is clarity
20 that over time payment is going to be linked to information
21 which can only flow from clinical information systems. Then
22 that becomes a factor in building the business cases at all

1 levels.

2 So my concrete suggestion is that we consider
3 adding to draft recommendation three a specific reference
4 that could read something like this: over time such a
5 policy should be designed to encourage the diffusion and use
6 of electronic medical records.

7 MR. HACKBARTH: Let us think about that. The
8 obvious other path is to make the sort of statements that
9 are in the draft papers in this chapter in the accompanying
10 text. And all other things being equal, I sort of prefer to
11 keep the recommendations simple and embellish with the
12 language in the text. But we'll think about how to address
13 that.

14 MR. SMITH: Thank you. Glenn. And Sharon and
15 Karen, thank you very much. This not only was a useful
16 paper today but the last several months worth of work and
17 the way that it's built have been particularly helpful. I
18 think we are all appreciative.

19 Let me pick up on Jay's comment for a bit. I was
20 going to wait and talk about it when we talked about the IT
21 thing. But I do think we should consider sending a signal
22 or maybe even being even stronger in arguing that by a date

1 certain these capacities need to be in place and systems
2 need to be in place which effectuate that. That should be a
3 condition of participation. I think we ought to hint at
4 that, even if we don't go so far as to say it. But I do
5 think the place to say it more directly is the IT chapter.
6 But back, Glenn, to where you began, the size
7 question is an interesting one. Arnie and Ralph talked
8 about it at some length, I think, at the October meeting.
9 We've all talked about it a little bit. We've got two
10 interconnected questions. One of them is how much is enough
11 to be potent? And we don't know the answer to that. My
12 suspicion, but it's an uninformed suspicion, is that 1 or 2
13 percent probably isn't very potent. And how to get a handle
14 on how much is potent, it seems to me that it's time to
15 involve some game theorists in helping us try to get a
16 handle on this. And that as we get more sophisticated in
17 thinking about this, we need more sophisticated information
18 than we have. And I'd like to see if we could pursue the
19 literature and maybe engage some consultants that could help
20 us.
21 The other question, Alan, is how much is enough to
22 be potent? And then how much is too much, so that it drives

1 people out? We don't know the answer to that, either. But
2 it does seem to me that as we proceed down the pay for
3 quality road that we ought to be prepared to drive some
4 people out. Again, we need to get more of a few than we can
5 get from our best guesses and intuition about at what level
6 of requirement and obligation and standard would we begin to
7 lose people? Or to what extent would the obverse happen,
8 which is a general upward leveling of performance which is
9 what we all assume, to some extent, we get out of this.
10 I'd like to be tougher about robustness but we
11 need to do that, or at least I need to do that being very
12 modest about how much I understand about the answer to how
13 much is enough. But my guess, Glenn, is 1 to 2 percent
14 isn't enough.
15 DR. REISCHAUER: Just on how much is enough, these
16 payments are going to be focused on a minority of providers.
17 So if they want to say a third of the providers, you're
18 talking about it being 3 to 6 percent. And I think the
19 notion is that, as we said, over time the amount would grow.
20 The total size of the pool would grow. And as we became
21 increasingly comfortable with our measures and they were
22 ferreting out the kind of quality that was important, you

1 could see this growing much more.

2 So I think this is not a feeling -- this is more
3 signaling in the first year or so about a more profound
4 change that is going to evolve over a five or 10-year
5 period.

6 MR. HACKBARTH: The one point that I would add to
7 that, I agree with all of that, is that to be practical
8 about this at the outset there is also an interaction
9 between update factors, the amount providers are paid, and
10 the size of this pool. In trying to start a new program and
11 move in a new direction, I think that's a constraint not
12 just for us but more importantly for the Congress that
13 they've got to deal with.

14 So if you're talking about a big spread initially,
15 bigger than 1 to 2 percent produces, you are potentially
16 bumping up against real economic and political constraints.

17 MR. SMITH: If I could, I agree with both what you
18 and Bob said. I don't think, Glenn, with all due respect to
19 you and all of my other colleagues, I just don't think we
20 know enough.

21 And Bob, the pool could be quite large if we're
22 looking to reward improvement, which we want to do as much

1 as we want to be reward attainment. The larger the pool
2 gets the last kick there is from the distribution of a
3 relatively small number. We just need some help in
4 figuring that out.
5 MR. HACKBARTH: And we need to move on. I just
6 want to be clear that I agree with your point about how much
7 I know and I feel like it's this big. [Indicating.]
8 I think we're going to be spending a lot of time
9 in this field and we'll have ample opportunity to learn more
10 and consult with different experts and the like.
11 Dave Durenberger, was your point on this
12 particular issue?
13 MR. DURENBERGER: I can wait.
14 MR. HACKBARTH: Next in the line then is Mary.
15 DR. WAKEFIELD: My comment relates to draft
16 recommendation one and it's a real targeted comment.
17 First, let me just say I support the
18 recommendation. the comment I have is related to the text
19 associated with it.
20 Karen, you mentioned that the 10 measures that are
21 being reported to CMS already and good participation
22 actually by CAHs, who are not obliged, and I think that's

1 laudable obviously.

2 Here's my question for you. Do you have a sense
3 of the extent to which either the CAHs or the small rural
4 PPS hospitals are able to report or are reporting across all
5 of the cells available? So in other words, are they having
6 sufficient cases in most of the cells to be able to put
7 something here? Or are they having to asterisk?

8 I'll tell you why I'm asking you that question,
9 because as we move in this direction I want to make sure
10 that if there needs to be a cautionary note there is in the
11 text, that talks about whether or not with low case counts
12 low and how do those hospitals reflect improvement if the
13 data are insufficient, if there aren't enough of the cells
14 basically that are filled?

15 So if you don't move the mercury in the
16 thermometer far enough because the N is too small in a
17 number of cells then that's an issue and I think that
18 cautionary note ought to be expressed.

19 On the other hand, our experience to date might
20 suggest it's not an issue. So can you answer that question?

21 MS. MILGATE: I can't answer it fully but I can
22 give you some of what we know on it. The data to look at

1 that specifically is now available on the CMS web site and
2 we haven't looked at it in great enough detail to know what
3 percentage of hospitals of X size, for example, could do all
4 of the conditions or not.

5 However, just to say one thing, we did look at
6 what's on the CMS web site and look at one particular large
7 hospitals in the area and found that even they had some
8 difficulties in terms of cells sizes for some of the
9 conditions you would think that would be broad. So I think
10 it is an issue. They've chosen some broad measures. As I
11 recall in a general analysis we did, we found on the
12 pneumonia measures they were more broadly applicable than
13 the heart ones, for example.

14 So I think we'll just need to look down the line.
15 But we didn't find hospitals that couldn't report on some of
16 them. Everyone could report on some of them. But I do
17 think it's an issue that we need to look at and that's one
18 reason we emphasize crosscutting measures for the hospitals,
19 as well.

20 DR. WAKEFIELD: If I could just add that depending
21 on what else you learn between now and January, if there is
22 a need -- in terms of structuring a quality incentive

1 payment policy, if there's a need that we could reflect in
2 text to accommodate this small sized problem, then I would
3 appreciate it if that point would be made. I've raised this
4 issue, I think in the last meeting as well as the meeting
5 before.
6 MS. MILGATE: That's a very good point and it also
7 raises another issue about how you might design it so that
8 you might emphasize in your index, for example, the
9 crosscutting measures versus the condition-specific measures
10 if, in fact, you had some concern about the simple size in
11 the beginning when you started just looking at some smaller
12 set of condition-specific measures. When you start
13 expanding it then, of course, it's less of an issue. And
14 that could be reflected easily in the text, yes.
15 DR. BERTKO: First of all, too comments. One to
16 be complementary to your report again and just say that the
17 large employer community certainly is supportive of this,
18 demanding of it in fact. And to the extent that Medicare
19 can take one of the leading roles in this, it makes it
20 easier all around to get this done.
21 The second comment is more specific to draft
22 recommendation five on collecting prescription drug data. I

1 think that this one ought to stand strongly because CMS and
2 the Office of the Actuary, from what I understand, will need
3 this same type of data to do both the threshold updates on
4 an annual basis and then more specifically on individual
5 level people who do reinsurance calculations in a very quick
6 basis. So having us ask for a modest additional stream of
7 data that's collected all at the same time seems quite
8 reasonable and a good synergy.
9 MR. MULLER: Let me also echo some of the comments
10 that John and specifically David made and also point out
11 specifically with regard to whether, for example, electronic
12 records should be a condition of participation and also the
13 size of the pool.
14 I would also point out that while oftentimes our
15 considerations do and our agendas and chapters overlap, they
16 seem to be more specifically overlapping today in a way
17 that's a little puzzling to me. For example, how I would
18 think and vote on the recommendation on these quality pools
19 is very much affected by what we do a little later on how we
20 think about the update. And as David pointed out, how we
21 think about electronic record is very much also how we look
22 at the chapter on information technology.

1 So I'm just expressing this concern out loud, as
2 we vote on these, as we come back later today and tomorrow
3 and then in January, there's an interrelationship in how I
4 think about these as stand alone items. For example, I'm in
5 favor of over a reasonably speedy period of moving towards
6 electronic record as a condition of participation, with some
7 outs for those places that really can't comply. But I would
8 think a large proportion of the country could comply. But I
9 also then think the quality pool is affected by the update
10 recommendation.
11 So I wanted to keep that in mind as we go through
12 these considerations over the balance of the morning because
13 we do have quite a bit of overlap in the policy issues here.
14 MR. HACKBARTH: I understand your concern about
15 that and let us think about how to manage the process for
16 January and make clear that the interactions are there and
17 address them appropriately.
18 DR. WOLTER: On the potency issue, I would just
19 say that -- and I don't know whether we're talking about a
20 percentage of the update or a percentage of the standardized
21 amount yet. And I don't know whether we're going to address
22 that, so that's one of my questions really, is will that be

1 part of our final recommendation?
2 But for our organization, which is really quite
3 small, we have about $61 million in Medicare net revenue.
4 And 2 percent of that would be a huge incentive to us to
5 have that at risk for quality. I think the track record of
6 the 0.4 percent does tell us a little bit of something about
7 the response that it got from the industry. So I wouldn't
8 really characterize this as a small incentive myself. Of
9 course, I live in that world.
10 I am very supportive of these recommendations. I
11 agree with Jay. I think this is the beginning of something
12 that will pay big dividends over time.
13 I do have a number of questions. The current
14 measures are quite narrow. There's a heavy focus on
15 cardiac. I know you've done a nice job, Karen, describing
16 expanded measures which are out there which can be used.
17 The question I have is how do those get put in
18 place? Where will the decisionmaking reside about looking
19 at the expansion of measures? The process of that and where
20 the expertise resides to put the right measures in place is
21 really a critical issue. So I don't know whether we should
22 be having any discussion about that, whether that's AHRQ or

1 IOM or a public/private group. But I think that's really
2 important.
3 Already one of the current 10 measures is under a
4 reasonable amount of question as really being the right
5 evidence-based measure anymore. And similarly, amongst
6 physicians we have so much specialization that in the
7 initial wave of this it's very likely that some will have
8 more opportunity than others, depending on which measures
9 are chosen. And that's going to present a dilemma in terms
10 of administration of this. I think that will be important.
11 If we were to look at the percentage of an update
12 as the mechanism for this, currently the hospital update is
13 geographically adjusted. So one question I'd raise there is
14 if we have a fixed portion of the update available based on
15 quality but we geographically adjust the whole update, some
16 organizations will find themselves with a percentage of that
17 update more at risk than others. So some details like that,
18 I think, are very important to deal with.
19 I'm also concerned, as is Mary, about the fact
20 that there are going to be many hospitals who do not provide
21 the services that may be in the initial wave of measures.
22 That would be similarly true for physicians. We just need

1 to make sure that doesn't automatically create a penalty in
2 terms of how the opportunity gets set up.
3 So those are really more process than detail
4 questions.
5 MR. HACKBARTH: Let me address a couple of them
6 quickly and then some others we may need to discuss offline
7 and come back in January with the conclusions.
8 With regard to how the pool was created. The
9 framework that we've talked about is that it's out of the
10 standardized amount, as opposed out of the update.
11 Mathematically, in terms of the dollars, it works out the
12 same way. But from my perspective, we said the standardized
13 amount so that you could move forward with quality pay for
14 performance even if there were a small update or no update
15 in any given year. We're trying to establish principles
16 here to endure over a period of time so I'm not sure that we
17 want to tie it to something as variable as the update.
18 That's my perspective on it.
19 The second question about who decides what
20 measures are ready to go, I think is a very important one.
21 I don't think it ought to be MedPAC. I don't think that
22 that is our distinctive competence, if you will. But I

1 think it's a critical question for the process and it links
2 to my earlier observation about what we want our well
3 accepted measures by credible experts.
4 And what I would hope is that over time what
5 evolves is an institution or a couple of institutions that
6 are renowned for being that kind of expert. Maybe NQF over
7 time, I don't know. The people who have both access to the
8 clinical expertise and the analytic expertise to say that
9 these are clinically appropriate and analytically reliable
10 valid measures.
11 So what I want to do is have that sort of
12 statement in the text, that this is how we see it evolving.
13 In any given year the final decision may not be delegated to
14 the private entity and will be made by the Secretary. But I
15 think it definitely has to be informed by credible expert
16 opinion. And that I felt very strongly about. This will
17 come to a crashing halt if that test is not met.
18 DR. WOLTER: So it might be important for us to be
19 very clear in the text.
20 MR. HACKBARTH: Yes.
21 DR. SCANLON: I think this is an incredibly
22 important step and deals with the most glaring flaw in the

1 Medicare payment policy, which is to pay everybody the same
2 regardless of quality. I think that the principles you've
3 outlined, I can feel very comfortable with all of them.
4 But at the same time, the structure sets up for me
5 almost an implicit additional principle which is that we
6 should be targeting these payments on a group of providers
7 that are doing something that's relatively homogeneous. I
8 think that's what you did last year in dealing with the ESRD
9 providers and the managed-care agencies.
10 I don't think that it's necessarily the case that
11 we've got here. Physicians are a very heterogeneous group.
12 Home health agencies are heterogeneous. And as Nick just
13 said, hospitals differ. I think if we don't provide an
14 opportunity for the individuals within each of these groups
15 to have the same probability of succeeding that we've
16 created an equitable and potentially an intolerable
17 situation.
18 When I went through the measures that we've
19 reviewed over the last few months, it's very clear that it's
20 uneven in terms of what it's going to be -- think about
21 physicians especially -- what different specialties are
22 going to do or what's going to be asked of them.

1 it's one thing to say we need IT, and I agree with
2 that completely. But then we say we don't want them just to
3 have a computer in their office, we want them to utilize it.
4 But the standards for what utilization is are going to
5 differ by specialty. It's going to be one thing if you're a
6 primary care physician and we're asking you did you deal
7 with your patients through your IT system? Versus say a
8 pathologist whose responsibility it would be to get a lab
9 report to the referring physician. Very, very different
10 kind of situation.
11 I'm concerned that we're not at the point that we
12 should be ready to be passing this off to someone else to
13 figure out all of the details. I'm thinking that we should
14 have spent more time on this to develop more structure here
15 that we can put into -- if you want to keep the
16 recommendations about -- into the text behind the
17 recommendation so that someone has a clear sense of how they
18 can proceed.
19 At this point, if I were to be given the
20 assignment of drafting the legislation, I'd be at somewhat
21 of a loss. And I might be in the situation of kicking it to
22 the next step, saying the Secretary shall figure this out.

1 And I'm not sure that's the best approach to this.
2 MS. BURKE: Let me begin, as Bill did, and suggest
3 that I, too, support the recommendations and think we are
4 headed in exactly the right direction. I also want to
5 underscore Bill's concern about how quickly we can move
6 across all of these venues given what we have available to
7 us in terms of measures. I think to make it successful, the
8 opportunity to be successful will be critical. So I want to
9 underscore exactly the points that Bill made. I have the
10 same anxieties about how ready we are to go on all fronts
11 across the board.
12 Let me also raise just a couple of other specific
13 questions or concerns. One, not only do we need to be
14 concerned about the relationship in terms of the update and
15 the funds that would be available to the extent we set up
16 any pool in the broader context. I also think we cannot
17 underestimate the impact that these changes will have.
18 While the recommendations often say there's little in the
19 way of impact in terms of spending or beneficiary and
20 provider, I think particularly to the point that Alan raised
21 about the issues for individual physicians as compared to
22 the physicians in large groups, a number at the these things

1 could, in fact, have a measurable impact on the cost of
2 doing business. I think we do want to encourage them to
3 begin to move towards the use of IT. And I think we'll talk
4 about that in the course of our conversations today. But I
5 think we ought not underestimate what the impact might be on
6 an individual physician or a physician in a very small group
7 as to the things that will be necessary in order to fully
8 participate.

9 Of particular note is the recommendation with
10 respect to lab claims. Again, as Alan suggested, I am less
11 concerned, as you pointed out, that this is an issue for
12 large labs and their capacity and already their existing
13 resources that allow them to report on claims data and
14 essentially transfer that information.

15 I am concerned about the number of cases where, in
16 fact, those services are provided by physicians offices and
17 their ability to do this and what it will mean in terms of
18 delays in terms of claims or the reconciling of the claims
19 in terms of that information.

20 So I think that further information for us in
21 anticipation of our discussion in January as to how quickly
22 one might imagine doing this, as compared to large lab

1 practices and large group practices, and how quickly we
2 might imagine that an individual physician's office could
3 participate successfully and be measured.
4 And then ultimately I have a question as to what
5 we would envision occurring with respect to our capacity to
6 look at the lab results and the treatment interventions and
7 what eventually occurred. I mean, it is clearly critical to
8 our understanding of the quality of the physician practice,
9 but I wonder about how quickly we're actually going to be
10 able to do that, in terms of individual physicians. So that
11 would also be something I would be interested in
12 understanding more fully when we meet in January.
13 And then finally, I did have a specific question
14 on recommendation two. There is a reference in the text of
15 the report to the activities going on in two states with
16 respect to the recording of a secondary diagnosis on
17 admission. I wondered, there are going to be issues about
18 the ability to correctly code and to what extent there are
19 errors and to what extent -- I mean, there's no penalty
20 that's referenced here in terms of failure to treat and
21 things of that nature.
22 But I wonder what the experience has been in those

1 two states? And have they, in fact, seen successfully the
2 ability to identify it and begin to track it?
3 MS. MILGATE: Just on that specific question, what
4 I've heard from those -- the way it would work is that
5 coders are in the history and physicals to identify
6 diagnoses already. So it would be simply recording whether,
7 in fact, one of those secondary diagnoses were present on
8 admission or not. so that's sort of the crux of how it
9 would happen.
10 What we've heard from those two states is when
11 they first put these requirements in place there was a lot
12 of training to make sure that coders did this correctly.
13 And what quality experts have told us is that over time, as
14 some of those originally trained coders have moved on and
15 others have replaced them the training hasn't been as
16 rigorous. And so some of the effectiveness of that coding
17 has gone down over time.
18 And they were very excited about the concept of
19 actually having it required on a national level because they
20 felt like, in fact, that would mean that it would be taken
21 very seriously as a part of the coding training that coders
22 get. So training is obviously a real key piece of making

1 this is done correctly.

2 MR. DURENBERGER: My comments are much like the
3 last three comments on the other side of the table and they
4 go to clarity and what do we mean by quality or pay for
5 performance? I think we've already demonstrated that if we
6 put a penalty up for not reporting process information
7 everybody will comply. We've already demonstrated in the
8 Premier demonstration that if you say 2 percent for some
9 more process reporting, you're going to get 2 percent for
10 more process.

11 So the principles that I would like to see
12 articulated here around a policy ought to be first, it
13 expedites the process of achieving the goal. Secondly, that
14 it's lasting change, not something every 10 years you're
15 going to start all over again with one of these MedPAC
16 commissions. And third, it ought to be done in the least
17 costly way possible because in the end these costs are being
18 picked up by premium payers and people.

19 For those of you that took the time to read Atua
20 Gwandi's [ph] piece that was sent to us, it tells this story
21 with regard to cystic fibrosis. The important part of that
22 story is not that Cincinnati was way behind. The important

1 part of this story is that there are places in America that
2 are already at the excellence we would all like them to be
3 at. And it's those people that need to get the signal as
4 soon as possible that they ought to keep doing the same
5 thing so that others will follow them. That's what I mean
6 by expeditious.
7 In regard to lasting, I suggest that we look not
8 just at individual doctors but we look at systems of care.
9 Because just changing a few doctors' behavior doesn't do it
10 unless you change the system within which these doctors
11 operate. I'm not saying you have to go to Permanente or
12 something like that. We've talked before about how to look
13 at that. But I think we'd get a lot more out of the lasting
14 side of this if we suggested to the Congress that whatever
15 policy they develop, they begin to focus on systems of care
16 rather than trying to apply this to individual docs all over
17 the country and then run the risk of 10 years from now you
18 finally break down the last national association of barrier.
19 The last thing that I would love to see and hear
20 on the subject of principles is, and in all of this work, is
21 reference to the IOM six aims. If we talk about performance
22 we ought to constantly be talking about it the way in which

1 people out there are already talking about it, in hospitals
2 and other places. And that is in terms of those six aims.
3 We've ought to suggest to the Congress and to legislatures
4 and others making health policy that they measure everything
5 that they do by those six aims. And then everybody in the
6 system, public/private, small/large, system/non-system, will
7 begin to understand that this will be in a permanent change
8 in the way we pay for health care.
9 MS. RAPHAEL: I will echo what everyone else has
10 said. I think the most important thing is Medicare must
11 lead and can really influence what happens throughout the
12 nation in many other areas.
13 There are two points I wanted to make. One is I
14 am a proponent of starting with the 1 to 2 percent pool
15 because I think right now the measures are narrow. For many
16 organizations 1 to 2 percent is significant, or whatever it
17 amounts to in payouts.
18 In addition to which, in general people in this
19 field want to succeed. We're competitive. We've learned
20 from Nursing Home Compare and Home Health Compare that even
21 if there isn't great differentiation it has the greatest
22 impact on provider behavior. And we respond with great

1 sensitivity to that. And also, because I think it takes
2 time to build the infrastructure to respond to these.
3 Secondly, one of the things that I feel we need to
4 pay more attention to -- and maybe it's kind of building on
5 what Nick was saying -- is I didn't see and hear a road map
6 for how we think this should evolve over the long term.
7 There's a lot of focus on measures. And measures are one
8 ingredient in a successful kind of value purchasing
9 strategy.
10 But I really think we need to think through how
11 are we going to get to consistent domains because we
12 ultimately want to be able to measure quality in a
13 longitudinal way. And we want to try to have more
14 integration even in a fee-for-service system. And in order
15 to do that, we do need to figure out where are each of these
16 sectors in regard to outcomes, process, patient experience,
17 structural measures, et cetera? And how are we going to get
18 further along the road? And where is the capacity going to
19 come from to do that?
20 I don't think that we've yet given thought to
21 that. We spoke briefly about who should be the ones to do
22 the measures and update them, and that's certainly something

1 we need to think about. But for me, to make this successful
2 there has to be some capacity. Is it in CMS that that
3 capacity needs to be built to really, over the long term,
4 execute this? I would just like to give a little more
5 thought in the text to that whole set of issues.
6 MR. HACKBARTH: A piece of that capacity that I've
7 long been concerned about, dating back to my time at HCFA,
8 is the research foundation which ultimately leads to
9 evidence-based standards of care. I have long felt we way
10 underestimate in the development of the knowledge base that
11 can then guide these things in the future.
12 We will try to lay out the road map or present a
13 clearer sense of direction for this. I think that's a
14 helpful comment.
15 Arnie and Pete and Bob, and then we really need to
16 move on.
17 DR. MILSTEIN: The IOM has repeatedly given us
18 advice in sequential reports over the last 10 years on this
19 topic. They keep saying it needs to be our goal and every
20 other program payers goal to achieve not just an incremental
21 boost but a massive boost in providers prioritization of
22 performance management, both quality and efficiency. I

1 personally thing this chapter is an excellent step in that
2 direction. I think it's terrific.
3 A few specific comments, not very many of them,
4 related to further refinement of the chapter, and most I
5 think I realized intended to respond to some prior comments
6 by some of my fellow commissioners.
7 On potency it's a tough call. I would, if
8 anything, favor stronger language that indicated no increase
9 in what we recommend in the near-term but maybe more
10 explicit about what we think the buildup -- the buildup
11 ought to be continuous until such time as we see such a
12 northward movement in performance that we say enough.
13 Because I think game theory will help us but I think this is
14 an area, as I read the literature, where we don't really
15 don't have good information on what incentives it takes to
16 get us how much further up. So I support the current
17 potency and I would love to see us also indicate that over
18 time we'd like to see it increased until we get where we
19 need to go.
20 On the hospital measures, it's the one area of the
21 report I want to just suggest look, the NQF has endorsed 30
22 safety practices. We've had a series of respected reports

1 in the last month saying we're now six years post To Err Is
2 Human and the estimated deaths. We have 30 hospital safe
3 practices. We have a method of reporting on where hospitals
4 stand in relation to those practices. Already 1000 American
5 hospitals are finding adequate for reporting. I love to see
6 us explicitly tie our recommendation to where hospitals
7 stand on the 30 safe practices.
8 With respect to NQF, I agree with the earlier
9 comment. Here's a multi-stakeholder body that's in the
10 business of endorsing performance measures. I personally
11 would support deferring to them explicitly, but I'm also
12 happy to leave the chapter as is.
13 On lab test results, with respect to Alan, it's a
14 serious business. It pertains not just to the Medicare
15 program but to terrorism control. If you want to do lab
16 tests, it's become a serious part of American day-to-day
17 activity. I just think you have to step up and be there.
18 So while I certainly agree we have to be mindful
19 of unintended consequences, I personally think that the time
20 is long past for ending what has been our implicit culture
21 of low expectations of both performance and performance
22 reporting of the health care industry. I don't think

1 there's anyone in this room who is today willing to accept
2 random assignment, if they were very ill, to any Medicare
3 participating doctor or hospital. And I think it needs to
4 be our goal that in a short amount of time we would be
5 comfortable with random assignment if we were seriously ill
6 because that's the predicament that Medicare beneficiaries
7 are in today.

8 MR. DeBUSK: For the sake of time I will yield my
9 turn to Bob.

10 MR. HACKBARTH: Are you going to agree with me or
11 you going to say something contrary?

12 DR. REISCHAUER: I'm going to say that I think the
13 issue that Bill raises is a very fundamental one which we
14 have sort of skated over completely. That we're all for pay
15 for performance and as an exhortation that's great. But are
16 we sending the Secretary down the road for which there are
17 no bridges at every river across crossing?

18 What Bill is saying is the system we can think of
19 for physicians may be totally inappropriate for certain
20 subcategories. And the issue which I think we should raise
21 in the text is whether we think this should go forward with
22 a broad brush, even though some of it would, in a sense, be

1 irrational really for certain subgroups. Or we should say
2 meaningful subcategories of these provider groups could be
3 created by the Secretary and the pay for performance
4 mechanisms directed at them. And as we develop other
5 measures for the other subgroups we apply it there. And I
6 think we should just raise that issue and not duck it.
7 MR. HACKBARTH: Okay, thank you very much.
8 The next item on the agenda is assessing payment
9 adequacy for hospitals. Jack?
10 MR. ASHBY: Good morning. This presentation will
11 address the adequacy of Medicare's payments to hospitals for
12 all of the services they provide to Medicare beneficiaries
13 and payment updates for inpatient and outpatient services in
14 2006. We have quite a bit of material on margins and cost
15 growth but before we get to those issues we wanted to
16 briefly review the evidence on the other payment factors,
17 other payment adequacy factors, much of which was presented
18 at the October meeting.
19 We presented evidence that access to care remains
20 strong, as evidenced by a small net increase in the number
21 of hospitals in the program and an increase in the share of
22 hospitals offering a number of specialty services. We found

1 that volume of services continues to rise and we found that
2 access to capital is generally good, as evidenced by large
3 increases in construction spending, bond issuances and
4 future expansion plans.
5 Today we have the results of the last of our
6 payment adequacy factors, quality of care, and for that we
7 turn to Tim.
8 MR. GREENE: We analyzed risk-adjusted mortality
9 indicators developed by the Agency for Health Care Research
10 and Quality. AHRQ chose these indicators based on evidence
11 that their rates were related to the quality of inpatient
12 care. It reports great variation among hospitals in
13 performance on these measures.
14 We examined changes from 1998 to 2003 in the in-
15 hospital and 30-day mortality rates of beneficiaries
16 hospitalized with eight conditions or procedures. Results
17 are generally consistent with those we reported last year
18 and with change from 2002 to 2003. A negative means a
19 declining mortality rate in this table.
20 In-hospital mortality improved across the board.
21 30-day mortality also generally improved. However, death
22 rates increased for patients hospitalized with pneumonia and

1 stroke. In both cases, rates per 10,000 discharges
2 increased less than 1 percent over the five-year period.
3 We also examined changes in AHRQ patient safety
4 indicators that identified potentially preventable adverse
5 effects related to hospital care. This slide shows eight of
6 the 13 patient safety indicators we analyzed. The risk-
7 adjusted rate per 10,000 discharges increased for six of the
8 eight indicators we display here from 1998 to 2003. Once
9 again, the results were consistent with what we reported
10 last year and for the 2002-2003 change alone.
11 Finally, we also examined data from the QIO
12 program on measures of clinically appropriate care for
13 hospitalized patients with specified conditions. I don't
14 have an overhead for this. Care improved for 18 of 25
15 measures. Despite the improvement, many beneficiaries are
16 still not receiving care known to be effective.
17 MR. ASHBY: Now, as we move on to our financial
18 information we see two themes for hospital payments in 2006.
19 The hospitals need to have fiscal constraint to restrain
20 their cost growth and that Medicare needs to pay more to
21 higher quality hospitals. But the evidence is mixed this
22 year. The other factors in our update model are generally

1 positive, as we just heard, but Medicare margins have fallen
2 rather substantially.
3 Our measure is the overall Medicare margin which
4 includes, along with inpatient and outpatient care,
5 hospital-based home health, SNF, rehab and psych plus GME.
6 As we see in this table, this margin has dropped a little
7 over four percentage points in 2003 to minus 1.9 percent.
8 The inpatient margin has dropped even a little more, almost
9 five points, while the outpatient margin fell 2.5 points.
10 One of the key reasons for the drop in margins in
11 both 2002 and 2003 was a large increase in unit cost, which
12 we will detail in a moment. But on the inpatient side,
13 there is one other key factor and that is outlier payments.
14 These payments were much larger than intended through 2002.
15 We then had reforms in the system and that has brought the
16 margin down a full percentage point in the first year.
17 I would also note that the 2003 margin reflects
18 the impact of provisions reducing both hospital-based SNF
19 and hospital-based home health payments.
20 The next slide shows our unit cost increases.
21 Focusing on the case mix adjusted numbers, inpatient cost
22 per discharge rose 7.4 percent in 2002. That's the largest

1 increase that we've seen since 1990. The increase then
2 dropped to 5.6 percent but it's still the largest increase
3 that we've had since '92. On the outpatient side we had a
4 smaller increase, 2.5 percent, and that smaller cost
5 increase explains the smaller drop in the outpatient margin.
6 One of the key reasons for the lower unit cost
7 growth on the outpatient side is that outpatient volume
8 increased very substantially in 2003, more than 10 percent.
9 We have some evidence, though, that the rate of
10 cost growth may be moderating. Let me clarify first that we
11 are using a different measure here. This measure covers all
12 hospital services for all payers. On the previous page we
13 were talking about a Medicare cost measure. With this all-
14 encompassing measure, we estimate 2003 cost growth at 5.1
15 percent. Then a survey that we sponsored together with CMS
16 provided the estimates you see here of 3.4 percent, using
17 the same measure, for the 12 months ending in June, 2004.
18 We also have BLS data that tend to corroborate the
19 reduced rate of growth. BLS reports that the rate of
20 increase for hospital compensation was 0.5 percent lower in
21 the 12 months ending June 2004 compared to the previous 12
22 months. And along the same lines, the rate of increase in

1 hospital employment is 0.7 percent down in 2004 over 2003.
2 We have to remember that the compensation rate and
3 employment combine to define labor costs. So these two
4 increases, the 0.5 percent reduction and the 0.7 reduction
5 are roughly additive. They imply a 1.2 percent decline in
6 the rate of increase which is consistent with the CMS/MedPAC
7 survey.
8 The next slide shows our margin projections.
9 First, a reminder that in projecting to 2005 we include the
10 effects of 2006 policy changes that affect the distribution
11 of payments. So what we're were estimating here is
12 basically what payments would have been in 2005 had 2006
13 policy been in effect at the time.
14 As we can see, the overall Medicare margin rises
15 0.4 from 2003 to 2005. But the inpatient margin rises more
16 due to several MMA provisions which more than offset costs
17 rising faster than updates. The outpatient margin, on the
18 other hand, falls due to a combination of the high-cost
19 growth and two MMA provisions that reduce payments. First,
20 the removal of the transitional corridors at the end of
21 2003. And second, removal of the hold harmless provision
22 which applies to small rural and sole community hospitals at

1 the end of 2005.

2 Next, we look at our margin projection by hospital

3 group. The MMA provisions primarily help rural hospitals.

4 Their margin, as you see, rises by 3 percentage points while

5 the urban margin stays the same.

6 Many of you will remember, though, that last year

7 at this time we projected that the rural margin would

8 surpass the margin of urban hospitals. But that estimate

9 was for 2004, reflecting 2005 policy, and two policies going

10 into effect in 2006 have changed the picture. First is the

11 outpatient hold harmless provision, as we mentioned a moment

12 ago. that policy only affects rural hospitals. Plus,

13 outpatient services comprise a larger share of costs for

14 rural hospitals which magnifies the effect.

15 Second is elimination of the 5 percent rural add-

16 on to home health payments. Again, the effect of this

17 provision is magnified by home health services comprising a

18 larger share of rural hospitals' costs.

19 MR. HACKBARTH: Jack, how big is the effect of

20 those two provisions?

21 MR. ASHBY: I'm not sure that I have an exact

22 figure on that. We could report on that next time. It's

1 buried in the modeling program somewhere

2 Now we move into the results of several analyses

3 of cost growth and we will be exploring the premise that the

4 rate of cost growth is directly linked to the flow of

5 revenue from private payers.

6 We begin by examining the growth in private payer

7 payments over time. Our measure is the ratio of payments

8 from private payers to the costs of treating privately

9 insured patients. As we see on this graph, the ratio

10 exhibits three distinct periods. It is moving up through

11 1992, it is moving down through 1999, and then up again

12 through the present.

13 In the first period, private payer payments

14 increased 2 percent more than costs each year, leading to a

15 16 percent increase in hospitals' profit on business from

16 the private sector. Most insurers still paid on the basis

17 of charges at that point, and engaged in little negotiation

18 or selected contracting. With this almost complete lack of

19 revenue pressure from private payers, hospitals' Medicare

20 cost per case rose more than 8 percent a year.

21 Then in the second period, we had almost the

22 converse. Private payer payments increased 2 percent less

1 than costs, resulting in a 19 percent drop in hospitals'
2 profits on private sector business. HMOs and other payers
3 obviously, at this point, began to negotiate harder and most
4 switched to paying for inpatient services on the basis of
5 DRGs or flat per diems rather than charges. With the now
6 extensive pressure on private payer revenue, the rate of
7 cost growth plummeted to only 0.8 percent per year.
8 Then, in the continuing third period, private
9 payments are once again rising faster than costs. Private
10 insurers now generally have less leverage than at any time
11 since the early '90s because of provider consolidation and
12 emphasis on products that grant free choice of providers.
13 The freer flow of funds from the private sector,
14 profitability has already risen by 6 percent, has once again
15 resulted in higher Medicare cost growth.
16 Finally, we wanted to emphasize that during our
17 earlier experience with high cost growth, the late '80s and
18 early '90s, the rate of growth in Medicare cost per
19 discharge exceeded the increase in the market basket by more
20 than 3 percentage points a year. But our predecessor
21 commission, ProPAC, continued to make update recommendations
22 in relation to market basket.

1 Even putting aside the adjustments that they made
2 at the time to compensate for base rates being too high in
3 the first year of the PPS, their recommendations during this
4 period averaged market basket minus 0.7 percent, including
5 the three years when the Medicare margin had dipped into
6 negative territory. The actual updates, as you see, were
7 even lower, averaging 2.5 percent.
8 Next, Jeff will continue looking at the
9 relationship of revenue and the rate of cost growth.
10 DR. STENSLAND: First, I will show that hospitals
11 facing financial pressure tended to have lower rates of cost
12 growth. This suggests that hospitals have a degree of
13 control over their costs. Second, I will show that
14 nonprofit hospitals in competitive markets tend to have
15 below average rates of cost growth. This suggests that
16 competition can restrain cost growth.
17 In this slide, financial pressure is measured
18 using profit margins on non-Medicare patients. We focus on
19 non-Medicare patients to highlight the impact of private
20 insurer payment rates which can be affected by competition.
21 Our definition of non-Medicare revenue includes payments
22 from privately insured patients, Medicaid and investment

1 income.

2 We find that nonprofit hospitals with non-Medicare
3 margins above 5 percent increased their cost at a rate that
4 was 2.3 percentage points above the market basket from 1998
5 to 2003. In contrast, hospitals under significant financial
6 pressure held their cost growth to 0.9 percentage points
7 above the market basket. In 2002 hospitals that were under
8 financial pressure were able to keep their standardized cost
9 per Medicare discharge down to $4,750, which is below the
10 level of costs incurred by hospitals facing less financial
11 pressure. Our finding that financial pressure has
12 restrained cost growth over the past five years is similar
13 to findings published by Gaskin and Hadley, who find that
14 financial restrained cost growth during the early 1990s.

15 We also examined cost growth among for-profit
16 hospitals and found similar results.

17 We measured competition using a Herfendahl Index.
18 In low competition markets the most dominant hospital had a
19 73 percent market share on average. From 1998 to 2003 a
20 nonprofit hospital in these lower competition markets
21 increased their cost at a rate that was 1.9 percentage
22 points above the market basket.

1 In contrast, nonprofit hospitals in highly
2 competitive markets grew their costs at a rate that was 1.3
3 percentage points above the market basket. The difference
4 of 0.6 percentage points is significantly significant.
5 Interestingly, nonprofit hospitals in lower
6 competition markets did not have higher costs in 2002. This
7 suggests they started from a lower cost point. This is
8 consistent with the literature which suggests that low
9 competition markets tended to have lower costs in the 1980s.
10 But in recent years, low competition markets tended to have
11 higher rates of cost growth.
12 We also tested the relationship between
13 competition and cost growth at for-profit hospitals. We
14 found that for-profit hospitals in low competition and high
15 competition markets had similar levels of cost growth. It
16 is possible that for-profit hospitals are more focused on
17 reducing costs, even when they do not face significant
18 competition.
19 To summarize what I've been saying, hospitals
20 under financial pressure were able to achieve below average
21 rates of cost growth. While below average, these hospitals'
22 costs still grew faster than input prices. This suggests

1 that cost growth was partially, though not completely, under
2 the control of hospitals. Other factors, such as physician
3 practice patterns, could be playing a role.
4 Nonprofit hospitals in competitive markets started
5 with slightly higher costs per discharge but they had lower
6 cost growth from 1998 through 2003.
7 I'll turn you back to Jack.
8 MR. ASHBY: Our next slide reviews our analysis of
9 hospitals with consistently negative Medicare margins which
10 we presented at the last meeting. These hospitals exhibit
11 the characteristics you see here, which add up to the
12 conclusion that they have not controlled their costs as well
13 as the average hospital, and even less so in comparison to
14 hospitals with consistently positive margins.
15 In addition, these hospitals generally have a poor
16 competitive stance in their market areas, as indicated by
17 higher costs and lower occupancy compared to their
18 neighboring hospitals. In short, the financial performance
19 of negative margin hospitals under Medicare is directly
20 linked to factors over which their managements have
21 considerable influence.
22 As in virtually all fee-for-service sectors,

1 hospitals exhibit a wide range of cost growth for inpatient
2 services. We'd like to illustrate the effects this
3 variation can have on the industry-wide margin. Measured
4 over four years to eliminate the effects of short-term
5 fluctuation, the top quartile of cost increases averaged
6 about 11 percent a year while the bottom quartile average
7 about 1 percent. These results are case mix adjusted.
8 But we found that many of the hospitals with the
9 largest cost growth had the lowest costs in the absolute at
10 the beginning of the analysis. So focusing only on the
11 subset of hospitals with above-average costs going in, if
12 these hospitals had held their cost growth to no more than 2
13 percentage points above the market basket from 2001 to 2003,
14 then the margin would have been 2.3 percentage points
15 higher.
16 We did this analysis only on inpatient cost but if
17 the dynamic carries to the other hospital services -- and
18 it's likely that it does given the extent of joint costs --
19 than the 2.3 percent higher margin would, all else equal,
20 carry through to our projection for 2005. And we would end
21 up with a positive overall Medicare margin rather than the
22 minus 1.5 percent that we estimated for all hospitals.

1 Turning to our conclusion on payment adequacy, as
2 I said at the outset the evidence is mixed. But hospital
3 mergers and the retreat of private payers have fueled cost
4 increases that the evidence suggests are excessive. And as
5 was the case in the late '80s and early '90, more of the
6 burden for controlling costs now falls on Medicare. Both
7 the need for cost constraint and the favorable outcomes on
8 other indicators of payment adequacy suggest a conclusion
9 that payments remain adequate through 2005.
10 Looking then to 2006, the first consideration is
11 that we no longer need a technology factor in the update
12 because MMA has introduced a new tech add-on payment for
13 inpatient services which is not budget neutral and we
14 already had a non-budget neutral add-on on the outpatient
15 side. Then our productivity adjustment is normally based on
16 the 10-year average improvement in total factor productivity
17 in the general economy which currently stands at 0.8
18 percent.
19 Last year we recommended a full market basket
20 update in light of the projected negative margins and
21 uncertainty about continuation of cost pressures that
22 hospitals may face. Again this year, we have draft

1 recommendations for full market basket update on both the
2 inpatient and outpatient sides. But there are several
3 points to consider in making your decision that come out of
4 our presentation today. That the current level of cost
5 increases is basically unsustainable. That private insurers
6 have not been contributing to cost containment in recent
7 years. That the rate of hospital cost growth may be coming
8 down in 2004 and beyond. And that other important
9 indicators, particularly access to care, quality, volume and
10 access to capital, all are quite positive. In light of
11 these factors, you may want to discuss the possibility of
12 recommending an increment below full market basket for our
13 recommendation.

14 I would also remind you that in conjunction with
15 the payment update, pay for performance would result in a
16 larger share of the money going to hospitals that achieve
17 high quality scores. Many hospitals would end up with a net
18 impact that's less than the across the board update but
19 Medicare would be providing high quality hospitals with an
20 increase at or above the update while sending a strong
21 signal to lower quality institutions.

22 Our last slide presents the two draft

1 recommendations. I don't think that we need to take the
2 time to read them. Pending your discussion this morning
3 both call for updates equal to market basket. These
4 recommendations would follow existing law as they stand, so
5 there would be no impact on baseline spending and they
6 should not have major implications for beneficiaries or
7 providers.

8 MR. HACKBARTH: As I see it, the big picture
9 question for us, and more importantly before the Congress,
10 is what is Medicare's role in this environment where we see
11 costs per case increasing faster than revenues per case and
12 hence not just low margins but a steep decline in the
13 margin? And do you believe that an important factor in the
14 rapid increase in cost is happening on the private side?

15 In that set of circumstances, is Medicare's role
16 to exert pressure that isn't coming from the private side
17 with the goal of trying to stem the increase in costs per
18 case? Or increase its rate of payment in order to try to
19 accommodate the rate of growth in costs and thus stabilize
20 the declining margins? I think that is, at the end of the
21 day, the question it needs to be addressed. And I think
22 Ralph has a point of view on that.

1 [Laughter.]

2 MR. MULLER: First of all, I found this
3 information very helpful and fascinating. Let me talk a
4 little bit about the cost and talk directly about Glenn's
5 other question.

6 For example, a big part of the cost of any
7 hospital, over 50 percent, are staffing costs, and they're
8 50 or 60 percent of the average. Usually the biggest
9 proportion of those costs are for nursing. One of the
10 things that happened in the '90s, under all the cost
11 pressures that are outlined in Jack's slide, is that many
12 hospitals around the country experimented with trying to
13 substitute other staff for nurses. There's been very
14 persuasive recent literature by Linda Aiken and some of her
15 other colleagues at the University of Pennsylvania that have
16 both indicated that outcomes across hospitals are better
17 when one has better staffing ratios. That's seen some
18 efforts in some states around the country to legislate
19 higher staffing ratios.

20 But furthermore, that if you have more RNs as a
21 proportion of your overall nursing population, and even
22 beyond that if you have more bachelor's prepared and

1 master's prepared. So really that having more
2 professionally qualified nursing has a direct effect on
3 patient outcome.
4 And since one of the broader themes that we have
5 is what are we paying for and pay for performance, having
6 clear evidence that better prepared nursing staff has better
7 outcomes is one of the reasons that the costs are going up
8 because the effort to move towards getting rid of nurses in
9 the '90s, both turned out to be bad patient care in terms of
10 measuring outcome.
11 So I think one of the reasons that, in fact, one
12 sees some cost increases that are above the norm, above the
13 rate of inflation, is hospitals are moving back towards
14 hiring more nurses and there's competition for nurses. And
15 as basic market theory will tell you, when people are trying
16 to hire more nurses, more RNs, more bachelor prepared,
17 you're going to have some inflation of that.
18 Secondly, as we know, there's been a very
19 considerable increase in malpractice. As the chapter
20 indicates, malpractice is still a modest proportion of the
21 overall budget but still when it's going up 20, 30, 40
22 percent a year over the course of several years, it starts

1 having an effect on the overall cost structure. Most of
2 that cost increase is not because there are more malpractice
3 cases but the average cost per case has been going on.
4 I think there are some very appropriate reasons
5 that costs have been going up more than the market basket.
6 I can go further on that. I don't want to go through the
7 whole litany today but certainly the effort to put nursing
8 more in the center of patient care with demonstrated effects
9 of quality is one of the reasons that hospitals have tried
10 to respond to the evidence that the efforts to go on the
11 other direction in the '90 had very adverse outcomes for
12 patients.
13 Secondly, to go to Glenn's question about the
14 relationship between how we look at the private market and
15 Medicare, we have over the course of the last several years
16 been looking at total Medicare margins as the best indicator
17 of payment adequacy. I think Glenn, you yourself and the
18 staff have been very forceful in arguing that we should look
19 at total Medicare margins and we should not look at total
20 margins. I think it's useful to have this information on
21 total margins, to wit by looking at the private payer
22 market. But in general, we don't look at total margins as

1 part of our Medicare payment adequacy calculation.
2 And as I've said in the past, if we're going to
3 start looking at total margins, which in fact I think we
4 implicitly do by looking at what's happening in the private
5 market, then we have to consider whether we're going to do
6 that across all of the categories in the Medicare program.
7 For example, there's 30 years of evidence that Medicaid
8 programs have squeezed nursing home payments. So if we're
9 going to start looking at total margins and whether Medicare
10 has an obligation to either compensate or not compensate for
11 want either Medicaid is doing or private payers are doing, I
12 think we have to look at that issue not just in isolation
13 here.
14 So I think moving from a basis where payment
15 adequacy has been determined by Medicare margins to one
16 where we take into account the private margin, I think is
17 useful information and obviously, as I've said before, there
18 seems to have been a lack of discipline in the private
19 market over the course of the last few years. I think that
20 lack of discipline has come from a lot of causes, both the
21 patient and political rebellion against managed-care in the
22 late '90s, the fact that private employers and plans and

1 providers have, in a sense, been able to move those costs
2 on. And whether one starts that reaction against those
3 increases by looking at the providers I think is the wrong
4 place to start. One should look as well at what is
5 happening on the plan side and what is happening in terms of
6 what employers are doing. I know we've had other
7 conversations about that.
8 But whether it's the role of this commission and
9 Medicare to make up for the lack of discipline elsewhere, it
10 obviously has to be understood. But in the past we have
11 said Medicare payment policy should be based on Medicare
12 margin. So I'm hesitant to start moving off it just when
13 it's convenient.
14 DR. SCANLON: Ralph, I interpreted the information
15 from the private side somewhat differently. I didn't think
16 we were really moving away from the principle of Medicare
17 margins but more using that as information to understand
18 what might be driving some of the cost growth or
19 facilitating some of the cost growth. And I think that's
20 important because the margin is the product of both the
21 revenue and the cost side and we need to understand that.
22 I think as I mentioned before, for me,

1 particularly in the hospital sector, the fact that it's
2 dominated by nonprofit institutions whose obligation and
3 mission is to serve their communities, I think it's
4 incumbent upon them to invest in their communities and
5 therefore to spend the money that they receive. So
6 depending upon how much is available, I think that's going
7 to influence the costs that we do observe.
8 Having said that I don't think we're moving away
9 from focusing on the Medicare margins, I would say that I
10 believe that we should be thinking over time about moving
11 away from focusing on the average margin alone. Maybe
12 that's too strong of a statement, that we've been focusing
13 on it alone but giving it so much attention because to me I
14 think the distribution of margins, the distribution of the
15 financial status of providers is something that is a more
16 appropriate focus.
17 We started with PPS in 1983 and we started off
18 giving great deference to the average, assuming that
19 everyone that was below it was more efficient and everybody
20 above it was less efficient. We got away with that, in some
21 respects, because there was enough slack in the system. But
22 the reality is that it's only an average and it's not an

1 average that's adjusted for all other relevant factors that
2 might influence a provider's ability to provide services.
3 And ultimately we've got to come back, as we do
4 think about being an efficient purchaser, come back to the
5 issue that our goal is access for Medicare beneficiaries.
6 And our goals should be access at efficient prices. They
7 may not be possible to have efficient prices by simply
8 having a national average with a very limited number of
9 adjustments.
10 So I think focusing on the distribution of
11 margins, who are the winners, who are the losers under the
12 current system, trying to understand more about why both are
13 in the situation that they're in, and then potentially
14 starting to introduce differential adjustments. This is
15 revolutionary, like pay for performance is revolutionary.
16 But it's potentially that we're at that point in time where
17 we have taken enough slack out of the system. We have
18 enough budgetary pressure on Medicare that we need to start
19 thinking about that.
20 MS. BURKE: I don't necessarily disagree at all,
21 Bill, with what you've said. But I think would be an
22 overstatement to suggest we haven't, to a certain extent,

1 done that. We have, in individual cases and individual
2 years, dealt with individual sets of hospitals, must notably
3 the rurals, where we have in fact isolated them and, in
4 fact, -- and I don't mean this in a pejorative way -- but
5 have bailed them out quite directly with fairly substantial
6 amounts of money. Not that I don't love rural hospitals,
7 because I do.
8 But I think there is a history there. I think
9 you're absolutely right. Those of us old enough to remember
10 1983, you're right. We began with this presumption of the
11 average and we moved from there. But there's no way in the
12 world you can describe what has occurred between then and
13 now as having stuck to that with any religious fervor at
14 all. We've gone in and intervened whenever someone thought
15 it was important to do so, whether it was with DSH or with
16 IME or with the rural bailouts.
17 So I think you're right. I think we need to be
18 more thoughtful about it. We need to be more specific about
19 it. It is clear we need to move in that direction. I do
20 support you in that respect. But I don't think to date
21 we've ever really stuck to the averages in any consistent
22 way.

1 DR. SCANLON: That was why I back tracked from my
2 first statement about focusing solely on the average. I
3 think we have moved away but we've moved away with really
4 very broad brushes. And I think that we may be at the point
5 in time where we really need to be much more discriminating
6 in terms of how we make adjustments and particularly how we
7 update payments over time.
8 DR. WOLTER: I guess I would say I'm a little bit
9 concerned about the balance in the text on this in terms of
10 the thesis that the inability of the private sector to
11 control costs is really sort of driving all of this. Just
12 to piggyback on a couple of things that Ralph said, in my
13 organization between 2001 and 2004 our malpractice premiums
14 went from $3.5 million to just over $11 billion, which is
15 basically our entire bottom line. When drug eluding stents
16 were introduced, even with the fairly rapid response by the
17 Medicare system, our net in the cath lab dropped by $1
18 million just because revenue to cost, based on the increased
19 cost of those devices, was quite a bit different. And then
20 of course, the labor issues and the nursing wages.
21 I think there are some real factors driving costs
22 that aren't just related to the lack of discipline in the

1 private sector, although maybe that is also an important
2 factor. So it would be nice to at least acknowledge that, I
3 think, in the text.
4 And then I would say that whatever, this is a very
5 broad brush and there are very significant regional
6 variations in how this plays out. In states like Montana,
7 only 40 percent of businesses even provide health insurance.
8 We have, for all practical purposes, one commercial payer.
9 We have very little ability to cost shift into the private
10 sector relative to some larger urban areas where economies
11 are stronger and there are Fortune 500 companies. We tend
12 to have a higher Medicare percentage.
13 So the payment update mechanism is a very blunt
14 instrument and it will have differential effects across the
15 country, depending upon those dynamics. And it certainly
16 would be, I think, much harsher in areas like mine than it
17 might be in other areas where you don't have that ability to
18 cost shift.
19 And then I wonder how the private sectors folks do
20 respond to this because certainly their costs and premiums
21 in many ways are driven by the costs going up that they're
22 seeing. And some would argue that's underfunding in the

1 public sector, not so much lack of discipline. But I would
2 certainly let them comment. I just wanted to introduce
3 those comments.
4 And then lastly, I do worry about moving away from
5 the update framework we've used in the past. My feeling is
6 that if we have a framework we've used and it would indicate
7 a certain uptake, but we can't afford it, we ought to say
8 that maybe we can't afford it as opposed to stretching the
9 arguments in a different direction.
10 Just a couple of more things quickly, Glenn, two
11 really. I'm very concerned about moving away from the
12 technology update. I think that the technology updates that
13 are referred to are very specific to new devices. They do
14 not cover things like the introduction of clinical
15 information systems. I don't believe that even with the
16 recent wave of grants we've done anything but touch the tip
17 of the iceberg of what it's going to take to fund the
18 important wave of technology coming down the road. The $138
19 million coming out of AHRQ, for example. To put that in
20 perspective, we're a small organization. The system we're
21 now introducing was a $10 million decision. As a percentage
22 of the $128 million, you can see what that represents.

1 I think that it would be very important to
2 maintain that technology update, personally. Perhaps it
3 ought to be tied a little tighter to actual implementation
4 of something. That might be a suggestion. But I really
5 worry about removing that at this very important time.
6 Lastly, I say this every year so I'll go ahead and
7 do it again. I don't think there's any evidence whatsoever
8 that there's differential cost allocation into the
9 outpatient sector relative to the impatient sector. I wish
10 we could stop saying that every year. I just don't think it
11 exists anymore.
12 MR. HACKBARTH: I just want to pick up on one of
13 Nick's points and that was the one about ignoring a well
14 established framework for making these decisions. I agree
15 with that. I don't think that we want to abandon, for the
16 sake of convenience, a framework that we have developed and
17 tried to adhere to. I really feel lousy about that.
18 I think the question is, or the issue is, that our
19 framework is a fairly elastic one. It doesn't produce a
20 single right answer. Just to be particularly clear about
21 it, it doesn't base decisions solely on margins, either at a
22 point in time or a trend. I think we've taken great care

1 over the years to say that the margin analysis is one piece
2 of information. We look at other factors like access to
3 capital, which I'm not sure Jack spent much time on today.
4 But in the paper there was a lot of evidence about the rapid
5 increase in capital expenditures. I'm sure there are lots
6 of legitimate reasons for that and we can discuss that.
7 But the important point is that this is not a one
8 dimensional framework that we've been using that says well,
9 you look at the margin and then you make a decision. I
10 think we look at a lot of different factors and they are
11 pointing in different directions right now and don't lead
12 you to a single obvious answer.
13 DR. WOLTER: That's why I went through some of the
14 counterpoints, I think, in some ways to the general theme in
15 the chapter. Because again, I think in regions like mine
16 when you see small businesses dropping insurance, that's
17 just another piece of information that if we're going look
18 at the total picture, not just Medicare margins, we need to
19 have all of that in our minds as we make these decisions.
20 MR. SMITH: Thanks, Glenn. Three brief comments.
21 First, on are we shifting away from the framework.
22 It's interesting I've been one who over the years has been

1 critical of the reliance on Medicare margins for a variety
2 of reasons. But actually, Ralph, I don't think we've
3 departed as much this year from that as you would suggest,
4 except in a different way. That there is a lot in here
5 which thinks about, and I think appropriately, Medicare in
6 the larger context of the way the whole health care system
7 is organized and the way payments are structured.
8 That raises a very interesting question, sort of
9 what's our responsibility? The implicit responsibility
10 suggested by the staff's work is gee, we maybe the only
11 anchor to restrain cost growth here in an environment where
12 the private side has come unglued. Is it our responsibility
13 to try to restrain cost growth, not just for taxpayers but
14 for all bill payers?
15 That is a bedeviling question but it shows up in
16 sector after sector after sector. I think that's the
17 departure here, rather than asking that question is the
18 departure, rather than a shift in margin. We probably ought
19 to talk about it a lot more.
20 Second, I find Bill's comment provocative in part
21 because I found the persistently low margin data that Jack
22 and his colleagues presented particularly provocative. The

1 suggestion in the written work and in our conversation last
2 month is that this is a management problem, that there are a
3 series of hospitals with persistently high negative margins.
4 And what they have in common and what the sources of those
5 persistently high negative margins have in common is crummy
6 management.
7 Bill, you're right, this isn't one-size-fits-all
8 and some of the distributional data, geographic and size
9 data, suggests that. But I'm more intrigued with the data
10 that suggests gee, there really is a big difference in the
11 way these places are run and figuring out how to target on
12 that big difference may be the most valuable thing we can
13 do.
14 And lastly, a question. Why no productivity
15 adjustment to the market basket suggested this year?
16 MR. ASHBY: I think that's the open question.
17 MR. HACKBARTH: In the draft recommendation?
18 Again, draft recommendations is basically a carryover --
19 MR. SMITH: Is this a test to see whether we'd
20 notice?
21 MR. HACKBARTH: No, actually I think Jack pointed
22 out that that was a part of our normal framework, if you

1 will, that was not present here.

2 MR. SMITH: What I was asking was a little bit

3 more, Glenn, of what was the thinking behind that departure?

4 MR. HACKBARTH: Last year, the draft

5 recommendation is where we were last year. You'll recall

6 the basic rationale for market basket last year was just the

7 extraordinary uncertainly we faced, both in terms of what

8 was happening on the cost side and that trend, but also on

9 the revenue effects, the complicated revenue effects of MMA.

10 So we said we'll go with market basket. But now the issue

11 is back squarely on the table of whether we ought to include

12 it this year.

13 It actually occurs to me that we've skipped over

14 one change in our normal framework. Our statutory charge

15 was amended. As you recall, we talked about this at the

16 retreat. In the list of factors and what we are to consider

17 in making update recommendations, language was added to make

18 it clear that the Congress wants us to consider the costs of

19 efficient providers, as opposed to just average providers.

20 That is a change in our framework.

21 MS. DePARLE: Haven't we done that? That language

22 is familiar to me from our discussions in the past.

1 DR. REISCHAUER: Rhetorically, I think we have but
2 analytically we haven't.
3 MR. HACKBARTH: And to me that's in part where the
4 persistent loser analysis comes in and you look at the
5 people who are losing not just in one year but chronically
6 losing money on Medicare business. Why is that? Is it
7 because they're less efficient, less successful, less well-
8 managed institutions?
9 DR. WAKEFIELD: A few comments. First of all, on
10 Ralph's point about nurse staffing and issues around that in
11 terms of cost. The quality data that you showed us at the
12 very beginning, one of the areas that it seems we're not
13 doing so well is in the failure to rescue concept. I'm not
14 sure how that was operationally defined across those
15 particular --
16 MR. GREENE: Actually, failure to rescue is
17 defined by the mortality rate associated with patients who
18 develop complications in the hospital and that's one where
19 we actually were doing better.
20 DR. WAKEFIELD: Was it? Okay, thank you.
21 MR. GREENE: That's consistent with the mortality
22 findings.

1 DR. WAKEFIELD: Never mind.
2 The point I was going to make is I think that
3 issue is tied to nurse staffing and the way it's been
4 operationalized in some studies. That was going to be my
5 point.
6 A couple of issues related to the handouts that
7 we're looking at for the first time. First of all, to
8 Sheila's point earlier about rural hospitals and the
9 bailouts. I just would want to make a small clarification
10 and that is that a lot of the provisions that were enacted
11 as part of the MMA were -- does it surprise you that I'm
12 going down this track? I know, take a recess and we'll have
13 a little conversation here.
14 The point I was going to make is that a lot of the
15 provisions that were enacted as part of the MMA were
16 actually supported, of course, by this Commission
17 empirically. So there was empirical data to look at,
18 equalizing the update factor, affecting DSH, low-volume
19 hospitals, et cetera, et cetera. I just want to make the
20 point that rural hospital administrators aren't out there
21 buying Lamborghinis just yet on that. And I don't think
22 that's what you were saying. I'm only reacting to the

1 bailout part of that.

2 MS. BURKE: Poor choice of words. Assistance
3 provided.

4 DR. WAKEFIELD: Empirically grounded provisions,
5 thank you.

6 So a small point but a couple of other points I
7 want to raise based on what I'm looking at here.

8 Jack, it seems to me that at least in the text
9 we're drawing a conclusion about what's within the control
10 of the administration of a hospital linked to what their
11 competition is in their region linked to margins. My
12 concern, of course, was hospitals with negative margins.

13 The question I've got is that we drop out critical
14 access hospitals and that, it seems to me, is not factored
15 in here. I don't know where we're at yet but we might be at
16 about 1000 hospitals now. I guess my question to you is do
17 you have a sense at all, how are we drawing this conclusion
18 when we're taking that set of hospitals out, trying to get a
19 better understanding of what's within the control and what
20 we're tagging is within the control of hospital
21 administrators? That's one question. I've got about one or
22 two to follow.

1 The second question that I've got for you, again
2 on the data we're looking at I think for the first time
3 right now, is that the outpatient margins really a double-
4 digit negative on the charts. That, of course, is where a
5 lot of small hospitals do a lot of their business, on the
6 outpatient side. So that's concerning to me. I'll couple
7 that concern with what you were suggesting in your remarks
8 about where we might be going in terms of the provisions
9 related to home health, that the expirations on home health
10 as well as the corridor protection for outpatient and impact
11 that those two provisions may be having on hospitals
12 viability. I'll hope that at some point in time we can come
13 back to that, not necessarily today obviously. But we can
14 better understand what's going on there because that's where
15 so much of the business is done in rural hospitals. That's
16 a real concern. That's more a comment.
17 The last question I've got is there's one slide
18 here where you're talking about -- let me see if I can find
19 it. The statement if hospitals with above average
20 standardized costs held their cost growth to 2 percentage
21 points above market basket, the 2003 margins would be 2.3
22 points higher. It seems to me, if I'm looking at the slides

1 correctly, that brings urban hospitals up slightly into a
2 positive margin, Medicare margin range. Am I looking at
3 that correctly? But it doesn't pop your rural hospital
4 category up into a positive margin. Rural hospitals are
5 still negative, if I'm doing the math correctly on that. Am
6 I?

7 MR. ASHBY: Let me just comment on the latter one.
8 In terms of averages, you're right, it would pull urbans
9 above zero and not rurals. We don't really know how it
10 would play out, though, if we simulated it by hospital. We
11 applied the same factor to all of them. So we're not really
12 quite sure how that would play out. I think it's probably a
13 bit of a leap to say that the averages would hold here.

14 DR. WAKEFIELD: So it could be misleading either
15 way?

16 MR. ASHBY: It could be. We'd have to go a step
17 deeper in order to answer that question.

18 Then back to the negative margin analysis for a
19 moment, I just wanted to point out that on the one hand it
20 is true, we did exclude CAHs from the entire analysis. We
21 did that only because they are outside of the PPS for which
22 we are developing an update recommendation here.

1 But we did want to point out, though, that despite
2 CAHs being omitted, the analysis showed that rural hospitals
3 still had neighboring facilities, neighboring PPS facilities
4 that is, within 15 miles. And compared to those
5 competitors, those with the chronically negative margins
6 were uncompetitive, as it were. They had higher costs in
7 the absolute and had lower occupancy. So there are some
8 differences their despite CAHs having been omitted.
9 DR. WAKEFIELD: Is there anything else you can
10 comment on related to the two provisions that expired and
11 how you see any of that playing here? That is, the
12 outpatient transitional corridor and home health.
13 MR. ASHBY: Just to acknowledge that they were the
14 key factors behind the decline in negative margins, which
15 was felt particularly on the outpatient side. So it's an
16 issue and it may well be one that we may want to look into
17 in future rounds.
18 MR. HACKBARTH: In fact, I think we ought to take
19 on another look at that. Mary, can I make one amendment on
20 your initial statement about our support for the rural
21 hospital provisions? I agree with 99 percent. I take pride
22 in that piece of work. I think it was very good MedPAC

1 work.

2 But just for accuracy in the record, in a number

3 of instances Congress went further than we recommended and

4 actually adopted some changes in that rural package that

5 were inconsistent with MedPAC recommendations.

6 DR. WAKEFIELD: Did you notice, Glenn, that I

7 spoke only to our scope of work and our contribution? It

8 was deliberate.

9 MS. DePARLE: I had a couple of comments. First,

10 I thought the work that we've done this year on the

11 hospitals with consistently poor or negative Medicare

12 margins was really fascinating. Today, in particular, I

13 heard some data that I had not heard before about the way in

14 which those hospitals may drive our perception or what the

15 numbers look like in terms of overall Medicare margins for

16 all hospitals. I thought that was really interesting. I

17 hope we will spend more time on that.

18 One of the things you noted was that also

19 associated with those hospitals is a lower occupancy. I

20 guess I would be interested in knowing more, in a more

21 granular fashion, whether that also is a proxy for -- well,

22 to what extent are there or are there not access problems

1 for Medicare beneficiaries in the area in which these
2 hospitals operate? I suspect that there are not. I suspect
3 they may be overbedded, as I would define that. I think
4 that would be interesting to know. And I think this work is
5 very important as we look toward the future.
6 MR. ASHBY: Let me just elaborate on what we
7 already found on that. The chronically negative margin
8 hospitals averaged about a 47 percent occupancy, compared to
9 I think it was 58 percent for the hospitals in their
10 markets. I think we can all recognize that that leaves
11 considerable room for patient care to be provided. So there
12 wasn't any immediate indication of access problems.
13 MS. DePARLE: I know we don't have a surfeit of
14 excess staff or resources, certainly not know, but that
15 might be an area where we can do some of the visits that
16 we've tried to do in the past, on other sectors, to just go
17 into a market and really drill down a little bit more and
18 see what's going on. I think it's really fascinating.
19 Secondly, on our update recommendation and the
20 extent to which it is or is not a mathematical formula, I
21 think we all agree here it's not a mathematical formula.
22 There is a judgment that goes into deciding what it should

1 be. But on the question that's on the table of whether we
2 should decide this year for a full market basket for
3 hospitals or something less based on our judgment about the
4 way things are trending within the hospital sector or larger
5 budgetary and deficit reduction issues, I guess my concern
6 about doing that, my concern about deviating from the draft
7 recommendation that you have on the screen here is that I
8 think we are not looking at -- if we were going to do that I
9 would want to look at the full context of Medicare spending.
10 Glenn, you said at the beginning of this session,
11 we had discussed earlier that we are not going to be making
12 recommendations, for example, on Medicare Advantage. There
13 are some other areas also that we're not covering. And with
14 respect to Medicare managed care in particular, with that
15 being $40 billion, I guess that Medicare is now spending on
16 that, and with some quite significant changes that have
17 occurred as a result of the Medicare Modernization Act that
18 will potentially increase that spending, we haven't spent
19 time really studying that here. But that makes me less
20 inclined to consider the overall budgetary context when
21 we're looking at these individual fee-for-service providers.
22 I think I would be more inclined to look at all of that

1 together if we were going to bring in what is, I think, sort
2 of an extraneous factor to look at here.
3 DR. MILSTEIN: I think if we're going to move
4 forward and refine our recommendations to reflect the costs
5 of so-called efficient providers, I would hope that we would
6 define inefficiency within two different frames of
7 reference. One is the efficiency of hospitals with respect
8 to the cost per stay. And secondly, efficiency of hospitals
9 with respect to total Medicare costs incurred in the 12
10 months following a hospital discharge. What's nice about
11 this with respect to the staff burden is the government
12 folks have already down a lot of these analyses for us.
13 The latter definition of efficiency obviously
14 exerts much more leverage on overall Medicare cost growth.
15 And so I would hope that it would, at a minimum, be equally
16 considered in determining the update required by efficient
17 hospitals.
18 DR. STOWERS: I just want Mary to know that I
19 would never use the bailout word.
20 For those rural additions that were in the MMA,
21 I'm just going to ask Jack, are they figured in here at all?
22 And some of those did apply to other urban and so forth. So

1 when we say that rural is going to be minus 6.2 or whatever,
2 is that taking into account those changes?
3 MR. ASHBY: Two issues, rural is not going to be
4 minus 6.2. In the projection it was minus 3.1 and that
5 very definitely does take into account all of the provisions
6 that are in the MMA.
7 DR. STOWERS: So it was just 6.2 in 2003 but
8 taking those into account it goes up to the into dust and
9 three by taking those that he goes into the 3.1.
10 DR. REISCHAUER: But not the critical access
11 hospitals.
12 MR. ASHBY: Right, critical excess hospitals are
13 outside of the analysis.
14 DR. REISCHAUER: They took a big chunk out.
15 DR. STOWERS: So then when we add the update on,
16 we're getting closer? Is that counting the update?
17 MR. ASHBY: The projection from 2003 to 2006,
18 first of all, takes into account MMA provisions or really
19 all payment provisions that are scheduled to go into effect.
20 But it also takes into account the updates between 2003 and
21 2005 that are already in law and our projection of cost
22 growth during that period. So it's an attempt to be all-

1 encompassing, if you will.

2 MS. RAPHAEL: I had a technical question, Jack. I
3 noticed in your chapter on nursing homes that we went back
4 and adjusted the market basket. I don't know if I
5 understand it correctly, but the update was adjusted at a
6 later point in time where there was some additional amount
7 added to the market basket.

8 MR. ASHBY: That was the forecast error provision
9 for SNF updates.

10 MS. RAPHAEL: Does that all pertain to --

11 MR. ASHBY: That was not pertain to the hospital
12 industry. That was a specific legislation provision for
13 SNF.

14 MR. HACKBARTH: And that's not something that we
15 ever embraced or recommended. That was something that
16 Congress included in MMA.

17 MR. ASHBY: It wasn't MMA.

18 MR. HACKBARTH: So it was done administratively.

19 DR. MILLER: They got the full market basket and
20 then the change was administrative. CMS made the correction
21 that added another 3 percent or 3.2 or thereabouts to it.
22 So the net impact on year was 6-plus percent.

1 MR. HACKBARTH: Okay. We are finished with this.
2 We will have a five to 10 minute public comment
3 period. Because of the time constraints, forgive me if I
4 interrupt. We really have a lot more stuff to go through
5 this afternoon. So please keep your comment brief and, in
6 addition, if anybody before you in line has made the comment
7 already, don't feel obliged to repeat it.
8 MS. COYLE: Thank you very much, Carmela Coyle
9 with the American Hospital Association. One comment on pay
10 for performance and one on the update.
11 I want to thank the Commission for their work on
12 pay for performance. As everybody is looking at this issue,
13 a lot of resonance on the concept but some real challenge as
14 to how you apply this in a government payment program.
15 I would like to suggest that the Commission may
16 want to consider some discussion in its chapter around what
17 is one of the most important connections here, I think. And
18 that is as you're looking at making recommendations about
19 the size of the performance adjustment and the time line,
20 it's so connected to which measures will ultimately be used.
21 A lot of reference to the 10 measures currently being used
22 as part of the voluntary hospital reporting initiative. As

1 you all may know well, those are all process measures. The
2 equation, I think, changes and could change quite
3 dramatically if you consider structural measures or outcomes
4 measures and would just ask that you may consider that.
5 Being a participant and a leader in the hospital
6 voluntary quality initiative also, would just like to share
7 both the spirit of the collaboration of that effort. It's
8 been great. But also the sobering experience, the literally
9 daunting challenges of the data collection, the reporting,
10 the validation of the data and all the rest that goes with
11 it, I think, for all of us, CMS, the Joint Commission, AARP,
12 AFL-CIO, has been a slower process than any of us would have
13 like to have seen. So I just offer that up.
14 On the update, one comment and that is this
15 conversation on the meaning of low-margin data. It has been
16 suggested that it may be attributable to management
17 problems. I would just like to reflect on the fact that we
18 have many hospitals who have high Medicare margins but lower
19 negative total margins. Yet their cost structure in the
20 efficiency is the same. the importance of recognizing the
21 policy issues, patient acuity issues, payer mix issues and
22 trying to understand what a negative margin means.

1 The commission staff presented, for the first time
2 in some time, a look at the hospital field that shows
3 negative performance under the Medicare program. I think
4 it's the most important finding of today. It was not in the
5 materials handed out but we were all scribbling dutifully.
6 The margin trend has been negative and has now been negative
7 since 1999. That is a four-year negative trend. And we
8 think that's important and would ask the Commission to
9 consider it, as well as the fact that Congress did make its
10 recommendations on the update for both 2005 and 2006 in
11 consultation with many stakeholders after just one year of
12 that, which includes the experimentation some quality
13 reporting. I think it would be unfortunate to move away
14 from that after just one year's worth of experience.
15 Thank you.
16 MR. SPIEDEL: Hi, Paul Spiedel with the Medical
17 Group Management Association. Thank you all for your
18 efforts on the pay for performance matter. It's a very
19 important topic.
20 One specific comment on recommendation number
21 five, extracting quality data from Part D claims. I believe
22 I heard staff suggest what one quality data you might

1 consider looking at is whether or not the patient has filled
2 the script. It's my understanding that most physician
3 practices do not currently enjoy this functionality. some
4 of the larger groups might, be I think most do not.
5 Which means there's probably -- well, obviously,
6 it's a significant impact on quality of care. But
7 additionally, it means some work would have to be done to
8 make it happen.
9 I see two ways you could do that. One, you'd
10 have to have a significant increase in physician and patient
11 communication, which likely would lead to increased office
12 visits, which would impact physician reimbursement through
13 the SGR. Or two, both the physician office and all of the
14 pharmacies that its patients use would have to have fully
15 interoperable electronic health systems to exchange that
16 data, which would require significant investment. So I
17 think it's important to recognize that there would be some
18 significant implications for providers from that.
19 And that point may be illustrative of the
20 importance of Drs. Scanlon's and Reischauer's suggestion
21 that you examine these things very fully. We're very
22 appreciative of all your work. We know that both the staff

1 and the commissioners have put a lot of time and energy into
2 this. I think as you look even more closely at some of
3 these issues, you might tease out more of these concerns
4 that might ultimately change your recommendations.
5 Thank you.
6 MR. HACKBARTH: Okay, we will adjourn for lunch
7 and reconvene at 1:30.
8 [Whereupon, at 12:48 p.m., the meeting was
9 recessed, to reconvene at 1:30 p.m., this same day.]

1 AFTERNOON SESSION [1:37 p.m.]

2 MR. HACKBARTH: Good afternoon. Next up on the
3 agenda are efforts to support adoption of health information
4 technology, and then specialty hospitals.

5 DR. WORZALA: Good afternoon. I'm here to present
6 our work on efforts to support adoption of health IT. Karen
7 and Chad also worked on this with me. It builds on the work
8 we did last June, lots of discussions with people working in
9 the field, both public and private sector, and our expert
10 panel in October.

11 Given all the recent activity in this area, your
12 mailing materials did cover considerable ground. Here in
13 the presentation I plan to be brief and focus on areas with
14 the draft recommendations. Feel free to bring up other
15 topics, of course.

16 Use of IT in health care is well low. However,
17 surveys that many providers are planning to invest. There
18 are many factors that are limiting adoption. These include
19 the cost and the complexity of the market. In addition, the
20 risk of failure is quite a high because successful adoption
21 requires both considerable commitment as well as cultural
22 and work process changes that are difficult to implement.

1 Finally, the way we pay for health care can result
2 in misaligned financial incentives. This means that the
3 individual testing in health IT may not reap all the
4 financial benefits of doing so. Finally, the technology
5 currently used has a limited ability to transfer data across
6 systems. Realizing the full promise of IT does require
7 addressing this problem as well.
8 IT has considerable potential to improve health
9 care, which has led many to believe that the government
10 should step in to support IT adoption. There is limited but
11 suggestive evidence linking IT use to quality improvements,
12 particularly for CPOE, bar coding, and clinical decision
13 support systems. There is little rigorous research on
14 efficiency but the anecdotal evidence suggests that certain
15 kinds of IT may improve it.
16 Research also indicates that a broad adoption of
17 IT that allows clinical information to flow across providers
18 could result in large, system-wide savings. While that
19 sharing of data across settings does not currently happen
20 very often, once developed it would probably help with
21 coordination of care. Finally, as the private sector and
22 Medicare move toward greater accountability for quality, IT

1 will become a valuable tool for performance measurement.

2 So while the case for government support of IT is
3 building, we should be mindful of certain risks as we
4 evaluate efforts to do so. As we've discussed previously,
5 IT investment is generally risky. Therefore, to the extent
6 possible, government funds need to be well targeted.

7 Second, government actions could have unintended
8 consequences. We've heard that successful implementation
9 requires very strong commitment to change. Supporting
10 adoption where that commitment is absent could actually
11 result in failures that set us back rather than moving us
12 forward. Also, as a principle, the government minimize
13 interference in what is essentially a private market.
14 Finally, we need to recognize the physical constraints that
15 are presented in our context chapter.

16 Your briefing materials review a number of actions
17 that the private and public sectors could take or are taking
18 to support adoption of IT. We have chosen to organize them
19 according to three goals. Those are, helping the IT market
20 develop, providing financial incentives, and encouraging
21 sharing of information across providers and patients. I
22 will touch on the actions that are being thought of and some

1 current efforts very briefly. Where additional actions seem
2 warranted we have proposed draft recommendations. I'll
3 circle back to those at the end.
4 The health IT market is constantly evolving. It
5 is also very technical, so providers do not always have the
6 knowledge or the resources that they need to assess their
7 needs and navigate the market. A number of very important
8 efforts are underway to address this problem targeted
9 primarily at physicians in small and medium-sized practices.
10 First, in consultation with HHS, the private
11 sector has begun an effort to certify IT products.
12 Certification should yield information on what these
13 products can do and increase providers' confidence in
14 choosing among them. Other organizations are involved in
15 technical assistance for providers, helping them to assess
16 their names, choose products, and implement work process
17 change. Specialty societies are doing this, and within the
18 Medicare program some QIOs are doing so as well.
19 Given the barriers of cost and misaligned
20 financial incentives, there may be a need to provide
21 financial incentives for the adoption of IT. I'll come back
22 to the role of pay for performance in a minute. Grants and

1 loans to individual providers for their IT systems have been
2 mentioned as a direct way to lower the cost of IT adoption.
3 However, the cautions we spoke of earlier might make large-
4 scale grants and loans of this type risky for the
5 government. They do little to address difficulties of
6 implementation and also risk displacing private capital. On
7 a more limited scale, however, grants can provide lessons
8 learned, and both the government and private sector have
9 been giving grants, with AHRQ recently announcing $139
10 million in grants over the next few years.
11 One of the promises of IT is to make necessary
12 clinical information and decision support available at the
13 time care is delivered. Currently, most health information
14 is shared among actors by phone, fax and paper. With IT
15 systems that can communicate across settings, patient
16 history and results of tests that were performed in an
17 outpatient settings could be available in the emergency
18 room. Similarly, changes to medications that were initiated
19 during a hospital stay could be available to a primary care
20 physician along with the notes documenting why.
21 Getting from here to there, however, takes
22 technical and organizational advances. So what actions can

1 the government and private sector take to facilitate that
2 evolution?
3 First, HHS, foundations and others have put
4 considerable effort into developing standards that will
5 allow IT systems to communicate with each other. These
6 standards address things like the content of data, the
7 vocabulary used to describe information, and how messages
8 are sent from one system to another. The development of
9 standards is crucial and the commitment to continue this
10 work is high.
11 Second, as standards are developed it becomes
12 important to ensure that they are used. I will return to
13 this issue later.
14 Third, health care is generally a local
15 enterprise, therefore, information really needs to flow
16 between providers within a community. I will also return to
17 the idea of encouraging community efforts a little bit
18 later.
19 Finally, some have noted that hospitals could be
20 well positioned to exchange data and facilitate adoption of
21 IT by allowing community physicians to utilize their IT
22 systems or by providing them with other IT resources.

1 However, the Stark and the anti-referral laws generally
2 prohibit this kind of arrangement.
3 There is a narrow exception to Stark for
4 community-wide health information exchange but it requires,
5 among other things, that hospitals share these resources
6 with all providers in the community, and most hospitals are
7 not likely to want to do this. So we believe the Secretary
8 should revisit the restrictions and provide guidance on
9 situations that do and do not comply with these laws,
10 otherwise the existing regulations could stifle important
11 advances in both information exchange and adoption of IT.
12 The MMA has directed the creation of safe harbors and
13 exceptions for these laws in the context of e-prescribing,
14 which may provide an opportunity to clarify how they may
15 apply to other uses of IT.
16 Now I will circle back on the areas where we have
17 proposed draft recommendations. You talked this morning
18 about pay for performance and noted that it is closely
19 linked to IT. I just want to let you know that for January
20 we are planning to bring these two topics together in one
21 chapter. It is a bit of a work in progress.
22 There are a number of ways in which pay for

1 performance could encourage adoption of IT. First, we could
2 include measures of IT adoption into the pay-for-performance
3 program.
4 Second, providers may find it easier to report on
5 quality measures using IT systems. This could motivate
6 adoption whether or not specific IT measures are used.
7 And third, the potential for additional funds from
8 good performance helps build the business case for IT to the
9 extent that IT helps achieve and report on the quality
10 measures.
11 So what kind of IT measures could be used in pay
12 for performance? There are basically two concepts here.
13 The first is to pay for IT adoption or to include measures
14 of IT adoption, which is really rewarding the acquisition of
15 a tool. We believe, however, that is to reward the positive
16 outcomes that derive from the actual use of the tool, or at
17 least uses that are linked to improved quality.
18 So that leads to the second concept, which would
19 be to reward functions of IT that lead to improved quality.
20 This approach would reward processes linked to desired
21 outcomes. It would also allow providers to meet the measure
22 with or without IT. I think this is important because

1 adoption of IT is an evolution and we don't want to limit
2 providers' ability to attain this kind of measure, at least
3 at first. Of course, using IT would make it easier to
4 achieve and report on functional measures, so there is still
5 an incentive for adoption. Over time there is room to move
6 to measures of actual IT use.
7 The Bridges to Excellence program does use some of
8 these concepts in its physician office link program. CMS is
9 currently working with them and NQF to further develop these
10 measures for use in a demo and to operationalize them.
11 Karen gave you some examples of this kind of measure this
12 morning for physicians. I won't go through those here, but
13 they are facilitated by use of IT and can be done without it
14 as well. In a hospital setting, an example of this kind of
15 measure would be ensuring that physicians check for drug-
16 drug interactions and allergies when placing pharmacy
17 orders. This is really the link between use of CPOE and
18 quality improvement. There you're pulling out the function
19 as opposed to talking about the technology.
20 So that brings us to the following recommendation.
21 Congress should direct CMS to include measures of function
22 supported by the use of information technology in Medicare

1 initiatives to financially reward providers on the basis of
2 quality.
3 Within this recommendation we think the first
4 place to start is the physician setting, given the central
5 role physicians plan in improving quality, and the
6 importance of encouraging IT in this sector. Some hospital
7 measures might be possible, particularly surrounding CPOE
8 functions. Other settings might need more development.
9 We see no spending implications from this
10 recommendation. For beneficiaries, we would expect some
11 improved quality of care. And of course, some providers
12 could receive higher or lower payments depending on the
13 quality of their care in any pay-for-performance initiative.
14 I want to touch briefly on some implementation
15 issues surrounding IT measures within pay for performance.
16 First, you do need a process for measure selection an
17 ongoing development, and you do need some coordination
18 between purchasers over measures ideally, and you would
19 want to work with the IT vendors to ensure that their
20 products include the ability to report on and to support the
21 functions in the measures.
22 The next few slides revisit actions to increase

1 sharing of data across providers. A major focus of activity
2 has been development of standards and that is a prerequisite
3 to solving the technical issues of how to share data.
4 Nevertheless, there's limited sharing of data across
5 providers at the moment, in part because these standards are
6 not yet in widespread use. Successful implementers,
7 including Geisinger, have noted that physicians place great
8 value on electronic access to information that was generated
9 outside of their own office. That would include laboratory
10 data, radiology reports, and pharmacy data. Having access
11 to this kind of information increases physicians'
12 willingness to accept IT.
13 However, these providers and also existing
14 community networks have reported that outside information
15 generally is not sent using data standards, and that makes
16 it very difficult to incorporate the information into their
17 own EHR systems or data repositories and to have it
18 available when it's needed. One example of a place where
19 standards are well developed but not widely used is clinical
20 laboratory data. Therefore, we can make a significant step
21 in achieving the goal of sharing clinically important data
22 by encouraging the use of standards in reporting lab

1 results.

2 This brings us back to a draft recommendation you
3 discussed this morning, which was that CMS should require
4 those who perform lab tests to submit lab values on claims
5 or separately using common vocabulary and messaging
6 standards. I'll focus on the last clause of this
7 recommendation and also note that as with all protected
8 health information you would also need to ensure the privacy
9 and security of data flows here.

10 But the idea behind the final clause of this
11 recommendation is that requiring use of vocabulary and
12 messaging standards for data submission to CMS would
13 spillover to use in reporting information to providers since
14 it's much more efficient for the labs to operate using a
15 single set of standards. Then the providers receiving the
16 information can easily incorporate it into their processing
17 EMRs or data repositories, and also share it with other
18 providers that might need it.

19 Currently, most labs have internal codes for
20 identifying their tests and reporting results to clients.
21 Codes are unique to each lab. However, vocabulary or coding
22 standards, such is LOINC, do exist, and LOINC in particular

1 has been endorsed by the American Clinical Lab Association,
2 the College of American Pathologists, and it is used as an
3 alternate code set by many of the major labs. It's also
4 been adopted by the federal government for us in its health
5 programs, including by CMS. Messaging standards such as HL7
6 are also generally accepted.
7 What would it take to achieve this standard? The
8 first step is to map local codes to the standard codes.
9 This is already being done by large labs and is probably not
10 an insurmountable task.
11 Second, it's necessary to ensure that laboratory
12 information systems can both accommodate these codes and
13 also transmit them. That may require some work on the part
14 of vendors, although we've been told that many systems
15 already do this.
16 As I mentioned, larger labs are moving fairly far
17 along this trajectory so it should be easy for them to do
18 this fairly quickly. It may, however, be necessary to have
19 some sort of phased implementation for smaller labs,
20 including those in hospitals and physician offices.
21 The last area I want to community information
22 exchange. Here we are talking about developing the

1 organizations and technical solutions to allow information
2 to flow among providers at the local level; physicians,
3 hospitals, and others providers, so it's available when
4 needed.
5 In addition to potential quality improvements, we
6 could also improve system and provider efficiency through
7 fewer repeat tests, and administrative efficiency. Finally,
8 being part of a local network and really having access to
9 information from other sources could encourage IT adoption
10 by individual providers.
11 Despite the importance of local data exchange
12 there are few examples currently operational. We did hear
13 about the one in Indianapolis in October. There are many
14 more under consideration and being developed across the
15 country. Some are being supported by grants, such as those
16 that AHRQ has made to five states for development of
17 statewide information exchange. In addition, the strategic
18 framework put forward by HHS this summer discussed the
19 importance of fostering regional collaborations.
20 So to further encourage clinical data exchange one
21 idea would be to provide additional resources through a loan
22 fund. Criteria for award would need to be established.

1 Specifics could include the types of providers involved,
2 their level of commitment, including financial commitment,
3 what kind of data they would share, how they would protect
4 the privacy and security of data, and how organizations
5 would work together, and how the projects could be sustained
6 over time. Evaluation criteria could also be developed to
7 further our understanding of what works.
8 The loan fund could be time-limited, recognizing
9 that we're encouraging, development, not ongoing
10 maintenance. The specific mechanism for the fund could be
11 left to the Secretary to propose. For example, would it be
12 a loan fund actually administered by a government agency or
13 a program run through private banks as is done for student
14 loans?
15 That brings us to our second and final draft
16 recommendation. The Congress should authorize an
17 appropriated loan fund for support of community health
18 information exchange projects. The spending implications of
19 this are a short-term increase in spending over the
20 baseline. For beneficiary and provider implications there
21 is potential for improved quality and coordination of care,
22 and some providers would benefit from the loans.

1 MR. DeBUSK: Under the pay for performance
2 examples there it says, ensuring physicians check for drug-
3 to-drug interactions and allergies when placing pharmacy
4 orders, inpatient and outpatient.
5 This has even more far-reaching advantages. One
6 of the things that is most difficult is all these pharmacy
7 programs. These pharmacies are not hooked together with
8 information. You may have a patient that is getting
9 pharmaceuticals from two or three different doctors and two
10 or three different pharmacies, and by approaching this in
11 this manner this has far-reaching value in trying to begin
12 to straighten up that whole area, because with the cost of
13 pharmaceuticals, and that being such an important part of
14 it, until that piece is cleared up it is going to be hard to
15 arrive where we need to arrive.
16 DR. NELSON: This is good and I support the
17 recommendations. There are a couple of areas that I think
18 need amplifying.
19 From what I understand, while a lot of the
20 attention is being given to the cost of the software and the
21 installation, inadequate attention is being given to the
22 cost of maintenance, and the impact on productivity; the

1 number of patients that a clinician can see in a day. There
2 are data from VA -- I talked to a person in the VA and they
3 said that with the installation of their electronic health
4 record productivity dropped 50 percent, and it's still down.
5 Now I don't know whether that's across the entire
6 system. I don't know how bid the denominator is. But I
7 think that some examination of the impact on reducing the
8 number of patients that can be seen in a day, particularly
9 during the phase-in period, is important, and some
10 information on that can be gotten from the VA and from some
11 of the public large integrated systems that are utilizing
12 the electronic health record.
13 I'd like to see some mention of an alternative
14 approach. That is, an open source, web-based electronic
15 health record that is developed and maintained by the
16 government itself, at least for programs for which the
17 government is the purchaser. It seems to me that for
18 patients or clinicians who are authorized to do so, to have
19 access to the electronic health record from any computer
20 that can get into the web would offer a lot of advantages in
21 terms of patients being able to enter data into their
22 electronic health record, their blood test, their blood

1 sugar results, their blood pressures or whatever. It could
2 avoid a lot of the interoperability headaches if that were
3 developed.
4 Finally, I'd like to see us make a recommendation
5 about funding the office of the coordinator. Now it may not
6 be timely, it may not be politically prudent to do so, but I
7 think this should be considered, because that's a very
8 important function that currently hasn't been funded.
9 I heard a physician who is in a system that uses
10 an electronic health record say that downstream he would
11 like to see a study on the number of deaths caused by an
12 electronic health record. It almost certainly would be less
13 than those saved. But practitioners really rely on their
14 medical record, and if they have an office full of patients,
15 maybe some of whom traveled a long way to get there, and
16 their record is down, they are almost certainly going to do
17 the best with what they've got, which is recall. In his
18 view, at any rate, that risk wasn't negligible. Some of
19 those recollections and guesses may be faulty it terms of
20 what medications they are on or so forth.
21 DR. CROSSON: I will make just a comment on the
22 productivity issue and then the other point that I wanted to

1 make. We obviously have spent a lot of time looking at this
2 issue. We have had two pilots in place in our northwest
3 region and our Colorado region over five years and we're in
4 the middle of rollout in other areas. So we are looking at
5 this, and as you can imagine our physicians are fairly
6 interested in this issue.
7 It is complex. One of the things we have found is
8 that there is an initial fall in productivity, particularly
9 for physicians who are not skilled in typing, and there's a
10 period of time during which the presence of the computer in
11 the examination room creates a new dynamic that both the
12 doctors and the patients have to learn.
13 But what we've generally found is that for most
14 specialties that re-equilibrates back to normal in a matter
15 of weeks, no more than a month or so, with one exception,
16 and that has to do with internal medicine where the
17 complexity of the patients as well as the number of tests to
18 be reviewed and communicated is considerably greater than
19 for other specialties. In some areas of internal medicine I
20 think there is a productivity loss that remains. It's in
21 the category of single digits. But for the other
22 specialties --

1 MR. HACKBARTH: Remains after five years or after
2 --
3 DR. CROSSON: I don't know that we've got that but
4 probably for six months or more. That one tends to be
5 related to age also, and practice styles, and learning new
6 ways. But there's a difference between internal medicine
7 and all the other specialties in that regard. But for most
8 specialties the rebound back to normal productivity is
9 pretty quick. I don't know that will be everybody's
10 experience, but that's been ours.
11 A point on draft recommendation number one. This
12 is complementary to the comment I made this morning in the
13 pay-for-performance area because clearly these are linked
14 and I know there is going to be some more work on that. The
15 recommendation talks about including measures of functions
16 supported by the use of information technology as part of
17 pay for performance. I absolutely agree with that.
18 But I think there is another point that shouldn't
19 be missed, and really goes beyond that. It goes beyond it
20 in terms of time and implications. In other words, it would
21 be further down the line but potentially they have more
22 implications. And that's that the essence of being able to

1 do pay for performance and to extend it to large numbers of
2 physicians and to deepen it so that is actually represents a
3 better biopsy of the care, if you will, is really only going
4 to be achieved once the systems are in use generally.
5 Just to give an example, if you wanted to take a
6 major health condition, high blood pressure, and what we
7 want to do is to have people have their blood pressure
8 taken, and when it's high to have it managed with
9 medication, diet, exercise or whatever. Then we want to
10 know the relationship between that, or the absence of that,
11 and further complications like strokes.
12 One of the confounding problems is simply that we
13 don't have people's blood pressures. We don't know what
14 they are because they are contained within the medical
15 record. To extract that by having someone go into the chart
16 and read it and write it down and put it into a computer
17 database is extremely expensive. The presence of a medical
18 record where the blood pressure is entered every time the
19 patient accesses care for any reason makes it much more
20 available and at virtually no cost.
21 So there are examples in many health conditions
22 where you simply can't get -- I suppose you could tack it

1 onto claims data like other things we've talked about, but
2 essentially it is not just rewarding -- in the beginning it
3 is putting the systems in place or obvious processes that
4 come out of the systems, to a payment system. But
5 eventually it is going to be linked to measuring things
6 which are only accessible through the use of the system, and
7 this would be an example. Somewhere, whether in the text or
8 in the recommendation I hope we can express that because in
9 the end that is going to be where this lives.
10 MS. RAPHAEL: I wanted to speak to the
11 productivity issue because I think that is an important
12 issue. We had a similar experience when we introduced our
13 electronic health record, which is also tied to the OASIS
14 assessment, because we have a 29-page assessment that we
15 have to do. We did have a drop-off in productivity, but we
16 did rebound, the same point that Jay described. I think
17 there is a period, but I don't think it goes on it
18 definitely.
19 I would say there is an issue that we had not at
20 all anticipated, which is that some of the patients really
21 say to our nurses, are you taking care of me or are you
22 taking care of the computer? This is my time with you and

1 it seems to me that all you're doing is recording
2 information in the computer, which is something we had not
3 anticipated. So we have some people who don't point of
4 service, which is defeating what we were trying to do, that
5 they would record all of this real-time, not later when they
6 have to recollect.
7 So that has been something that we have been
8 trying to tackle, and it is something to keep in mind.
9 Particularly we find it with older patients, those 85 and
10 older who have a lot of issues and really want you to listen
11 to them. This is the high point of their day when you are
12 there. So I do think that is important.
13 The other point I did want to make is I really
14 believe the most important recommendation is that our loans
15 should be targeted to setting up community health networks,
16 because we are trying experiments now where upon admission a
17 hospital will send us information, or we can electronically
18 exchange information with a physician. It is very powerful.
19 It really makes a huge difference to be able to do that,
20 because patients' situations are changing constantly, and
21 being able to say to a physician, there is a problem with
22 the medication, we think someone needs to come in and see

1 you, we want to schedule an appointment and really move to
2 do that has changed quality in very tangible ways.
3 But I don't think those things are going to happen
4 where it's not provider-based without some kind of external
5 pressure. I think that if you want to make outcomes, you
6 are more likely to adopt information technology if you think
7 it is going to make a difference in your performance. But
8 this is an area where I really do think we need some extreme
9 pressure and possible loans.
10 MR. HACKBARTH: On the computer in the room issue,
11 the experience of my colleagues was that it changed the
12 dynamics, as Jay said. There were some patients who perhaps
13 never liked it, but with other patients it was actually an
14 engaging tool, the ability to graph information, show trends
15 in various lab results and the like over time actually aided
16 the conversation and helped the physician make the points
17 they were trying to make.
18 MS. DePARLE: I just wanted to strongly endorse
19 what Alan said about amending recommendation one to say
20 something about funding the Office of Information Technology
21 at HHS. If this is as serious as I think we mean it to be
22 and a national priority, that office should be funded.

1 MR. HACKBARTH: Maybe, Chantal, you should say
2 just a word about that. I know some people have seen the
3 press reports about what happened in the appropriations bill
4 but not all commissions may be aware of where that stands.
5 DR. WORZALA: My understanding is that the
6 President's budget requested $50 million for the Office of
7 National Coordinator for Health Information Technology or
8 ONCHIT as it's called, and somehow in the appropriations
9 process, although some funds had been included on the House
10 side, they weren't on the Senate side, and in reconciliation
11 it was not included in the omnibus bill that came out.
12 There is funding for the office, I believe to the level of
13 $4 million or something like that. The additional funding
14 was meant to go for grants and loans and contracts.
15 MR. SMITH: Two quick points, one about a
16 recommendation we did make or we are considering and one
17 that I wonder if we should consider. For all the reasons
18 that Carol said it strikes me that we ought to seriously
19 consider over time, and with care about the pace of
20 introduction, but that we ought to consider having the
21 capacity to manage and update an electronic medical record a
22 condition of participation. Carol suggested that the

1 incentive here needed to be financial. I don't think we
2 have any evidence that it needs to be financial. There are
3 potential downstream benefits to the investor, whether it is
4 the physician investor or the hospital investor. If we
5 start down that road and learn that there are financial
6 problems, we can address those without any serious loss of
7 pace.

8 But for all of the reasons that we have talked
9 about for the last year, Chantal, much of what is in the
10 materials that you sent us, it seems to me we ought to up
11 the ante here, and use Medicare's power as a player in this
12 marketplace, to insist that we go down this road. We don't
13 have any more powerful tool than condition of participation.
14 Along with and subsequent to, the development of standards
15 and protocols and interoperability standards it seems to me
16 we ought to say, this is part of what you have to be able to
17 do to participate down the road, and then put a timeline on
18 that.

19 Conversely, I'd be perfectly prepared to support
20 recommendation two, which argues that we ought to build this
21 community infrastructure and the highways necessary, and
22 that we ought to use public resources to do it, if we had

1 any evidence that the absence of public resources is the
2 obstacle to getting it done. When the expert panel met with
3 us a couple months ago that wasn't raised as the problem.
4 There were many more institutional relationship problems and
5 universality problems than financial problems.
6 There is no contrary argument, Chantal, in your
7 presentation that suggests that we've got a real financial
8 problem here. We appear to be solving a financial problem
9 without having argued or adduced any evidence that there is
10 one. So in the absence of that I'd be disinclined to create
11 another load fund. There may be some advantage. I suppose
12 it's a little bit like a tax break, whether or not I need
13 it, I'll use if you pass it. But it seems we ought to make
14 a stronger case that access to financing is the obstacle
15 before we provide it.
16 MR. HACKBARTH: As someone who's interested in
17 this concept but not yet wedded to it, I do think some more
18 information would be helpful that perhaps we can get from
19 Clem McDonald and some other people involved in this about
20 to what extent there are costs that are difficult to cover.
21 The information we have, there are very few of these
22 community networks in existence and that would suggest that

1 there may be some problems out there and that not all is
2 well. So let's nail that down.
3 The reason that I wanted to at least have it here
4 for discussion, and we may decide not to recommend it in
5 January, is that it seems to me that there may be an issue
6 that -- we already have issues with individual providers
7 having sufficient incentive to invest in their own computer
8 system software, work re-dos and the like. To what extent
9 are there additional costs to create a community network
10 over and above those that are truly public goods that may
11 not be developed, may not be adequately invested in without
12 some public support? That's the question, and I'm offering
13 it as a question as opposed to an answer at this point.
14 DR. REISCHAUER: Do we have evidence that the
15 average provider in a community like Indianapolis, there's a
16 higher acceptability of IT and the use of this if one of
17 these networks exists? Because it strikes me that there
18 might be an externality here. There might not be a
19 financial barrier, but if you put some money on the table it
20 what happen faster and the benefit of it would be a more
21 rapid spread of something that we think will improve health
22 care.

1 DR. WORZALA: I think that's a good point. Just a
2 couple quick comments on that.
3 First, I think there is a real cost to this.
4 There are very few of these things around because it is hard
5 to have a collective effort where you have a collective tax
6 to do something that will support the public good and the
7 collective good, but who will bear the cost? I think it's a
8 fairly classic area where public investment is needed. I
9 will certainly go out and talk to Santa Barbara and
10 Regenstrief about their cost. These are multi-year
11 developments of projects that, I know Regenstrief, for
12 example, is funded by a foundation. So I will certainly
13 bring you back information on that. But there are clearly
14 costs there and they go over several years. Again, it's
15 something where it's very hard to tax individuals for
16 something that ends up being a collective good.
17 MR. DURENBERGER: My comment was going to be on
18 the context. I don't necessarily see this as a stand-alone
19 subject. Anybody can address it, and it gets to be a little
20 bit like the elephant. In the context of the real problems
21 we have in front of us, this needs to be hooked to
22 performance in some fashion, be it a subset on one of the

1 tools like profiling or resource use or something like that
2 so that we build a case for it.
3 With regard to the Indianapolis example, and I've
4 been there a couple of times and I've known Clem a long time
5 and I was there a couple -- I think you should go. I don't
6 have all the answers.
7 But the answer to Santa Barbara and the answer to
8 Indianapolis is people in the community who realized that
9 both the cost and the quality of health care had to change,
10 made the decision, and developed the dynamics in that
11 community to make things happen. It was a combination of
12 having a Regenstrief with the clinical informatics pioneers
13 right there to give you the language and to encourage you to
14 think this is not like trying to send a rock to the moon and
15 things like that. It was also the presence of major
16 companies in the medical field that were willing to invest,
17 not because they had products involved but because they had
18 employees all over the community that in one way or another
19 would --
20 Then it was the primary care doctors, and this
21 network is referenced in here. And it was community health
22 centers. It was just linking up -- not starting at the top,

1 the high expense stuff, but they were linking up primary
2 care, they're linking up community health centers. And then
3 it was a very creative Medicaid director in Indiana with a
4 lot of pressure. And I have heard her say many times, the
5 only way to keep the cost pressures off of Medicaid is to
6 enhance the quality of the performance of the system, and
7 that's why we're in it.

8 So it is in that context that I would love to see
9 us present the role of information technology. When I
10 looked particularly at that second draft recommendation,
11 that comes right out of the 1960s; let's create a loan fund
12 and let's scatter money around the country and things like
13 that. Indiana valued getting one of those of five grants
14 from AHRQ because it was recognition. Not because they had
15 to have $50 million or something like that to make something
16 happen, but because it was recognition that this cross-
17 section of the community was about to do something that was
18 unique in the country.

19 So the ultimate decision it seems to me, whether
20 it is Indiana or wherever it is, is going to be a
21 combination of motivation and incentives, and it is going to
22 come from the community up, because every one of these

1 hospital systems can make these decisions. Then the
2 question will be, will the health plans raise the money to
3 help them, or do you have to waive for the federal
4 government to do it? So if in some way we can express that
5 it is an important thing to do but not try to suggest that
6 the national government has some responsibility to make it
7 happen, but in effect to find out what is its most
8 appropriate role in facilitating this for the purposes that
9 we think as a Medicare program, whether it's physician
10 practice or whatever.
11 MR. HACKBARTH: One of the differences between a
12 loan and a grant is that if you take out a loan you need to
13 have some sort of plan for how you are going to pay it back,
14 as opposed to I got money and I'm going to spend it and we
15 will see what happens tomorrow. So ideally what you would
16 have with a loan program is people developing a business
17 model of how somebody can take over responsibility for
18 sustaining this, and charge a fee, and collect revenue that
19 allows them to service the loan and make it into some sort
20 of a business. That's the notion I have in my head at least
21 of how this might go.
22 A couple people at different times have raised the

1 issue of the interrelationship among these various topics.
2 They are just all over the place, the connections and that
3 is important for us to try to get right. I thought I heard
4 you say, Chantal, that ultimately this information will be
5 packaged in the pay-for-performance chapter; is that right?
6 DR. WORZALA: Yes.
7 MR. HACKBARTH: I'm glad to hear that. I think
8 that is a critical link. As I've said and many other
9 commissioners have said often, having this information
10 infrastructure is going to be a critical, if not maybe the
11 most important determinant of how quickly we can move down
12 the pay-for-performance path because it will address the
13 cost of information issue. So it's good that's going to be
14 combined.
15 DR. WAKEFIELD: I really like the orientation
16 toward community and the focus that is put on that, both in
17 the background material that we were provided and also in
18 your overview here. I don't know if you've had a chance to
19 take a look at it or not but the Institute of Medicine
20 released about a month ago a new report as part of their
21 quality series focusing on health care in rural America and
22 improving quality. There's an entire section of that report

1 that talks about IT.

2 It talks about potentially some of the

3 opportunities for moving, maybe even more expeditiously in

4 some rural communities, with a community-based orientation.

5 But it also talks about some of the unique barriers and

6 obstacles that are absolutely present in some rural areas

7 and not so much in urban areas. So I would just hope that

8 that informs the thinking and the layout of at least some of

9 the text where you think it makes sense to reference it in

10 the document that does go forward. It's brand new and

11 captures a few key concepts.

12 With regard to the loan recommendation, I don't

13 know that you can get there but it does seem to me that to

14 the extent that there could be any sort of targeting of that

15 -- and I don't know that one could do that -- but that we

16 ensure that those communities and organizations that are in

17 greatest need actually have access to some sort of financial

18 support that will allow them to move on the IT front.

19 Particularly because, to the extent we do link that to

20 payment policy we've got to make sure that they can get

21 their on the front end.

22 Some of the examples that you gave in the text

1 that are very good, the AHRQ example with grants was a
2 grants match opportunity. I know personally of facilities
3 that would have loved to have gone there but financially, at
4 least at that point in time, their perception, they couldn't
5 match. So if there's any way that we can frame this to a
6 way of targeting this toward those most in need that might
7 be something to think about.
8 Also when I think about loans I'm thinking about,
9 if they couldn't match then how are they going to compete
10 for a loan? And is there a way to think about or give a nod
11 to loan forgiveness? For example, if X is accomplished, or
12 something is tied to this investment in terms of performance
13 and quality, then could a piece of that loan be forgiven on
14 the back end? That's probably more complicated than we can
15 get into here, but holding organizations absolutely
16 responsible for achieving outcomes if they have access to
17 any public funds, and then recognizing that maybe that
18 degree of need isn't the same across-the-board.
19 DR. WOLTER: This is really a nice chapter,
20 Chantal. I think the areas you identified where policy can
21 advance technology, really outstanding, so my next comment
22 is a nit-pick. That is on page 18, given the scope of

1 existing grants, more may not be needed. Relative to what I
2 said before, I think really the total of grants thus far is
3 minuscule in the context of what is really going to be
4 needed to implement technology.
5 Now it may well be that there is capacity in the
6 industry, as David was suggesting, although I would argue
7 that that is pretty uneven capacity, and I think there are
8 many places, whether it's small physician offices or smaller
9 hospitals that are going to be very hard-pressed to come up
10 with this funding. I am actually quite certain of that. So
11 I'd make a pitch again as we look at our update framework
12 going forward that technology piece may continue to be
13 important although we may want to tighten up how it is
14 linked to actual implementation of technology.
15 Just a couple other things. I can't emphasize the
16 importance of some increased flexibility in Stark and
17 kickback regulation, because if there is some capacity on
18 the part of large players to work with physician offices or
19 to work with smaller rural hospitals, these right now are
20 such huge barriers. In fact if I'm remembering the
21 community hospital presentation from Indianapolis, they're
22 still gun-shy about how to promote access amongst the

1 players until they have some of that sorted out. That's
2 well-stated here already but I just wanted to emphasize
3 that.
4 Also if we're going to move to interoperability,
5 the whole issue of standards and getting vendors to realize
6 that they really need to be making the move toward
7 interfaces and other abilities to deal with legacy systems
8 really is important.
9 Then lastly, the whole intersection with the
10 privacy and security regulations is critical as well. We
11 are running into a lot of difficulty implementing our system
12 across the region as we work with other facilities, in terms
13 of who has access, how do we protect privacy and security,
14 what additional software has to be purchased to allow us to
15 run audits. There's a huge cost there and a huge area of
16 regulation to comply with, so that's another important
17 issue.
18 DR. MILSTEIN: I think the direction of the
19 chapter is terrific and I'm very supportive. These are
20 really a couple of suggested tweaks, and you can probably
21 guess in what direction, and also a couple questions.
22 First of all, I think the need to specifically

1 incentivize IT is a symptom of the fact that we have a long
2 ways to go in terms of incentivizing the right things in the
3 Medicare program. If we were incentivizing the right things
4 then you wouldn't have to separately incentivize IT.
5 For example, if you look at the analysis of return
6 on investment, it's whoever is reaping the benefits of
7 greater longitudinal efficiency that benefits primarily from
8 IT, especially for smaller physician practices. If we were
9 incentivizing smaller physician practices for superiority
10 and longitudinal efficiency then it would completely change
11 the economics of return on investment in IT and it would
12 make sense for them to do it.
13 I support the prior notion that the reward of IT-
14 enabled functions should be short-term and I would vote for
15 very short-term rather than intermediate short-term. I
16 really like the idea of going to very quickly incentivizing
17 performance or incentivizing a fully interoperating
18 electronic health record. I'll come back to that in a
19 minute.
20 A second comment is some of the negative
21 productivity effects that have been described that are
22 associated with implementing IT in a particular physician

1 office setting, those effects are usually measured without
2 regard for new IT-enabled opportunities to further re-
3 engineer clinical processes. Once you've got a good, smart
4 EHR operating, that enables you to take quite a few low-risk
5 ambulatory interactions and allow medical assistants and
6 nurse practitioners to do them. That's seldom factored into
7 the equation that suggest that this is a major impediment to
8 productivity.
9 The third area is maybe just a question. We
10 incentivized in our recommendations one facet of
11 interoperability standards. That is we focused on the labs.
12 I'm curious why we didn't focus on the other facets that the
13 Secretary of HHS has already endorsed. I'm thinking about
14 DICOM for imaging. If you are going to bill for an imaging
15 study, why not -- you might have some DICOM-formatted
16 results that go along with it.
17 Lastly, and this really ties into my first
18 comment, if we do, sooner rather than later, incentivize
19 interoperating rather than interoperable, interoperating IT
20 systems, then you don't need to then subsidize the start up
21 of these networks. The private sector can see that if
22 within four years it becomes a Medicare condition of

1 participation to have an interoperating EHR, then the
2 private sector can -- then the capital needed from the
3 private sector to respond and build these EHRs, because they
4 know they have a lot of customers within four years of
5 stepping forward. So it does reduce the need for setting up
6 the additional grant program.
7 DR. WORZALA: Just a quick comment on the lab. I
8 think you need a vehicle, and I certainly support the notion
9 that you need to move from laboratory to other sources of
10 information too. But since we have this recommendation on
11 the lab value, that gives us the vehicle. But I will beef
12 up the discussion of other types of information flow as
13 well.
14 MS. BURKE: I agree, it's a terrifically useful
15 chapter and gives us some serious things to think about in
16 the context of what we're trying to do in moving this
17 forward.
18 Having said that, I in fact would not support this
19 recommendation, for a variety of reasons. It is not in any
20 way to suggest that I don't think it is important that we
21 clearly state our desire for an increase in the amount of
22 information that is exchanged, or in the need to invest in

1 the technology and systems necessary to allow that to occur
2 increasingly.
3 I oppose it for a couple of reasons. One, it may
4 just be a timing issue. But as I read the chapter, you cite
5 about $150 million worth of investment in this kind of
6 activity that has already occurred. The department has the
7 authority to invest. You see the Department of Agriculture
8 is invested. There are a variety of other sources that are
9 invested. I think the likelihood in the near term of an
10 appropriated account being created that would be anything
11 close to $150 million, given the current budget concerns, is
12 reasonably unlikely. Not because it is not an important
13 issue but because of all the other issues that are
14 confronting us.
15 I also think that creating loan programs bring
16 with them a whole series of issues about how one chooses
17 among different priorities in terms of the allocation. The
18 administrative complexity of running a major program bring
19 along a lot of issues that force lots of politics to play
20 out in terms of how one might go about allocating that.
21 I think we can achieve this in a different way,
22 and I think more realistically, at least in the near term,

1 through using what mechanisms are currently available, and
2 also looking to the private sector. Again, it is not that I
3 don't agree with what we're hoping to do nor that we ought
4 not incentivize people. We've talked about a lot of issues
5 with respect to the update factors, with respect to the
6 adequacy of the payment and how we are asking people to do
7 things and creating incentives for them to do so in terms of
8 the payment system.

9 I just don't think at this point in time that this
10 particular proposal makes a great deal of sense, nor is it
11 likely to be realized in the near term. But I think we
12 ought to look at other ways of creating the same reality
13 through existing programs or through flexibility that the
14 Secretary currently has. But setting aside essentially
15 rifle shots, freestanding appropriated accounts, is a tough
16 thing to do, and I'm not sure that right now is the time
17 that I think the Commission ought to be in fact suggesting
18 that as compared to looking at other ways to achieving the
19 same end.

20 DR. NELSON: I didn't want my earlier comments to
21 be misinterpreted. I understand the importance of IT in
22 reconfiguring the way health care is delivered, and I fully

1 support that. Obviously, the downstream potential for
2 increased productivity is there as teams are developed and
3 so forth. But for the solo and small-group practitioner,
4 particularly in primary care, their concern is what about
5 next year? The up-front investment and the decreased
6 productivity may be enough to determine whether they can
7 stay in Panguitch or whether they have to move to Salt Lake,
8 and that should be important from the standpoint of our
9 mission.
10 MR. HACKBARTH: Thank you, Chantal.
11 Next up is specialty hospitals.
12 MR. PETTENGILL: Good afternoon. In this session
13 we're going to talk about some further results and draft
14 recommendations for the mandated specialty hospital study
15 which is due in March. In previous meetings we have
16 discussed the first four topics listed on this slide. Now
17 we would like to turn to potential solutions for some of the
18 problems that we have identified. I will talk about
19 potential changes in Medicare's prospective payment system
20 and Ariel will then talk about other non-payment options.
21 At the October meeting we demonstrated that the
22 payment rates in Medicare's hospital inpatient prospective

1 payment system result in large differences in relative
2 profitability across and within DRGs. These differences in
3 relative profitability create financial incentives for
4 hospitals to specialize in relatively profitable DRGs, and
5 also to select low severity and relatively low-cost cases
6 within DRGs.
7 These relative profitability differences arise in
8 part because of a failure of the DRGs to fully account for
9 differences in severity of illness that affect the cost of
10 care. This problem might be addressed by making severity
11 refinements to the definitions as we have illustrated using
12 the all-patient refined DRGs.
13 Differences in relative profitability also arise
14 because of problems with the relative weights. One problem
15 with the relative weights is that they're based on charges
16 which reflect systematic differences in markups for
17 ancillary services such as laboratory services, imaging, or
18 supplies compared with the markups for other services. This
19 problem might be addressed by substituting cost in place of
20 charges as the basis for the weights.
21 An additional problems is that standardizing
22 charges, as we do now, to eliminate differences in cost

1 across hospitals is not fully effective. This problem might
2 be addressed by using relative value weights instead.
3 A third problem is that charges for most cases
4 that are paid as outliers are included in the calculation of
5 the DRG relative weights. This causes the weights for high-
6 cost categories to be overstated because that is where the
7 outlier cases are concentrated. This problem could be
8 remedied by reducing the weights for each DRG DRG
9 proportionately.
10 To evaluate these potential policy changes we
11 simulated their effects using our file of more than 10
12 million claims. We used our inpatient prospective payment
13 system payment model for fiscal year 2002 to estimate the
14 payments for each claim. We also used previously developed
15 estimates of cost for each claim, which were based as you
16 recall on taking charges and reducing them using the
17 appropriate cost-to-charge ratio from the hospital's
18 Medicare cost report for the same time period.
19 We couldn't simulate every possible combination of
20 these four changes so what we did is we selected the
21 combinations that are shown on this slide with the idea that
22 we could show the effects of each policy individually and

1 also show the effects of logical combinations of policies.
2 Perhaps the smallest change that you might make would be to
3 use hospital relative weights in place of standardizing the
4 charges with no other changes. We took that as the first
5 model.

6 The second model adds severity differences to the
7 DRGs, but the weights are still based on charges and the
8 outlier policy remains as it is currently.

9 The third model adds cost-based weights in place
10 of charge-based weights.

11 The fourth model then adds DRG-specific outlier
12 offsets. In the last case we did not run a full simulation
13 of this model. We had done that in 2000. Instead we
14 estimated a rough approximation, but we believe that this
15 approximation gives a good indication of what the likely
16 effects would be.

17 For each model we focused primarily on two issues.
18 One is payment accuracy. How would the policy changes
19 affect differences in relative profitability across and
20 within DRGs? How would they affect the extent of favorable
21 selection now enjoyed by physician-owned specialty
22 hospitals, for example?

1 The other issue is the impact on inpatient
2 payments to hospitals. These policy options would not
3 affect aggregate payments under Medicare because the
4 Secretary is required to maintain budget neutrality when
5 changing the DRG definitions or the weights, and that's what
6 these policies do. But we would expect these policy options
7 to affect the distribution of payments among hospitals, so
8 it's important to know how much.
9 We also addressed some administrative burdens
10 associated with these options, and I will return to that
11 later when I talk about some of CMS's administrative
12 concerns.
13 Now let's look at the results on payment accuracy.
14 This chart shows how the policy options would change
15 hospitals' opportunities to gain or lose up from
16 specializing in certain DRGs. The bars indicate the shares
17 of payments that would fall in DRGs that have national
18 relative payment-to-cost ratios lower than 0.95, shown in
19 gold, greater than 1.05, in pink, and in between in green.
20 The middle bar basically tells the story. Under
21 current policy the payments are pretty evenly distributed
22 across those categories. As you add each policy change, the

1 differences in relative profitability compress toward one,
2 which is the national average. Under the fourth model at
3 the far right, 86 percent of the payments are in DRGs that
4 have relative profitability ratios within plus or minus 0.05
5 of the average.
6 If you were to look at what happens to relative
7 profitability ratios for APRDRG severity classes, that is
8 within DRGs, then you would see that opportunities for
9 selection within DRGs also diminish as we move across
10 models. These same patterns are reflected in each DRG,
11 which you will see next.
12 This table illustrates for DRG 107 what I just
13 told you overall. For this DRG relative profitability,
14 which is 10 percent above average under current policy,
15 falls to 1.0, the average, when all four policy changes are
16 included. The effects of adding the policy changes are
17 similar for virtually all DRGs whether they start off above
18 or below one.
19 Now let's look at what happens to opportunities
20 and incentives for selection with DRGs across severity
21 classes within the DRG. The bottom four lines on this table
22 show the relative profitability ratios across severity

1 classes under each model. Under current policy Medicare
2 patients in severity classes one, two, and three are
3 relatively attractive on average because their relative
4 profitability ratios are greater than one. Adopting
5 relative value weights would not have much effect on
6 hospitals' incentives for selection because you can see that
7 relative profitability ratios don't change much.
8 But as you would expect, adding DRG refinements,
9 which means calculating a separate payment rate for each
10 severity class within a DRG, that action would substantially
11 diminish incentives for selection across the severity
12 classes.
13 Now note how the hierarchy of relative
14 profitability across severity classes reverses when we add
15 DRG refinements in the second model. Patients in classes
16 one and two, which were relatively profitable under current
17 policy, now would be less relatively profitable. This
18 reflects the treatment of outlier cases in the weights and
19 the uniform financing of outlier payments. When differences
20 in outlier prevalence are addressed in the fourth model,
21 this hierarchy of relative profitability disappears, and
22 along with it, measurable opportunities for selection.

1 Note also in the last column that relative
2 profitability ratios for severity classes don't always
3 encompass the overall average. We checked this out because
4 it was a little disturbing. In part it is because the
5 APRDRG severity classes do not match the DRGs one for one.
6 The concordance is more complicated. These severity classes
7 include about 5,500 cases that are from other DRGs than 107.
8 When you pull those cases out and look at it again it does
9 now encompass the overall average. It also could reflect
10 some of the limitations of using our rough approximation for
11 model four rather than a full simulation.
12 Now I'd like to turn to what the policy changes
13 would do to patient selection at the hospital level. This
14 table shows what happens to expected relative profitability
15 for hospital groups. The measure tells us what a hospital
16 group's expected relative profitability would look like
17 given its mix of cases if all the hospitals in the group had
18 national average relative profitability for each APRDRG
19 severity class. Thus, it indicates the extent to which
20 hospitals have a favorable selection of patients across
21 severity classes.
22 Physician-owned heart, orthopedic and surgical

1 hospitals all have a favorable selection given their mix of
2 cases under current policy. Other groups, however, do not
3 have a favorable or unfavorable selection on average. As we
4 move across models, expected relative profitability
5 diminishes for physician-owned specialty groups but it
6 remains essentially unchanged for other groups. The results
7 for community hospitals here are somewhat misleading,
8 however, because many individual hospitals within these
9 groups would have either a favorable or an unfavorable
10 selection of patients under current policy. You just don't
11 see it here because you are looking at the average.
12 Note that selection on average turns relatively
13 unfavorable for orthopedic and surgical hospitals under the
14 third model. This again reflects the treatment of outlier
15 payments.
16 Now I'd like to turn to the impact on inpatient
17 PPS payments among hospitals. Although I'm not showing it
18 here, the impact on payments at the group level reflects
19 essentially what you see here. There's a strong tie-in
20 between selection and payment.
21 If we reduce the relative profitability in DRGs
22 that have high ratios now, payments for the hospital that

1 have lots of cases in those categories are going to fall.
2 It is as simple as that. Thus, payments would decline
3 progressively more under each model for the physician-owned
4 groups. The average decrease for physician-owned heart
5 hospitals, for example, would reach almost 10 percent under
6 model four. For broader categories of community hospitals,
7 payments would remain essentially unchanged on average. But
8 again, remember that's somewhat misleading as you'll see in
9 the next chart.

10 This table shows how all the policy options
11 combined in model four would affect payments for individual
12 hospitals. This is different from the table that we sent
13 you in the mailing. At the time we didn't have these
14 estimates for model four so we sent you model three. The
15 numbers here show the shares of hospitals in each group that
16 would fall in different intervals of the percentage change
17 in payments. As you can see, payments would decline
18 substantially for physician-owned heart and orthopedic
19 hospitals because they have lots of patients in the DRGs or
20 severity classes with high current profitability ratios.

21 For community hospitals, payments would fall for
22 hospitals that have a favorable selection now, but they

1 would increase for hospitals that have an unfavorable
2 selection under current policy. The size of these changes
3 suggest that a transition policy would be desirable in
4 implementing these policies.
5 These findings lead us to offer the following
6 draft recommendations. In developing the draft
7 recommendations we've separated the potential policy changes
8 based on the limits of the Secretary's authority under
9 current law. In this recommendation we're talking about
10 actions that the Secretary can take now. We have a separate
11 recommendation for changes in the outlier policy which would
12 require legislation.
13 The Secretary should improve payment accuracy in
14 the hospital inpatient PPS by adopting three refinements.
15 The current DRGs should be refined to more fully capture
16 differences in severity of illness among patients. The DRG
17 relative weights should be based on the estimated claim-
18 level cost rather than charges, and the weights should be
19 based on the national average of hospitals' relative values
20 in each DRG.
21 The second draft recommendation concerns the
22 outlier policy. The Congress should amend the law to give

1 the Secretary authority to adjust the DRG relative weights
2 to account for differences in the prevalence of high-cost
3 outlier cases. Note that this would mean financing outlier
4 payments through proportionate reductions in the weights
5 rather than through the current 5.2 percent uniform
6 reduction in all payment rates.
7 The third recommendation recognizes the need for a
8 transition. To mitigate the impact on providers, the
9 Congress and the Secretary should ensure that the case mix
10 measurement and outlier policies recommended earlier are
11 implemented through a transition.
12 The implications of these draft recommendations
13 are shown on this slide. They would not have any effect on
14 overall Medicare spending because the Secretary is required
15 to maintain budget neutrality. But the devil is in the
16 details, as it is always is, and the actual budget impact
17 here might vary depending on how CMS deals with potential
18 increases in payment that result from potential upcoding,
19 and also on exactly what sort of a transition mechanism is
20 adopted.
21 These policies should have little or no impact on
22 beneficiaries, but as we've seen, adopting these policies

1 would change the distribution of payments among hospitals,
2 raising them for some and lowering them for others.
3 Finally, I'd like to turn to the administrative
4 burdens associated with these policy changes. We've spoken
5 with CMS staff and we tried to think of ways to address some
6 with their concerns. These policy issues raise important
7 concerns primarily related to DRG refinement and to using
8 estimated costs in place of charges.
9 One concern is that DRG refinement could result in
10 many groups with small numbers of cases, and potentially
11 unstable weights. We are not endorsing the APRDRGs with
12 their 1,400 groups; just using them to illustrate the kinds
13 of gains that CMS could achieve. The refinements should be
14 made selectively, taking into account differences in costs
15 across the categories and also the numbers of cases
16 involved. Much of the potential benefits of refinement
17 might well be achieved without adding a large number of
18 groups.
19 Another concern raised by CMS relates to increases
20 in payments due to coding. This problem is real, but in the
21 Benefits Improvement and Protection Act, the Congress gave
22 the Secretary the authority to make a prospective adjustment

1 to the standardized payment amounts to offset anticipated
2 increases in payments resulting from upcoding. The
3 Secretary hasn't used that authority to date, but CMS has a
4 dataset of re-abstracted medical records that could be used
5 to make projections of the extent of any likely upcoding.
6 A third issue is how to make refinements without
7 rewarding avoidable complications. You discussed that this
8 morning in the context of pay for performance. This is that
9 issue of identifying conditions that were present at
10 admission on the record. I don't think I have anything more
11 to add to that than you discussed this morning.
12 There also issues related to the burden and
13 timeliness of using estimated costs in place of charges. It
14 is hard work, as I can tell you. We think that one way to
15 limit the burden might be to compute cost for claims
16 periodically and then use the relationship between the cost
17 weights and charge weights to adjust annually-computed
18 charge weights for an interim period until you re-estimate
19 costs again, perhaps five years later. That would solve a
20 lot of the concern about burden.
21 Now Ariel will discuss non-payment options.
22 MR. WINTER: Even if CMS were to make these

1 improvements to the inpatient payment system there could
2 still be inequities between physician-owned and non-
3 physician owned hospitals. Thus, I will be describing
4 options to reduce these inequities by revising the section
5 of the Stark law that governs physician ownership of
6 hospitals. I'll also discuss the potential for gainsharing
7 arrangements to better align physician and hospital
8 financial incentives.
9 To quickly review the Stark law, it prohibits
10 physicians from referring Medicare or Medicaid patients for
11 certain services to a provider with which the physician has
12 a financial relationship. However, the law allows
13 physicians to refer patients to hospitals in which they are
14 investors as long as their interest is in the whole hospital
15 rather than a hospital subdivision. This is known as the
16 whole hospital exception.
17 Over the last several years a growing number of
18 physician-owned single specialty hospitals have emerged.
19 The MMA placed a moratorium on the development of new
20 physician-owned single specialty hospitals to which
21 physician investors refer patients. This expires in June
22 2005.

1 We've previously discussed with you the concerns
2 with physician referral to hospitals that they own so I
3 won't spend too much time on these points. Briefly, the
4 main concern is that physician ownership may improperly
5 influence their professional judgment. It could create
6 financial incentives to refer patients to the hospital owned
7 by the physician, which may or may not be best for the
8 patient. It could also create financial incentives to
9 recommend additional services with high expected marginal
10 profits, such as heart bypass surgery. There's also a
11 concern that physician investment could create an unlevel
12 playing field between facilities because physicians
13 influence where patients receive care.
14 On the other hand, advocates of physician-owned
15 hospitals have argued that they provide more efficient and
16 higher quality care. However, the evidence we presented in
17 November shows that most physician-owned hospitals do not
18 have lower Medicare inpatient costs. We do not know whether
19 they provide better quality care.
20 These concerns lead us to the following draft
21 recommendation.
22 The Congress should eliminate the whole hospital

1 exception in the Stark law for all new hospitals and direct
2 the Secretary to develop criteria for grandfathering
3 existing hospitals. This would prohibit physicians from
4 referring patients to new hospitals in which they have an
5 ownership stake, whether they are single specialty or full-
6 service hospitals.

7 It would allow physician referral to pre-existing
8 physician-owned hospitals, but the Secretary should develop
9 criteria to prevent the excessive expansion of these
10 hospitals. For example, by developing subsidiaries or
11 bringing in new physician investors. We expect that
12 Congress would make this change retroactive to the end of
13 the moratorium to prevent a growth spurt of physician-owned
14 hospitals when the moratorium expires in June.

15 One question is whether to make an exception for
16 new physician-owned hospitals in rural areas. Almost 20
17 percent of the physician-owned hospitals that we identified
18 are in rural areas. Each of these areas currently has at
19 least one community hospital, so access does not seem to be
20 a problem. We'd like to get your feedback on this question.

21 In terms of spending implications, we estimate no
22 effect. We think there would be a small effect on providers

1 because it would prevent physicians from referring patients
2 to new physician-owned hospitals. And we estimate no impact
3 on beneficiaries.
4 In developing this recommendation we considered
5 two other options but decided to not propose them. One was
6 to protect a minimal level of physician investment in
7 hospitals. We felt, however, it would be difficult to
8 determine a level at which professional judgment is not
9 affected. The other idea was to prohibit the referral of
10 patients to only single specialty hospitals owned by
11 physicians, but we thought it would be difficult to draw a
12 clear line between single specialty and full-service
13 hospitals. I'd be happy to take questions about these two
14 ideas at the end.
15 The next topic we will discuss is gainsharing
16 arrangements in which hospitals and physicians share savings
17 from cost-reduction efforts that involve physicians, such as
18 reducing the use of unnecessary supplies and ancillary
19 services. We believe that gainsharing could better align
20 hospital and physician financial incentives, but could be
21 structured to have fewer risks than outright physician
22 ownership of hospitals.

1 The potential benefits of gainsharing include
2 encouraging hospital and physician cooperation to deliver
3 care more efficiently, and countering the silo effect
4 created by separate payment systems for physician and
5 inpatient hospital care.
6 However, there are some concerns with gainsharing.
7 The OIG has ruled that gainsharing violates a legal
8 provision that prohibits hospitals from offering financial
9 incentives to physicians to reduce services to Medicare
10 patients. This was meant to prevent hospitals from paying
11 physicians to discharge patients quicker and sicker under
12 the inpatient payment system. Thus, gainsharing
13 arrangements could harm the quality of patient care
14 depending on how they're structured. They could also create
15 incentives for physicians to refer patients to the hospital
16 with which they have the most lucrative financial
17 arrangement.
18 The OIG recognized that gainsharing has the
19 potential to improve care and reduce costs as long as there
20 are proper safeguards. HHS needs the statutory authority to
21 develop these protections. So here are some ideas for
22 safeguards which are based on a gainsharing arrangement that

1 was approved by the OIG.

2 There should be measures to protect quality of
3 care. These could include specifying the cost-saving
4 actions that are to be undertaken, and setting a threshold
5 for the appropriate use of services. There should also be
6 measures to minimize financial incentives that might affect
7 physician referrals. An example would be basing potential
8 savings on physicians' prior-year admissions, which would
9 reduce the incentive to increase admissions.

10 Thus our final recommendation is, the Congress
11 should grant the Secretary the authority to regulate
12 gainsharing arrangements between physicians and hospitals so
13 that quality of care is protected and financial incentives
14 that could affect physician referrals are minimized.

15 We estimate no impact on spending. In terms of
16 provider implications, this would allow providers to deliver
17 care more efficiently and there is the potential to improve
18 the quality of care for beneficiaries.

19 This includes our presentation and we'd be happy
20 to take any questions.

21 MR. HACKBARTH: If I may let me start with an
22 observation. I have no problem whatsoever with competition.

1 In fact I believe in competition and I think that in the
2 course of our discussion of this issue and the case studies
3 we have seen evidence that competition can stimulate needed
4 improvement. Moreover, specialization to me is not a
5 problem, per se. I believe the thesis that specialization
6 has the potential to improve quality, improve efficiency,
7 improve patient satisfaction, and improve physician
8 productivity. I don't have any problem believing those
9 things.
10 As we've gone through this research and discussed
11 the issues, my big concerns here are about an unlevel
12 playing field, where we have competition but the rules of
13 the gam are different. And we have competition but we have
14 a payment system that is sufficiently inaccurate that some
15 type of organizations can win, potentially at the cost of
16 others and at the expense of the community.
17 So what I'm about here is trying to figure how we
18 can preserve competition, have the right set of rules that
19 allow the competition to proceed fairly and with the maximum
20 likelihood of benefit to patients, the community, and the
21 Medicare program. It's not about being against
22 specialization, per se.

1 I think it might be helpful if we could have our
2 discussion on the two parts, the payment issues first, and
3 then second on the gainsharing and whole hospital exemption,
4 just to allow us to focus the conversation a little bit. So
5 let's start with the payment issues.
6 Any questions or comments about that work?
7 DR. SCANLON: I couldn't be a card-carrying
8 economist if I was against specialization or competition so
9 I would agree with you completely. I think we have in the
10 analysis of the payment system, the DRGs, identified that we
11 really have created an unlevel playing field, so the
12 movement to correct that is something that is appropriate in
13 this context but it's also appropriate more generally for
14 hospitals overall.
15 There's one other thing that we haven't talked
16 about in terms of the unlevel playing field and that is a
17 problem that is fundamental to the health care system and
18 that's the information imbalance between patients and
19 providers. That's what I think relates to the part of the
20 recommendation in terms of removing the whole hospital
21 exception. Because patients, frankly, rely upon physicians
22 for helping them make the decision as to whether or not they

1 are going to get services and there's an inherent conflict
2 of interest that exists. I know that most physicians don't
3 exploit that conflict but we do need to be concerned that
4 it's present in marketplace and it distorts decisions that
5 we see. So I think we should keep that in mind as well as
6 we're thinking about the second of these recommendations,
7 because fixing the payments does not change the nature of
8 that.
9 MR. MULLER: I think the work the staff has done
10 here is incredibly helpful because while we have all
11 suspected over many years that there's a lot of variation
12 inside the DRG system, to actually specify the magnitude of
13 it, and especially how deep the differences among the
14 severity classes I think is a major advance in our
15 understanding. So I am in favor of the recommendations
16 towards doing the kind of rebasing that allows us to have a
17 system, which has a lot of flaws that we discuss all the
18 time, but have a system that more fairly represents the true
19 cost of care.
20 As we've said at other times as well, we shouldn't
21 have a payment system that basically advantages those who
22 select patients adverse to provide care. So if the art in

1 the process is to select patients of less severity and get
2 paid very handsomely for it, that undermines the whole
3 payment system. Again, an imperfect payment system but it's
4 the one that we have. So taking away that advantage I think
5 is of importance so that in a system that pays on average we
6 continue to reward people for providing care to the full
7 spectrum of patients rather than rewarding them for
8 selecting a subset of those patients. So I'm in favor of
9 those kind of recommendations.

10 I know you want to separate the recommendation so
11 I will come back later on the other matters, but I share
12 Bill's concern that we have now shown evidence that this
13 selection bias that I'm speaking is exacerbated when there's
14 ownership issues involved. So I think we need to deal with
15 those forcefully as well.

16 If you want to do it in that sequence I'll come
17 back later. Thank you.

18 MR. HACKBARTH: Other comments on the payment
19 issues?

20 DR. STOWERS: I just want to be sure that we
21 really do make the point that this readjustment of the
22 payment system affects all hospitals. We have it bury in

1 the middle of this specialty hospital chapter. I'm not sure
2 that came as much as it should.
3 The second thing is, in light that it does affect
4 all hospitals -- I hate to be Mary here this morning and
5 talk rural hospitals, but just by the mere nature of
6 community hospitals they're going to be taking care of the
7 less severe APRDRGs inside the DRGs, I would think. So I'm
8 just curious if we've taken a look down through, and if that
9 might lead to the thought that if it does should we be
10 focusing more on the code sets in the beginning that are
11 affecting the specialty hospitals like the orthopedics or
12 the cardiac until we are really sure about what the
13 unintended consequences might be in other settings. I'm
14 sure you've thought about it. I was just curious what you
15 were --
16 MR. PETTENGILL: We have looked at that and this
17 is the relevant table, and rural is the middle column in the
18 bottom section. What you can't see there is that the
19 overall average change in payments for rural hospitals is
20 plus 0.5 percent under the fourth option. What you can see
21 here is that you have got 33 percent in the one to five
22 positive category and 16 percent in the more than five; 17

1 percent in the middle, which is basically negligible effect,
2 and then 25 and eight on the downside. In fact there are
3 quite a lot of rural hospitals that have an unfavorable
4 selection of patients now and that would be remedied. There
5 are a somewhat smaller number of all hospitals that have
6 favorable selection and that would be remedied as well, and
7 they would lose money.

8 DR. MILLER: But that effect could also be coming
9 from the outlier policy shift as well, right?

10 MR. PETTENGILL: This includes all four policies.

11 DR. MILLER: That's my point, is that there could
12 be a selection effect that is showing up here, but also an
13 effect from the outlier policy.

14 MR. PETTENGILL: But in effect that amounts to a
15 selection effect, because what you're doing is charging them
16 for outliers when they don't have them.

17 DR. MILLER: I just want to be clear that there's
18 a couple -- when we are using the word selection most people
19 are going to immediately think about complex and less
20 complex patients, and I think he's making a point about
21 that. But there are other parts of this policy like the
22 outlier that could have a beneficial effect for some set of

1 rural hospitals here, looking at the right end of the
2 distribution, which I don't think most people think of as
3 selection, although I do understand how you are speaking of
4 it.
5 DR. REISCHAUER: Can I just talk a little about
6 these numbers? It seems that we have a Lake Woebegone
7 effect in the sense that while it's budget neutral, over 50
8 percent are in the top half of the class, so some of these
9 things -- these are institutions not weighted by revenues.
10 MR. PETTENGILL: That's exactly right.
11 DR. REISCHAUER: So let's not get too excited
12 without knowing how much of the market we're really talking
13 about.
14 MR. PETTENGILL: Some of my colleagues when I
15 first showed this slide noticed the same thing and they
16 said, this can't be true. By in fact it is. If you look at
17 the share of payments that fall in each interval and you put
18 that together with the average percentage change for
19 hospitals in each interval and you multiply the two together
20 and get the weighted average, it comes out exactly the same
21 as the overall effect.
22 MR. HACKBARTH: Can I offer a couple additional

1 observations about this table? When I first saw it it
2 immediately occurred to me that independent of the specialty
3 hospital issue what this table says to me is the system is
4 out of whack. Even if we didn't have the specialty hospital
5 phenomenon at all we'd be wanting to refine the payment
6 system.

7 MR. MULLER: I think Bob's point, if we go to
8 slide eight it shows why with that 47 and 27 on the left,
9 there's such an advantage to having the low severity patient
10 when that gets adjusted there's a lot to spread back over to
11 the other hospitals. That's how I explained to myself the
12 phenomenon you noticed.

13 MR. HACKBARTH: The second observation about this,
14 if you're a member of Congress and think about the amount of
15 money that's being redistributed here, it is daunting. We
16 can do transitions and that sort of stuff but this is big
17 stuff. This is very important and will have significant
18 impacts on the system.

19 The other way to look at that is the big numbers
20 are also an indicator of how urgent it is to do. They are a
21 sign of how maldistributed the dollars are right now. So I
22 think this is just a critical piece of work.

1 MR. SMITH: Building on what you just said, I
2 think there needs to be a recommendation four in the first
3 half of this, and that is until recommendations one through
4 three are fully implemented the moratorium ought to stay in
5 place. That these distortions are so extraordinary, and at
6 least anecdotally folks are waiting at the door to attenuate
7 the distortions on July 1, looking at these numbers makes it
8 clear why competition and specialization are good ideas.
9 But the playing field is not level and it's not going to get
10 level until the first three recommendations are implemented
11 and we ought to keep the moratorium in place until that
12 occurs.
13 DR. REISCHAUER: When you did this you are
14 adjusting all the DRGs to the APRDRG system?
15 MR. PETTENGILL: Yes.
16 DR. REISCHAUER: You said that staff at CMS said,
17 this is a daunting exercise. I was wondering if you went
18 through DRGs if in a lot of them you wouldn't find quite
19 this amount, or in some of them you might find very small
20 amounts of variation, and the simplification would be to
21 take the top 50 or something like that in terms of dollar
22 value of effect and move forward that way and you'd get 90

1 percent of the correction that is necessary. Or maybe that
2 is not true.
3 MR. PETTENGILL: I think typically the way it
4 works is if you look at the difference in costliness between
5 severity class one and severity class two, sometimes the
6 difference is not all that great. So you would say, given
7 the variance in cost within the groups it's not worth
8 speaking the distinction.
9 Similarly, sometimes the difference between three
10 and four is not that great and you would probably say that
11 one we could throw away without losing much. There will be
12 other cases where -- remember the APRDRGs were defined for
13 all patients, not just Medicare patients, so there a lot of
14 categories in there that are for patients under 17, or for
15 maternity stays and things like that. So there are a lot of
16 categories that you could throw away almost like that.
17 DR. REISCHAUER: But there must be also some which
18 there are very few people in some of the categories.
19 MR. PETTENGILL: And differences are big? Yes,
20 there would be some like that. There you would have to make
21 a judgment about whether to make the distinction or not.
22 You might in that case want to look at a couple of years of

1 data to see whether the relationship is strong and stays
2 stable from year to year.
3 DR. MILSTEIN: One of the learnings from the last
4 three or four years of more frequent clinical reengineering
5 within ICUs is that hospitals that have gone through that
6 successfully have enjoyed very substantial reductions in the
7 frequency of outlier patients. I just raise as a question
8 for further staff evaluation whether or not we ought to
9 think about slightly modifying recommendation two to,
10 instead of adjusting for differences in the hospital's
11 actual prevalence of high cost outlier cases, to instead
12 think about accounting for differences in a hospital's
13 projected prevalence of outlier cases based on the illness
14 burden of who's coming in the front door, so we do not find
15 ourselves inadvertently rewarding hospitals who, due to less
16 success in managing more severely ill patients end up with a
17 large number of outliers.
18 Our ability to do that or our confidence in doing
19 that should be substantially increased to the degree our
20 previous recommendation from the morning is adopted. That
21 is that Medicare requires as a condition of payment coding
22 of a secondary diagnoses with respect to whether or not

1 they're present on admission. That will substantially lift
2 our ability to assess patient severity of illness at the
3 time of admission.
4 DR. CROSSON: Just to jump on board, I think the
5 rebasing of DRGs, the need for that screams from the data.
6 There's no question about that. The question I had Bob
7 already asked so I'll have to think about that.
8 MR. HACKBARTH: Let's turn to the recommendations
9 on gainsharing, the whole hospital exemption, and also I'd
10 include here what Dave has raised about the moratorium. I
11 would welcome comments on those issues.
12 MS. DePARLE: My comment was about the moratorium.
13 I was flipping through the pages of our document to see -- I
14 couldn't remember whether Congress even asked for our
15 opinion on this. But it does seem to me that given the
16 evidence that's been presented to us and that we've been
17 talking about the last few months that it would be a shame
18 to open this back up again until these issues get addressed.
19 So if it's appropriate for us to make a recommendation on
20 the moratorium I would agree with Dave that we should
21 recommend that Congress extend the moratorium until they are
22 able to deal with these issues.

1 MR. MULLER: I agree with Dave and Nancy-Ann on
2 the moratorium and I also am in favor of draft
3 recommendation four, again for some of the same reasons,
4 that we shouldn't have biases in patient selection being a
5 key part of the system. Obviously we're looking for access
6 for patients. We shouldn't be rewarding people for how they
7 select, so I'm for recommendation four as well.
8 DR. REISCHAUER: While I agree with the thrust of
9 what David, Nancy-Ann and Ralph have that said, I worry that
10 if we just say keep the moratorium in effect until these
11 other changes take place, the other changes might not take
12 place. While they scream to us, there will be people who
13 scream when they are put in place. I would be much more in
14 favor of extending them for whatever sounds like a
15 reasonable length of time for the Secretary and CMS to do
16 this job, but to leave their possible disappearance as a
17 threat that would push reform forward.
18 DR. CROSSON: I'm going to offer a little
19 contrarian perspective here on the whole hospital exception
20 thing. I think we heard early on from the staff interview
21 process that there were really two reasons brought forward
22 for physicians engaging in ownership or partial ownership of

1 the hospitals. One was the obvious one and perhaps the
2 overriding one, was in fact an opportunity to profit from
3 the successful hospital. But another one that was also
4 fairly prominent for certain physicians and groups of
5 physicians was to try to establish an environment which
6 better fit with their practice style. And particularly the
7 issue of efficiency, not so much of the hospital itself
8 which was examined here, but the efficiency of the
9 physician's practice itself; having an operating room
10 available at a time and place and a nature that fits with
11 the practice and the like. We saw that pretty prominently
12 in the interviews.
13 The problem is disentangling those two
14 motivations, and it is not possible to do that for human
15 beings most of the time. But I thought as we went along in
16 the discussion that there might be a way to do that. For
17 example, the idea of limiting the gain that an individual
18 physician or group could see from this kind of ownership
19 might do that, not in absolute way but potentially in a
20 substantially mitigated way. I understand the objections
21 that are raised to doing that. It is complex, particularly
22 the issue of group ownership versus individual ownership

1 makes it harder to figure how you would do that.

2 But I do have some concern about simply removing
3 the whole hospital exception because then there will be a
4 loss for some physicians of that potential opportunity to
5 have that practice environment, and potentially to engage in
6 a kind of constructive competition, if you will. In other
7 words, if you could somehow get rid of the unbalanced
8 incentives by rebasing the DRGs, and in fact get rid of the
9 substance and perception of conflict of interest for the
10 physicians then you'd have essentially a marketplace
11 phenomenon of an arguably efficient hospital, more
12 satisfying to the physicians, perhaps arguably producing
13 better quality and the like. The question is, is that
14 possible to do?

15 I just wonder whether or not -- and I'm fully
16 supportive of extending the moratorium to date certain until
17 we get to a point where the DRG rebasing could take place.
18 But I just wonder whether in the context of a final
19 recommendation we could spend some time -- for example, I
20 could imagine, to go back to the mechanism that brought
21 about some of the nation's medical groups in the beginning,
22 an environment in which physicians could create, for the

1 purposes of holding partial ownership in a hospital, a not-
2 for-profit community benefit organization which would in
3 fact remove that part of the incentive and yet still allow
4 partial ownership by physicians for the purpose of having
5 influence and creating the kind of practice environment.
6 That or something like that is the mechanism that created,
7 years ago, the foundation model which led to some of the
8 group practices.
9 MR. HACKBARTH: I may be not following you, but if
10 in fact they use the vehicle of a not-for-profit entity --
11 DR. CROSSON: Just for the physician ownership
12 piece, not for the hospital itself.
13 DR. MILLER: So the way I understand the
14 mechanism, you're saying that the physicians could have
15 ownership in the hospital. Their ownerships would be
16 organized in a not-for-profit foundation. There could be
17 other investors that would just invest as a regular
18 investment, and anything that the physicians realize out of
19 the investment stays with the non-profit foundation, which
20 is headed to the purpose.
21 DR. CROSSON: Yes, community purpose. I'm not
22 advocating for that. I'm just saying that it might be

1 worthwhile prior to the final recommendation to explore that
2 and other possibilities to essentially separate those two
3 physician goals, and if that were possible we might end up
4 in a different place.

5 MR. HACKBARTH: Unfortunately we're not going to
6 have time to engage in a lengthy discussion of this today,
7 but as we work through these issues over the next month we
8 can talk about those ideas. To the extent that we change
9 the profitability of the DRGs that will reduce some of the
10 incentive to go down the whole hospital exemption path and
11 physician ownership. To what degree it will reduce it I
12 don't know, but it will diminish the potential gain.

13 I am equally drawn by the gainsharing idea because
14 I do believe that there is something to the idea of
15 aligning, giving physicians and hospitals the opportunity to
16 work together and achieve gains together and share the
17 benefits together. We've heard that as one of the
18 motivations for owning your own hospital. I think that
19 ought to be generally available within defined boundaries,
20 and hence the recommendation for legislation authorizing
21 gainsharing. I think that could be quite constructive for
22 the whole system, for not-for-profit hospitals to have that

1 opportunity, particularly at the threshold of the pay-for-
2 performance era when getting physicians to work with
3 hospital administration is going to determine how successful
4 these efforts are.
5 So the short answer is we can look at some
6 different configurations of these several pieces.
7 Other comments?
8 DR. WOLTER: I think this is excellent work and I
9 am really very supportive of the recommendations. I think
10 the gainsharing also is very important.
11 I was wondering if in the recommendation we could
12 promote a little bit more actively that promotion of quality
13 is part of how incentives might be supplied as part of the
14 gainsharing, so that it's cost-reduction but it is also
15 actively working on promotion of quality. Clearly that
16 could involve payment to physicians and should, and we could
17 maybe be a little bit more explicit about that.
18 A little bit like Jay I'm wondering, does there
19 need to be some conversation about group practice exceptions
20 related to ownership of these types of facilities, because
21 there are organizations where payment to physicians is
22 totally benchmarked in different ways, totally separate from

1 how the services and reimbursement comes into the
2 organization. We do have those exceptions in some of the
3 other Stark regulations, so we may want to think about that
4 nuance.
5 We may also want to think about suggesting that
6 hospitals be more active in including physicians in
7 operating councils or governance activities of some of these
8 services because I think that gets to some of the issues Jay
9 was referencing as well.
10 MR. HACKBARTH: The issues surrounding the Stark
11 law are very complicated issues and that's one reason that
12 I'm open to think about other ways. I'm a little bit
13 uncertain about the potential of touching one piece of that
14 framework without understanding all of the ramifications and
15 all the different pieces. So I for one want to do a little
16 bit more thinking about this issue.
17 MR. DURENBERGER: First, I am sorry I wasn't here
18 for the second day of our November meeting at which did get
19 into -- apparently you talked about the quality side of this
20 issue. I agree with what you said about competition,
21 haven't seen the kind of competition we really ought to have
22 in the system in a long time.

1 But I particularly want to accent the values of
2 specialization, having been part of the original decision to
3 do DRGs but not do Part B at the same time, not knowing
4 there would be implications to it. I've just watched over
5 time the benefit of specialization. Hospitals have not
6 been responsible for increased access or the increased
7 quality that comes from specialization in this country.
8 It's been physicians, and particularly surgeons, and a lot
9 of other physicians, who have created opportunities,
10 starting with the ophthalmologists, and we can now go into
11 interventional this and that and non-invasive this an that
12 and the other thing.
13 So I agree with what Nick and Jay have just said
14 about whether it's within the context of, someplace in this
15 context, the critical factor for beneficiaries is the
16 quality of their care. The critical difference in making
17 that happen is not the hospital. It's going to be the
18 doctor because the doctor can influence the practice
19 environment, the clinical environment, the hospital itself,
20 all of the things that have to exist in a hospital. To the
21 degree the doctors in a community like mine and others have
22 not had that opportunity because all the leverage is in the

1 hospital, and all the leverage is in some other part of the
2 hospital from where they're working, I would really hate to
3 see any set of recommendations here that would take that
4 incentive away from specialization. I'm talking principally
5 about being involved with some of the fruits of performance,
6 some advance control over how that performance is translated
7 into the highest and best outcomes.
8 I'm not sure exactly how to get there but the
9 bluntness of the second part of this recommendation, and
10 even the way the first part gets to practically zero on
11 everything including a whole lot of fairly creative,
12 inventive parts of the health care system in cardio,
13 cardiovascular, orthopedics and so forth, bothers me just a
14 little to it. But I think the comments that Nick and Jay
15 particularly made, and you have made, give me some assurance
16 that when we try to deal with what's the law here that we
17 will be able to find what my concern is that we are looking
18 for.
19 MR. HACKBARTH: Thank you. Good work.
20 Next is payment adequacy for skilled nursing
21 facilities.
22 MS. LINEHAN: Good afternoon. I'll discuss

1 payment adequacy and updating payments for the SNF sector.
2 Sally will then discuss ways to improve Medicare's
3 monitoring of quality.
4 In our March report we will be making an update
5 recommendation for SNF services for fiscal year 2006.
6 Current law calls for full market basket update to SNF rates
7 in 2006 and that update is 2.9 percent. The Medicare
8 program's skilled nursing facility payments were $14.7
9 billion in 2003.
10 I'll summarize some information I presented in
11 October and then move on to some additional information on
12 quality, access to capital, and margin information.
13 Medicare beneficiaries' use of SNF care increased
14 between 1996 and 2002. The number of SNF episodes and the
15 proportion of PPS discharges to a SNF both increased during
16 this period. Some work by the OIG and MedPAC has found that
17 access is generally good for patients seeking SNF care, but
18 those that need certain services may experience delays. The
19 OIG is currently doing work to look at current access for
20 SNF services.
21 With respect to supply we see them from 2003 to
22 2004 the total number of SNFs participating in Medicare

1 remained almost unchanged, with the number of hospital-based
2 SNFs declining 6 percent and the number of freestanding SNFs
3 increasing by about 1 percent. Occupancy rates in nursing
4 facilities have been on the declines since the 1990s.
5 Between 2001 and 2002 overall volume of SNF
6 services increased, total payments, discharges, covered
7 days, and average length of stay all increased. The average
8 payment per day actually declined. This follows a 13
9 percent increase in average payment per day between 2000 and
10 2001.
11 Now I'm going to turn to quality. First I'll show
12 a table we updated with a full year of data for 2001 and
13 half a year of data for 2002. With the addition of these
14 updated data you see that the shares of SNF patients
15 rehospitalized within 30 days for all of these measures have
16 increased.
17 For example, in 1999 3.7 percent of SNF patients
18 were rehospitalized within 30 days with an electrolyte
19 imbalance and in 2002 that share increased to 4 percent.
20 These rates are adjusted for patients' expected rates of
21 rehospitalization and calculated using all SNF stays, not a
22 sample of stays. What's discouraging is that these show

1 declines during a period of time when all SNF payment add-
2 ons were in place.
3 So taken together, the results I just showed you
4 and other quality indicators I presented in October show a
5 mixed picture of SNF quality with most measures trending
6 down. Results from Chris Hogan's work on episode endpoints
7 after 30 days showed a decrease in mortality but an increase
8 in readmissions and a decrease in discharge home between
9 1996 and 2002. Trend data from 2002 to 2004 on the three
10 short-stay patient quality indicators from CMS's Nursing
11 Home Compare showed one measure improving, one with no
12 change, and one that didn't have multiple years of data so
13 we couldn't do a trend.
14 However, experts believe that these measures may
15 be misleading, the Nursing Home Compare measures. Although
16 here I've presented data on the few on quality indicators
17 specific to short-stay SNF patients for purposes of
18 assessing quality trends across industry, Sally will discuss
19 ways to improve SNF-specific information to better monitor
20 quality of SNF care in the future.
21 Access to capital for SNFs varies by nursing home
22 control size and whether the facility is part of a larger

1 organization. Not-for-profit nursing homes had and continue
2 to have limited access to capital, but large for-profit
3 chains appear to have some improved financial performance
4 over recent years. Several report capital expansions in
5 2003. An index of seven publicly-traded companies operating
6 SNFs increased 12 percent between January and October 2004
7 while the S&P 500 decline 0.47 percent.
8 Providers currently regard Medicare payments as
9 favorable but Medicare payments make up on average only
10 about 12 percent of SNFs' payments, although more for some
11 large for-profit chains. Potential refinements to the RUG-
12 IIIs and the accompanying loss of remaining payment add-ons
13 introduce uncertainties about the future of Medicare
14 payments. The industry is especially concerned about these
15 refinements because SNFs rely on Medicare payments to
16 subsidize Medicaid payments.
17 In fiscal year 2003 Medicare margins for all
18 freestanding SNFs, which are about 90 percent of all SNFs,
19 averaged 11 percent. Hospital-based SNF margins were
20 negative 87 percent in 2003. Based on 2003 cost report data
21 we estimate that the 2005 aggregate Medicare margin for
22 freestanding SNFs is 13 percent. Margins for rural

1 facilities, which are about one-third of total facilities,
2 are higher than those for urban facilities.
3 We also find differences between facilities
4 associated with one of the top chains. Margins for the 20
5 percent of facilities associated with a top-15 chain
6 averaged about 16 percent while margins for other facilities
7 averaged about 9 percent.
8 Consistent with our work in other sectors, we
9 looked at SNF margins across multiple years for a consistent
10 cohort of freestanding SNFs. We found that 5 percent of
11 SNFs in the cohort had a negative margin in all four years.
12 Of the remaining 95 percent of facilities, 60 percent had
13 consistently positive margins and 35 percent had both
14 positive and negative margins. The cohort of SNFs with a
15 higher share of Medicare days were more likely to have
16 consistently positive margins. We also found that three-
17 quarters of SNFs that were part of a chain had positive
18 margins in all four years while only 54 percent of the
19 remaining SNFs had consistently positive margins.
20 SNFs' cost of providing care have changed
21 dramatically since the implementation of the PPS in response
22 to payment incentives. Before the PPS, Medicare payments

1 were based on facilities' incurred costs. Medicare imposed
2 payment limits for routine services such as room and board
3 but did not limit payments for capital and ancillary
4 services, including therapy. The GAO and the OIG found that
5 costs during this period were excessively high. For
6 example, costs growth for ancillary services averaged 19
7 percent per year between 1992 and 1995 while the cost of
8 routine services increased an average of 6 percent annually.
9 Under the PPS, SNFs have incentives to decrease
10 their costs of providing each day of care. We analyzed cost
11 growth for a cohort of freestanding SNFs with cost data in
12 each year between 2000 and 2003. Preliminary results show
13 that freestanding SNFs average annual per-day cost growth
14 for Medicare beneficiaries was 3.6 percent in aggregate
15 between 2000 and 2003. Market basket increase during this
16 period generally tracked these cost growth numbers. Fifty
17 percent of the cohort had average annual per-day cost growth
18 between 0.2 and 7.9 percent. These findings are consistent
19 with other research findings that SNFs have reduced their
20 costs in response to the incentives inherent in the PPS.
21 This brings us to our draft recommendations, the
22 first of which is that SNFs should be able to accommodate

1 cost changes in 2006 with the 13 percent Medicare margins
2 they have in 2005. The 2005 margin was projected assuming
3 that costs will grow by the full SNF market basket in 2004
4 and 2005. We recommend that the Congress eliminate the
5 update for payment rates for SNF services for fiscal year
6 2006.
7 This recommendation would reduce spending relative
8 to current law. With a Medicare margin of 13 percent we do
9 not anticipate that this recommendation will have major
10 implications for beneficiaries or the majority of providers.
11 Our second recommendation is one that we have made
12 for the past three years. It's that the Congress
13 immediately give the Secretary the authority to remove some
14 or all of the 6 percent payment add-on currently applied to
15 the 14 rehab RUG payment groups and reallocate some portion
16 of the money to the non-rehab RUG groups to achieve a better
17 balance of resources among all the RUG groups.
18 This reallocation of resources would be a
19 redistribution of spending already in the system. We
20 anticipate that this would redistribute spending among
21 providers and improve access for beneficiaries.
22 DR. KAPLAN: In this chapter we also discussed the

1 need to improve Medicare's quality indicator specific to SNF
2 patients. We exclusively focus on measuring quality for
3 monitoring purposes and for MedPAC's assessment of payment
4 adequacy. Our first look at these measures tells us that
5 SNFs are not ready for pay for performance.
6 To better understand what information CMS
7 currently collects to monitor SNF quality we interviewed
8 representatives of CMS, researchers, clinicians, nursing
9 home quality improvement organizations, the NQF, QIOs, and
10 the SNF industry. We also reviewed the literature.
11 CMS collects three quality indicators specific to
12 SNF patients. They are the percentage of patients with
13 symptoms of delirium that represent a departure from usual
14 functioning on a 14-day assessment, the percentage of
15 patients at the 14-day assessment with moderate pain at
16 least daily, or horrible excruciating pain at any frequency,
17 and the percentage of patients who developed a pressure
18 ulcer or had a pressure ulcer worsen between the 5-day and
19 14-day assessments. Forty-nine percent of SNF patients have
20 a 14-day assessment.
21 The experts we interviewed believe the SNF-
22 specific QIs are too limited. They believe that the QIs are

1 limited by the focus of the data used to construct the
2 indicators, the validity and reliability of information, and
3 the timing of data collection. In addition, they pointed
4 out that the QIs do not focus on whether beneficiaries
5 benefit from the care they receive in SNFs or whether
6 patients achieve the goals for their care.

7 The source of the indicators, the minimum dataset,
8 or MDS, was developed as a care plan for nursing home
9 residents and is therefore focused on people receiving long-
10 term care. In contrast, SNF patients generally are in the
11 SNF less than 30 days and are expected to improve.

12 Current information on the validity and
13 reliability of the three QIs is inconclusive. A validity
14 study by a CMS contractor determined that the three SNF
15 indicators were in the top class of validity and that
16 indicators were very reliable. However, GAO has expressed
17 concern about the representativeness of the validity study
18 and also questioned the finding that the QIs are very
19 reliable. In an earlier study of reliability the same
20 contractor found high rates of error in the MDS items on an
21 individual SNF basis.

22 The experts pointed out that the timing of the MDS

1 assessment is problematic for determining whether SNF
2 patients improve over the course of their care. For
3 example, 80 percent of SNF patients are in a RUG
4 rehabilitation group, but we are unable to tell whether that
5 rehab improves their functioning because ADLs are not
6 measured at admission and discharge.
7 The experts suggested other quality indicators.
8 Two of the three indicators they suggested are fairly
9 available from existing administrative data, although not
10 from the MDS. Experts unanimously recommended that
11 rehospitalization be used as a measure of quality.
12 Researchers frequently used this QI. For our payment
13 adequacy assessment we have adopted potentially avoidable
14 rehospitalization for five conditions, as Kathryn discussed,
15 because these are risk adjusted and generally can be
16 attributed to poor care in SNFs.
17 Most patients prefer to go home from a SNF rather
18 than remain receiving long-term care in a nursing home.
19 Experts recommend a discharge to the community as a measure
20 of quality. Estimates of the share of SNF patients who do
21 return to the community range from 42 percent to 70 percent
22 depending on the research sample.

1 Finally, improvement in functional ability or ADLs
2 were also recommended as a QI specific to SNFs. This QI
3 would acquire measuring ADLs for all patients at admission
4 and discharge.
5 The draft recommendation is on the screen. CMS
6 should develop and use better SNF-specific quality
7 indicators. Further, CMS should collect information on
8 activities of daily living at admission and discharge to
9 support the assessment of quality of care provided by these
10 facilities.
11 The implications of this recommendation are no
12 impact on Medicare spending, beneficiaries would benefit
13 from QIs that assess whether they benefit from the care they
14 receive, and SNFs would have a small increase in
15 administrative burden but could have better information for
16 quality improvement or marketing.
17 That includes our presentation.
18 MR. DURENBERGER: I gave up after the first year
19 or trying to argue the 12 percent versus the 88 percent, but
20 I do want to make an argument about expanding either the
21 draft recommendation or certainly the content behind the
22 draft recommendation.

1 Both Bill and I were recently selected to be on
2 another commission called the National Commission for
3 Quality Long-term Care, and one of the things that we know,
4 not because we are on that commission, is that we have never
5 quite been able as a nation or as a community, we have never
6 been able to match up expectations that people have about
7 long-term care or short-term care in nursing facilities with
8 the capacity of people who are in the professions to
9 deliver. So we have opted for a quality system that is not
10 the kind of quality system that any of us would want, and I
11 think you've both pointed that out to us. It is largely a
12 regulated system, national regulations implemented at the
13 state level. A lot of professionals instead of being in the
14 care business are busy filling out forms and reporting on
15 this, that and the other thing and calling me every time my
16 mom falls out of bed or whatever the case may be.
17 So one of the challenges in matching expectations
18 and capacity within the system -- I guess the other point I
19 want to make is that to the extent that there is an
20 implication in any of this that there's an industry out
21 there that's simply making enough money and not caring about
22 quality, that is not the case, because largely this

1 commission at the National Quality Forum is being financed
2 by the industry because they're so anxious to get the
3 answers to the question that we are raising here.
4 But no matter how this comes about after we go
5 through some process of matching up expectations, capacity,
6 we are going to get to financing, which is where I was two
7 years ago when I first started being concerned about this,
8 and that is, you get what you pay for. Unless you figure
9 out how you are going to pay for quality, and what that
10 means -- you've got to determine what quality is in this
11 area -- we're saddled with a system which is 12 percent
12 Medicare so we just look at that little piece of it, then
13 over here is Medicaid and we all know what's happening to
14 the Medicaid, and then there's the poor beneficiaries out
15 there, or the poor families out there paying for all the
16 rest of it, and nobody is in charge.
17 So I just have these fairly strong feelings that
18 I'm not expressing very well, that I would like to see, even
19 though I know we have to focus on the 12 and I know we're
20 probably going to end up with this kind of recommendation, I
21 think we ought to elaborate on that on behalf of the
22 population of Medicare-eligible people whose needs are not

1 being served by the current system. All the dual eligibles
2 and everybody else I talked about earlier, their needs are
3 not being met by a system that is fractionated between the
4 Medicare, the Medicaid, and does not deal effectively with
5 what we would like to see dealt with here, which is what is
6 quality and how should quality be paid for, whether it's in
7 the Medicare system, the Medicaid system, or in private pay.
8 So I would hope I could persuade us to structure
9 some language that would expand this recommendation as it
10 relates to quality so that it is more focused on all of
11 these people that are out there in the system rather than
12 just on the Medicare reimbursement.
13 MS. RAPHAEL: I'm just wondering if we can take
14 that last recommendation, which I think is very important --
15 I mean, the second recommendation we have made before. It
16 is a repeat performance. I guess in January there's
17 supposed to be something coming out.
18 But the third recommendation seems a little soft
19 to me given what we have seen here, which is that the trends
20 don't seem to be very promising. Most people going into a
21 nursing home is a very difficult event. Even if you are
22 there for 15 days or 20 days, it is one of the most

1 important health events you're going to experience. So
2 seems to me that we have to do more and we have to do this
3 with greater urgency than we are conveying here.
4 I don't know whether we should separate out the
5 admission and discharge, whether that's easier to do or
6 harder to do, whether it's easier to fold in the potentially
7 avoidable rehospitalizations, and tracking discharge to
8 community, and functional improvements. But I just feel
9 that we need to get going in this area and we shouldn't be
10 here next year again saying, we really can't do anything in
11 this area because we haven't made any progress.
12 MR. HACKBARTH: I agree about expressing a sense
13 of urgency. Ordinarily we do that in the text as opposed to
14 putting exclamation points in the recommendation.
15 [Laughter.]
16 DR. MILSTEIN: My comments are along the line of
17 Carol's. I think that particularly with respect to the two
18 quality measures based on administrative data, relative to
19 the gain if we were to have this in place, this doesn't seem
20 to me terribly challenging to construct. Maybe short of an
21 exclamation point, at least a recommended date by which
22 these better measures are in place, including the initiation

1 of the collection of the functional status measurement at
2 the time of admission and discharge. The inputs for these
3 are already available and I personally would say, not to
4 exceed a year from the date at which we make the
5 recommendation.
6 MR. HACKBARTH: Any others?
7 Thank you.
8 Next is home health.
9 MS. CHENG: Last month I presented the first half
10 of our payment adequacy analysis for this factor and I'd
11 like to acknowledge the work of Chad and Sarah on our staff
12 for a lot of the work that they put into that analysis.
13 Today I will bring you the second half of this analysis,
14 along with a draft recommendation for your reaction.
15 To get us oriented, we're discussing the update
16 for calendar year 2006. In the past we have discussed home
17 health updates for fiscal years, but that was before the MMA
18 changed the update cycle for this sector from a fiscal year
19 one to a calendar year one. Under the current law this
20 update is market basket minus 0.8.
21 Medicare spent about $10 billion on home health
22 services in 2003, and the Office of the Actuary projects

1 that home health spending will continue to grow at an
2 average annual rate of 4.7 percent over the next 10 years.
3 Using a different set of assumptions, especially regarding
4 the growth of private plans versus traditional fee-for-
5 service, the Congressional Budget Office estimates an annual
6 growth rate of 11 percent over the same period.
7 Last month we discussed three factors that suggest
8 current payments for home health are adequate.
9 Beneficiaries' access to care is good although some
10 beneficiaries continue to experience some access problems.
11 The quality of care as measured by the Home Care Compare
12 dataset has improved slightly, and we have noted that home
13 health agencies are now entering the program at a greater
14 rate than they were exiting it.
15 The new pieces of the adequacy analysis that I
16 will bring to you today include trends in the volume of
17 services. What we note this year is that trends that we
18 have measured in the past are continuing. The number of
19 episodes has continued to increase between 5 percent and 10
20 percent in 2003, depending on how you treat episodes that
21 lap over the beginning or end of a calendar year.
22 But at the same that the number of episodes has

1 increased, the number of visits or minutes within an episode
2 has continued to decrease. The average number of minutes
3 per episode fell 8 percent from 2002 to 2003. The average
4 number of visits per episode fell from 18.8 in 2002 to 17 in
5 2003.
6 The other part of our adequacy analysis that I
7 will present to you today is our consideration of the
8 relationship of Medicare's payments to costs. We do this
9 looking at the freestanding home health agencies.
10 We are projecting a decrease in the margins for
11 home health agencies from their current level of 13.6 in
12 2003 12.1 percent for all agencies in the aggregate.
13 Private proprietary agencies continue to have the highest
14 margins while voluntary fall in the middle and government
15 agencies have lower margins.
16 In the past rural agencies had slightly higher
17 margins than their urban counterparts. That was due in
18 large part to rural add-on payments. However, you will see
19 in 2003 and again in 2005 that relationship has changed.
20 Rural agencies have a margin of 10.6 while urban agencies
21 have 14.1. The lack of any rural add-on for a year between
22 2000 and 2005 and the sunset of the current rural add-on

1 which we pull into our 2005 projection are both reflected in
2 that 2005 margin.
3 Hospital-based home health agencies reported
4 margins of negative 4.6 in 2003.
5 As we've seen in years past, the financial
6 performance of individual agencies vary a great deal around
7 this average aggregate margin. About 20 percent of that
8 home health agencies had negative margins in 2003. In
9 contrast, on the other end of that spectrum 25 percent of
10 home health agencies had margins above 25 percent.
11 This year we also took a somewhat different look
12 at margins and we looked at accumulation of margins rather
13 than just a single year at a time. The PPS for home health
14 has been in place for about three years so we have a three-
15 year cumulative margin for home health agencies. When we
16 look back over that entire period we find that most agencies
17 have accumulated large positive margins. Consistent with
18 our single-year measurement, private agencies had higher
19 margins than voluntary or government ones, and urban fared
20 better than agencies with mixed caseloads, which is to say
21 some of their patients were in urban areas and others were
22 in rural areas, and urban fared better than those with

1 entirely rural caseloads.

2 When we look at this three-year cumulative margin,
3 80 percent of all agencies had a positive three-year margin
4 and 20 percent had negative ones.

5 We also took an opportunity this year to look at
6 the cost per episode for a three-year cohort. Between 2001
7 and 2003 for the agencies that we could include in all three
8 of those years, aggregate cost per episode fell by 1
9 percent. This aggregate decrease is the combined effect of
10 some agencies' large cost reductions and other agencies'
11 small increases in costs. Large agencies in terms of the
12 volume of services that they provide had costs that fell 6
13 percent while the smallest agencies in terms of volume costs
14 grew 4 percent. We also observed that rural agencies' costs
15 fell 13 percent.

16 The decreases in the visits and the number of
17 minutes per episode are probably the chief drivers behind
18 the decrease in costs that we observe over this period.
19 Also, some agencies report that adopting such care
20 improvement technologies like wound dressings, or
21 technologies such as point-of-care computers and telehealth
22 have also allowed them to improve nurse productivity and

1 reduce their costs. Rural agencies have also reported to us
2 anecdotally that over this time period they've been
3 rationalizing the travel patterns of their nurses which has
4 allowed them to reduce some of their costs.
5 In the second phase of our framework, having
6 considered the adequacy of payments in the current year, we
7 also look ahead to see what changes we anticipate in the
8 coming year. For home health we note that wage pressures
9 from the nursing shortage and also successfully union
10 negotiations will increase the prices of labor in this very
11 labor-dependent sector. We also believe that the slow
12 diffusion of science and technology in this sector will
13 continue. These influences will tend to offset the cost
14 reductions that we've observed so those cost reductions may
15 not continue as we look forward.
16 The market basket projection for the increase in
17 prices for home health is 3.1 percent for 2005. A
18 combination of generally positive indicators of access and
19 quality along with more than adequate current margin and
20 slow cost growth suggest that agencies should be able to
21 accommodate cost increases over the coming year without an
22 increase in base payments.

1 As your draft of this home health chapter notes,
2 some of the research that we presented at our last meeting
3 regarded the variability of services in this sector, raises
4 questions about the structure of the payment system as well
5 as the level of home health payments. We will pursue those
6 questions about the structure of payment in at least two
7 ways over the coming year. We have a mandated congressional
8 report in which we'll be looking at the relationship between
9 case mix and financial performance, and also we are going to
10 take a look at the PPS and alternatives to prospective
11 payment for this sector perhaps as a chapter in our June
12 report.
13 The draft recommendation that we are bringing to
14 you for your consideration is that the Congress should
15 eliminate the update to payment rates for home health care
16 services for calendar year 2006.
17 The spending implication would be a decrease in
18 spending over the baseline. But because of their current
19 aggregate margins and our belief of changes in the coming
20 year we find no major implications for beneficiaries or for
21 providers.
22 With that I'd like to open it up to your input and

1 questions.

2 MS. DePARLE: Like some others on the Commission

3 I've met with some home care agencies recently and they had

4 data and numbers on margins that was very different from

5 what we are looking at. They say that it's from CMS and

6 they have questioned me about why do we use such different

7 data, and I'm going to lob it over to you because I don't

8 know the answer. They say they have data that's from cost

9 reports that doesn't show these kinds of margins.

10 MS. CHENG: I haven't had a chance to sit down and

11 go specification by specification over my model and their

12 model so I can't speak to the specifics. I know that two

13 areas that cause our margins to differ, sometimes a great

14 deal, are the inclusion of hospital-based home health

15 agencies in the aggregate.

16 The second is whether or not you're looking at

17 this sector on an aggregate basis or a facility-weighted

18 basis. It makes a big difference in this sector because

19 some agencies have caseloads of over 5,000 Medicare

20 beneficiaries so when we revenue weight we are looking at

21 what the experience of most of our beneficiaries are when we

22 look at our aggregate. If you facility weight it you're

1 giving it equal weight to the performance of some of the
2 agencies on the other end of the spectrum, and the smallest
3 agencies in this sector see fewer than 100 patients a year.
4 But if you facility weight it you are giving equal weight to
5 that experience as you are to the experience of 5,000
6 beneficiaries at a larger agency.

7 MS. DePARLE: So the CMS data you believe includes
8 hospital-based home health agencies and our data does not?

9 MR. PETTENGILL: Our data does not include the
10 hospital-based.

11 DR. MILLER: They say themselves that they have
12 some skepticism about the hospital-based data. That was
13 actually in a couple of newsletters that they put out.
14 Correct me if I'm wrong, when they do the facility-weighted
15 data -- and I'm remembering this from previous years so I
16 could be wrong on what's currently going on -- they were
17 still getting positive margins, were they not?

18 MS. CHENG: I don't know what their most recent
19 estimate looks like.

20 DR. MILLER: But in the previous year I thought
21 that they were, and they weren't small as I recall.

22 MS. CHENG: They were smaller than the margins --

1 DR. MILLER: They're smaller than ours, no
2 question. But I didn't think they were negative.
3 MS. CHENG: I think that's right.
4 MS. DePARLE: From what they told me they're not
5 negative but they're much smaller, single digit numbers than
6 what we're seeing the last couple years.
7 DR. MILLER: The way I remember it is numbers like
8 half of what ours were when you go to a facility-weighted
9 approach.
10 MR. HACKBARTH: It seems to me that revenue-
11 weighted, the way we do it, is the right way to do it. This
12 is the way we do it across all industries and not just home
13 health. But in particular when you are talking about these
14 tiny home health agencies that may not even be anywhere near
15 efficient units, I don't think you want your payment policy
16 driven by lots of very small units. You want a sense of
17 overall how your payments are comparing to costs and that
18 requires revenue weighting as opposed to facility or
19 provider weighting.
20 Anything else on that, Nancy-Ann?
21 MS. DePARLE: We had a long discussion -- I'm
22 looking at Sheila because I think I was sitting by here the

1 last time. We had a long discussion sometime in the last
2 six or eight months about this benefit and how much it had
3 changed, and our questions about how much of that was
4 intentional, and whether the frailest beneficiaries were
5 still being served in the way that we wanted them to be.
6 So I'm still mulling those things, and I guess in
7 my discussions with these home health agencies they have
8 made the case that their margins are much smaller than the
9 numbers we're looking at, and I hear our answer to that.
10 But secondly, that something like the rural add-on that
11 they've gotten has been critical to some of their agencies
12 in being able to continue serving beneficiaries. I don't
13 know, Sharon, if you've had a chance to look at that, the
14 rural add-on in particular, and whether we think that's
15 legitimate.
16 MS. CHENG: We did continue to look at agencies by
17 caseload, and when we measured their margins in the
18 aggregate the rurals are now lower than the urban. Before
19 the add-on sometimes made them actually flip above the
20 urban. But when we projected the margins by type the rural
21 margin was still positive.
22 MR. HACKBARTH: Remind me where we are. Was it

1 last year that we recommended the 5 percent add-on be
2 extended? Was that rural home health?
3 MS. CHENG: Two years ago.
4 MS. DePARLE: One of the most optimistic things I
5 saw from the home health agencies that I talked to was the
6 way in which they are being able to use the OASIS data that
7 they are collecting now to really manage the care of their
8 patients and to have a much better sense of how the patients
9 are progressing, and how they are doing. That, as we look
10 at all the bulk of the work that we have been doing today on
11 quality, is a very hopeful sign.
12 MR. HACKBARTH: Let me just engage in some MedPAC
13 speak here for a second. It's our custom to the distinguish
14 between the aggregate level of payment and the distribution
15 of payment. Based on these data, based on many years of
16 discussion of this, I don't think the issues here are so
17 much about the aggregate level of money flowing into the
18 home health industry from Medicare but rather the
19 distribution of those dollars and whether we are getting the
20 dollars to the right places and they accurately track with
21 the cost of treating different types of patients. We
22 included a passage last year as I recall in our report

1 identifying that as a concern.

2 In addition to that, we received a mandate in MMA

3 to study the case mix issue and the report on that is due

4 when?

5 MS. CHENG: November 2005.

6 MR. HACKBARTH: So that's a piece of work that I

7 think is critically important and I think can start to give

8 us some new thoughts here. So I continue to feel confident

9 that this is the right update recommendation. I don't want

10 people to construe that as I think everything is hunky-dory

11 in the home health world. I don't believe that to be the

12 case.

13 MS. RAPHAEL: I think the study that we have to do

14 is important, I just have one question. It is my view that,

15 we looked at the DRG system today 21 years after its

16 inception and we saw what had happened. I believe three

17 years after the home care PPS some of the same trends are

18 already apparent and that we are not really paying for the

19 true cost of care. There are certain areas where we are

20 rewarding what Ralph would call the art of selection rather

21 than the true resource consumption.

22 So one of my concerns is whether by looking at the

1 case mix adjuster whether we are really going to get at that
2 broader issue which I think is the same issue but in a
3 different sector.
4 MS. CHENG: I have been trying to interpret our
5 request from Congress pretty broadly. What I hope to be
6 able to do with this report is to determine whether or not
7 case mix is related to financial performance, and in so
8 doing tease case mix out from some of the other things that
9 we will be able to learn about the patients that agencies
10 take and their efficiencies. So I hope to use the full set
11 of OASIS information, so not only will we be able to look at
12 the pieces that go into determining the case mix, but we
13 could also pull in things like comorbidities, is there a
14 caregiver at home, what is the Medicaid caseload?
15 So what I hope to be able to do is put all those
16 pieces together so I will be able to say, case mix might be
17 part of it but let's find out, if that is not the whole
18 story what the story is. So I'm trying to take that pretty
19 broadly.
20 DR. MILLER: Even before we got the mandate, as
21 part of our agenda Sharon is going to be looking at pieces
22 of the program, and you'll remember either the last meeting

1 or the meeting before that, she went through the outlier
2 policy. So we are trying to zero on each of the pieces of
3 the program to begin to do this. Whether we have this
4 mandate or not and whether we house all of what we find in
5 the mandated report or not this is an agenda for Sharon.
6 MR. MULLER: I will just second Carol's concern.
7 I suspect as we look into this we will see some real case
8 mix weight issues, at least that's been my experience in
9 this field. I think getting those weights right, for the
10 reasons that Carol mentioned, is important. So we'll know a
11 lot more of this by November. I think from your answer to
12 Carol's comment you have the flexibility to look fairly
13 broadly at this and some of the severity issues we were
14 looking at in the DRG system you'll look at as well.
15 MS. CHENG: We don't have a nifty APRDRG to pull
16 off the shelf but we will be able, I hope, to include in our
17 models some of the other things that OASIS tells us about
18 the patients and some important things like comorbidities,
19 cognitive impairment and --
20 MR. MULLER: I think you'll see some of these
21 rehab/non-rehab issues that we discussed in the past coming
22 through quite clearly once you look at this.

1 DR. WAKEFIELD: A couple comments. The rural
2 agency margin concerns me a bit because of the downward
3 trajectory and also in light of our discussion this morning
4 in our update discussion about what might be going on in the
5 hospital side of the equation, knowing that we've now moved
6 from a 10 percent rural add-on that expired last year down
7 to a 5 percent add-on. I would say that is obviously
8 contributing to the direction that this margin is going.
9 The recommendation concerns me a bit about no update at all
10 given that downward trajectory for rural home health.
11 Part of what's always been a nagging concern for
12 me in the back of my mind is how we define access here. We
13 say pretty strongly that access is solid given the way we
14 define it. And the way we define it is using zip codes, and
15 whether or not a Medicare beneficiary has been serviced
16 within that zip code in the previous 12 months. I think we
17 have to keep in mind that some zip codes in the western part
18 of the United States are larger than some states in the
19 northeast, or they're awfully big. If that's an
20 overstatement it's probably not too much of an
21 overstatement.
22 What I hear from rural health care agencies is

1 they are looking rapidly at 25 mile radii. We would never
2 pick that up, that they've pulled back, if they are
3 servicing a 25-mile radius in terms of what happens to the
4 other hundreds of miles or thousands of miles. So I'm
5 always a little bit nervous about access for Medicare
6 beneficiaries. So those are my concerns about the direction
7 that the margins are moving on home health agencies in rural
8 areas and that makes me nervous about the recommendation as
9 it stands, no update across-the-board.
10 DR. STOWERS: Just to build on what Mary is
11 saying, I totally agree with all that is wrong with the
12 system and the rehab side versus acute care, chronically ill
13 patients and this group is more apt to be taking care of
14 those ones that we're most concerned about in the system.
15 I've never seen it done but I'm just wondering while we're
16 waiting on the study if in the recommendation it could be
17 holding level except adding the market basket to level
18 things out in the meantime for the rural in the
19 recommendation. I don't know if we can split that or not,
20 or whether it would be easier to add the 5 percent back in.
21 MR. HACKBARTH: I think that is what you would
22 want to do as opposed to having a different market basket

1 that then gets in the base and in perpetuity you've got a
2 different level. A temporary add-on is I think the
3 preferable way of dealing with what might be short-term
4 problems.
5 DR. STOWERS: But I think we've got some pretty
6 clear numbers here that we probably did need the 10 percent
7 that we had before and maybe the Commission needs to come
8 out and put that back where it was in the meantime.
9 DR. NELSON: I think we ought to build some
10 caveats around our interpretation of the quality
11 information. I think improvement at walking around,
12 improvement in bathing, patients who are confused less often
13 and so forth, those kinds of measures are helpful for the
14 agency to internally use and lead to quality improvement by
15 telling them where to put their emphasis. That may help
16 some.
17 It is of less value in publicly reporting in
18 leading patients to be able to select a home agency because
19 they all subjective, they all self-reported. There isn't
20 anything quantifiable in here. They are of virtually no
21 value in making an assumption about whether the quality of
22 care is getting better or worse, just because they are all

1 subjective.

2 So I think a sentence in there that's says that

3 it's pretty hard to make quality conclusions based on the

4 current measures doesn't make us look naive.

5 MS. CHENG: I will certainly try to capture your

6 concern, I just wanted to maybe understand it a little

7 better. When we measure patient outcomes in this setting we

8 are using the patient assessment tool. All lot of the

9 fields that we using -- not for all of the OBQIs but for

10 some of them -- are also payment fields. So we have got

11 FIs. We have got some level of audit that do look at this.

12 And the home health agencies or held to the same standard as

13 anyone else who submits a claim, when you submit the

14 evidence that supports that claim there's a standard that

15 has to be upheld. A lot of these measures are based on

16 that.

17 CMS has also done a fair bit of testing on the

18 validity and the reliability of these measures and I can

19 certainly bring that back to you. There are differences in

20 the reliability and the validity of measures within the

21 whole set of 41, but for many of these the science suggests

22 that they are fairly reliable and valid measures. So I

1 would like to capture your concern but I need to understand
2 it a little but.
3 DR. NELSON: Maybe I need to be corrected, but
4 improvement of walking around, for example, is entirely in
5 the eyes of the beholder on whatever day they want to say
6 it. Improvement of bathing, or patients have less pain.
7 You ask a patient, are you having very much pain? All I'm
8 saying is that it may be that that is accepted and has been
9 validated and that is what the field is using, and I think
10 if they are using it for their internal purposes that is
11 great. But if I am trying to select a home health agency
12 that is best for my family, they don't tell me very much,
13 because the variations are very small -- I have looked it up
14 -- from agency to agency and it depends -- they are entirely
15 based on the perception of the person making the observation
16 in the home and that person obviously has a bias if it's
17 being used in the marketing sense.
18 DR. MILLER: If there's a bias, these are the same
19 measures that are used for payment purposes as well. You go
20 through and you make the assessment on OASIS. If there's a
21 bias here then the bias is towards saying that they're doing
22 less well in order to up the category that you are in. I

1 think some of what you're picking up on here is that we are
2 looking -- these are the same metrics that are used for the
3 payment purposes. We do believe that there's probably some
4 issues around the reliability, because there are issues that
5 are recognized, there's guidance, and in a sense the same
6 kinds of issues that surround what Sharon was saying, any
7 submission of a claim apply here.

8 The way I could get to your point is I can see
9 how, particularly if there are small variations in this, how
10 as a public reporting device there's probably an issue there
11 and I think we could probably make that point. But if your
12 point is that you think that this metric doesn't work at
13 all, I think we have larger issues because we have been
14 talking about this as our payment classification system.
15 This is how patients are classified and this is one of the
16 things that we're thinking about, part of it, for pay-for-
17 performance. So I want to make sure we understand the depth
18 of your comment here.

19 DR. NELSON: It probably isn't productive for me
20 to push it any more. I guess I'm thinking of performance
21 measures in a much more rigorous application.

22 DR. SCANLON: A question that might shed some

1 light on this, and that's the issue of what scale is in
2 OASIS, and I can't remember. But in many of the activities
3 of daily living scales what we're talking about is questions
4 like, do you require the assistance of a human being, do you
5 require the assistance of equipment, or do you walk unaided.
6 It's not whether when you're walking are you walking,
7 stronger, faster or anything like that. It's much more
8 discrete and therefore much more objective, even though
9 sometimes they will ask questions about how much difficulty
10 you have. But I guess I'm not sure what's in the OASIS but
11 it's potentially comes across a little stronger than what it
12 may seem like when it says improvement in walking.
13 DR. NELSON: That's helpful.
14 DR. REISCHAUER: Ray and Mary are worried about
15 whether 6 percent represents an adequate margin, and in some
16 other provider groups we'd be happy with 6 percent. Surely
17 there is an inequity when one group has 6 percent and the
18 other group has 10 or 13 or something like that.
19 But I was wondering if we could zero in on some of
20 the other dimensions we look for urban-rural and not just
21 margins. One of them would be quality. Is there any way to
22 see what the trend in quality has been? Overall you say we

1 have had some small uptick in quality. But is that true if
2 you cut it urban-rural?
3 The main issue which Mary focuses on,
4 appropriately I think, is access. This is very hard because
5 the incidence of home health use varies all over the lot,
6 state by state or region of the country by region of the
7 country. I was wondering if you looked at similar
8 geographic areas, North Dakota, but you looked at the trends
9 in geographic areas and saw if the percent of, or the number
10 of services per 100,000 Medicare beneficiaries is trending
11 the same way in those rural areas as it is in the urban
12 areas. And your anecdotal evidence that there are home
13 health agencies there, but some of them are shrinking their
14 service areas, or it's just less easy for people to access
15 their services would show up in something like that, whereas
16 it doesn't show up in the measure that you are using for
17 access.
18 MS. CHENG: There's not a lot of time between and
19 January but I can --
20 DR. REISCHAUER: This could be for next year. I
21 think this discussion, if I remember correctly, has occurred
22 every year I have been on the Commission.

1 MS. CHENG: What I can also bring back, the OIG
2 took a look at access and they compared urban access and
3 rural access. We were hoping to have a refreshed version of
4 that report for this sector in this cycle, and they have
5 told us that they're not going to be able to have final
6 results in time for us to look at it. But I can ping them
7 and see if there's any kind of initial result that they
8 would be willing to share, because they have undertaken that
9 effort again, to really get into urban-rural access
10 differences and they have been interviewing providers, area
11 agency on aging, and discharge planners to get on-the-ground
12 look at that.

13 DR. WAKEFIELD: Just on the quality issue, a
14 little bit of the feedback that I've gotten from the part of
15 the field that I pay a little bit more attention to is that
16 some of the quality improvements are not necessarily due,
17 some would say, due to actual improvements in the patient,
18 but rather from some of the agencies themselves better
19 documentation or variability in documentation. That has
20 been in the back of my mind as well as I read the quality
21 piece of this, how much is capturing what is really going on
22 and how much is just a change in staff assessment

1 techniques? I would defer to Carol about that but I can
2 tell you from the agencies they would attribute some of the
3 bumps up or leveling to changes in how people are coding
4 information.
5 On the margins, did you give us a margin in home
6 health based out of hospitals? Did you give us a Medicare
7 margin on that, when you went through your narrative but not
8 on the slides, because I thought I heard something related
9 to hospital-based home health margins.
10 MS. CHENG: We looked at the margins reported by
11 hospital-based home health agencies and in 2003 that
12 aggregate is negative 4.6.
13 DR. WAKEFIELD: When I was speaking earlier I was
14 really speaking to freestanding seeing a fall down to six as
15 you pointed out, but also to the outpatient, because I
16 didn't see it up here but I thought I had heard you say
17 that.
18 MR. HACKBARTH: I would think that the cost
19 allocation issues get especially important when you're
20 talking about small, hospital-based home health agencies. I
21 don't know exactly how the cost would be allocated, but
22 relatively small allocations of cost could have a big impact

1 on the margin for a small agency. Whether that's reality,
2 that ought to be recognized in payment.
3 DR. STOWERS: I just wanted to answer Bob. I may
4 not have said that very well. I really was talking access,
5 because if we have had a recent change in law that dropped
6 the reimbursement in the rural areas by 5 percent, I don't
7 see there's any way that that rural agency that is taking
8 care of more chronically ill medical patients compared to
9 the urban that probably has a higher number of rehab, which
10 we know there is a discrepancy, could be offering the same
11 services at 6.1 -- although I know a lot of areas of
12 medicine would like to have a 6.1 -- compared to other
13 agencies that have a 13.2 percent.
14 If we talk equal access to care for Medicare
15 beneficiaries in home health, I don't see how two agencies
16 standing side by side could pull off equal -- maybe it takes
17 a long-term study of true access and quality to see that it
18 does translate. But intuitively, you would think that an
19 agency that had its profit margins dropping in half while
20 the other agencies are maintaining essentially the same
21 profit margin would have to make some adjustment in the
22 services that they were providing. That is why I was saying

1 it looks like to me we were where we belonged before the 10
2 percent.
3 DR. REISCHAUER: Notwithstanding my initial joke,
4 I was actually trying to find some metric to support your
5 case. I was trying to be a friend.
6 MR. HACKBARTH: We are to the final agenda item of
7 the day, dialysis services.
8 MS. RAY: Good afternoon. In the session we will
9 continue our discussion that we started at the October
10 meeting about the adequacy of Medicare's payment for
11 outpatient dialysis services. I'd like to first take you
12 through a quick history of dialysis payment policy pre-MMA
13 and post-MMA. I want to do so because of the significant
14 changes that have been mandated by the MMA and that will
15 begin on January 1, 2005.
16 I think from my perspective there have been three
17 major developments in outpatient dialysis payment policy.
18 The first is when the composite rate was implemented in
19 1983. Congress mandated the implementation of a prospective
20 payment rate which is called the composite rate, and the
21 payment rate was designed to include all nursing services,
22 supplies, equipment, and drugs associated with a single

1 dialysis session. The payment rate, the composite rate was
2 based on 1977 through 1979 cost reports.
3 The second major development from my perspective
4 was the approval of erythropoietin in 1989. This was the
5 first major dialysis injectable drug. Since then payments
6 for these separately injectable drugs have increased
7 relative to composite payment. MedPAC data goes back to
8 1996. There we saw the split at 70 percent composite rate,
9 30 percent injectable drugs. Now looking at 2002-2003 data
10 we see the split at about 60/40, 60 percent composite rate,
11 40 percent injectable drugs.
12 So this table summarizes the pre-MMA payment for
13 outpatient dialysis services in 2004. You'll note a couple
14 of items here. First, there is a $4 difference between
15 freestanding and hospital-based facilities. This $4
16 difference stems from the Congress mandating HCFA to develop
17 one rate for hospital-based facilities and another rate for
18 freestanding. Using the 1977 cost report data they found a
19 $4 difference which they attributed to overhead, not to
20 differences in patient case mix or complexity.
21 The other point I would like you to take home here
22 is the payment for separately billable injectable drugs.

1 Erythropoietin payment is mandated during this pre-MMA
2 period by the Congress so both freestanding and hospital-
3 based facilities are paid $10 per 1,000 units. Note the
4 difference for other separately billable drugs, 95 percent
5 AWP for freestanding facilities. Hospital-based, by
6 contrast, facilities get reasonable cost.
7 So let's turn now to the third major development
8 in outpatient dialysis payment policy and that is the
9 passage of the MMA and the fact that it will begin to be
10 implemented by CMS beginning on January 1, 2005. There are
11 three big changes that will start in 2005. The first is the
12 add-on adjustment to the composite rate. The second is case
13 mix adjustment, and the third is paying for most injectable
14 drugs, but not all, based on the average acquisition cost.
15 So let's start with the add-on adjustment, what is
16 it? The add-on adjustment represents the profit margin
17 associated with all separately billable injectable drugs
18 furnished by freestanding facilities, and erythropoietin
19 furnished by hospital-based facilities. So when you take
20 this pool of money, this profit margin, and you distribute
21 it equally across all treatments it calculates up to an add-
22 on adjustment of 8.7 percent of the composite rate. So both

1 freestanding and hospital-based facilities will receive this
2 8.7 percent add-on adjustment to their composite rate
3 beginning on January 1.
4 In case my words aren't clear, here is a graphic
5 description of the composite rate. Here you see the $4
6 difference. This is in 2005. And you see the 8.7 percent
7 application of the add-on adjustment.
8 So this table summarizes all of the changes that
9 will occur beginning on January 1. The composite rate will
10 be increased by 1.6 percent, so you see now the payment rate
11 will be $128 for freestanding, the base rate, versus $132
12 for hospital-based. That reflects the 1.6 percent update.
13 The add-on adjustment is the same for both facility types.
14 Case next adjustment is the same. I want to note that the
15 case mix adjustment, payment will be adjusted using six age
16 groups and two body mass measures. Height and weight is
17 going to be used to calculate the BMI. Beginning on January
18 1, facilities will be required when they submit a dialysis
19 bill to also report patient's height and weight.
20 Now you will note the continued difference in
21 payment for injectable drugs. For both facility types
22 erythropoietin will be paid on average acquisition cost.

1 Where does this average acquisition cost data come from?
2 From a report that was mandated by the Congress and
3 submitted by the IG during this year. They looked at the
4 average acquisition cost for erythropoietin in the 10
5 leading dialysis injectable drugs for freestanding
6 facilities. They reported 2003 data for these injectable
7 drugs.
8 However, you will also note that other injectable
9 drugs other than erythropoietin, hospital-based facilities
10 will continue post-MMA to be paid reasonable cost. For a
11 very small minority of drugs currently, freestanding
12 facilities will be paid average sales price plus 6 percent.
13 DR. NELSON: How does the average acquisition cost
14 for Epo now compare with the previous payment?
15 MS. RAY: I don't have the exact number. Pre-MMA
16 Epo was $10 per 1,000 units. Post MMA it's about $9.70-
17 something. But facilities will also be paid separately
18 post-MMA 50 cents per syringe used for Epo. So it actually
19 comes out to be a little bit more post-MMA for Epo.
20 MedPAC has repeatedly recommended expanding the
21 payment bundle and modernizing the outpatient dialysis
22 payment system. We set forth a series of recommendations in

1 our 2001 report. I think the MMA does take some small steps
2 towards our recommendations, most notably by implementing
3 the case mix adjustment. But the MMA has created some
4 problems and the Commission might want to think about
5 identifying these issues in the March report and continuing
6 to work on them in the spring.
7 There are four issues that we raised in your
8 briefing materials. The first relates to the different
9 composite rate payments between facility types. Now that
10 payment is case mix adjusted it may not be necessary to
11 continue this payment differential between freestanding and
12 hospital-based facilities.
13 The second issue concerns the add-on adjustment.
14 This methodology may not be the most appropriate way to pay
15 for dialysis services. As noted by MedPAC and other
16 researchers, the current drug payment policy promotes the
17 less than efficient use of drugs by certain providers. The
18 add-on adjustment continues to base payment on a less than
19 efficient policy.
20 The third issue relates to the post-MMA method of
21 continuing to pay injectable drugs using three different
22 methods. At issue here is potentially just using one

1 method, some sort of average acquisition cost that the MMA
2 calls for, but using the same method to pay for all drugs
3 across freestanding and hospital-based facilities.
4 The fourth issue concerns the comprehensiveness of
5 the average acquisition cost data from the IG. It does not
6 include all dialysis injectable drugs and the long-term
7 sustainability of it. It will be updated each year by the
8 PPI, but as time goes on it may not accurately represent the
9 acquisition cost if negotiating practices change between
10 providers and manufacturers.
11 The other issue that we raised in your briefing
12 materials concerned monitoring and improving quality. Here
13 I just want to be very brief and note our pay-for-
14 performance recommendation that we made in last year's March
15 report.
16 Your briefing materials also laid out MedPAC's
17 longer-term workplans concerning continuing to monitor
18 beneficiaries' access to care, particularly with the changes
19 mandated by the MMA, and looking at ways the continue to
20 improve outpatient dialysis payment policy. I would be
21 happy to take any questions you may have about that.
22 So let's move on to looking at payment adequacy.

1 Recall at the October meeting we discussed the first four
2 measures that are highlighted in yellow. We did not find
3 major problems with beneficiaries' access to care. We will
4 follow up on one finding, that closures may be
5 disproportionately occurring in areas where a higher
6 proportion of the population is African-American. Dialysis
7 quality is continuing to improve for some measures, and both
8 capacity and volume of services continue to increase.
9 So let's move on now to the two measures we have
10 not yet discussed and that is access to capital, and
11 Medicare payments and costs in 2005.
12 Concerning access to capital, indicators suggest
13 that providers have adequate access to capital. There was
14 an announcement just this week that the third largest
15 national dialysis chain will be purchasing the second
16 largest chain, and according to the public announcement they
17 will be relying on bond and bank debt to do so. This
18 suggests that the capital markets are confident about the
19 dialysis sector.
20 However, there are three developments that could
21 affect long-term access to capital in the future which we
22 will continue to monitor. Two relate to the changes in

1 Medicare policy, the MMA and the Epo monitoring policy, and
2 the third relates to a subpoena that was issued to three of
3 the national chains related to their lab testing and use of
4 certain injectable drugs.
5 I'd like to now discuss Medicare's payments and
6 costs. The first thing we looked at here is the
7 appropriateness of cost, and we looked at it two ways. The
8 first way we looked at changes in cost per hemodialysis
9 treatment between 1997 and 2003. There are a series of
10 points I'd like you to consider.
11 There seems to be three distinct periods here.
12 Costs grew modestly between 1997 and 2000 at about 2 percent
13 per year. Let me interrupt myself and say that this is for
14 freestanding dialysis facilities only. So we have modest
15 cost growth in the late 1990s. Like some of the other
16 institutional providers, costs increased substantially
17 between 2000 and 2002, and costs declined by 1.5 percent
18 between 2002 and 2003. This is based using cost reports for
19 each of these time periods. There were facilities that were
20 open and had cost report data in each of these years.
21 We're going to follow up on this decline in cost
22 per treatment. What we do know so far is when you look at

1 the change in cost by category, that is capital, labor,
2 other direct, and general administrative, you do see
3 differences here. General administrative costs increased
4 the most between 1997 and 2003, by about 5 percent per year.
5 By contrast, other direct costs decreased by about 1.8
6 percent per year. So in January we will report back to you
7 on the changes in cost growth per category within each of
8 the years.

9 I'd also like to point out here that, as you
10 discussed in some of your earliest sessions, we are looking
11 at averages here. Cost growth varies. Overall we have an
12 average annual cost of about 2.2 percent, but per-treatment
13 costs for facilities in the 25th percentile of costs grew at
14 about 0.3 percent. By contrast, facilities in the 75th
15 quartile, costs grew at 4 percent.

16 Moving into the other aspect of how we look at the
17 appropriateness of cost, we looked at the relationship
18 between the costs that providers report on their cost report
19 and what is ultimately found to be Medicare allowable. The
20 industry has criticized MedPAC in the past for continuing to
21 use an audit factor based on 1996 data. So we analyzed the
22 2001 cost report. Keep in mind that the BBA has a

1 requirement that the Secretary audit dialysis facilities'
2 cost reports.
3 We still find a difference between reported and
4 allowable costs for those facilities that were audited.
5 What we did is we looked at the cost per treatment using
6 this year's 2001 cost report and compared it to last year's
7 2001 cost report. So we will continue to apply an audit
8 factor, but in a more defined fine manner than we have done
9 in the past. Specifically we will apply it to those
10 facilities that you do not have settled cost reports.
11 So this leads us now to the Medicare margin for
12 freestanding facilities estimated for 2003 and projected for
13 2005. Here you are looking at the aggregate Medicare margin
14 composed of payments and costs for both composite rate
15 services and the separately billable drugs. I know I'm
16 repeating myself but this is 2003 cost report data merged
17 with 2003 claims submitted by freestanding facilities.
18 These margins do reflect the audit factor.
19 Next up in our framework is to consider how
20 providers' costs will change in 2006, the coming year. I
21 want to start with the growth in input prices between 2005
22 and 2006. We have adopted the CMS market basket and they

1 project prices will increase by 2.8 percent.

2 Next let's consider MedPAC's policy goal of

3 encouraging provider efficiency. In past year's we have

4 applied the productivity goal in our recommendation and I

5 think commissioners should consider several points for

6 continuing to do so for 2006. The cost growth between 1997

7 and 2003 is less than the cost growth as predicted by the

8 CMS market basket during this time period. The cost per

9 treatment has declined between 2002 and 2003. And our

10 adequacy measures, access, capacity quality, and access to

11 capital are strong.

12 The other factor that could potentially affect

13 providers' costs is new scientific developments. As we have

14 concluded in the past, these are mainly associated with

15 separately billable drugs and in 2005 they will continue to

16 be paid for separately.

17 So this leads us to a draft recommendation for you

18 to discuss. The spending implications, it will increase

19 spending over the baseline. In terms of beneficiary and

20 provider implications, no major implications.

21 MS. DePARLE: Nancy, thank you for a very strongly

22 done job here. Thank you for updating the audit factor,

1 because I think I'm one of the ones who has raised that with
2 you before, that it was out of date.
3 There were some things that were highlighted a
4 little bit more in the text of the document than you were
5 able to in this short presentation, and I guess I would say
6 that I would think we might want to consider recommendations
7 around some of them. The $4 difference between the
8 freestanding facilities and the hospital-based facilities in
9 composite rate really sounds like an historic anomaly. I am
10 not sure why that needs to continue. That is something that
11 highlighted in the text.
12 The issue around the add-on adjustment and how it
13 is spread both between the freestanding facilities and the
14 hospital-based facilities in a way that results in the
15 hospital-based facilities getting more of the adjustment
16 than one might argue the formula should entitle them to.
17 This is from the rule that was done this summer. We talked
18 about that in here and I thought we were against that, or I
19 thought we didn't think it was fair. So I for one think
20 there should be a recommendation around that.
21 The finally, you have highlighted, for me anyway -
22 - I am not sure I understand a compelling reason where there

1 are different ways of paying for drugs, injectable drugs,
2 among the different settings. I think we should at least
3 consider whether there is something we could say about that.
4 DR. REISCHAUER: As information that would inform
5 my support or lack thereof for Nancy-Ann's proposal with
6 respect to eliminating the hospital differential, a pot of
7 money was created by looking at the excess profit from
8 freestanding and from hospitals, lumping it together,
9 dividing it by total composite spending, and coming up with
10 one percentage and then applying it back to the differential
11 composite rates.
12 I guess my question would be, if you just looked
13 at the money that was being taken away from hospitals, what
14 percent of their total composite spending was that? And if
15 I looked at the portion that was taken away from the
16 freestanding related to their composite -- because if we're
17 taking away unequal amounts or percentages, why would we be
18 adding them back equally, and it might give a justification
19 for eliminating that. Do you understand what I'm saying?
20 DR. MILLER: Some of the reason we didn't rush to
21 recommendations here, although we think there's a whole set
22 of issues that have been implicated here -- and I'm going to

1 say something that might not be as complicated as that
2 hopefully -- but he's on to something here.
3 The reason that we did not rush to recommendations
4 here is this gets really complicated. A couple of things to
5 consider here.
6 For example, if you wanted to continue to protect
7 the dollars that move from freestanding to hospital-based
8 you might end up with more than one rate. But in the same
9 breath we were talking about, should this $4 differential
10 continue? So there's a couple questions here.
11 Another question is if the money is in fact going
12 to change hands, part of the reason it changed hands is
13 because the two different types were reimbursed differently
14 for drugs. One was actually profiting from the AWP spread
15 and one was being paid on reasonable cost. Which of those
16 was right is the $64,000 question.
17 MS. DePARLE: Or which profited the most? I also
18 would say, didn't Congress say it was supposed to be budget
19 neutral?
20 DR. MILLER: They said budget neutral but that --
21 MS. DePARLE: To me that means it goes to the
22 places where it came from.

1 DR. MILLER: That's the question. The other
2 question is, if you're going to change hands, should it all
3 go to -- it went from freestanding to hospital-based, but
4 there are other options here. It could go back to the
5 program. It could go to low-income beneficiaries. There
6 are a lot of questions here.
7 Then on the drugs, I think precisely what the
8 Nancy is setting up here is, we now have at least three
9 different mechanisms. We don't know the incentive
10 structures, and before we say let's do one and rationalize
11 it, we also ought to understand the impacts here because
12 somebody might say, I'm going to move away from these drug
13 regimens if you change to a different reimbursement.
14 MR. HACKBARTH: Can I add to the list of
15 questions? I wasn't clear as to why when we are going
16 through all of the changes in the payment for separately
17 billable drugs that we continue reasonable cost payment for
18 hospitals into the future. I understand maybe historically
19 why they were treated differently but what was the thinking
20 about continuing that going forward?
21 MS. RAY: CMS's comment about that in the final
22 rule was that the IG didn't report on that so therefore they

1 are leaving the reasonable cost method as is.
2 I just want to follow up on one point that Mark
3 made about the add-on adjustment and what should the
4 composite rate payment be. After 21 years, it raises the
5 issue, do we really know what the costs are? Perhaps some
6 additional research, additional study, time and motion study
7 or something is another option to throw out on the table
8 when you open up this whole can of worms here.
9 MR. HACKBARTH: Other comments on this?
10 DR. REISCHAUER: Enlighten me on the conversation
11 you had with Alan in which he said what's the AAC like
12 compared to what we were paying before, and you said, it's
13 gone from $10 down to $9-something but we're adding 50 cents
14 for each needle.
15 MS. RAY: That's for Epo. But for other drugs --
16 DR. REISCHAUER: But you came up with a higher
17 payment and I thought some of this profit that we were
18 taking away came from Epo, but maybe it doesn't. Does it
19 all come from other injectable drugs?
20 MS. RAY: No.
21 DR. REISCHAUER: Because how could we take it away
22 and then say, but we're going to give you back more than we

1 took?

2 MS. RAY: Part of it does come from Epo. Part of

3 it also comes from the other injectable drugs. When you

4 look at the difference between pre-MMA and post-MMA for the

5 other drugs there is more of a difference in the payment

6 rates than there is for Epo. Epo, thinking back to the

7 data, was the smallest difference between pre- and post-MMA,

8 at least was my read of the data.

9 DR. REISCHAUER: But you suggest that the

10 difference has a difference sign on it in your answer to

11 Alan.

12 MS. RAY: The average acquisition cost is in fact

13 lower than the pre-MMA payment rate, but now beginning post-

14 MMA, facilities will be paid the 50 cents per administration

15 of Epo.

16 The other thing I want to say is the average

17 acquisition cost derived from the IG and applied by CMS is

18 the weighted average from both chain and non-chain

19 facilities, and you will see a difference in the profit

20 margin. The IG noted that overall for all injectable drugs

21 there was a 22 percent profit margin for chains versus I

22 believe it was a 14 percent profit margin for other

1 injectable drugs.

2 MR. HACKBARTH: Anybody else?

3 All right, thank you.

4 We will now have our brief public comment period.

5 Please keep your comments brief and to the point. If

6 someone else makes the same comment in front of you, please

7 don't repeat it.

8 MS. SMITH: Kathleen Smith with Fresenius Medical

9 Care. The answer to the question that was just being asked

10 is, the reimbursement was reduced from $10 per 1,000 units

11 of the drug administered to $9.72 per 1,000 units. The 50-

12 cent administration fee is per administration. Many

13 thousands of units are given per administration, so didn't

14 raise 1,000 to $9.72 plus 50 cents.

15 MR. LANE: Larry Lane, Genesis Health Care. I

16 want to thank Senator Durenberger for his comments on the

17 SNF quality issues. I would like to make four quick points.

18 First, probably to recognize the significance of

19 Sally's comments about discharges from the SNF level, that

20 over half to three-quarters of SNF patients are discharged

21 back to the community. For some of us in this room that

22 have been around the long-term care issue for a long time,

1 that is a token of tremendous success. We're making some
2 progress.
3 Second, a zero update will have a negative impact.
4 There's a relationship between reimbursement and staffing.
5 The OSCAR data in fact confirms that, and we have provided
6 that information to the Commission.
7 Third, would ask that you be very clear on the
8 issue of whether to retain RUG add-ons, that aggregate
9 dollar amount, or to eliminate them. The market basket and
10 the loss to the RUG add-ons in 2006 would account to being
11 almost 12 to 15 percent of the per diem. Translates into
12 about 1.5 percent of the total margin. And if you take
13 certain assumptions about Medicaid, we will be back at a
14 zero margin level and we will have destabilized the
15 profession once again.
16 Finally would be, a little surprised the
17 Commission has not addressed the issues of how to provide
18 pharmacy under the Medicare Part D to nursing home
19 residents. It is a concern. We do not know on 1/1/06 how
20 the program is going to be implemented and what its impact
21 is going to be on SNF residents.
22 Thank you.

1 MR. KENLEY: My name is Rod Kenley. I founded a
2 company called Aksys Limited about 14 years ago that markets
3 a device that it is specifically designed for daily home
4 hemodialysis. Id' like to make a comment in strong support
5 of a rapid implementation of the expanded bundle.
6 There are probably over 350 clinical reprints and
7 peer review journals that support the significant
8 improvement in clinical outcomes in patients that are
9 dialyzed on a daily basis in their own homes. This
10 encompasses both improvements in mortality, about 2.5 times
11 less mortality, less hospitalizations, and significantly
12 less drug consumption, meaning the patients are much better
13 off and the taxpayers spend a lot less on these patients.
14 Yet there continues to be disincentives from the
15 reimbursement standpoint for the clinics to expand their
16 provision of home hemodialysis or home dialysis in general.
17 Getting to the expanded bundle we think will go at least
18 part way to reestablishing some of the incentive for home
19 dialysis that was originally intended in the 1983 composite
20 rate. We would highly encourage the commissioners to please
21 resist any attempts to delay the institution of this
22 expanded bundle.

1 MR. FENNIGER: Randy Fenniger, American Surgical
2 Hospital Association. I would only ask that the record
3 reflect that I got nowhere near a light switch today and was
4 very careful to sit somewhere else.
5 Regarding the recommendations that were discussed
6 today, as I recall we got into this whole debate because of
7 allegations that specialty hospitals owned by physicians
8 were harming community hospitals. I have yet at any of the
9 presentations your staff has made to see any evidence that
10 such has been taking place. Going back to last month's
11 meeting, in fact that was a conclusion that profits remained
12 approximately the same as other hospitals in 2002, and also
13 that there is no apparent change or no noticeable change or
14 significant change in utilization in the analysis that was
15 presented. So I would have to ask, what are we trying to
16 really address here?
17 If the issue is really what is called cherry-
18 picking or the deliberate or inadvertent manipulation or
19 movement of cases, the recommendations that have been made
20 regarding DRG changes, if endorsed by the hospital awful
21 industry and accepted by Congress, would seem to deal
22 directly with those kinds of issues by eliminating any

1 financial incentives. So if people invest in these
2 hospitals for a financial incentive and the ability to
3 manipulate cases and profit from it, you will take that away
4 from your recommendations.
5 This raises the question of whether or not you
6 need to continue the moratorium. I would argue that you do
7 not, because if Congress accepts your recommendations on the
8 DRG changes, the market will take notice. Those people who
9 were planning to enter the market simply to profit will go
10 find some other place to invest their capital. Those people
11 who were planning to develop hospitals for other reasons
12 than profit would still continue to do that and try to make
13 the best possible situation out of it under the new rules.
14 Several of you spoke to the need for competition,
15 innovation, specialization. I would ask you, who is going
16 to do that? If you take away the ability of physicians to
17 do it, where does the competition come from? I don't have
18 the answer but I think it is something that you would need
19 to consider.
20 I would note further that in your presentation by
21 your staff in September it was pointed out that hospitals
22 frequently commented or did comment that the presence of a

1 specialty hospital in their community was a wake-up call and
2 they improved their services. To take away the ability of
3 physicians to invest in these hospitals is a call to go back
4 to sleep. I am not sure that is a desirable outcome for
5 public policy either.
6 Finally, let me address the grandfathering clause
7 that was in the recommendation, which was a pretty tight
8 grandfathering clause. Sounds like my old Presbyterian
9 minister grandfather.
10 Grandfathering will not work. The investments
11 that have been made, whether they've been made by the
12 individual physicians, corporations, or hospitals will be
13 rendered valueless very quickly if you eliminate the whole
14 hospital exemption. That is not going to protect the
15 billions of dollars of assets that people have already
16 invested in in various parts of the country. Of course,
17 that's not just limited to physicians, as you know from your
18 own data. That is hospitals like Baylor, that is hospitals
19 like the one in Kalispell, Montana and other places around
20 the country where there are joint ventures between hospitals
21 and physicians to establish these.
22 I hope you'll give consideration to these ideas

1 over the coming month and that we will have an opportunity
2 to discuss these further before you take your final votes.
3 Thank you.
4 MR. WEINBERG: Hello, my name is Tom Weinberg.
5 I'm with DaVita and I'm commenting on the dialysis portion.
6 Ms. Ray, thank you for the report, and especially thank you
7 for noting the issues relating to the difference between
8 hospital-based centers and freestanding centers are paid.
9 If I understood the question Dr. Reischauer, I think about
10 this stuff all the time but it is true that more of the
11 money in the pot, as you put it, of money that was to be put
12 into the composite rate, came from the freestanding centers
13 as opposed to the hospital centers. So over 10 years about
14 $1.8 billion will be shifted away from the freestanding
15 centers' reimbursement because of the way that CMS
16 instituted one add-back payment to see composite payment as
17 opposed to having separate add-backs for hospital versus
18 freestanding.
19 Then I have two questions, one relating to the
20 audit adjustment, and the second having to do with the
21 payment adequacy predictions for 2005. On the audit
22 adjustment, again thank you for taking a look at that again

1 and updating that data. That is a very important matter and
2 we appreciate that. I believe from your comments that I
3 understand that a sample in 2001 cost reports were looked
4 at, so I would ask the Commission and the staff to look at
5 the question, are there differences between the audit
6 adjustment experiences among regional and national chains
7 versus single or very small operators of dialysis
8 facilities?
9 Then second with respect to the payment adequacy
10 for 2005, I'd like to ask to make sure that the Commission
11 and the staff ask and answer the question, is MedPAC using
12 the same predictions of the growth in into what drug
13 spending would have been under the old law as CMS used in
14 predicting what the payment should be when predicting what
15 the update should be? This is important for 2005 but it
16 will also be important for 2006 as we determine whether the
17 intent of MMA, which was to be budget neutral, has been
18 carried out. So is MedPAC using the same factors to predict
19 future spending as CMS used in its final rule?
20 Thank you.
21 MR. CHIANCHIANO: Good afternoon, I'm Dolph
22 Chianchiano from the National Kidney Foundation. Briefly, I

1 wanted to add to the comments about the landscape for
2 dialysis services in the United States, and particularly to
3 point out two administrative developments that could affect,
4 hopefully for the better, the provision of dialysis services
5 in the United States.

6 First of all, Medicare is going to issue draft
7 regulations which will revise the conditions of coverage
8 which basically have been around since 1976. This is the
9 first time there has been a thorough look at the conditions
10 of coverage for dialysis providers since 1976. That notice
11 of proposed rulemaking is supposed to appear in the Federal
12 Register, or least on the CMS web site, on December 23.

13 The other administrative development is that CMS
14 has empaneled a group of technical experts to develop
15 clinical performance measures for the treatment of disease
16 among dialysis patients. Here again, that may affect the
17 utilization of vitamin D analogs in the dialysis facilities,
18 and hopefully for the better of the dialysis patient.

19 Thank you.

20 MR. MAY: Don May with the American Hospital
21 Association. I have two quick comments.

22 First on the update for home health and skilled

1 nursing facilities. A couple things when you look at the
2 hospital-based margins, the negative 87 percent. I know
3 we've talked about cost allocation. I don't believe there's
4 any amount of cost allocation that can explain negative 87
5 percent. While refinement is on the way, I think the point
6 that Larry Lane brought up about making sure some of those
7 add-ons stay in the base is an important one that the
8 Commission may want to consider next time. That refinement
9 is really needed to make sure that payments improve for
10 costly cases.

11 I think in the home health area, as Carol
12 mentioned, there's a real need to look at the refinement and
13 the case severity that's happened. These have not had the
14 annual recalibration that happens in the hospital side so
15 the distortions grow even broader.

16 I think in light of that, until those happen
17 though, something to make sure that you ensure access. A
18 lot of these hospital-based providers have closed. The ones
19 that haven't are there because of the access concerns.
20 They're in rural areas, and a potential need for an update
21 to cover those large losses and maintain access is probably
22 something to consider.

1 Second, on the niche provider issue. Julian has
2 presented a lot of really interesting and in-depth analysis
3 today that I'm sure we'll all be scanning and waiting for
4 the detail to come out so we can really get into the numbers
5 and look at some of the impacts. Just from what was
6 presented today you can see the wide redistribution and
7 distribution of funding that can happen. Understanding
8 those impacts is going to be very important moving forward.
9 The point Dr. Reischauer brought up about
10 understanding what may be a targeted look at refinement of
11 the DRGs might bring -- I know you are already overworked as
12 a staff, but maybe seeing what that might bring would be an
13 interesting dynamic to do and could help to understand how
14 looking at different components and the implementation of
15 those may ease the burden of doing this and making some of
16 the payment reforms that are needed over time.
17 I think short of that, and given the complexity of
18 making these changes, I want to highlight the importance of
19 the draft recommendation on eliminating the whole hospital
20 exception, and as several commissioners mentioned, extending
21 the moratorium to make sure that we have time for those
22 payment reforms to come into place.

1 Thank you.

2 MS. LLOYD: Danielle Lloyd with California
3 Hospital association. First, I support everything that Don
4 just said before me but I will move on to health information
5 technology.

6 Some of the commissioners, and I assume from the
7 discussion of a previous expert panel that I missed, have
8 suggested that financing is not necessarily a very big
9 barrier in the adoption of health information technology. I
10 can certainly share with you that the California hospitals,
11 all of our members expressed that this is certainly the
12 first and foremost problem. We can't even get people at the
13 table to consider other problems such as our relationship
14 with our physicians, and interoperability, and other such
15 things without the money to get things started, or seed
16 money, which we were hoping obviously to get some more money
17 in the appropriations process this year, but obviously that
18 didn't happen.

19 There's also the suggestion that foundations in
20 the private sector can foot the bill for this. That is true
21 to some extent. They are certainly providing money in
22 number of different areas, but they're not going to fund it

1 everywhere. Obviously, as you've seen from Jack's
2 presentation on our hospital margins, we have meager if not
3 negative margins. More than 50 percent of the hospitals in
4 California are operating in the red. We just cannot afford
5 this.
6 So in your considerations of finalizing these
7 recommendations and also in terms of moving forward, I think
8 that the financial considerations definitely should be
9 weighed a little bit more heavily than I think I heard in
10 today's discussion.
11 Thank you.
12 MR. HACKBARTH: Okay, we reconvene tomorrow
13 morning at 9:00 a.m.
14 [Whereupon, at 5:13 p.m., the meeting was
15 recessed, to reconvene at 9:00 a.m., Friday, December 10,
16 2004.]
17

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 10, 2004
9:05 a.m.

COMMISSIONERS PRESENT:

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

1 P R O C E E D I N G S

2 MR. HACKBARTH: Today is physician day. The
3 doctor is in, right. So we have a series of presentations
4 and discussions related to physician payment issues, the
5 first of which is on measuring resource use. Anne, are you
6 leading the way?

7 MS. MUTTI: Yes. This presentation is about
8 resource use measurement and it is the same topic we called
9 provider profiling in the October meeting. We just prefer
10 the title of resource use measurement because it better
11 describes the underlying concept.

12 Today I will briefly review the discussion that we
13 had in the October meeting and present a draft
14 recommendation for your consideration.

15 Why resource use measurement? The prime
16 motivation for this strategy is its potential to reduce the
17 variation in practice patterns that is not improving patient
18 outcomes. We know from the Fisher and Wennberg work that in
19 regions in the country in which physicians and hospitals are
20 providing many more services, beneficiaries are not
21 experiencing better quality of care outcomes or
22 satisfaction.

1 This suggests that, in general, if physicians who
2 have more resource intensive practice styles moderated their
3 practice patterns the nation could save money on health care
4 without sacrificing quality.
5 For Medicare to realize the potential savings
6 implied by this finding, physicians must be able to first
7 assess their practice style and evaluate whether they tend
8 to use more or less services compared to their peers or what
9 evidence-based research recommends. It is also important
10 that physicians be able to consider their resource and
11 quality measure results in tandem, since that's the best
12 measure of value in health care services.
13 So to explore the potential of resource use
14 measurement, one option is for Medicare to begin measuring
15 the resource use of its physicians. Medicare does have a
16 wealth of claims data, so it is in a good position to feed
17 that information back to physicians on what their practice
18 patterns look like. Medicare would need to develop or
19 attain a measurement tool to interpret the claims data. We
20 talked about some of the various tools available in the
21 marketplace now at our last meeting, and would just note
22 that many of the private sector purchasers are gravitating

1 toward episode measurement and that it has several
2 advantages over other approaches.
3 As we also mentioned in October, to be useful
4 whatever measure that Medicare would use should produce
5 accurate results. That is, that the measurement tool should
6 reflect differences in practice style, not differences in
7 the health status of its patient population, not differences
8 resulting from statistical error or incomplete data.
9 The measurement tool and the results should also
10 be actionable, which means that they should be specific
11 enough and credible enough to inform physicians how they may
12 want to change their practice styles if they feel it is
13 necessary.
14 A number of implementation issues would need to be
15 addressed. These include how patient care would be
16 attributed to a physician, how risk adjustment will be
17 performed, and what the minimum number of observations or
18 episodes assigned to a physician should be before that
19 physician can be measured.
20 While we plan to do further work on identifying
21 characteristics of a good measurement tool and successful
22 implementation, you may want to consider making a broad

1 recommendation for the March report supporting Medicare's
2 use of resource use measurement. The recommendation might
3 be worded as follows: The Secretary should use Medicare
4 claims data to measure fee-for-service physicians resource
5 use and confidentially educate them about how they compare
6 with their peers. The Congress should direct the Secretary
7 to perform this function.

8 We actually believe the Secretary has the
9 authority to require carriers to perform this function and
10 we understand that there is some activity among certain
11 carriers in this area, and it seems to be primarily related
12 to detecting improper billing. So in any case, we don't
13 think that the effort that carriers are doing now is a
14 comprehensive one. For that reason, Congress may want to
15 give the Secretary a clearer direction of the purpose of the
16 intent here.

17 With respect to the spending, beneficiary and
18 provider implications, the short answer that we have up on
19 the slide is no impact, but there is definitely a longer
20 answer, which is that our hope is that this would make a
21 difference, that physicians would adjust their practice
22 style when given in a way that would decrease spending and

1 possibly improve quality of care. Research suggests that
2 this may well occur.
3 At the same time, the Commission may want to
4 consider options to promote the ability of plans and
5 providers themselves to measure resource use. One approach
6 could be to have Medicare share its data with private
7 purchasers and we understand that this is not currently
8 permissible due to privacy laws that protect physicians'
9 privacy just as any other citizens. Having access to
10 Medicare claims data with physician identifiers would allow
11 private purchasers to better measure the resource use of
12 their physicians and measure more of their contracting
13 physicians.
14 Medicare might benefit from a spillover effect of
15 this approach to the extent that physicians do modify their
16 practice styles it would likely apply to all types of
17 patients, not just those that are covered by private
18 purchasers. However, as was alluded to at the last
19 meeting, there may be an unintended consequences of this
20 approach, also.
21 Another possibility, as you discussed yesterday,
22 is to lift the current restriction on gainsharing

1 arrangements and instead give the Secretary authority to
2 regulate these arrangements. This policy could encourage
3 physicians and hospitals to measure resource use during a
4 hospital stay because now it would allow them to share in
5 the savings resulting from their efforts.
6 You may want to primarily consider that
7 recommendation in the context of specialty hospitals but
8 it's just worth nothing that it would also encourage and
9 provide another opportunity for resource use measurement.
10 In terms of future work, we think of this as sort
11 of our first step and we're looking forward to doing more
12 work. We want to look at what characteristics of
13 measurement tools and implementation appear to improve
14 accuracy and the ability of physicians to act on those
15 results. We'd like to identify potential area such as types
16 of services or patients or specialties for Medicare and the
17 private sector to focus their measurement efforts.
18 On this point, we did provide an illustration in
19 your draft paper of the potential information resource use
20 measurement can yield. There we present what one vendor's
21 approach to resource use measurement tells you about the
22 practice pattern variation between specialists, the

1 consistency of that variation across regions, and variation
2 within a specialty in a single region.
3 We hope to do our own work along these lines in
4 the coming months and, at this point we'd like to turn it
5 over and get your comments.
6 DR. BERTKO: First of all, I'd like to recognize
7 the excellent work that Anne and Kevin have done in pulling
8 this all together. I think the data they've gathered and
9 organized is in a pretty coherent form for something that's
10 fairly technical.
11 Again, and Arnie's not here this morning. He
12 grabbed me before he left yesterday and said that I should
13 talk twice as much for both of us. I'll try to refrain from
14 that.
15 On the first part of it, I guess I'd like to
16 strongly support the recommendation, which I think falls
17 under our wider rubric of saying let's measure things, let's
18 disclose them, let's help physicians understand in
19 particular where there are going and how they compare. I
20 look to the other physicians in our group here to make
21 comments upon that.
22 In particular, from my perspective, as a policy

1 goal of reducing the cost of Medicare, the expenditures,
2 without any likely deterioration in services or stinting on
3 services, this is one that just by disclosure has the aspect
4 of being a big number. I think Arnie and I have both thrown
5 out a number that says in its most effective form it might
6 include savings of as much as 10 percent, which I think is a
7 small part of the 30 percent or so that Fisher and Wennberg
8 had said. They had a number, I think, which was up near the
9 30 percent range.

10 So when we're talking about budget savings in
11 future years, this is not a switch you can just click and
12 recognize those savings immediately. But we've got to start
13 somewhere, akin to the comments on IT and others, and this
14 is a good place to start.

15 Secondly, on the spillover effects of this, if the
16 promise of the MMA to deliver regional PPOs, particularly in
17 areas that are not big urban areas, are to be realized I
18 would suggest that this is one of the things that the
19 private sector needs to have some access to. The Medicare
20 fee-for-service database is incredibly rich in things. And
21 with the proper controls on the use of the data, I think
22 could be just extraordinarily helpful in again making the

1 MMA come through and in recognizing some of the savings
2 there while furthering public policy goals.
3 The last comment is just to say if you haven't
4 looked at the charts there, you probably won't be surprised
5 by the variation. But seeing it in actual numbers is always
6 stunning. And when you put it together with the New Yorker
7 article that we saw that relates it to real people, this is
8 something that I think should be strongly considered by our
9 group in terms of promoting it with Congress and CMS.
10 MR. HACKBARTH: Let me just add to what John said
11 about the rubric that this comes under. As I said several
12 times in previous meetings, I think that we have reason to
13 expect that given not just the budget deficit but the long-
14 term fiscal challenges facing the Medicare program,
15 demographically driven challenges, that there's going to be
16 growing pressure to economize. My greatest fear is that
17 happens in an environment where we treat all providers as
18 though they are equal and subject them to the same pressure,
19 the same squeezing, when in fact they very a lot, not just
20 physicians but all types of providers.
21 I think it's incumbent on us to, as John said,
22 begin building tools that will allow us to make more

1 sensitive, appropriate adjustments as we move into that
2 environment. And that's very much the way I see this. This
3 is an investment in developing a tool that hopefully will
4 get increasingly refined, sophisticated and helpful to
5 physicians in understanding their practice. I think it will
6 take time and investment to get it to that point. I'm not
7 sure you can just open up the box and say this is great. So
8 I have a longer-term perspective in looking at this.
9 MR. MULLER: Let me add my commendation to you, as
10 well, for this work. Over the last two days and, of course,
11 over the fall we've talked about a number of ways in which
12 one could achieve the kind of ends that both John just spoke
13 to and you have in the chapter. You have the kind of
14 measurement in reporting look here. Yesterday we talked
15 about pay for performance. You have something in here on
16 gainsharing that came up, as well. We talked about
17 electronic health medical records yesterday. And while we
18 didn't discuss it in this session, the expansion of Medicare
19 Advantage.
20 As you think about those various policy tools and
21 levers and so forth, do you have any kind of sense of
22 ranking of where the bang for the buck is in those? It's

1 not that one just uses one of those, and obviously a lot of
2 them are used in a complementary way. For example, a lot of
3 the comparative work is obviously advantaged by having
4 electronic records and so forth.
5 But could you speak a little bit to where the kind
6 of comparative advantages of those various tools that one
7 might use?
8 DR. HAYES: One distinction that you made in there
9 was between Medicare Advantage and fee-for-service. At this
10 point, we have what, at least 85 percent of Medicare
11 beneficiaries in fee-for-service. And so for my money, at
12 least, you want to pursue tools that allow some work in that
13 area. And this measuring resource use tool that we're
14 talking about here is one that can fit in that.
15 Beyond that, it's really a function of how many
16 Medicare beneficiaries are in the different parts of the
17 program, be it Medicare Advantage, be it the regional PPOs -
18 - which I guess is part of Medicare Advantage -- but within
19 that sector. I guess what I'm trying to get at here is the
20 key driver is just where are the beneficiaries? And what
21 tool can you use for most of those beneficiaries, the
22 largest number of those beneficiaries?

1 MR. MULLER: In part, I don't think we generally
2 do this because it's more akin to the return on investment
3 type of analysis in terms of if one went down these courses.
4 Obviously, they all have a lot of intrinsic merit.
5 But if in the world of CMS constantly being
6 overloaded with all the tasks, especially after the Act last
7 year, we've spoken for many years about just the general
8 strain on their administrative capacities. Perhaps -- and
9 it's not something we're going to do in the next month or so
10 -- but as we keep developing this theme, and as you
11 mentioned this theme is not going away anytime soon --
12 perhaps considering where in comparisons one might want to
13 push investment in terms of what we know about both likely
14 outcome, ease or difficulty of implementation, et cetera.
15 So that might be a course for us to consider, again not in
16 the next month, not to make Mark nervous, but over the
17 course of maybe next year.
18 I think we've all, those of us who have been
19 watching Jack's work for 30 years, you keep asking yourself
20 why doesn't this get more traction? Obviously inside the
21 policy community it has gotten a lot of traction in the last
22 year or two or three. But thinking about what steps one

1 takes to implement, I think, is important because if, as
2 either Kevin or Anne said, just on the face of it people
3 would act on it, it would have happened a long time ago
4 because a lot of this information has been out there for a
5 long time. So thinking what policy tools one wants to use
6 and what kind of order, I think, is a fruitful thing for us
7 to consider.

8 DR. MILLER: This is not exactly on your point but
9 you also mentioned the resources and the ability of CMS to
10 respond to these things. And as you think about the last
11 couple of days, we've asked a lot of things and there's
12 definitely an issue there of how much they can do,
13 particularly given what's going on what MMA.

14 But one point here is that they also have greater
15 contracting authority now and the ability to pick
16 specialized contractors to do specialized types of work now.
17 That would still take money, but it does also mean that you
18 could perhaps envision something like that and not having a
19 central office, a huge impact on central office activities.
20 You could see if you could handle a lot of this through a
21 specialized contractor.

22 It still has implication for the agency. That

1 have to oversee it. They have to make sure that the data
2 travels to the contractor. There is some possibility.
3 That's not to ignore your point about the priorities, that's
4 well taken.
5 DR. NELSON: Physicians are understandably
6 concerned about economic credentialing, tiering, profiling,
7 exclusion from plans because there's been some unhappy
8 experience with the private sector in the past on that.
9 Having said that, there's no question about the need to
10 reduce waste and I'm not arguing with this recommendation a
11 whit. I fully support it. Everything we can do to reduce
12 waste is important to do.
13 I always remember that the best internist in our
14 group was a man who remembered every diagnosis he'd ever
15 missed in his whole career. He was a high utilizer because
16 one person's wastefulness is another person's thoroughness.
17 Obviously, practice guidelines are a good approach to use
18 that.
19 The point that I want to make in all of this is
20 while confidential sharing of information with providers,
21 physicians and others, makes sense and will be accepted, it
22 will be accepted with some suspicion about what comes next.

1 And if what comes next is public disclosure or, God forbid,
2 exclusion from Medicare-based economic performance in the
3 absence of really good severity adjustment, then obviously
4 there will be a real concern about patient dumping and
5 adverse selection in order to protect your profile. I think
6 we just have to bear that in mind.
7 That's not an issue as long as the information
8 remains confidential. But if it starts being publicly
9 displayed, then we're going to have to make sure that
10 there's a adequate severity adjustment.
11 DR. CROSSON: I support this direction, also. I
12 think it makes a lot of sense. My own life experience would
13 suggest that the large majority of physicians have an honest
14 desire to the right thing.
15 As Ralph said, Jack Wennberg's life work provides
16 information, though, that that right thing seems to be
17 different in different places and at different times. And
18 the reason for that is complex, or the set of reasons for
19 that vary. Some of it has to do with different cultures
20 that appear to be supply related that arise in different
21 parts of the country. And then there's other patterns of
22 care that don't seem to have any good reason other than it

1 just happens to be the custom that has developed over a
2 period of time.
3 I think this tool works. I know it works. It's
4 one of the tools that has led to, I think, the success over
5 time of prepaid group practices for a couple of reasons.
6 Number one, there is, in that setting, the infrastructure to
7 collect the information in the first place. There's a
8 culture of acceptance, generally speaking. And there's also
9 the natural peer group in that setting that allows
10 disclosure within that group and creates some of the
11 constructive pressure to use the information.
12 There is, as has been mentioned, a sort a
13 hierarchy here that moves in two directions in terms of the
14 utility of this information. The first level of utility is
15 just awareness. That is awareness by the individual
16 practicing physician. It's also the safest, I think, the
17 least controversial in many ways.
18 Perhaps more effective than that is disclosure to
19 some sort of peer group. As I said, in some group settings
20 that peer group is readily available. In other settings one
21 could project it might be more difficult to construct. But
22 that is a different level -- it creates a different level of

1 feeling of competitiveness among physicians which can be
2 constructive. It also then raises, as has been mentioned,
3 the barriers and the concern about this.
4 Finally, the next level would be the addition of
5 incentives connected to the performance. I think that both
6 increases the effectiveness and potentially also raises the
7 barriers. Somewhere in there, over time, there needs to be
8 judgment made about matching the level that's used with the
9 accuracy of the information at least, as has been mentioned
10 also.
11 But in general, I think this is exactly the right
12 thing to do.
13 DR. REISCHAUER: I thought you folks really did a
14 nice job condensing a lot of information and providing us
15 with a feel for this. But of course, my reaction was the
16 more you gave us the hungrier I got.
17 I particularly was interested in these variations
18 and sitting scratching my head trying to think why do
19 dermatologists and ophthalmologists have these huge
20 variations? These are adjusted for variations in the
21 diagnosis or whatever it is, and we don't know the outcomes
22 so we don't know if somebody who used a lot of resources

1 cures the person and the other ones don't.

2 We also don't know does this measure adjust for

3 the instance in which one provider is viewed as

4 unsatisfactory by the patient, so after going to

5 dermatologist A and being told well, there's really nothing

6 much you can do, that individual goes to dermatologist B and

7 gets a whole a set of services, whether there is an

8 adjustment made for that kind of situation.

9 DR. BERTKO: Bob, let me try to address that one.

10 I think Doug Cave, who I think is the source of this

11 particular data, and because this is episode-linked, in the

12 case that you hypothesized here if there were two visits but

13 triggered by the same incident or diagnosis, those would be

14 lumped together. And so probably one of the two would own

15 the episode or possibly both.

16 DR. REISCHAUER: Even if they were both

17 dermatologists so the person that then lavished the services

18 on would also get, in a sense, the burden of the earlier --

19 DR. BERTKO: That's likely to be true.

20 DR. REISCHAUER: The next little rumination here

21 is what is a region? Upper Midwest Region I, I mean how big

22 a thing are we talking about here? And is it really a

1 market area? I was thinking of the relative supply of
2 dermatologists. Would I, as a beneficiary, look at all of
3 these people as equally probable source of care? Or is the
4 upper Midwest half of Michigan? In which case there could
5 be submarkets within this and these could be reflected --
6 all of the dermatologists in the suburban Detroit area could
7 be in the 10th decile because there's a whole lot of them.
8 And to maintain their incomes they provide a lot of services
9 per beneficiary.
10 DR. HAYES: Our understanding is that these market
11 areas correspond pretty closely to Medicare payment
12 localities for physician services, of which there are 89.
13 So in general, we're talking about metropolitan areas being
14 single localities and the rural areas outside of the
15 Metropolitan areas in a state being another locality. Now,
16 there are exceptions.
17 DR. REISCHAUER: What I was interested in is would
18 these people really regard who we are saying their peers are
19 as their peers? If it's a metropolitan area, I think the
20 answer is yes. If it's northern Michigan versus Southern
21 Michigan --
22 DR. BERTKO: Let me expand on Kevin's statement

1 here. Separate from the tables you saw, those of us using
2 it would typically isolate a metropolitan statistical area,
3 let's say Cincinnati, which would include the Cincinnati,
4 Ohio counties, a couple of the Northern Kentucky counties.
5 And it would be the places where people could normally, who
6 worked in downtown Cincinnati, live and go to. And to the
7 best of my knowledge, from our contracting people, it is
8 looked at as their peer group. It's not the formal type of
9 grouping that Jay would have in his organization but it is
10 literally the community of say dermatologists who operate in
11 the Cincinnati area.
12 DR. SCANLON: Remember, there's only 89 and that
13 there's about 250 MSAs. So there has been a lot of
14 compression. A number of these might correspond to what
15 might be --
16 DR. REISCHAUER: A number of them have to be very,
17 very big. I understand that. Undoubtedly, the whole of
18 North Dakota is part of one of these, not to pick a state at
19 random.
20 DR. SCANLON: I also want to say this is an
21 excellent job, in terms of highlighting an issue that we
22 should have addressed many, many years ago. The fact that

1 Jack Wennberg has had 30 years of providing us this kind of
2 information and we haven't reacted is very lamentable.
3 I'd like to underscore what Ralph started and what
4 Mark commented on, as well, which is the issue of the
5 challenge that this may present to CMS in terms of existing
6 resources. And it also suggests that maybe we even want to
7 put some of that into the recommendation. I know that you
8 talked yesterday about keeping the recommendations simple
9 and putting things into the text.
10 But this issue of CMS resources is something that
11 is truly problematic. Only this week again the GAO reports
12 on the 1-800 number. And while people may point to CMS as
13 the problem there, having come from GAO and having dealt
14 with Nancy-Ann while she was at HCFA on many of these
15 issues, in some respects you sort of feel guilty issuing a
16 report like that because you understand being given an
17 impossible task and being stretched so totally thin that you
18 can't manage all kinds of different activities. And this is
19 the natural result. And only by the grace of God you're not
20 in the same position because you haven't been given that
21 impossible assignment.
22 This issue has been raised repeatedly but it

1 hasn't been resolved. It's important as we talk about
2 making Medicare much more viable, much more efficient for
3 the future, that it's not going to come if there's not the
4 investment in administrative resources. This is a good
5 example where there may be a return on investment. So the
6 authorizers can go to the appropriators and potentially make
7 a case that we really need to think about increasing the
8 resources.
9 So I would encourage us to think about modifying
10 the recommendation some to underscore this point, that it's
11 not going to be done at zero cost. It shouldn't be done by
12 bumping other things which may have equal priority, but
13 that's what would happen if this came through as a mandate
14 to CMS. They would have to think about what are we going to
15 substitute?
16 DR. MILLER: Can I ask a couple of you to comment
17 on this, and I don't disagree with your point. Is it worth
18 making clear that resources can mean more than just dollars?
19 Because I think sometimes -- and Nancy-Ann, you may want to
20 comment on this or not -- that there's also flexibility
21 issues. The contracting reform gave the agency a lot more
22 flexibility to go after things in a certain way and there

1 may be other flexibilities.

2 So I don't disagree with the comment but we might

3 also want any more global about --

4 MS. DePARLE: Yes, and thank you, Bill, for

5 raising this. I do agree, not surprisingly, that I actually

6 think we should have a more global recommendation on

7 resources because while I think we can acknowledge that

8 Congress in the last year has given the agency more

9 resources, it's not clear that those will be long-lived or

10 the extent to which they're just dedicated to the new Part

11 D. And a lot of what we been talking about, the pay for

12 performance, this, a lot of the efforts that we take need to

13 be made around data collection, will all require an

14 investment of resources, whether it's staff for CMS or just

15 more contractors or, as you pointed out with the GAO report

16 the other day, people to do oversight, to make sure things

17 are really happening.

18 I would heartily endorse the idea of some sort of

19 a more global recommendation.

20 DR. BERTKO: Let me only opine as not a

21 professional opinion but one on Ralph's question, which I

22 think is a very good one. Where do you get the bang for the

1 buck? And out of his five here, I will say that the two big
2 ones, I think, are this IT in two ways.
3 First of all, if you're making an investment --
4 and Nancy-Ann, I'll look to you in your new role and say if
5 you're looking for an investment in something you look for a
6 university that's big. And 30 percent of Medicare dollars
7 are gigantic. Whether we get to five, seven, eight, 10, 12
8 percent of that, it's a worthwhile goal and it's something
9 that some of us on the under-65 side have begun to achieve.
10 The IT one, which I think is the same size, is
11 longer off. I'm part of a company in the decision team that
12 invests $100 million a year in IT, which is small in this
13 concept but big for our company. The pay-off on those is
14 long-term. We need to do it. I was part of an older
15 company that went out of business because it stopped doing
16 it -- at least out of this business -- and I would ask Jay
17 maybe to comment on that.
18 But the two of these would seem to be, by dollar-
19 wise, far and above potentially all the other ones rolled up
20 together. Even as good as they are, I mean P-for-P and
21 other things do have potential but will they have big dollar
22 changes? Probably not as much or they'll be even further

1 out than the IT one.

2 MR. DURENBERGER: I think my comments will be in
3 the same vein, but they're really addressed to the nature of
4 the recommendation.

5 I thought the work was great so I took it and I
6 called a bunch of health plans in Minnesota and they're all
7 using it. They come back with very, very interesting
8 results, as John knows only too well and as do others in
9 terms of variation, even in the great place like Wobegon and
10 all of that sort of thing. And there are specific
11 recommendations about where to focus and so forth.

12 And they also recognize the fact that it's one
13 thing for the health plans to have this information and it's
14 quite another to get the physicians to change their
15 practice.

16 So then you look in a community like ours to an
17 institution that already exists, like the Institute for
18 Clinical Systems Improvement, which does that sort of thing
19 and it doesn't need the Secretary to tell them to do it.
20 You cross the border over into Wisconsin and you look at
21 what now a 19-member physician group collaborative is doing
22 along the very same line.

1 The point I think I'm trying to get to is if we
2 could use a couple of weeks to think about a better way to
3 say what we really would like to get done, other than that
4 Secretary Gingrich should use claims data to educate
5 physicians. I mean, it just doesn't strike me as being a
6 realistic -- and I understand about contracting and things
7 like that. But I'm just sharing with you -- and I went
8 through -- the imaging thing is like this. Some of the
9 other recommendations are like this and, like all the rest
10 of you, I'm all for this stuff.
11 There's something about telling the Secretary that
12 he's going to have to do this and then he's going to have
13 educate all these docs without my better understanding of
14 what it means when Secretary Gingrich or Secretary DeParle
15 or whoever it is, is going to do it that flies in the face
16 of the way it actually operates in communities like Jay
17 comes from and other places. So that's one part of it.
18 MR. HACKBARTH: I want to make sure that I
19 understand. Without committing to particular language,
20 could you just suggest how you would change this?
21 MR. DURENBERGER: No, I can't. I can't because
22 maybe you substitute the Medicare program or something like

1 that, or maybe it's an additional sentence that gets to the
2 point of how the Secretary will use the data to educate
3 physicians that's bothering me just on the basis of what I
4 have seen in our own community about the way you can
5 effectively -- and it's done within groups. It's done
6 within something like the Institute for Clinical Systems,
7 which gets through the whole system.
8 MR. HACKBARTH: But let me just pursue it because
9 I really want to understand where you want to go. I think
10 that sort of embellishment, enrichment of the
11 recommendation, I normally think that's what the subsequent
12 text is best for doing, as opposed for trying to shrink it
13 down to a sentence or two. I almost want, in a sense, the
14 relatively simple recommendation to call the reader to now
15 read the subsequent paragraphs to get a fuller understanding
16 of what this means, as opposed to try to cram too much into
17 the recommendation. That's my thought.
18 MR. DURENBERGER: I'm with you. Again, I wish I
19 had an answer but I don't have an answer, so let me go to
20 the second one which relates to the discussion we've been
21 having, which is the issue of resources. It's real. No
22 matter what we say about it, it's going to happen. The

1 resources won't be there. The priorities will be different
2 and you'll have some secretary walking out like Tommy
3 Thompson did last week saying I wish I'd done this, I wish
4 I'd done that. And everybody knows the reason he didn't do
5 it is because Josh Bolton told him he couldn't do it or
6 whatever the case may be.
7 And I just had one of these examples. We've
8 launched, after September of last year, launched this effort
9 to pay for quality with certain kinds of physician groups
10 over a certain size. One of the largest ones in Minnesota
11 has just written a letter to the Secretary saying they
12 intend to withdraw from this program. Why are they
13 withdrawing from the program? Because OMB has changed the
14 so-called bonus payments for this Institution.
15 This particular institution is a world leader in
16 diabetes treatment. It said why ask us to do diabetes?
17 We're going to go to congestive heart failure. And then
18 somebody then tells them how you're going to do congestive
19 heart failure and changes the rules of the game once they're
20 into it. And then they have to write this letter saying,
21 you know, we wanted to use our leadership in these various
22 fields to educate ourselves and other people about how to do

1 it but then the plug gets pulled.

2 I don't know where that takes us in terms of a
3 bunch of words but it takes me to an emphasis on what Jay
4 was saying earlier about the way in which systems of care
5 and communities that sponsor, if you will, systems of care
6 and connections between health plans and physician groups or
7 clinical systems and so forth can be appropriately rewarded,
8 which sort of like takes the whole thing to another level of
9 implementation, which you may not want to get into simply
10 when we're talking about resource use.

11 But I wanted to express it now rather than repeat
12 it when we get to some of the rest of these sort of things
13 because the same general concern applies in each of the way
14 these recommendations get worded. This is so important.
15 It's got to get done. Humana can't do it as well as they
16 could, nor could Health Partners or a lot of the people in
17 Minnesota get it done. And they could do it faster if, in
18 fact, Medicare was behind them.

19 I've expressed my concern. Thank you.

20 MR. HACKBARTH: Other comments, questions? Okay,
21 good work. Thank you.

22 Next is imaging.

1 MR. WINTER: Sorry for the technical difficulties
2 there. I think we got it straightened out.
3 I'll be talking about strategies for managing the
4 use of diagnostic imaging services in fee-for-service
5 Medicare. At our October meeting we described tools used by
6 private plans to control the use of imaging procedures while
7 ensuring access to appropriate care. We also highlighted
8 similar approaches taken by Medicare and other government
9 programs. That discussion provides the context for the
10 policy options that I will present today.
11 Before we get to the options, I want to quickly
12 review the different steps involved in an imaging procedure.
13 Starting from the top of the chart, the physician decides to
14 order a diagnostic test for a patient. Next, a provider
15 performs the study. The provider could be a hospital,
16 physician office or freestanding imaging center. If the
17 provider is paid under the physician fee schedule, it bills
18 for the technical component. Finally, a physician interpret
19 the images and writes a report which is sent back to the
20 ordering physician. The interpreting physician bills for
21 the professional component. The same physician can both
22 perform and interpret the study, in which case they submit a

1 global bill that includes both components. In addition, the
2 same physician who orders the study, that is the one
3 treating the patient, may also in some cases perform and
4 interpret it.
5 We're going to discuss policies that would affect
6 different steps of this process, so please keep this diagram
7 in mind as we move along.
8 Here are the options I'm going to talk about
9 today. The first set are based on approaches being used by
10 several private plans. The second set are ways to clarify
11 the Stark self-referral law as it relates to imaging
12 services. In considering which options to recommend, we
13 weighted the likely administrative costs against the
14 expected benefits.
15 The first option is to educate beneficiaries about
16 the risks, benefits and appropriate use of imaging
17 procedures. The risks can include overexposure to
18 radiation. The goals of this effort would be to help
19 patients make better decisions about their care and to
20 counter demand stimulated by direct-to-consumer marketing.
21 This option would primarily affect the first stage of the
22 process in which a physician orders an exam. At this point

1 patients can express their preferences about whether a study
2 should be ordered and, if so, what type. Several private
3 plans are engaged in educating their members but the
4 effectiveness of their efforts is not been studied yet. CMS
5 could launch an education campaign using tools like
6 pamphlets or its web site. It could also encourage
7 physicians to inform beneficiaries about the risks and
8 benefits.

9 Here's the first draft recommendation: the
10 Secretary should educate beneficiaries about the risks and
11 benefits of imaging, including the dangers of radiation
12 exposure associated with overuse of imaging procedures.

13 We estimate that there would be no impact on
14 Medicare spending, although the administrative costs for CMS
15 could be high depending on the design of the program. We
16 estimate no impact on providers. The recommendation could
17 result in better quality care for beneficiaries but we don't
18 have specific evidence to support this.

19 The next option is to measure physicians use of
20 imaging services. This could be done as part of the broader
21 initiative that Anne just discussed or done exclusively for
22 imaging. This would focus on the physicians who order the

1 studies rather than those who perform and interpret them.
2 CMS would develop measures of imaging volume per beneficiary
3 for patients seen by a given physician. CMS would then
4 compare these measures to peer benchmarks or clinical
5 guidelines and confidentially provide this information to
6 physicians. The goal is to encourage physicians who order
7 more tests than the average to reconsider their practice
8 patterns.

9 Which leads us to draft recommendation two: the
10 Secretary should measure fee-for-service physicians use of
11 diagnostic imaging services and confidentially educate them
12 about how they compare with their peers. The Congress
13 should direct the Secretary to before this function.

14 Although we are unable to estimate any spending
15 impact, this initiative has the potential to reduce spending
16 by encouraging the more prudent use of imaging services. In
17 addition, Medicare's administrative costs should be
18 relatively low. We think that this could lead to better
19 quality care for beneficiaries with a minimal impact on
20 providers.

21 The next option relates to coding edits for
22 imaging services. Private plans use three types of edits

1 for imaging claims. One type of edit detects unbundling of
2 services which is when a provider submits a claim with two
3 related billing codes and one code is a component of the
4 other. Another type of edit detects mutually exclusive
5 services, which are procedures that should not be performed
6 at the same time. The third type of edit adjusts payment
7 for multiple procedures done on contiguous body parts. Many
8 plans pay the full amount for the first service but a
9 reduced amount, usually half, for the second service.
10 The first two types of edits apply to both the
11 technical component and professional component of a
12 procedure while the third type applies only to the technical
13 component.
14 Although Medicare has developed edits for
15 unbundling and mutually exclusive procedures, some private
16 plans have more rigorous edits. For example, we spoke with
17 a radiology benefit manager that does not pay for both an
18 MRI and CT of the same region of the body because it
19 believes that the second test yields no additional
20 diagnostic information. Medicare does not currently adjust
21 payments for multiple imaging procedures.
22 Draft recommendation three is the Secretary should

1 improve Medicare's coding edits that detect unbundled and
2 mutually exclusive services and reduce the technical
3 component payment for multiple diagnostic imaging services
4 performed on contiguous body parts. CMS may want to consult
5 with private plans and radiology benefit managers about the
6 coding edits. CMS should also communicate these edits in
7 advance to physicians so they can bill correctly.
8 We expect that this would reduce Medicare spending
9 although we don't know by how much. The administrative
10 costs should be small. Private vendors estimate that coding
11 edits reduce imaging spending by about 5 percent for their
12 commercial plans. The provider implications would be small
13 and there would be no impact on beneficiaries.
14 The next option is to set quality standards for
15 imaging providers. These would apply to the providers who
16 perform the study and bill for the technical component.
17 There's some evidence that the ability of providers to
18 furnish quality imaging studies may vary. For example, Blue
19 Cross Blue Shield of Massachusetts inspected 1000 imaging
20 providers to evaluate the quality of their technical staff,
21 equipment and other features. The plan found that 31
22 percent of the sites had at least one serious deficiency

1 such as equipment that was not properly calibrated. Poor
2 quality studies can lead to repeat tests, missed diagnoses
3 and inappropriate treatment. For example, a study published
4 in the Journal of Vascular Surgery found that non-accredited
5 vascular ultrasound labs produced a relatively high number
6 of inaccurate carotid ultrasound exams. If not detected,
7 these inaccurate findings would have led to the wrong
8 treatment for the patients. Several private plans require
9 outpatient imaging providers to meet basic standards for the
10 imaging equipment, technicians, quality of images and
11 patient safety.
12 As we discussed on October, the federal government
13 has set standards for some modalities such as mammography
14 and Medicare has developed standards for some settings that
15 provide imaging such as IDTFs or Independent Diagnostic
16 Testing Facilities. However, there are currently no
17 national Medicare standards for imaging performed in
18 physician offices. The one partial exception is that some
19 carriers have set standards for vascular ultrasound studies
20 that apply to physician offices as well as hospitals. We
21 think it's important for CMS to set national standards for
22 each imaging modality that would apply in all settings.

1 Because CMS has limited resources, it should
2 select private accreditation organizations to ensure that
3 providers meet the standards. CMS should also have the
4 power to change the list of deemed organizations. Several
5 groups currently exist that accredit different kinds of
6 imaging facilities.
7 Draft recommendation four is: the Congress should
8 direct the Secretary to require that all diagnostic imaging
9 providers meet quality standards for imaging equipment,
10 nonphysician staff, the images produced and patient safety
11 protocols.
12 We estimate that this would reduce Medicare
13 spending because it should reduce the need for repeat tests
14 but we are not able to quantify savings. CMS's
15 administrative costs should be relatively low because it
16 would deem private organizations to verify Medicare
17 standards. Some imaging providers may incur costs to meet
18 the standards. For example, they might need to invest in
19 newer equipment or higher credentialed technicians, although
20 many providers already receive private accreditation.
21 This recommendation should lead to better care for
22 beneficiaries because improving the quality of imaging

1 studies should increase diagnostic accuracy.

2 The next option is to develop standards for

3 physicians who wish to bill Medicare for the professional

4 component of imaging studies, which includes reading the

5 images and writing a report. As with the performance of the

6 study, the quality of the interpretation may vary by

7 provider. CareCore, which is a radiology benefit manager,

8 examined a sample of imaging reports produced by non-

9 radiologists. They found that many of the reports lacked

10 key demographic and clinical information on the patients.

11 The goal of standards would be to improve the

12 accuracy of imaging interpretations, and thus diagnosis and

13 treatment, reduce the need for repeat interpretations or

14 tests, and reduce the incentive for less qualified

15 physicians to self-refer, that is to order studies and then

16 perform and interpret them using equipment in their own

17 offices.

18 Several private accreditation organizations set

19 standards for physicians who interpret imaging studies.

20 These standards are based on formal training, continuing

21 medical education and experience interpreting a certain

22 number of studies. In some cases, experience or specialty

1 certification can substitute for formal training.

2 CMS should use similar criteria to set standards
3 for physicians who wish to bill for the professional
4 component of a study. CMS should select private
5 accreditation organizations to ensure that physicians meet
6 the standards and should have the power to change the list
7 of deemed organizations. To ensure that beneficiaries have
8 access to imaging services, CMS may wish to apply less
9 stringent standards for physicians in medically underserved
10 areas.

11 Although private plans sometimes restrict payment
12 for imaging procedures to certain specialties, Medicare may
13 not want to do so. The practice of medicine is evolving
14 quickly and specialty training may change over time. Thus,
15 CMS should consider developing criteria that are flexible
16 enough to allow physicians of different specialties to
17 receive payment.

18 Draft recommendation five is the Congress should
19 direct the Secretary to develop standards for physicians who
20 bill Medicare for interpreting diagnostic imaging
21 procedures. The standard should be based on the training,
22 education and experience required to interpret studies. The

1 Secretary should have the authority to set less stringent
2 standards in medically underserved areas.
3 We expect this policy to reduce Medicare spending
4 because unqualified physicians would no longer be able to
5 bill for interpreting imaging studies. The administrative
6 cost for CMS should be low because the agency would deem
7 private organizations to verify the standards. There would
8 be some impact on providers because some physicians may be
9 unable to meet Medicare standards or may have to gain the
10 experience and training to meet the standards. We expect
11 that this would improve the quality of imaging studies
12 received by beneficiaries.
13 Now we're going to move on to the topic of
14 physicians self-referral of imaging services. Private plans
15 we spoke with expressed concern about physicians ordering
16 high-cost studies and providing them in their offices.
17 There is evidence that physicians who invest in imaging
18 facilities or have equipment in their offices order more
19 tests than other physicians.
20 The Stark law prohibits physicians from referring
21 Medicare or Medicaid patients for certain services to
22 providers with which the physician has a financial

1 relationship. This applies to designated health services
2 which includes radiology and certain other imaging services
3 that are mentioned in the statute such as MRI, CT and
4 ultrasound.
5 However, the Stark law and the final rule issued
6 by CMS allow physicians to engage in several activities with
7 regards to imaging. They can own facilities that provide
8 nuclear medicine services, including PET scans, and refer
9 their patients there. This is because CMS has said that
10 nuclear medicine is not a designated health service covered
11 by Stark.
12 Physicians can also provide imaging and other
13 services on their own office practices under the in-office
14 ancillary exception. The rationale is that some tests, such
15 as x-rays or clinical laboratory tests, may require quick
16 turnaround time and we are not recommending any changes to
17 this exception.
18 Physicians can also own entities that provide
19 services and equipment to facilities that are covered by the
20 self-referral prohibition. We'll discuss the first and
21 third issues in greater detail.
22 In the Stark final rule CMS had to decide which

1 specific services should be included as radiology services
2 under the Stark law. The Agency decided to exclude nuclear
3 medicine services because they believed that are not
4 commonly considered to be radiology. However, CMS has
5 recently said that it plans to issue a rule that would add
6 nuclear medicine to the list of Stark covered services.
7 We propose recommending that CMS make this change
8 the following reasons. One, there has been rapid growth
9 over the last four years in the use of nuclear medicine
10 procedures paid under the physician fee schedule. Second,
11 CMS has been expanding the conditions for which it will
12 cover PET procedures, which creates opportunities for the
13 increased use of these services. And third, it appears that
14 there is room to classify nuclear medicine as a radiology
15 service. For example, the examination used by the American
16 Board of Radiology to certify diagnostic radiologists
17 includes nuclear medicine.
18 Draft recommendation six is the Secretary should
19 include nuclear medicine and PET procedures as designated
20 health procedures under the Ethics in Patient Referrals Act.
21 This would prohibit physicians from owning nuclear
22 medicine facilities to which they refer patients but they

1 could still provide them under the in-office ancillary
2 exception.
3 We expect there would be some savings because
4 there's evidence that physician ownership of facilities
5 providing nuclear medicine services leads to higher use.
6 There would be an impact on physician who own nuclear
7 medicine facilities. We don't think there would be an
8 impact on beneficiaries.
9 I'll move on now to the issue of physician
10 ownership of entities that provider services to facilities
11 that are covered by Stark. I'm going to use this diagram to
12 explain what the Stark final rule prohibits and allows.
13 It prohibits physician A, at the top, from owning
14 the imaging center at the bottom right if he or she refers
15 patients there. However, physician A can own a company, at
16 the bottom left, that leases equipment to the imaging center
17 for a per service fee. Every time the imaging center uses
18 the equipment to do a procedure, it pays the equipment
19 company a fee and the physician investor receives a share of
20 that fee. This creates a financial incentive for the
21 physician to refer patients to the imaging center.
22 The Stark law was intended to minimize these

1 incentives because they could lead to overuse of services.
2 We've heard anecdotally that these arrangements are being
3 developed between imaging providers and physician-owned
4 equipment leasing companies. These arrangements are allowed
5 because CMS defines physician ownership under of the Stark
6 law as ownership of the entity that actually submit claims
7 to Medicare or Medicaid. Physicians can own companies that
8 least equipment or services to providers without any
9 restrictions.

10 Draft recommendation seven is the Secretary should
11 expand the definition of physician ownership in the Ethics
12 in Patient Referrals Act to include interest in an entity
13 that derives a substantial proportion of its revenue from a
14 provider of designated health services.

15 This change would prevent the creation of
16 physician-owned companies whose primary purpose is to
17 provide services to facilities covered by the Stark
18 prohibition on self-referral.

19 The Stark law gives the Secretary the authority to
20 define ownership so we don't think that this would require a
21 statutory change. We expect that there would be some
22 savings because this would prohibit arrangements that could

1 create financial incentives for physicians to refer patients
2 for additional services. There would be some impact on
3 providers in terms of limiting the types of companies from
4 which they could lease equipment or services and there would
5 be no impact on beneficiaries.

6 This concludes the presentation and I would be
7 happy to answer any questions.

8 MR. HACKBARTH: Let me just try to frame the
9 discussion for second. As I listened to Ariel talk about
10 recommendations one and two, I saw some connections to the
11 discussion we just had with regard to resource management,
12 in particular with recommendation one, the beneficiary
13 education. We have often noted many, many issues on which
14 we need to invest more effort in beneficiary education and
15 there's a shortage of resources to do that.

16 So that raises the question in my mind where does
17 this fit in the hierarchy of beneficiary education needs.
18 So that's one question.

19 Recommendation two obviously is a very direct link
20 to the resource management discussion and what I'd like to
21 ask is whether we think it makes sense to have a separate
22 recommendation here or maybe just the one resource

1 management recommendation with cross-references between the
2 chapters and discussion?
3 So I'd like reactions to those questions.
4 DR. STOWERS: First, Ariel, I think it's a great
5 chapter but I've got a few comments I'd like to make along
6 the way, and we've talked about it.
7 First, I think if there was ever a chapter that
8 it's important is set the right tone and have a good broad
9 overlook from every angle, it's probably this one because in
10 the physician community there's probably not a more
11 sensitive area right now because it involves so many
12 specialty societies and that kind of thing. So I think we
13 have to be very careful throughout the chapter when we
14 mention one specialty society that might be doing
15 accrediting or whatever, to be mentioning several and that
16 sort of thing.
17 One of the things on tone right off the bat that
18 kind of bothered me, and I don't think it's the intent. It
19 seems that when the intent behind all of this has to do with
20 the more expensive tests, the ultrasounds and the nuclear
21 studies and that sort of thing that might be performed in
22 the office, but there are several sentences and one in your

1 presentation that say setting standards for physician
2 interpretation reduce the incentive for less qualified
3 physicians to provide imaging service in their own office.
4 And then, in our chapter on the next page, some physicians
5 who ordered imaging studies also performed them on equipment
6 in their own offices rather than referring them elsewhere.
7 I think we run the risk in this, if that was to be
8 held literally, of really affecting access to patient care
9 and for sure quality of patient care, because it's perfectly
10 appropriate in my mind, that if somebody comes into my
11 office and I have physician-owned equipment in there to do
12 radiology and it's some distance to the hospital for me to
13 do a follow-up chest x-ray on their pneumonia, as opposed to
14 the elderly patient having to do a 10 mile round-trip in
15 traffic or 20 miles rural or whatever, to do that. Or for a
16 patient with a fracture that comes in to get a cast removal.
17 It would be absolutely silly for them to have to make a trip
18 to the hospital at that point, rather than just walk down
19 the hall and get a quick film on there.
20 But yet the chapter doesn't reflect -- I know you
21 mentioned it a little bit a while ago about convenience and
22 that kind of thing. But I think we have to be very careful

1 about that access.

2 And another thing, it's much more economical under
3 Part B for that to be done in the physician's office,
4 sometimes by three-to-one, of what it would be if we
5 referred them on over to hospital to get that done.

6 MR. HACKBARTH: Ray, I share that concern. I
7 don't think we want the message to be that we are against
8 imaging studies being done in the physician office.

9 DR. STOWERS: I think this chapter really sent
10 that message.

11 MR. HACKBARTH: I think what we want to say is
12 that if they're done A, the equipment has to be properly
13 maintained, the technicians have to be capable of running
14 the equipment, and the person who reads the image needs to
15 have appropriate qualifications to do that. There are many
16 types of physician organizations that have this built-in
17 capability and I think that's appropriate for all the
18 reasons you identified.

19 What I worry about is the proliferation of the
20 equipment and the service being done by people who aren't
21 qualified to do it on equipment that isn't properly
22 maintained.

1 DR. STOWERS: The second thing I was getting ready
2 to go to is this increased volume from doing that or the
3 amount -- we refer all through the chapters to the number of
4 films that are poor quality or the number of films that
5 might have that be repeated. There's a lot of mights in
6 there that I think on this critical of an issue we need to
7 have some numbers. I mean, is it 5 percent of the films
8 that have to be repeated because of in-office equipment? If
9 we don't have some kind of measurement of that, you wonder
10 if it's worth going into a nationwide accreditation federal
11 system to look at all of this equipment when all states are
12 already inspecting. Every year our x-ray equipment gets
13 looked at. It's inspected. They measure the output. And
14 I'm wondering, and yet we're talking about setting federal -
15 - is there enough bad films and bad equipment in here to
16 really make that recommendation worth implementing? I think
17 if so, the chapter ought to reflect that.
18 DR. MILLER: I'll take your mind back to a panel
19 that we had. I can't remember now but several meetings
20 back, was it March? Where there was some information
21 presented by -- I don't remember whether it was the plans or
22 one of the management organizations -- talking about what

1 some of the error rate and the redo rates are.

2 We also have, since then, talked to several other

3 organizations that do this kind of thing. What they've

4 showed us is their commercial numbers and look at the

5 variation by specialties. In some instances, even their

6 Medicare lines of business.

7 The thing about these data is that they're not

8 national in scope. If an employer has brought them in and

9 said I need you to help me manage my imaging, it's on that

10 set of lives. So we don't have certainly comprehensive data

11 from a Medicare source that says how many Medicare tests

12 have to be redone or are not qualified. But we do a very

13 strong indications, and you saw bits and pieces of it in

14 that panel, that there is some variation here.

15 I think the last thing I'll say and stop is that

16 we also -- and Ariel can speak to this much better than I

17 can -- think that there is a lot of variation in how much

18 oversight there is in the quality of the equipment. We have

19 heard that, as well.

20 DR. STOWERS: I totally agree with that.

21 DR. MILLER: To build the case better.

22 DR. STOWERS: To help build the case a little bit

1 that we're not comfortable with the current system of
2 inspection. But I think we may be in error here not to at
3 least mention that there is a system that's inspecting this
4 equipment out there already, and that kind of thing.
5 MR. HACKBARTH: Ray, you raised an important issue
6 about whether this is worth the effort. If the numbers are
7 small, as you say, is it worth the effort of going through
8 all of this? In a sense, this reminds me of the specialty
9 hospital discussion.
10 The dilemma that you face is on the one hand you
11 don't want to do things that are unnecessary that are
12 administratively costly or politically costly. On the other
13 hand, if you let trends run their course, the genie is out
14 of the bottle and you never get it back in.
15 Frankly, one of the concerns I have in this area
16 is that the genie's trying to climb out of the bottle and we
17 see a proliferation of this things that once it happens it's
18 done. It's in place, you can never reverse it.
19 DR. STOWERS: Personally, I agree with you.
20 Again, I was just talking about kind of the tone that was
21 set here about that. I think we need to beef that up a
22 little bit. So I wasn't disagreeing necessarily with the

1 conclusion. It's just that I've already heard well, there's
2 already inspection process going on and all of that. If we
3 really are trying to contain that.
4 Another thing that is not mentioned in the chapter
5 is that one of the things in our practices that considerably
6 increases volume on the number of x-rays is the radiologist,
7 after they get the films of sometimes not knowing the
8 patient and adding on more and more tests for that reason.
9 And the clinician that's standing here with the patient is
10 saying I don't need that. The patient has already gone home
11 and they're well and that was two weeks ago.
12 So I think this hedging that occurs, whether it's
13 because of the PLI problem or other things in the country,
14 is a significant factor in increasing the volume that
15 happens long after the patient care is concluded and over
16 with. That may be worth at least mentioning in here as a
17 cost in this volume problem.
18 MR. WINTER: If I could address a couple of things
19 you mentioned. In terms of the evidence of the
20 effectiveness of facility standards or standards for the
21 physician interpreting the test, there are a couple of
22 published studies that I'm aware of of plan experience. One

1 of them is the Blue Cross plan that I mentioned in
2 Massachusetts where they implemented standards for both the
3 facility, that is the equipment and the technicians, and for
4 the physician interpreting the test. They did find a
5 reduction in imaging spending. So there's some evidence of
6 that. It's not national. It's based on these two plans.
7 DR. STOWERS: I just think it may be worth
8 mentioning.
9 MR. WINTER: We can definitely highlight that
10 more.
11 DR. STOWERS: And then on the accreditation thing,
12 again I think we have to be very careful again to include
13 all specialties in that. Invasive cardiology, for example,
14 or nuclear cardiology now has a minimum of six months
15 training just on that procedure in order to do it. And yet
16 the inference there is that we may want a radiology or some
17 other specialty overseeing that, which has six months of
18 total nuclear training in their entire residency program.
19 So I think it was here, except that when we're
20 talking accreditation in the chapter here, ACR was the only
21 name that popped up in the text.
22 DR. MILLER: If there's any misunderstanding about

1 this, I want to be clear about it. When we set this problem
2 up, we pointed out how some of the private vendors go at it.
3 They go through and they have CPT codes. And they say these
4 CPT codes you are trained to do and these ones they're not.
5 If you're not trained -- they don't all do this, but one of
6 the strategies.

7 That is not the strategy we're pursuing. We feel
8 that it's exactly as you said. Things are dynamic, training
9 is changing. And over time, certain specialties may become
10 more proficient than let's say this particular moment at
11 using and interpreting images. And what we're trying to do
12 is set up a process that recognizes that and allows the
13 Secretary to set the standards and organizations to
14 administer it. So that anyone who meets them would be able
15 to bill Medicare.

16 MR. HACKBARTH: Not specialty-based but knowledge-
17 based. And you can get the training and be certified as
18 having the requisite knowledge regardless of your initial
19 specialty.

20 MR. WINTER: If I could just finishing on a couple
21 comments you said. In terms of the state radiation control
22 boards, my understanding is that not all states have these

1 kinds of boards that monitor the equipment in physician
2 offices and other providers. And even states that have
3 them, there are big differences in how aggressive and how
4 well enforced these standards are. There are lots of
5 limitations on resources to run these programs.
6 DR. STOWERS: This might be a good comment to have
7 that in there.
8 MR. WINTER: We'll definitely talk about that some
9 more.
10 And then your concerns about the specialties. I
11 think what we might want to do is in describing the
12 recommendations on accreditation standards and incentives
13 for physicians, is perhaps suggest that the Secretary
14 consult with different specialty societies in developing the
15 standards to ensure that everyone has a voice.
16 DR. STOWERS: Good.
17 One other thing that just has to do with -- it's
18 kind of a personal thing with me practicing. I've always
19 wondered about the cost to Medicare where a patient hits the
20 emergency room -- and I'm not talking about when I'm
21 covering the emergency room as a family doc or ER doc, and I
22 have a 15-year-old in a motor vehicle accident and we do

1 neck x-rays and I have the radiologist overread that and
2 that kind of thing. Not at all.
3 But when I bring the patient through the emergency
4 room and I obviously see the fractured hip and then I bring
5 in the orthopod and they take them to surgery and before,
6 during and after films are taken throughout that entire
7 process. And then the patients in rehab by Monday or
8 Tuesday. And then we come in and we have -- I had a patient
9 bring me this bill.
10 Then we have the radiologist overread, or
11 whoever's assigned by the hospital to overread all of these
12 films, which came to -- it got into thousands, low
13 thousands, but to overread all of that care that had already
14 happened and the patient was already -- I wonder about this
15 whole look at overreading, double reading.
16 Because there's another box actually on the
17 majority of films that occur in your original diagram. And
18 that's a box of the person that's treating the patient often
19 gets a very small fee for the treatment is institute care or
20 the reading of the film to institute care. But then it goes
21 on often for the consultant or the radiologist to look at
22 it.

1 There's a real big PLI factor in here, I know,
2 that affects the volume. But there's another one that I
3 think is even bigger in dollars that affects the need for
4 secondary and overreading of films when what I think you're
5 going to find is that -- and I'm circling around to where I
6 think if we do go on through this accreditation process, it
7 may actually help that situation. Because if it becomes
8 that this orthopedic surgeon is qualified to read the hip
9 fracture and do that kind of thing, then maybe Medicare can
10 start saving on the back end and the patient can start
11 saving on the back end. Because the deductible that this
12 patient had to pay for the reading of the x-rays was what
13 brought them into me.
14 So as we get into this accreditation process, I
15 think as we look at the potential savings done the road,
16 that may not be all bad in the process. So I just want you
17 to think about how much of the necessity of overreading and
18 all of that may be something to reevaluate, and when it's
19 medically necessary and when it's not to have that
20 consulting done.
21 My last point, real quick, is that there is an
22 exponential growth in the amount of radiology services that

1 are leaving this country. We have multiple hospitals
2 through I know our region of the country and I know through
3 all regions of the country. The two fastest growing readers
4 of our films in the country right now are India and
5 Australia. And some of them are U.S.-trained physicians and
6 some aren't. They can actually, in some of the clinics
7 where I have teaching going on, they can actually get their
8 films back read quicker all digitally than they could walk
9 them six blocks down the street to the radiologist at the
10 hospital to get them done. And I'm talking tens of
11 thousands of films, including Medicare patients.
12 So as we talk about this accreditation process and
13 interpretation, there's even a lot of physician groups that
14 have the x-ray equipment and we're talking about accrediting
15 who's reading the films. A lot of times nowadays it's not
16 the physicians that own the equipment. They've got an
17 agreement which used to cost tens of thousands of dollars
18 for the equipment. Now it's a few thousand, it's all
19 Internet-based, it's quickly done.
20 And I think not to mention that somewhere on, this
21 changing trend of who's serving our Medicare patients, is
22 something I think is important right now. At least I know

1 in the rural areas. But one city that's using this now is
2 over 100,000 and every hospital that I know if in that area
3 is using these type of distant services.
4 So it gets back to now you can have your
5 radiologist in Hawaii and your hospital is on the East Coast
6 and no in-house radiology and that kind of thing. Because
7 the technology has just come to this point.
8 The quality is actually, in most cases, better
9 than putting up the regular films and that sort of thing.
10 But it does somewhat isolate the consultive relationship
11 between a physician that's there to help and deal with the
12 patient. It makes it a very kind technical read at that
13 point.
14 I'm done, Glenn, I'm sorry.
15 MR. HACKBARTH: Those are very helpful comments.
16 DR. WAKEFIELD: I only wanted to comment and I
17 wanted to comment on this even before you raised the issue,
18 Glenn, about draft recommendation one as one of the
19 solutions to the challenges in this particular area.
20 When I was reading through the background text
21 associated with this, I really had a question about whether
22 or not this merited recommendations status, if you will.

1 Generally speaking, I'm all for beneficiary education. I
2 think it's tremendously important.
3 But I really wonder whether this is a meaningful
4 way to address the problem? And, even if done across all
5 Medicare beneficiaries, is it likely to make a difference?
6 I didn't have a sense that we've got as good a
7 data here about this as an intervention. There was some
8 reference to it being done on the private sector. But I
9 just didn't have a sense that the data were there indicating
10 the extent to which it made a difference.
11 And also, I wasn't exactly sure about any
12 quantifying of exposure. So how frequent is this a problem?
13 How many people are being put at risk? To what extent? I
14 didn't see that well documented, unless I breezed through
15 that too quickly.
16 I actually am a lot more concerned about the
17 significant risk that I do think was based on some
18 documentation to beneficiaries associated with poor
19 equipment being used. I don't know how you engage a
20 beneficiary there. But that, to me, provided a more
21 significant risk than this one.
22 So this one didn't bowl me over, as the others do,

1 in terms of a solution to this problem.

2 MR. MULLER: Also with regard to recommendation

3 one, some of the evidence emerging is that in the imaging

4 studies, especially some of the more comprehensive ones like

5 the whole body scans, start detecting a lot of things that

6 don't then need interventions but the interventions ensue.

7 This goes back to our discussion of resource utilization and

8 so forth. And I think the field is not as well developed.

9 I would say the bigger risk now is the

10 interventions that aren't necessary. I say the field is not

11 as well-developed but both in terms of the surgical

12 interventions -- I mean, you see things. And then

13 obviously, once you see things on these, like for example

14 the whole body scans, the patient has a lot of interest in

15 doing something even when perhaps there is no other

16 symptomatic evidence.

17 So I think one thing we have to be attentive to,

18 again going back to the utilization discussion we had both

19 earlier today and yesterday, is that the magic of this

20 imaging also now starts detecting things that have no other

21 symptomatic expression. And therefore, you start getting a

22 lot of interventions, especially surgical interventions,

1 that may not be necessary and could probably have more
2 consequence that the dangers of radiation exposure.
3 So again, where we ultimately decide to go with
4 this recommendation I'm not sure either, based on Mary's
5 comments and yours. But if we do stay with this
6 recommendation, I would at least suggest a partial amendment
7 that also looks at the risks of overutilization.
8 DR. WOLTER: I had the same concerns about
9 recommendation number one, I would say. And I don't
10 honestly know what it is about the current risks to
11 beneficiaries given the current technology. So that would
12 be one question, how risky is it and how many individuals
13 annually are at risk? And then would this be even the right
14 tactic to reduce that risk if we had data about how much
15 risk there is?
16 I guess the thing I'm wondering about is if we are
17 ignoring one of the major leverage points to control imaging
18 studies? I think much of the increase in imaging is because
19 it's fabulous technology and what we can do now compared to
20 25 years ago with imaging and the things it does for us is
21 incredible.
22 But to the extent there's inappropriate

1 utilization of imaging studies, I think that pricing and
2 reimbursement is at play. When I look at imaging, it's one
3 of the handful of service lines that allows organizations to
4 achieve a bottom-line. So I hesitate to say this but I
5 think that there is not competition around pricing in
6 imaging, at least in many parts of the country.
7 Some imaging services are actually not well
8 reimbursed. Mammography, for example. It's very difficult
9 to break even on mammography. However, CT, MRI, ultrasound,
10 nuclear medicine are large margin services and I think that
11 looking at the reimbursement models would be a leverage
12 point for control of inappropriate utilization.
13 MR. HACKBARTH: At the last meeting Nick and Alan
14 and maybe some others raised the issue of the accuracy of
15 our pricing for this particular area of physician services
16 but maybe some others. And much as we have, in the hospital
17 sector, been saying we've got to look at the accuracy of the
18 pricing and the price signals we're sending, I think some of
19 that applies here as well.
20 Now we haven't gone into our customary research
21 analytic mode on that. So what I had envisioned we were
22 going to do is identify that as a concern that we have and

1 an area for further analysis and research.

2 MR. WINTER: If I could just add to that that the
3 coding edits recommendation, the second part of that does
4 address the pricing issue because the issue there is that
5 you're doing two tests an contiguous body parts. You get
6 paid the full amount for both tests, even though we have
7 reason to believe that there are fewer resources being used
8 for the second test because you've already invested time in
9 preparing the patient and clerical time and supplies. And
10 so there are savings to be gained there. And so this is one
11 recommendation that does address the issue of proper
12 payment.

13 MR. HACKBARTH: I would like to see some reference
14 to that issue.

15 DR. MILLER: And not to miss your point, we had --
16 and actually Bill and I were discussing this this morning a
17 little bit.

18 We do have an expectation to get back to path on a
19 number of places. We talked yesterday about the guts of the
20 home health reimbursement system. We had talked at our
21 planning session over the summer the notion of looking at
22 some of the parts of the physician fee schedule, the

1 relative values, some of the geographic adjustment, that
2 type of thing. And once we get over the fury of the next
3 couple months or the workload of the next couple months, try
4 and return to path on those couple of things. So your point
5 is taken and we can note it here in the text.

6 DR. REISCHAUER: I have a semantic nitpick and
7 then some comments on a couple of the recommendations.

8 It's our tradition to say the Secretary should in
9 our recommendations and mostly we're talking about process.
10 The Secretary should institute a system of pay for
11 performance or he should develop measures of resource
12 utilization and share those with the docs.

13 But in some of these cases, we're talking about
14 dealing with the beneficiary and it really sounds a little
15 absurd. The Secretary should educate or the Secretary
16 should measure. You have this vision of the Secretary with
17 his ruler out there measuring something.

18 And what we really want is that Medicare should
19 get involved in these, not that the Secretary should be
20 doing it. I think we should fine tune the way we make some
21 of these recommendations.

22 I am positive about recommendation two through

1 seven but like several other of the commissioners, I am very
2 dubious about recommendation one. We aren't exactly making
3 a strong case where we say it has no spending implications,
4 it has no implications on the providers and no implications
5 on the beneficiaries. You sort of scratch your head and say
6 yes?

7 And I am dubious, like I think Mary was, that this
8 would have much of an impact. I think it's very important
9 to get this information out there. How you use the
10 information is a little difficult because, as some of the
11 people have pointed out, there is the number of images that
12 are done but there's also the quality of the machine that
13 makes a difference, and probably more of a difference.

14 But if you were a women of childbearing age or a
15 guy who's worried about where he puts his laptop when he
16 does his computer work, you might pay attention to this.
17 But when we're dealing with a population over 65 and these
18 are impacts that go on and have implications many years down
19 the road, and your doc is saying I want to see what the
20 problem is, you're very likely to be influenced by the
21 change in a probability from one in 10,000 to one of 5000 of
22 getting cancer or something.

1 So I agree that we should probably have some
2 paragraphs about this but not make a recommendation on this
3 at all.
4 With respect to recommendation five, this might
5 expose the depth of my ignorance, but it strikes me that
6 this is a huge change in how Medicare operates and one that
7 I'm not opposed to. But we shouldn't treat it like -- and
8 you can correct me -- that it's just sort of a little fill
9 up here or there. Am I not right that if I were a
10 psychiatrist I would be able to bill for some surgery or for
11 fixing a broken bone or something like this? In we're
12 saying yes, but with respect to reading images you have to
13 have this kind of training or that kind in addition to your
14 M.D. And I think if that is all true, we should really make
15 it clear to the reader that -- and this is maybe beginning
16 to move in a long-run appropriate direction which, because
17 we have the tools to do it, we're doing it. But let's make
18 it clear.
19 With respect to recommendation six, Ariel can
20 educate me on this, but aren't PET scan machines like a
21 couple of million dollars and they weigh a couple of tons?
22 I mean they aren't the kind of thing you'd find in most

1 offices. They've gotten smaller? So we have a laptop PET
2 scan?
3 MR. HACKBARTH: MRIs once were the same issue.
4 Oh, nobody would have this in an office. This is too big,
5 too expensive, too complicated.
6 DR. REISCHAUER: But I think some of the text sort
7 of reads like x-ray, MRI, PET, they're sort of all the kinds
8 of things you could have around the kitchen when, in fact,
9 some of these things really are quite different.
10 Lastly, I think there are a lot of advantages to
11 having imaging capability within physicians office,
12 convenience, cost, efficiency. And so we want to preserve
13 those positive aspects.
14 When we get into talking about accrediting the
15 technicians and certifying the machinery, et cetera, which I
16 think is completely appropriate, we shouldn't kid ourselves
17 that this is going to increase the cost of being able to
18 provide that service and to justify that cost some people
19 will drop having these machines in their office. That has
20 its negative dimensions. And others will be tempted to
21 increase volume because you've got to pay for this more
22 specialized technician. You have to pay for the higher-

1 quality machine, et cetera, et cetera.

2 My guess is that quality will improve but so will
3 cost. It might be just my CBO reflexes that cause me to
4 feel that, but I think there is a positive cost to this.

5 MR. HACKBARTH: Let me just pick up on Bob's point
6 about the magnitude of the change implied by the
7 certification. I agree 100 percent, this is a very
8 important change and we shouldn't diminish its significance.
9 I think it's important because of where things seem to be
10 moving as I said earlier, to address issues before they
11 become unaddressable. It is true that a psychiatrist could
12 do surgery from Medicare's perspective. But I think that
13 there are other controls there. The hospital would make
14 sure that that doesn't happen.

15 The issue here is that we have things moving
16 outside of those institutional structures into physician
17 offices where there aren't any other controls of any type.
18 So I think that's the case for moving ahead here.

19 I didn't get all the hands on this side, so let's
20 just go down. Jay?

21 DR. CROSSON: Thanks. First, I want to compliment
22 Ariel for the work. I know how hard he's worked on this.

1 This was, I think, probably a tough assignment among all the
2 assignments that get passed out.
3 I do think that among the recommendations there's
4 going to be a difference among them in terms of the
5 likelihood that they're going to be effective in impacting
6 the problem at hand, which is the rising cost. I think I
7 agree with others who said that recommendation number one
8 probably is the weakest of them in that regard. It may not
9 justify the resources.
10 But I wanted to talk for a minute about the issue
11 of how to really impact the in-office costs of the
12 diagnostic procedures. That may well be, as you just
13 mentioned, the area of most concern. It seems to me that
14 this issue of when to do a diagnostic test, what the
15 threshold is for doing a diagnostic test, the number of
16 different tests that get done as opposed to one, it's the
17 belt and suspenders phenomenon. And then also, the
18 frequency of tests. How many tests to do over what period
19 of time are the relevant issues often.
20 Also, I think that some of these tests are done
21 kind of one off, that is an odd situation gets the test.
22 But a lot of them are done in a fairly repetitive manner

1 based upon a given presenting complaint or diagnostic
2 suspicion or something like that. In other words, it's the
3 idea of batteries of tests over time. And that's where the
4 phenomenon kind of accumulates.
5 To the extent that it is repetitive and
6 predictable, I think maybe some work needs to be done there
7 to identify the situations in which that's true because it's
8 not true in all.
9 Then it begins to raise the possibility of
10 bundling payment, bundling the payment for professional
11 services with the payment for the diagnostic studies based
12 on an application of some understanding of the frequency
13 with which over a population the studies ought to be done.
14 It's not an idea dissimilar from prospective payment to
15 hospitals for what became DRGs. It sounds complex to think
16 of but I'm sure it sounded at least as complex to the people
17 who were coming up with the DRG idea. I think you can
18 estimate the frequency that a test would need to be done or
19 repeated or three tests instead of one test based upon
20 knowledge of disease processes.
21 And I'm just wondering whether or not somewhere in
22 here, perhaps related to recommendation two, which really

1 calls for the development of more detailed information which
2 is provider specific, specialty specific -- admittedly for a
3 different purpose, which is educating the providers. But I
4 wonder whether out of that, and perhaps one justification
5 for having it is a separate recommendation, might be the
6 addition of the idea that it might be worthwhile to gather
7 some information over the next year or two to try to
8 understand in this area where there is that kind of
9 coalescence of commonality such that for selected diagnostic
10 procedures -- and I don't want to name a specialty -- but
11 for patients coming in with this sort of routine complaint
12 that you could begin to bundle payment for professional
13 services and for diagnostic services.

14 I think then you begin to create the situation, as
15 with other prospective payment systems, where the economics
16 become less of a factor in those discretionary decisions.

17 DR. MILLER: Ariel, there are two things that were
18 occurring to me while he was saying that. One is is there
19 anything in the editing protocols that we've talked about
20 with folks that looks at any of that, the notion of
21 frequency? I'm going to catch a claim if you're getting
22 your second MRI in a week. Is there anything like that that

1 we saw? And then secondly, his notion of bundling. In any
2 of our discussions was there this notion of putting the
3 diagnostic and the interpretation is --
4 DR. CROSSON: I'm not talk about bundling the
5 various fees for the diagnostic procedure. I'm talking
6 about bundling the payment to the physician or group --
7 DR. MILLER: For the entire condition.
8 DR. NELSON: Ultrasounds and pregnancy.
9 MS. DePARLE: You decide how many you do.
10 DR. MILLER: We touched on issues like that, this
11 was over a year ago, at one point in the commission. We
12 were talking about the fact that they have global payments
13 for post-surgery in Medicare right now, and talked about
14 some of these ideas. So we can come back to some of that
15 and work it up.
16 DR. REISCHAUER: If we could do that successfully
17 and scientifically, then you wouldn't care about doctor
18 ownership. You get rid of that problem completely.
19 MR. WINTER: Mark, we learned about one company
20 that develops edits has an edit where they don't pay for a
21 second repeat -- certain repeat tests that are done with a
22 week of the original test by the same physician. So those

1 kinds of edits are out there. Medicare could investigate
2 using them.
3 On the second issue, remind me what that was
4 again, that you raised?
5 DR. MILLER: Bundling on the basis of --
6 MR. WINTER: We hired a contractor to talk to
7 folks at the carrier level, at CMS level, and outside
8 experts about the different approaches we were considering
9 and hearing about from private plans. One of the ideas that
10 they brought up was the idea that Jay mentioned and Mark,
11 you talked about, the notion of bundling the fee for
12 treating the patient with the fever for the diagnostic test,
13 to encourage greater efficiency. So we've heard about that
14 idea a little bit. It's a very interesting idea.
15 MS. DePARLE: I, like Jay, want to commend Ariel
16 and Kevin and Anne and the whole team for the work that's
17 been done here. This has been almost two years, I guess, of
18 work drilling into this subject. And I think it's important
19 and I agree with Bob that it is significant and starts on a
20 new path for Medicare, one that is supported by the
21 evidence. They have already started doing a few things like
22 this. I think we talked about the power wheelchairs where

1 they're now saying only certain docs can prescribe those.
2 But it is new and I think we should recognize that.
3 I had a couple of comments. On recommendation
4 five, Ariel, this pegs a little bit off of something that
5 Bob said. But we are saying that the Secretary should
6 develop standards for physicians who bill Medicare for
7 interpreting the procedures. And I agree with that. We've
8 seen strong evidence and heard from others' evidence that
9 that is needed.
10 But I guess I wonder about why it's just the
11 professional component? Because to get to when the wrong
12 test is ordered or when the physician is ordering one that
13 is inappropriate, I mean I guess the earlier recommendation
14 gets to the poor quality of the image. But when the wrong
15 thing is ordered, when one is not needed. And remember
16 here, we've been talking about the cost to Medicare but the
17 beneficiary is paying something here, too. This is a big
18 payment for them.
19 I wonder how much it is, really? We can look at
20 how much it's grown as a component of the physician fee
21 schedule, look at how much beneficiaries have been paying.
22 Someone referred to them asking for tests, and I'm sure

1 there's some of that. But I think most of us, when it comes
2 to this kind of thing, are just listening to our clinician
3 say I think we need this.
4 I just wonder if focusing just on the professional
5 component for this recommendation really gets to what we
6 need. We want to make sure that the clinicians who are
7 ordering these tests are trained to know what to order and
8 when to order. So I don't know how to get to that, but it
9 seems to me that could be more than just the professional
10 component.
11 MR. WINTER: That's a really good point. And when
12 we talked to private plans, the way that they would get at
13 the issue of the physician knowing when to order the test
14 and what test to order, a couple of strategies they used
15 included measuring the resource use, which we've talked
16 about, and then supplementing that with directly targeting
17 physicians who are high users with specific education in
18 different ways.
19 Another one is preauthorization, which we've not
20 proposed here and would be very difficult for fee-for-
21 service Medicare to do. But that's one way where they
22 directly evaluate whether a request is necessary, comparing

1 it to clinical guidelines. So those are some strategies
2 they've used. We have brought in the measuring resource
3 approach to our set of recommendations.
4 The one about educating beneficiaries was designed
5 to give them better information about what test is necessary
6 and to counter some of the direct-to-consumer advertising
7 that's out there. But everyone has raised very good points
8 about the recommendation.
9 MR. MULLER: Aren't you talking about stage one in
10 Ariel's first box, versus I thought this recommendation was
11 about stage two.
12 MS. DePARLE: It is but I guess I'm saying that I
13 think we also heard that a component of this is not just
14 whether the person who interprets the test is really
15 qualified to do it. And then that results in some repeat
16 tests and additional tests, and et cetera. Or necessary
17 tests. But there's also a question of whether, when
18 ordering the study, the clinician orders the right study.
19 MR. MULLER: Almost any physician can be in box
20 one. A far more limited set can be in box two. Generally,
21 we prefer that to be people who have the kind of training
22 that Ariel mentioned. But a psychiatrist or a neurologist

1 could be a box one. He can't be in box two, most likely.
2 MS. BURKE: But Nancy-Ann raises a much bigger
3 question. There is this secondary question, which is once
4 the test is ordered whether the person reading it is the
5 right person to have read it and is qualified.
6 But the bigger question is has, in fact, the right
7 test been ordered, which I think Ariel points out. Part of
8 that is in the question developing standards and looking
9 over the long-term in terms of resource utilization in
10 practice patterns of individual physicians. But it is the
11 much more critical question that begins the process.
12 Can I ask a question about the second piece of
13 this, which is the box two, which comes after box one has
14 been dealt with? I'm going back to the point that was
15 raised about the frequency now of that work being referred
16 out, in fact out of the country, but to organizations. And
17 I wonder how the recommendation five would apply in those
18 situations where, in fact, they are now having
19 interpretations done by organizations in India or wherever.
20 How does one, in fact, apply requirements about training and
21 those kinds of details if, in fact, that is happening --
22 MS. DePARLE: And do they bill? Those outsource

1 people in India bill Medicare?

2 MS. BURKE: How does that work?

3 DR. STOWERS: I think what I was getting at there

4 is exactly what you guys are getting to. You've got

5 somebody qualified to even order the film. Let's say you

6 have really good equipment and you have somebody that is

7 really qualified to read the film. Let's assume all the

8 people I was talking about are really qualified.

9 What's in the chapter, though, is kind of an

10 inference that if you have somebody really qualified to read

11 the film and you have really good equipment that that's

12 going to affect volume. It's this is in-between thing that

13 you're talking about that affects volume because as these

14 films are sent out electronically and done, they're read at

15 whatever volume they come.

16 MS. BURKE: Let me parse out the question I'm

17 asking. There is the question of whether the test is the

18 appropriate test. That big question has to do with practice

19 patterns and looking at -- and that does drive volume.

20 The very specific question I'm asking is when, in

21 fact, it is sent out to be read, when it is referred out

22 electronically to some place, whether it is in the U.S. or

1 whether it is overseas, I want to understand practically
2 who, in fact, bills for that interpretation? And how does
3 one apply a standards to an interpretation that is occurring
4 in India by some company whose expertise is in reading
5 films? Who actually bills for the interpretation in that
6 setting? And how does one apply standards in that an
7 environment.
8 MR. WINTER: This is an issue we'll have to look
9 into so more. I wasn't aware of the issue that you guys
10 have raised.
11 MR. MILLER: Can I just parse through a couple of
12 questions? Here's what I'm hearing. First of all, when you
13 ask the question about --
14 MS. BURKE: If the state of Montana is going to
15 China to have their films read --
16 DR. NELSON: By an unlicensed physician in that
17 state.
18 MR. HACKBARTH: Let's do some research on this.
19 It's an interesting point that Ray has raised. We can't
20 answer it definitively right now. We just don't have the
21 facts. And so thanks for flagging that, Sheila.
22 The other piece of this, about is the person

1 ordering the appropriate tests, obviously gets to the heart
2 of the volume issue. Help me physicians here, but I think
3 it's a difficult thing to get a grip on. Sometimes a
4 primary care physician will just ask for a consultation from
5 a radiologist and the radiologist will decide what to do and
6 you're basically asking for help and the decision is made
7 there.

8 If the equipment is moving into physician offices,
9 it may be that other physicians are deciding what images to
10 order and they may not have the qualifications to do that
11 well. So I think there are lot of different patterns of
12 practice here.

13 MS. DePARLE: That was my point, is that I think
14 we have more work to do there.

15 DR. REISCHAUER: But I think the question is
16 whether we should walk before we run, because what you're
17 talking about is part of a much larger issue which could
18 apply equally well to expensive lab tests.

19 MS. DePARLE: Yes, and I said we had more work to
20 do there. I just wanted to highlight this. I wasn't clear
21 on what we thought we were getting at with that
22 recommendation because I think it deals with a piece of it

1 and I think the profiling piece of our other recommendation
2 on the resource measurement will deal with some of it.
3 Maybe that's the walking before we run.
4 My second point had to do with recommendation
5 number six. Here maybe I differ a little bit with what Ray
6 and some others have said. No, it's not six. It's the one
7 about Stark, number seven.
8 I thought in the chapter we did a good job of
9 discussing Stark and the reasons why there was an exemption
10 from the self-referral laws for in-office ancillary imaging.
11 I'm sympathetic to that from a number of fronts, patient
12 convenience where that's a factor. There may be rural areas
13 where there is not another place to get it done that's
14 convenient, and that certainly is compelling.
15 I also think that there could be cases where the
16 office payments that physicians are getting are so low from
17 Medicare and perhaps from other insurers, as well, that they
18 are driven to try to do other things to make money, to make
19 a living. I think that may be part of what's motivating
20 this.
21 But I do think we have some more work to do here.
22 I think what we heard from those plans who presented us was

1 that they thought this was a big source of the increase in
2 volume. They at least think, in their plans, that there is
3 a substantial part of it that's inappropriate. I don't
4 think we know the answers for Medicare about what's
5 appropriate and what's inappropriate.
6 I would ask Senator Durenberger and others whether
7 Congress really intended, when they included this exemption,
8 to allow MRI machines in lots of primary care doctors
9 offices who might or might not be really trained to do that
10 kind of work. And we heard, I think, some pretty disturbing
11 evidence, maybe some of it's anecdotal and we need to drill
12 into that, about the quality of the imaging that's being
13 performed. And I think, Bob, you're right, some of it was
14 from Utah because I remember that.
15 So some of our recommendations will get at that.
16 But I would hope that we will do some more work around this
17 piece of it because I think that is a significant factor.
18 DR. STOWERS: The only thing I was saying in that,
19 and I agree with everything you're saying, is the inference
20 that all of that is not good or all of that increased volume
21 is not good. Because if I'm in the office and I'm trying to
22 convince a patient that they need to get their cholesterol

1 done or whatever, and it's a manner of having to go to the
2 hospital when they're busy in their lives and all of that,
3 and sit for an hour until they get through the lab and all
4 the process and redo the paperwork and everything that goes
5 with that, as opposed to being able to come in fasting and
6 go down the hall and get your lab work done.

7 MS. DePARLE: I totally agree with that.

8 DR. STOWERS: I'm not disagreeing with all the
9 rest. There's a lot of work that needs to be done but I
10 think we can't just look at it from the side of well, it's
11 increased, and it's bad. That's all I was trying to --

12 MS. DePARLE: And I think we've made some big
13 steps here. We say it will be difficult to parse out what's
14 appropriate and what's not.

15 DR. STOWERS: Exactly.

16 MR. HACKBARTH: We need to be clear, we are not
17 against integrated organized practice. What we are in favor
18 of is qualified people doing it with accurate equipment.

19 MR. DURENBERGER: I'll be brief. I smiled when
20 Nancy said maybe Senator Durenberger can tell us what people
21 intended.

22 I had this group of students in Washington in

1 September and Pete Stark came and presented to them. And of
2 course, one of the first questions was about the Stark bill.
3 And he said actually, much of that was written by Nancy-Ann,
4 Bruce Vladek and all of their predecessors. They just put
5 my name on it. So that's the answer to her question.
6 MR. HACKBARTH: So it's the DeParle law from now
7 on.
8 MR. DURENBERGER: I didn't know if he used your
9 name, but he said you know the government did the
10 regulation.
11 But I want to make a comment about will add
12 section on growth of imaging in Medicare, just a comment on
13 the larger chapter. Because if we look at only this
14 chapter, I'm reminded of a presentation I saw Clem McDonald
15 make recently where he shows this big mobile CT scanner out
16 in front of the church. He says they get there before the
17 first service and they stay until after the last service so
18 all of these Medicare beneficiaries or whoever can troop out
19 of the church and go right through the scanner. That's what
20 this chapter implies about imaging.
21 There's a whole another side of imaging, the
22 technology, the people who use it that I think needs to be

1 told. And I would suggest -- I'm not going to try to tell
2 it. I'm just saying that as you present a chapter like
3 this, we ought to talk about how we increase the quality and
4 reduce the cost by moving it out of hospitals. How
5 migration of less invasive diagnostic, how imaging as a
6 therapy, that sort of thing sets up yes, but you need to do
7 this. Just a suggestion.
8 MR. HACKBARTH: And I absolutely agree with that,
9 Dave. From my perspective what makes this area so
10 compelling is that we have the conjunction of several
11 different factors. One is the technological innovation and
12 the wonderful things that can be accomplished now with
13 imaging and the equipment getting smaller and less costly
14 and being able to move into different settings. We ought to
15 be very clear that those are tremendous developments and we
16 are all in favor of them.
17 But when you take that development and combine it
18 with frankly the pressure that many physicians feel under
19 income from other sources, combined potentially with
20 mispricing of services within Medicare program creating
21 unusual profit opportunities, it's the conjunction of those
22 three forces that may cause some problems for the program.

1 And we need to address them earlier rather than later, or
2 things will really get out of hand.
3 That's my message on this topic. Dave, did you
4 have something to add?
5 MR. SMITH: Two quick things, and most of what I
6 wanted to say has been said and said well. I won't repeat
7 it.
8 I had a different concern with recommendation
9 seven than Nancy-Ann's. I was thinking well, what happens
10 if the doc owns the building in which the equipment that the
11 doc doesn't own is utilized and somehow the fee or the rent
12 or the condominium structure is on a utilization basis? Or
13 what happens if the doc owns the company in Banglore to
14 which the images are sent to be read and that company, in
15 turn, bills the doc who, in turn, bills Medicare? I don't
16 know that any of that's true, although I would bet it is all
17 true.
18 It strikes me that trying to do something as
19 narrowly framed as seven exposes the extent to which it is
20 very hard to keep up with this sort of financial
21 architecture and engineering and it sort of sounds silly if
22 you think about gee, what's next. So I wonder if we ought

1 to do seven.

2 It struck me, though, that the some of the
3 problems, the Stark problems that seven appropriately
4 attempts to address, would be better addressed by two things
5 that got raised by people earlier: Nick talking about the
6 pricing anomalies here, which to the extent that they are
7 true, and I have every reason to think that Nick is probably
8 right here, are more likely to be driving volume than
9 anything else. And Jay's notion about can't we bundle this?
10 If we do bundle it, than the problems of being at least as
11 quick to innovate on the regulatory side as entrepreneurs
12 are on the gaming side go away the bigger and more
13 appropriate we make the bundle.

14 Those are not things we can craft recommendations
15 about between now and January but they are two things that I
16 think ought to be at the center of new and continuing work
17 here.

18 One other thing. Carol and I live in a market
19 that is bombarded with direct-to-consumer advertising for
20 imaging services. The comfort, the size of the television,
21 the ease, the position as you get scanned now. The notion
22 that the Secretary could speak with a voice that would in

1 any way compete with what's already out there, if you live
2 in New York, is just preposterous.
3 MR. DURENBERGER: Or any other place.
4 MR. HACKBARTH: Okay, we need to move ahead.
5 We've succeeded in falling behind again, but this was a very
6 helpful discussion. I think we really refined our message
7 somewhat through this exchange. Thank you, Ariel, for your
8 good work.
9 Because we're behind, we're going to have to move
10 quickly ahead to our next subject. Our next subject is
11 assessing payment adequacy for physicians. Whenever you're
12 ready, Cristina.
13 MS. BOCCUTI: So, as Glenn said, I'll be
14 presenting an assessment of payment adequacy for physician
15 services. Factors for this analysis include beneficiary
16 access to physicians, physician supply and service volume.
17 Then I'll discuss expected cost changes for 2006 and finally
18 present a draft recommendation for your consideration.
19 In October, I presented findings from three
20 beneficiary surveys on access to physician services. So in
21 a 20 second recap, the general findings from the survey were
22 that the majority of beneficiaries report little or no

1 problems accessing physicians. A small but persistent share
2 of beneficiaries, however, report having problems,
3 particularly those who are transitioning beneficiaries,
4 those who have recently moved to an area or switched to
5 Medicare fee-for-service. A somewhat larger share of
6 beneficiaries, though still a minority, report having
7 difficulty getting timely appointments.
8 Medicare beneficiaries have the same or better
9 access to physicians as privately insured people aged 50 to
10 64. When we excluded beneficiaries over the age of 74, the
11 similarities between the groups remained on almost all
12 measures. Large surveys show slight improvements between
13 2002 and 2003. Our smaller but more recent survey tracked
14 2003 and 2004 and did not find statistically significant
15 differences.
16 So the key point from beneficiary surveys is that
17 we do not have evidence of increased access problems.
18 We also examined physician surveys regarding the
19 proportion of physicians who are accepting new Medicare
20 patients. In general, the most recently available data
21 indicate that most physicians are willing to accept new
22 Medicare beneficiaries. The most recent survey information

1 comes from the National Ambulatory Medical Care Survey or
2 NAMCS and results from this survey show that 96 percent of
3 office-based physicians had open practices in 2003. That
4 is, they accepted at least some new patients. 94 percent
5 with at least 10 percent of their practice revenue coming
6 from Medicare accepted new Medicare patients. Each of these
7 rates increased one percentage point compared to the 2002
8 NAMCS.
9 So in short, this survey does not find evidence
10 that physicians are decreasing their acceptance of Medicare
11 patients.
12 This year we added a few analyses of summary
13 claims data to boost our examination of physician supply in
14 the Medicare market. First, we looked at the entry and exit
15 and found that the number of physicians with Medicare
16 patients is increasing. Indeed, between 1999 and 20002,
17 more physicians have entered the Medicare market than
18 exited. By being in the Medicare market, I mean having at
19 least 15 different Medicare patients. And using this
20 delineation prevents us from counting physicians who
21 provided services only on an emergency basis or as coverage
22 for colleagues who were temporarily unable to treat them.

1 Using this cutoff also provides us with a
2 conservative estimate of the number of physicians in the
3 Medicare market. As shown in this table, physicians who
4 started seeing Medicare patients outnumber those who stopped
5 seeing Medicare patients. And thus, the ratio of physicians
6 to beneficiaries logically increased from 11.7 to 12.3. So
7 although an overwhelming of physicians stayed in the market
8 between 1999 and 2002, changes in physician entry and exit
9 do still affect existing physician/patient relationships and
10 could explain in part a persistently small share of
11 beneficiary complaints about access problems. Nevertheless,
12 the number physicians treating Medicare patients has
13 increased.
14 Still using summary claims data, we also looked
15 for trends in the number of different patients physicians
16 saw, that is their beneficiary caseloads. Our analysis
17 shows that median Medicare patient caseloads grew by 23
18 patients between 1999 and 2002 and essentially steady
19 between 2001 and 2002. In this type of analysis, we look
20 for signals of access problems and the increasing or steady
21 caseloads that we see here do not signal to us that
22 patients, on average, are having more difficulty finding a

1 physician or scheduling appointments.

2 So our median case analysis does not suggest a
3 decline in access.

4 We also looked at concentration of patients to
5 physicians. Changes in the concentration of patients to
6 physicians between 1999 and 2002 shows that the
7 concentration has remained extremely steady within carrier
8 areas. Carrier areas are roughly equivalent to states.
9 This steadiness suggests that the task of looking for a
10 physician who is taking Medicare patients did not get any
11 harder over the study period as the distribution of
12 caseloads among physicians in each carrier area is virtually
13 unchanged over the study period.

14 To supplement our information on physician supply,
15 we also look at some other less direct measures: physician
16 rates of signing Medicare participation agreements and the
17 share of allowed charges for which patients accepted
18 assignment. The share of physicians signing participation
19 agreements with Medicare increased slightly to 92 percent in
20 2004. Assignment rates have remained high. Keep in mind,
21 however, that physicians report that they sign participation
22 agreement and accept assignment to take advantage of several

1 associated benefits. Chief among them is that they can
2 receive payments directly from Medicare rather than
3 collecting the entire payment from the beneficiary. For
4 many physicians, this convenience makes it worth it to them
5 to forego the small increase in payments that they would
6 receive if they balance billed.

7 In our payment adequacy analysis, we look at
8 changes in the use of services by Medicare beneficiaries.
9 As we look at claims data through 2003, we do not see
10 decreases in volumes, at least among broad categories of
11 services shown at this chart. Across all services, volume
12 grew about 5 percent between 2002 and 2003. Among broad
13 categories of service growth rates vary but all were
14 positive. As in past years, imaging and tests grew the
15 most. From 2002 to 2003 the imaging growth rate was 8.6
16 percent per beneficiary and the growth rate for tests was
17 9.4 percent. These rates are slightly lower than the 2001-
18 2002 rates, but they're still quite high.

19 In our analysis, we do see some decreases in
20 blamed for specific services but it's not clear that the
21 decreases are a sign that payments have become inadequate.
22 In general, the decreases that we see are quite small and

1 they follow rapid increases in previous years.

2 One small increase I'll mention, which is really

3 only about 1 percent, that we want to keep our eye on is new

4 patient visits for evaluation and management. This small

5 decrease indicates that beneficiaries are, on average,

6 seeing slightly fewer new doctors. Although average annual

7 growth for these services has historically been low, a

8 decline is unusual. Although this slight decline could

9 suggest some difficulty making new appointments, it could

10 also suggest that beneficiaries are satisfied with their

11 doctors and are thus seeking new ones less often.

12 Overwhelmingly however beneficiaries, on average, have

13 continued to use more services each year.

14 Another factor in our payment adequacy analysis is

15 usually a comparison of Medicare's payment rates for

16 physician services with average private insurer -- is the

17 comparison that we usually do between Medicare payments and

18 private insurer payments. Unfortunately, attaining the

19 private payer data has taken more time this year than in

20 past years, so we expect to be able to present our private

21 payer comparison analysis in January.

22 So next I'll move on to the second part of our

1 adequacy framework, changes in cost for 2006. The
2 preliminary forecast for input inflation is an increase of
3 3.5 percent as provided in CMS's medical economic index,
4 what we call the MEI. As you know, within this total, CMS
5 sorts the specific inputs into two major categories:
6 physician work, and that includes salary and fringe benefits
7 allotted for physicians, and that's expected to increase by
8 3.4 percent; and physician practice expensive, which is
9 expected to increase by 3.6 percent. That includes
10 nonphysician employee compensation, office expenses, drugs
11 and supplies, medical equipment and PLI, which is forecast
12 increase by 8.4 percent.
13 Some physicians, particularly those practicing in
14 certain geographic areas and those whose specialty includes
15 high-risk procedures, report PLI premium increases that are
16 much higher than what is forecasted in the MEI. Recall
17 however that the fee schedule is Medicare's primary tool for
18 reimbursing services differentially to account for PLI
19 premium variation by service and geographic area. Indeed,
20 the final rule for 2005 physician fee schedule increased the
21 PLI relative value units for many surgical services and
22 other procedures based on new premium information.

1 The other factor that we consider in our input
2 cost analysis is productivity growth. Our analysis of
3 trends and multifactor productivity suggest a goal of 0.8
4 percent.
5 So for your discussion this draft recommendation
6 before you is similar to the one in our previous March
7 report. The Congress should update payments for physician
8 services by the projected change in input prices, less 0.8
9 percent in 2006.
10 Drawing on the numbers from the previous slide, we
11 would have a preliminary update of 2.7 percent for 2006,
12 which is similar to the modest increase Congress legislated
13 in recent years.
14 The beneficiary and provider implications, there's
15 no changes is meant -- when we say no change here for the
16 beneficiary and provider implications, what we mean is that
17 this update would preserve beneficiary access to care and
18 maintain payment adequacy to providers. For spending
19 implications, any increase in physician payment would
20 increase spending relative to current law because existing
21 law, as it stands now, calls for a decrease in payments for
22 2006 through the SGR. On that same note, we don't present a

1 five year impact estimate because under current law any
2 change in the update would be taken out in subsequent years.
3 So for your discussion I'll recap just a couple of
4 points. First, the access, supply and volume measures
5 suggest that access is good for the majority of
6 beneficiaries. Second, recall that the MMA included added
7 payments to physicians, such as bonuses for scarcity areas
8 and establishing a GPCI floor over and above 1.5 percent
9 updates. These additions are all in place throughout 2006.
10 Keeping these points in mind, the Commission may want to
11 discuss a lower update for 2006.
12 That concludes my presentation and I'm happy to
13 answer any questions.
14 MR. HACKBARTH: Let me just expand on the final
15 point. Last year the legislative update or the update for
16 this year was the 1.5 percent. I think we actually noted in
17 our report last year that if you took the 1.5 percent and
18 then combined it with a GPCI floors and the like, that the
19 net increase in dollars going into physician payment was
20 obviously higher than the 1.5 percent and not that far off
21 of our recommendation of a MEI minus productive; is that
22 right?

1 MS. BOCCUTI: I think, to have the record
2 straight, the chapter didn't make that connection
3 explicitly.
4 MR. HACKBARTH: Oh, we did not. I remember we
5 discussed it.
6 MS. BOCCUTI: We presented the timeline of when
7 the MMA, the bonuses and the GPCI floor, et cetera, when
8 they were in effect. We noted that they occur over and
9 above the 1.5 percent update.
10 MR. HACKBARTH: So the GPCI floor -- the 1.5
11 update expires and it is not in effect in fiscal year 2006,
12 the GPCI floors continue how long into the future?
13 MS. BOCCUTI: Through 2006.
14 MR. HACKBARTH: The end of 2006.
15 MS. BOCCUTI: Well, it's calendar year 2006, so
16 there's a piece of it in fiscal year 2007.
17 MR. HACKBARTH: Thanks for the clarification.
18 DR. NELSON: I think I'll say this for the fifth
19 time in five years that to me, as a physician, using the
20 Bureau of Labor Statistics multifactor economy-wide
21 productivity growth makes absolutely no sense for a segment
22 of the economy that productivity may very well drop as a

1 product of transitioning to an electronic health record.
2 While I understand the theory -- well, I don't understand
3 the theory. I would much prefer that we left productivity
4 out or that we based it on some surrogate for productivity
5 for Part B services.
6 DR. SCANLON: I know we've talked about how the
7 SGR has gotten out of whack due to errors in the past and
8 then also the interventions that have tried to deal with
9 those errors without changing it fundamentally, as well as
10 the signal that it's not sending to individual physicians.
11 But at the same time, I have maintained a concern about the
12 fact that we need to send a signal about what's happening
13 with respect to the volume of services and the fact that
14 physician services are unlike hospital care or some of the
15 other services in Medicare in that the volume precludes us
16 looking carefully at them, though our recommendation earlier
17 we are proposing to at least start in that direction. But
18 that's going to be contingent upon having the resources to
19 do it.
20 I just wonder if we were to start the SGR today or
21 a formula you like it today and forget about the past
22 errors, what would be the recommended increase? Not

1 necessarily recommended, but what would be the resulting
2 increase in fees in 2006 and how would that compare to the
3 MEI minus the productivity factor?
4 Because I note this volume increase continuing
5 over all this period. I'd like to know what would have been
6 the implications of that if the SGR was applied?
7 MR. HACKBARTH: What would the SGR formula have
8 produced if we hit the reset button?
9 DR. SCANLON: Hit the reset button and started it
10 at the latest possible point we can. Factor out all the
11 errors, factor out to congressional interventions and think
12 about it.
13 MR. HACKBARTH: Do you know the answer to that?
14 MS. BOCCUTI: No. We can expound on that but
15 Kevin has a long history of working on this issue and
16 happens to be sitting at my left. And if he wants to add
17 anything.
18 DR. MILLER: To rescue Kevin, if I understand what
19 your question is are you asking what the SGR would produce
20 if just say the last year was in place?
21 DR. SCANLON: Right. If we started -- and I'm not
22 sure exactly which years to use. But let's say we took 2003

1 fees and we looked at what would happen with respect to the
2 change in the SGR factors, taking into account 2002 to 2003
3 volume growth, what would be the resultant increase for
4 2004? I think we can do it at a very aggregate level.
5 DR. NELSON: Well, if you believe in the
6 behavioral offset, the volume would have gone up because
7 payments per service would have gone down.
8 DR. MILLER: You're asking what the update would
9 be.
10 DR. SCANLON: I'm asking what the update would be,
11 and I'm seeing that volume is going up but I'm wondering
12 what would have been the restraint on fees that would have
13 been introduced by the SGR in the most current period.
14 DR. HAYES: This is just a rough approximation but
15 we know from the work that's been done by the actuaries that
16 the -- what we would want to do here is to contrast the
17 volume growth that's shown on this slide here with the now
18 10-year moving average of GDP growth. And any difference
19 between the two would represent a violation of the target.
20 It would mean that volume growth has exceeded the target.
21 My recollection of the 10-year moving average of
22 GDP growth is that it is in the area of 2, 2.5 percent,

1 somewhere in that area. And volume growth 2002 to 2003 was
2 somewhere close to 5 percent. So we're looking at that
3 kind of a difference that would --
4 MR. HACKBARTH: What about the beneficiary growth?
5 Number of covered beneficiaries? That was per beneficiary.
6 Just to be clear for the record about this, Bill,
7 the problems that we have had with SGR aren't limited to the
8 fact that it's produced some bad numbers because of errors
9 and forecasting problems and all that stuff. They're much
10 more fundamental than that. In fact, we first recommended
11 repeal of SGR before the cuts occurred because we thought it
12 was a fundamentally flawed mechanism. It wasn't the
13 dramatic cuts that moved us to that position.
14 The principal objection, and we had a list of four
15 or five, but the principal objection is that it applies
16 across the board to all physicians regardless of their
17 individual performance, and that makes it unfair. But
18 equally important, it makes it utterly useless as a tool to
19 motivate changes in behavior. And so that's the long-
20 standing MedPAC critique of SGR, not just the bad numbers it
21 produces.
22 DR. SCANLON: And I tried to acknowledge that by

1 saying that among its problems was it didn't send signals to
2 individual physicians. But on top of that, certainly the
3 discussions these days have been dominated by the errors and
4 the fact that there's been the interventions and the fact
5 that to get back on the SGR path as legislated is virtually
6 inconceivable.
7 MR. HACKBARTH: Other comments? Questions? Okay.
8 Thanks.
9 The last item is some physician payment reform
10 issues. Joan?
11 DR. SOKOLOVSKY: I guess much of what I'm going to
12 say has come up in discussion in the course of morning, but
13 am presenting a new idea or an idea that's new to Commission
14 discussions today. The chair asked me to present an
15 animated discussion because it was at the end and it was
16 new. I think he was talking about my presentation but I
17 chose to take him literally. So I ask you to keep at least
18 one eye on the screen as I go through this.
19 The Commission has long recognized that the
20 current Medicare physician payment system does nothing to
21 incentivise coordinated evidence-based medical care. The
22 system does not reward quality care nor recognize when

1 services provided are inappropriate or inefficient. Today
2 we have reviewed strategies that Medicare can use to
3 encourage the use of efficient evidence-based medicine.
4 Some of these strategies were developed and have received
5 considerable testing in the private sector.
6 The Commission has spent considerable time
7 analyzing three of these strategies: paying for
8 performance, measuring physician resource use and
9 controlling inappropriate growth in imaging services. The
10 Commission, in fact, in the past two days has considered
11 recommendations on the use of these tools. The other two
12 strategies, creating separate volume targets for accountable
13 defined groups of physicians and recalibrating prices for
14 physician services, are newer to our agenda. At this
15 presentation we will discuss some of the policy and design
16 issues that must be considered if Medicare were to implement
17 separate volume targets. In future sessions we will analyze
18 issues around the pricing of Medicare physician services.
19 We recognize that none of these tools is
20 sufficient to solve current budgetary problems that have
21 been made worse by the payment system but believe that they
22 each have the potential to improve both quality and

1 efficiency within the program. This should look familiar to
2 you, the volume of physician services provided to Medicare
3 beneficiaries has been growing steadily since the Congress
4 established the physician fee schedule. The per capita
5 volume of physician services used by beneficiaries increased
6 by more than 30 percent between 1993 and 1998. Our work on
7 physician volume growth demonstrated that volume growth has
8 accelerated in recent years and in the four years from 1998
9 to 2003 per capita growth in the volume of physician
10 services increased by nearly 22 percent.
11 While some of this volume growth undoubtedly
12 contributed to the health and well-being of beneficiaries,
13 for example increased use of preventive services, other
14 increases probably did not. And as many people have already
15 mentioned today, the work of Wennberg, Fisher and others has
16 shown wide variation nationally in the volume of physician
17 services. Their research has shown that after we control
18 for input prices in health status the volume of physician
19 services is driven partly by local practice patterns and
20 partly differences in physician supply and specialization.
21 Greater volume is often not associated with any demonstrable
22 improvement in health outcomes.

1 Because of rapid growth in the volume of physician
2 services in the 1980s Congress established an expenditure
3 target for the fee schedule based on growth in the volume of
4 services. Problems with the initial standard led to its
5 replacement as part of the 1997 Balanced Budget Act. That
6 law established the sustainable growth rate, or SGR, as the
7 new expenditure party for Part B services. The SGR is based
8 on the number of beneficiaries in fee-for-service Medicare,
9 changes in input prices, the effects of law and regulation
10 and gross domestic product. The GDP, the measure of goods
11 and services produced in the U.S., is used as a benchmark of
12 how much growth in volume society can afford. The basic SGR
13 mechanism is to compare actual spending to target spending
14 and adjust the update when there is a mismatch.
15 Criticisms of the SGR are widespread. Some
16 analysts focus on how it is calculated and what services it
17 includes. For example, many have suggested that
18 prescription drugs should be removed from the expenditures
19 used to calculate volume growth. Prescription drug share of
20 expenditures that are subject to the SGR have almost tripled
21 over the last seven years.
22 Similarly, although the effects of changes in law

1 and regulation are included in the SGR calculation,
2 increased utilization caused by national coverage decisions
3 generally are not. CMS may have the authority to address
4 such issues administratively and commissioners may want to
5 discuss these issues.
6 Another criticism concerns the pattern of
7 unrealistic negative updates that the SGR will require
8 unless the Congress acts to prevent implementation. For
9 purposes of this discussion, we do not address the scheduled
10 string of negative updates. We recognize that this has
11 tremendous budgetary implications but we do not believe
12 Congress will allow seven years of negative updates for
13 physicians.
14 The focus of this presentation is more conceptual.
15 MedPAC has consistently raised criticisms about the SGR,
16 both when it set updates above changes in input prices and
17 below changes in input prices. And our criticisms are based
18 on the following. Most importantly, it's flawed as a volume
19 control mechanism. Because it's a national target there is
20 no incentive for individual physicians to control volume.
21 In fact, in the short-term physicians may have an incentive
22 to increase volume.

1 It's inequitable because it treats all physicians
2 and regions of the country alike, regardless of their
3 individual volume influencing behavior. It creates no
4 incentives for physicians to develop structures of care that
5 coordinate beneficiary care across multiple physicians and
6 sites of care. And lastly, it disassociates payment from
7 the cost of producing services.
8 If Congress determines that budget concerns make
9 elimination of the SGR impractical, multiple volume target
10 pools could be a way to minimize the worst aspects of the
11 SGR, the lack of individual incentives to control
12 unnecessary volume. Congress could create an alternate pool
13 for some physician groups with its own expenditure target.
14 Physician groups would voluntarily apply for inclusion in
15 the alternate pool. Services provided by members of groups
16 accepted into the pool would be aggregated in a separate
17 pool with its own expenditure target.
18 In order to participate in this pool the group
19 would have to meet certain criteria. The focus would be
20 that the group have a means of organization, accountability
21 and commitment to the use of evidence-based medicine. Some
22 possible more specific criteria could be the use of clinical

1 information technology, the use of systematic quality
2 improvement techniques, the development of processes of
3 coordinated care for patients with multiple chronic
4 conditions and especially their willingness to be part of a
5 collective, transparent, monitoring and improvement process.
6 CMS could deem an entity to assure that groups meet these
7 standards.
8 We can talk about what kind of groups could join
9 the alternate pool. Multispecialty group practices we would
10 see as a model for the kind of groups that we would
11 anticipate wanting to join. There are currently over 600
12 multispecialty group practices with more than 50 physicians
13 in the United States. They are located in all parts of the
14 country in both urban and rural areas. Among those groups
15 those such as the Permanente Group, the Mayo Clinic, the
16 Marshfield Clinic and Geissinger, they have adopted
17 techniques to bring up to date medical science
18 systematically to the practice of medicine. They monitored
19 the impact of these techniques on the outcome of care for
20 patients and many have electronic medical records and other
21 information technology.
22 But importantly, the pool would not be limited to

1 these groups. The goal would be to make the criteria for
2 participation in the alternate pool high enough so that it
3 provides incentives for physicians to develop organized
4 processes of care but not so high that certain kinds of
5 physicians -- for example rural physicians -- would
6 automatically be precluded from joining.
7 Other possible organization types could include
8 IPAs and other smaller groups of physicians who have
9 developed alliances among practices often to contract with
10 health plans. Similarly, single specialty practices could
11 affiliate with other groups. These organizations could be
12 adapted to share information and resources.
13 Another possibility, particularly in rural areas,
14 could be the medical staff of a hospital. In either case,
15 the groups would likely have to develop organizational
16 structures to meet the accountability and communication
17 standards that would be necessary for inclusion in the
18 alternate pool.
19 Clearly, this idea raises many design and
20 administrative issues. One set of questions is about how
21 the target should be set. It could be the same as today,
22 based on GDP. Alternatively, targets could be based on the

1 actual experience of the groups in question. Targets could
2 be different in regions where volume is already high. They
3 could also take into account cases where more efficient and
4 effective physician care might reduce hospital spending.
5 But we would emphasize that the policy is about controlling
6 unnecessary volume.
7 Decisions about the types of groups that could
8 participate in the alternate pools also would have
9 administrative consequences. Individual physicians would
10 have to decide whether they chose to affiliate with the
11 newly reorganized entity. Administratively, members of the
12 group would have to establish identity codes so that CMS
13 could measure service use within the group. And at a
14 minimum, CMS would have to develop processes to measure the
15 volume of services provided by the group and its continued
16 adherence to the criteria for membership in the alternate
17 pool. Recall that some of these issues have already been
18 discussed in our presentations on pay for performance and
19 measuring resource use.
20 One of the most critical design issues concerns
21 the number of alternate pools that should be established
22 since one of the key goals of the policy is to link

1 individual incentives to control unnecessary volume with
2 payment.
3 MR. HACKBARTH: This is a MedPAC moment here.
4 History is being made.
5 [Laughter.]
6 DR. SOKOLOVSKY: It would make sense to have
7 smaller pools where physicians had more ability to influence
8 the behavior of their peers.
9 [Laughter.]
10 DR. SOKOLOVSKY: I have to stop here and give all
11 credit to Chad, who did this.
12 On the other hand, larger pools would be easier to
13 administer and would likely result in more stable estimates
14 of volume growth. Because of the importance of geographic
15 differences in practice patterns it might make some sense to
16 create regional volume pools. Under this scenario areas
17 with relatively conservative practice patterns, like the
18 upper Midwest, could have separate volume targets from
19 higher volume regions in other parts of the country.
20 While this presentation really just begins to
21 sketch how an alternate volume target could be established,
22 many issues obviously remain. Four of the most important

1 are these: CMS would have to devise a way of attributing
2 the services received by individual beneficiaries to
3 specific pools without locking beneficiaries into receiving
4 care from any specific group. Some health plans have
5 developed algorithms that attribute patient care to
6 particular groups on the basis of the percentage of care
7 they receive from any one group. Such a methodology might
8 be adapted for Medicare but it would likely be a more
9 complex process. Questions to be answered would include do
10 all of the physician services received by the beneficiary
11 count within the pool even if only 30 percent of the
12 patient's care was provided by group members?
13 Accountability will not be perfect and pools will
14 have to deal with the free rider problem. It is to be hoped
15 that other tools like pay for performance and measuring
16 physician resource use can help take into account
17 inefficient providers with inefficient groups or efficient
18 providers who are in the basic pool. The system must ensure
19 that groups do not have an incentive to discourage patients
20 with high volume medical needs or discourage group
21 membership by physicians who provide high-quality care to
22 patients with particularly costly medical conditions. Risk

1 adjustment is very likely to be needed.

2 Finally, separate volume pools should be combined
3 with pay for performance and other measures so that all
4 physicians have incentives to provide high quality evidence-
5 based medicine.

6 MR. HACKBARTH: Let me just pick up on a couple of
7 points that Joan made and say a little bit more about the
8 context. As Joan indicated, this is a very complicated
9 concept that we're just really scratching the surface on.
10 So what I contemplate is not that we would make a boldfaced
11 recommendation at this point. I don't think we've thought
12 through enough of the detail. It could be as we think
13 through detail we may find there are insurmountable problems
14 and it's not a good idea. So we don't want to go so far as
15 a boldfaced recommendation.

16 When I had envisioned was we would have a passage
17 in the physician chapter that would say that if Congress
18 elects to keep some form of aggregate volume constraint,
19 even if it deals separately with the budgetary problems and
20 can figure out a way to fix that, that it still wants some
21 aggregate limit on volume, that this would be a way to
22 potentially deal with that critical problem that I

1 identified earlier, that the SGR working on a national basis
2 is unfair and does not reward appropriate behavior.
3 So it's sort of a directional statement. We'll
4 see what interest there is in it. If there is interest in
5 it, then we can invest more resources and time in
6 development. If there's no interest, particularly given all
7 of the other things on our plate, I don't want to consume a
8 lot of commissioner time or staff time on wasted
9 development.
10 So in a sense, we're posing a question and seeking
11 guidance.
12 Just one other point before it open it up for
13 discussion. Joan, I think you said at the outset if the
14 budget cost of repeal makes repeal impossible, then maybe
15 look at this. But I want to be clear that I don't think
16 this or any other reasonable set of policies will solve the
17 budget problem created by SGR. The hole is so deep now that
18 the set of reasonable policies that could achieve those
19 goals is zero. It is a null set. And so somehow the budget
20 issue needs to be addressed separately from policy. So I
21 don't want this to be seen by any way as a way of dealing
22 with the SGR budget hole. It just wouldn't work.

1 DR. CROSSON: Thank you, Joan. I think it would
2 probably come as no surprise that I think this is a good
3 idea. But I have no illusions that this is a simple idea.
4 This is a complex idea, as you said. Developing this would
5 neither be easy nor quick.
6 However, It's an extremely powerful idea and it's
7 one that really goes to the heart, I think, of at least part
8 of the volume escalation problem which has to do with
9 appropriateness. I think again we mentioned earlier today
10 the life's work of Jack Wennberg is a testament to that.
11 I think over the last number of years of my career
12 people have said to me in various venues it's really too bad
13 that we can't nationally get the benefit of the whole
14 prepaid group practice experience because it seems like a
15 nice model that has, over time, balanced quality and
16 appropriateness of services in a good way, a way that's
17 garnered respect and is generally liked by the patients.
18 But of course, the whole trappings of it, the complexity of
19 building groups and developing payment methodologies of that
20 kind, are kind of difficult to imagine for the country.
21 Isn't there something or some set of things that we could do
22 to, in fact, develop some of those benefits?

1 I think we've talked about some things already in
2 this session that I think move in that direction. I think
3 the pay for performance does that. I think the development
4 of information technology and its ability to integrate
5 physician practice virtually moves in that direction.
6 I think this idea is an additional one that does
7 that in two ways. Number one, it provides opportunities for
8 group practices -- prepaid or not -- around the country,
9 particular those who are not prepaid really, to deepen their
10 own incentives to be rewarded for their capability to manage
11 with the infrastructure they have. And right now they have
12 no incentive. A group practice, for example that's paid
13 fee-for-service, is in the same pool with all other
14 physicians in the whole country, as was described.
15 Therefore, while these practices may in fact have the
16 capabilities to do some of the wise management of resources
17 in this area there's no particular financial incentive.
18 They suffer the same reduction potentially that everyone
19 else does.
20 Secondly, and I think this was mentioned by Joan,
21 is this kind of mechanism offers the potential for other
22 physicians in looser economic organizations or in no

1 economic organization over time to become part of one and to
2 began the process, combined with pay for performance and
3 electronic interconnectivity, to be part of some sort of
4 system -- call it integrated system or whatever you want to
5 call it -- that, in fact, has the capability to be what we
6 would like to say is accountable over time, which is in the
7 interest of Medicare. It's in the interest of beneficiaries
8 and in the interest of the Trust and all of us.

9 Because, in fact, it begins a process of moving
10 towards what we might call a 21st-century delivery system,
11 which is what we need.

12 So there's no illusions about the simplicity of
13 this. It is complex in it's design. There will be a lot of
14 concerns about it. But again, as I said earlier,
15 prospective payment for hospital services must have seemed
16 equally as daunting in the beginning when people began to
17 look at that. So I would strongly support continued
18 analysis in this area.

19 MS. DePARLE: I, too, find this a very hopeful
20 discussion but don't want to underestimate the difficulty
21 that it would engender. I guess I'm going to add to that a
22 little bit because, among all the materials that we got

1 before the meeting, we got a letter -- actually addressed to
2 you but all of us got copies -- from a group of specialty
3 medical societies. In reading it, I thought there was a
4 point that was made that I wish that I had made yesterday.
5 And maybe somebody did and I just didn't hear it. But that
6 as we go down the road of paying for performance and looking
7 for better outcomes and quality that there might be a
8 relationship between that and the volume of physician visits
9 or other clinician visits that would have a very perverse
10 interaction with what we currently have, the SGR, and maybe
11 even what we would do down the line with the ideas that have
12 been laid out on the table.
13 And I just hope that as we look at paying for
14 performance that we recognize that in some cases it might
15 require more doctor visits. And so then that would have a
16 weird interaction with what we're doing. Maybe you made
17 that point but I didn't hear it.
18 MR. HACKBARTH: In fact, part of our historic
19 critique of SGR has been based just on that. Some volume is
20 good. Some volume increases are good. Some are not. And
21 just to treat them all as though they're problematic is just
22 not right. And so that would be one of the challenges here

1 is not to arbitrarily constrain volume but have a more
2 discriminating set of tools. And obviously the merger of
3 this with pay for performance would be critical.
4 MS. DePARLE: And the merger of pay for
5 performance with the current system, which I agree with you
6 that there's no reasonable set of alternatives out there
7 that can solve the SGR problem in the short-term, and to the
8 extent that it's a budgetary problem it's a huge one come at
9 a time when we don't need another budget problem. But
10 assuming that it stays out there for a while, if we are
11 moving towards pay for performance, I think we'll have to
12 take that into account.
13 The second thing, Joan invited us to talk about
14 other things that were out there, some of which the agency
15 might do -- I forget the language you used. And so I will
16 mention that in reading the materials that have come my way
17 from the AMA and others about the problems with this, and
18 actually from Chairman Thomas I believe last year, I was
19 intrigued by this notion about what impact would it have if
20 you took the drug spending out? and to what extent is that
21 really under the control of physicians? And is it fair
22 somehow to have it in there? And in looking at it, I've

1 become convinced that it really probably doesn't make sense
2 to have it in there and that CMS could take it out.
3 I don't think that is has that great an impact on
4 the problem in the sense that I don't think it solves the
5 problem of negative updates or unstable updates. But I at
6 least find that compelling. We haven't really discussed it
7 here. But since Joan invited us to be animated and also to
8 talk about things like that, I'm going to say that I would,
9 at least, support that.
10 MR. HACKBARTH: Why don't we just spend a minute
11 on that and I'm aware of the time and we have to move along
12 quickly.
13 There are proposals floating around for taking out
14 drugs, not just going forward but also retroactively to the
15 beginning of SGR. And the affect of that obviously would be
16 much larger in terms of reducing the budget hole. In fact,
17 some people think it could largely eliminate it. I can't
18 vouch for that. I don't have any independent verification
19 of that.
20 The question that would raise from my perspective,
21 about MedPAC endorsing that, is that as you well know we
22 have, for a number of years, urged Congress to change the

1 Part B drug payment formula, which they have now done. We
2 did that, realizing that there was a spread between the
3 amount the physician would receive and the amount it cost
4 him or her to buy the drugs. That is physician income.
5 That's not drug company income, that's physician income.
6 And so how we would logically square our
7 identification of that problem with saying it ought to be
8 retroactively taken out of the SGR would be something we
9 would need to think about.
10 Now people say well, it only went to certain types
11 of physicians. I'm not sure that that's a logical basis.
12 All various types of services only go to select specialties.
13 So that's a very quick reaction, not definitive
14 one way or the other, but some initial thoughts.
15 We need to get through our list here.
16 DR. REISCHAUER: While Joan has come up with a
17 very interesting alternative, I think it would be a mistake
18 to go forward with a description of just one alternative,
19 especially when there's 1000 problems in implementing
20 something like this, no matter how attractive it is, because
21 it will look in a way like this is our endorsement or our
22 best shot. And probably it's best to have three things,

1 even if they aren't fully fleshed out, and even if they're
2 all substantially flawed.
3 In that spirit I offer a flawed alternative, which
4 we can say well, maybe this would do something but there's a
5 lot of problems with it, too. And that would be to vary the
6 update by risk-adjusted resource utilization. And in the 89
7 regions, for those that had utilization over the national
8 average risk-adjusted, lop half a percentage point off the
9 update.
10 And you'd say well, that's a little fairer than
11 punishing everybody. And it sort of says to southern
12 Florida, if that's a region, if you don't have a mechanism
13 for getting your act together, get a mechanism and start
14 talking to one another about what you can do because over
15 the long run this things going to bite.
16 I'm sure there are many other equally flawed
17 alternatives.
18 MR. HACKBARTH: I agree with your point, Bob. I
19 would have no problem whatsoever with saying there are
20 different directions. If you choose to go down the path of
21 narrower groups of accountability, there are different ways
22 you could cut it, just geographically or this way. My own

1 particular interest in this path is that my experience, even
2 as a nonphysician, is that physicians do better working with
3 other physicians and meaningful groups, talking about how to
4 improve care.
5 DR. REISCHAUER: I don't think we should get into
6 an argument on is Joan's less flawed than the alternatives.
7 Probably it is. But I was just trying to think of some
8 other things to put on the table so that we don't look like
9 we're endorsing this.
10 MR. HACKBARTH: Fair enough.
11 DR. STOWERS: I'll be real quick. When I first
12 heard about this there was something that just really made
13 me take a little caution. And I think Bob's getting exactly
14 to where I was feeling about it.
15 And that is, I don't doubt that we're mixing
16 quality and volume here, and I think that's a lot of the
17 thing that leaves funny feelings. Because one thing could
18 cut the volume and that would be to get away from the
19 regions of the country where the big specialty groups are
20 that cross refer and do all of that. Because if we look at
21 the states with the cost per beneficiary being high, it's
22 where the managed companies have been and where all of the

1 large multispecialty groups are.

2 So the more we've organized in groups has happened

3 and been stimulated by being in areas where we have already

4 high expenditure. And the areas that we are least likely to

5 have this kind of group activity is where we see the inverse

6 reaction of higher quality at lower volume.

7 We say there's a dislink between the two. I can

8 see going into this but I kind of like Bob's idea or

9 something of targeting those areas, whether it be you get

10 your update if you show certain cost savings and maintain

11 volume, or whatever like that. But if you're in one of

12 these low states for already cost per beneficiary I really

13 wonder what the stimulus there is going to be to bring in

14 the cost of organizing groups and all of that, just in order

15 to get the -- I just think we're going to have to think

16 about and be careful not to have the large states or those

17 states with big multispecialty groups and that ability, be

18 able to organize and get the bonus payment, leaving these

19 other states in some kind of a pool with the high utilizers,

20 which would put them being brought down even more.

21 I guess we're really going to have to look at

22 that. I think the whole idea is fascinating and it could

1 probably be made to work. But I think the complexity here -
2 - and what baseline we're going to build from, I think, is
3 what I started to hear from Bob that I'd been thinking. Are
4 we going to start, in the really high utilizer states,
5 adding on a percent or two or three on what they're already
6 getting compared to the states that have been very efficient
7 in the care that they've been offering who may not be able
8 to get the bonus payments? So we've just got to look at all
9 of that a little bit.
10 MR. HACKBARTH: Again, I think that describing
11 different paths is the right thing to do. I'm not sure that
12 I would agree, Ray, with your characterization that the
13 states with group practice are all the high-cost states. I
14 think if you look at it on an input price adjusted, risk-
15 adjusted basis it's mixed. I'm not going to say that
16 they're all low-cost states but I don't think it's accurate
17 to say that states that have group practice are high-cost
18 states.
19 MR. MULLER: In the spirit of quick comments, the
20 pools remind me very much of Part B capitation and all the
21 pluses and minuses of that. I think hopefully, it's seven
22 or 10 years after the demise of that capitation, and we're a

1 little bit better at risk adjustment. Pay for performance
2 is a little further along. Obviously, the national
3 geographic variation is more on our screen that it was
4 before. So perhaps in line with the comments that have been
5 made by Bob and others, we could go more in that direction.
6 One of the advantages of looking at how this
7 compares to capitation is we at least had a reasonable run
8 of working with that and we know what some of the pluses and
9 minuses were. One of the big minuses is it became so
10 tempting, since that was a tool for accountability, to throw
11 a lot of other things into there that weren't controllable
12 like drug costs, the expansion of outpatient imaging. So
13 all of a sudden we had something that was working in some
14 places reasonably well, especially in the group practices
15 that had a long tradition of working together, the Kaisers,
16 et cetera, the Geissingers, the Mayos. And then we started
17 asking them to solve the problems of not just Medicare but
18 health costs in general by throwing a lot of outpatient
19 stuff and drug stuff, and so forth, into the Part B pools.
20 So I think maybe, if we think about this in a more
21 cautious way and not expect the physician community to solve
22 all of the problems of the health system but to take

1 advantage of the groups that have been created in the last
2 20 or 30 years, to take advantage of the maturity with which
3 they have looked at these issues, and benefit from say the
4 last 10 years of better thoughts about risk adjustment, pay
5 for performance, et cetera, this might be a good way to go
6 back.

7 Because I think in the longer term, some version
8 of capitation -- I've said this before -- has to come back
9 because it's the only way really to have professional
10 judgment be exercised on utilization. And since there's all
11 kinds of reasons to see that utilization is only going to
12 keep going up because of the advances in science and
13 technology, et cetera, we have to bring the professional
14 judgment back into the utilization equation.

15 And I think capitation was something that
16 obviously has been vilified over the last 10 years but we
17 need some way to resurrect it and bring it back. One of the
18 ways may be to not burden it with the burden of solving all
19 the problems of the health care system.

20 MR. DURENBERGER: First, on behalf of Arnie, add
21 to the list on the first page don't pay for medical errors
22 or something to that effect. The Health Partners example.

1 I won't take it from there. You can ask Arnie or John how
2 best to do that.
3 Secondly, simply a comment on the value of just
4 proposing this variety of approaches. I think we'll get a
5 very positive reaction from a lot of communities around the
6 country. Particularly I think the latter one that we're
7 calling the pools or whatever we're calling it, I would
8 suspect we would be pleasantly surprised by the dimension
9 that can be added to the recommendations by the provider
10 community. Jay just gave us an example of that if we simply
11 put it out there for people to look at.
12 The third thing that relates to that is the
13 linkage that comes between the provider groups or the
14 clinical systems and the health plans. I think as we look
15 around the country, probably the places which you will find
16 upper quartile on quality and lower quartile on pay, you're
17 going to see direct linkages between the practice systems
18 and community-based health plans.
19 So that is to be encouraged in the evolution of
20 this and I think we give that opportunity to a lot of
21 people.
22 DR. NELSON: I think your idea is certainly worthy

1 of laying out there. I'm not sure that we -- it sounded at
2 first blush like it was the kind of thing we'd need Ira
3 Magaziner to help organize for us.
4 I think it's important to remember though that
5 about half of the physicians in the country are organized
6 into groups of five or less. And it would be important to
7 provide opportunities for those groups to also participate
8 in networks. You mentioned that but I think the reality of
9 the distribution in the small practice units really needs to
10 be taken right at the front.
11 And Bob, the idea of geographic distribution
12 differences, by that differential incentives based on
13 geography, it strikes me that one of the primary influences
14 that would have would be on capacity, that areas with a low
15 reimbursement rate in comparison would have a negative
16 inflow of providers of services over time. And that might
17 be a good thing.
18 DR. REISCHAUER: I mean, we're in a sense
19 punishing people who are overproviding, so there's no
20 indication that there's an access problem here.
21 DR. NELSON: I understand that.
22 DR. REISCHAUER: It's just the opposite, there's

1 too much access.

2 DR. NELSON: I'm saying though that it might not

3 be so much that you're punishing people through the lower

4 update that the impact would really be to reduce capacity.

5 And I'm saying that not necessarily that's a bad thing. But

6 you also have to consider that there may be some high-cost

7 shortage areas that would be impacted as well. Shortages in

8 certain specialties or whatever. It might be a rural area

9 that for a host of reasons is just relatively inefficient.

10 DR. REISCHAUER: This is resource utilization.

11 It's the number of services you provide. And if you were

12 providing well above the average for the nation per

13 beneficiary, you know these places which never get ahead.

14 DR. NELSON: I'll take an urban area. There may

15 be areas --

16 DR. REISCHAUER: I don't want to defend what I

17 think has a lot of problems.

18 DR. NELSON: I just wanted to point out that we'd

19 have to consider whether or not there might be impact on

20 shortages by virtue of redistribution of services.

21 MR. HACKBARTH: Just to add to our list of

22 conceptual alternatives, I think Arnie, if he were here,

1 might say that another one is based on the Wennberg idea of
2 de facto delivery systems that exist around hospitals that
3 the empirical data show that patients are shared by
4 relatively distinctive networks of physicians who have no
5 legal relationship to one another. And there might be
6 multiple hospital systems within a given geographic area.
7 So it's not the geographic model.
8 So for the sake of completeness, that might be a
9 third path to add to the list.
10 DR. WOLTER: Just a couple of things. I think
11 there's potentially a lot of merit in this. I think there
12 are pros and cons to tying it directly to SGR and volume
13 control issues which certainly would be one of the goals.
14 But since we're just in the brainstorming phase,
15 my pitch would be that what we're really trying to do is
16 incent the development of systems of care and that we're not
17 so much trying to come up with policy that recognizes how
18 care is organized today, but with policy that creates change
19 in terms of how health care delivery is organized.
20 And in that regard, it would be very nice to pitch
21 this around the six Institute of Medicine aims, so that
22 reduction of waste is clearly one of the main goals but the

1 connecting of the dots to the pay for performance and
2 quality and patient safety is also put together as part of
3 this proposal.
4 And I would also urge us, since we're just
5 brainstorming, to think about the next step where we might
6 put a percent or two of the Part A pool together with some
7 of the pay for performance pool and Part B and some of
8 what's being discussed in this proposal in a pool so that
9 the networks then start to include hospitals as well as
10 organized groups of physicians so that we then truly start
11 to be patient centered and follow the patient across these
12 different settings of care. I think that would be very
13 worthy.
14 And there is a lot of devil in these details but
15 I, for one, think this would be doable if we put our minds
16 to it.
17 DR. BERTKO: Again, just a couple of short
18 comments supporting the concept, echoing Nick's comments now
19 and Jay's word accountability here. I would just, having
20 worked with the attribution issue, suggest that particularly
21 for smaller medical groups, I've seen some that we've looked
22 at that have five or six docs, four of whom who seem to

1 participate full-time and one guy who floats around with
2 four or five different organizations. This might lead to
3 calling out which system and which group they're in.
4 That's a thing to add to Joan's list now, which is
5 would there be a lock in so somebody would be recognized for
6 a year as part of this system or organization?
7 MR. HACKBARTH: A lock-in of the physician?
8 DR. BERTKO: Yes, into the concept for purposes of
9 doing the calculations.
10 MR. HACKBARTH: Just by way of clarification, the
11 way I had conceived of this was that from the beneficiary
12 perspective there is no lock-in. So this is something we do
13 within the context of fee-for-service, free choice Medicare.
14 We have Medicare Advantage for beneficiaries who wish to
15 lock themselves into a particular delivery system.
16 MR. SMITH: I'll be very brief. The devil in the
17 detail's of Joan's plan or Bob's plan is obviously there's a
18 lot of attribution, the free rider, baseline problems.
19 We'll have to work at those. But I do think there's a big
20 difference between what Joan described and what Bob
21 described and it's universe alley. I think, building on
22 Nick's comments, that the notion that if we're going to try

1 to use revision of the SGR as a way to try to build more
2 patient-centered system practices, we really do want to
3 include everybody.
4 And if you are in a high utilization area that is
5 in trouble on day one with its utilization baseline, you
6 will pretty quickly figure out how to work with your peers.
7 And I don't think we want to lose the incentive power here
8 of everybody's in rather than simply those who can take
9 advantage relative to the current flawed SGR. We ought to
10 look for a model which is inclusive rather than an opt-in
11 model.
12 MR. HACKBARTH: Okay. Thank you very much.
13 Thanks for the animation. It's exciting.
14 DR. REISCHAUER: If I could just say one thing,
15 and this is personal here. We can't call it Joan's plan.
16 She only agreed to do this if it was not called Joan's plan.
17 So we need to stop that.
18 [Laughter.]
19 MR. HACKBARTH: Okay, we'll have a brief public
20 comment period. I would urge the commenters to keep in mind
21 that we have commissioners who are thinking about the
22 airport, and so please keep your comments very brief and

1 avoid duplicate comments, please.

2 DR. THOMAS: My name is Suma Thomas and I am a
3 board certified cardiologist and speak on behalf of the
4 American College of Cardiology.

5 We believe much of the growth in imaging is
6 legitimate and falls within appropriate patient care
7 criteria. Medicare population demographics, innovations in
8 imaging, shifts in the site of service for some procedures
9 and the continuing evolution of medicine are obvious
10 contributing factors to a surge in office-based imaging.

11 In-office imaging by a patient's physician is
12 designed to be patient-centered, cost-effective and of high
13 quality. Frankly, it is in the best interest of continuity
14 of patient care. Unfortunately, the discussion on this
15 issue has focused almost exclusively on the so-called
16 problem of self-referral of imaging services by non-
17 radiologists.

18 We are encouraged by today's discussions and ask
19 for a thorough analysis of this issue. Credible data is
20 needed to back up the largely anecdotal evidence derived
21 from interviews with eight health plans and two radiology
22 benefit managers. We feel this has been a largely one-sided

1 examination of the issue and there needs to be greater input
2 from the non-radiology health care provider community.
3 As a physician, I am perhaps most deeply troubled
4 by discussions and the June MedPAC report that imply imaging
5 performed by radiologists is beyond reproach and therefore
6 imaging performed by any other physician specialty is
7 substandard. On the contrary, we suggest that specialty
8 imaging such as cardiovascular imaging, which requires
9 extensive knowledge of the heart and how it functions, may
10 be best performed and interpreted by a specialist
11 comfortable not only with the imaging but also with the
12 patient and their specific health problem.
13 We ask you to provide a full examination of the
14 reasons for growth in office-based imaging and to seriously
15 consider the implications of your recommendations before
16 sending your report to Congress. We are happy to provide
17 the commission with any additional information and assist in
18 any way. Thank you.
19 MR. RICH: Thank you, Mr. Chairman. My name is
20 Bill Rich. I'm Director of Health Policy for the American
21 Academy of Ophthalmology. I'm also Chairman of the RUC, the
22 Relative Value Update Committee. I'm only going to wear my

1 Academy hat today.

2 The first, we are not privy to some of the

3 resource studies that you have in your book, but having been

4 a data geek and looked at the claims data in Medicare for

5 the last 10 years, I suspect the reason why you see dramatic

6 changes in resource allocation per physician is the same

7 reason you see in a number of audits given to geriatricians.

8 Your numerator is probably very, very granular, ICD-9 and

9 then diagnosis.

10 The problem is with any resource allocation to

11 physician there is no granularity to the denominator.

12 There's only one claim identifier for an ophthalmologist.

13 We have six specialties. So within general ophthalmology,

14 we average about 5 percent diagnostic tests per individual.

15 A retinal ophthalmologist will order about 50 percent.

16 So I think that most of the allocation studies per

17 physician are flawed because we do not have the ability to

18 identify subspecialties.

19 Secondly, if you look at the volume data, I think

20 there's some good reasons to see it expand, some good bad

21 and some bad. The good reasons are, to go back to Ms.

22 DeParle's comments, there are actually studies that show

1 that new performance measures do lead to increases in
2 utilization. The National Eye Institute looked at a period
3 where there was a 7 percent increase in volume of Medicare
4 beneficiaries. Working with primary care we developed
5 treatment protocols for diabetics and macular degeneration,
6 dramatically decreased the effect of those disease on
7 blindness. But if you look, there was a threefold increase
8 in office-based visits and diagnostic codes directly related
9 to those ICD diagnoses in an eight-year period. So you had
10 a threefold increase. I would encourage the staff to look
11 for other examples of that. That's a good cause of volume
12 increase.

13 The bad one is, to go back to Dr. Scanlon's point,
14 is economic. We created dramatic economic incentives for
15 diagnostic testing and imaging. And if you look at 1998, we
16 moved to a single conversion factor. We had a 16 percent
17 increase in imaging and testing. The practice expense
18 distribution led to somewhere between a 30 to an 80,
19 sometimes over 100 percent increase. So indeed, we have
20 created tremendous economic incentives to do testing.

21 And the last thing is, that's borne out in the
22 RUC, where we've seen, if you look at the first five years

1 of the RUC, the volume of codes that are brought and now
2 being offered to the public. There's a 50 percent increase
3 in the number of codes the last five years that are really
4 diagnostic and testing. The reason is we do not have a good
5 way to do good technology assessment.
6 Ms. DeParle couldn't do it at CMS because of
7 political pressures. The specialties are getting sued when
8 we try to do it. So I would encourage the commissioners as
9 a future project to look at how we can better address
10 technology assessment in the future.
11 One point of information for Mr. Smith, all those
12 incidents of rental and things are regulated very tightly in
13 the OIGs. There are certain safe harbors. And if you want
14 to look at where scans are going overseas, you look at
15 independent testing facilities. That's how they're done.
16 Thank you.
17 MS. WALTER: Hi, Deborah Walter, the Association
18 of Community Cancer Centers.
19 While the data that Cristina was showing to
20 support her arguments on payment adequacy serves as a good
21 baseline, it appears that MedPAC is making a general
22 characterization that everything here is okay in terms of

1 patient access and physician exit and entry. But what I
2 find troubling here is that this discussion completely
3 ignored the changes to how physicians will be reimbursed for
4 2005 given the implementation of the MMA. And the concerns
5 that certainly the oncology community anyway is expressing
6 over their ability to continue to be able to provide
7 services to cancer patients.
8 There has been a lot of discussion about whether
9 or not there will be a mass exodus at some point of
10 physicians. And again, I think that having this kind of
11 analysis really is done in very much a bubble and it's very
12 disingenuous to make statements as global as these without
13 at least referencing the MMA and the potential implications
14 of this going forward in terms of physicians willing to stay
15 in the system.
16 MS. MELMAN: Hi, my name is Diane Melman and I'm
17 speaking on behalf of the American Society of
18 Echocardiography.
19 I want to again reiterate very briefly the self-
20 referral slant to these discussions is very, very
21 disturbing. The only evidence that has been cited by staff
22 is a more than 10-year-old study that preceded the Stark law

1 and that has been discredited. I'd be delighted to -- we
2 have spoken with staff about this and would be delighted to
3 speak with them again.
4 The areas of growth, of major growth, MRI and CT,
5 the most expensive technologies and the most extensive
6 growth, are not the areas where physician ownership in-
7 office ancillary testing is going on. It's mainly in
8 ultrasound. it's mainly in CT. And it's, to some extent,
9 in nuclear cardiology. I would ask that the commission take
10 an objective look at where the growth is and to very clearly
11 distinguish issues of utilization from issues of quality.
12 Mixing those two up leads to very mixed-up public policy and
13 ultimately denial of access to appropriate care.
14 Accreditation and credentialing, the American
15 Society of Echocardiography very, very strongly supports
16 accreditation. However, accreditation is not all vanilla.
17 Accreditation has a very, very significant economic downside
18 at the accrediting agency, as in the case of MRI and CT, is
19 associated with a particular specialty. The only
20 accrediting organization in MRI and CT is with the American
21 College of Radiology. The published journals of the
22 American College of Radiology specifically indicate that

1 credentialing and accreditation can and, in some cases many
2 authors have said, should be used to keep non-radiologists
3 out of the specialty.
4 Before making any recommendation on accreditation
5 or credentialing, I would ask this commission to look very
6 clearly at the practicalities of handing that over to a
7 private group.
8 Finally, to say that accreditation and
9 credentialing are without cost is not correct. Any hospital
10 administrator can tell you that accrediting and
11 credentialing is with cost. It might not be cost to the
12 Medicare program. It is cost to providers. It is cost in
13 terms of time. It is cost in terms of administration. And
14 it is cost in terms of trouble. I would very, very strongly
15 urge you to rethink and think very clearly about the idea of
16 getting the Medicare program into a credentialing situation
17 which, at any local or national level, has the very strong
18 potential to result in turf wars run amok.
19 Thank you.
20 MR. HACKBARTH: Okay. We're finished.
21 Just one reminder for the commissioners about the
22 physician payment issues. We do have mandated reports now

1 in progress on the access to oncology services issue. And
2 so you will be hearing much more about that in the coming
3 meetings.
4 [Whereupon, at 12:20 p.m., the meeting was
5 adjourned.]
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