MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

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WILLIAM J. SCANLON, Ph.D.
NICHOLAS J. WOLTER, M.D.

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P R O C E E D I N G S

MR. HACKBARTH: Welcome to our guests. We have a long and challenging session planned for today.

This morning will be devoted to the mandated report on the SGR. We'll have three distinct sessions on that. And then this afternoon we will turn to our update recommendations.

So the first item on the SGR is a discussion of outliers. Niall, why don't you lead the way.

MR. BRENNAN: Thank you, Glenn. Good morning.

As you all know, the Deficit Reduction Act mandated MedPAC to complete a report on alternatives to the current SGR and a payment system based on the identification of physician outliers was one of the mandated areas for analysis.

Today, we'll be presenting our latest findings related to our assessment of two commercially unavailable episode groupers and how they perform on Medicare claims and their suitability for measuring physician outliers.

Again, I'd like to thank Megan and Jennifer, both of whose work is represented in this presentation.

To briefly review, the two groupers we're using

are Episode Treatment Groups, created by Symmetry Data Systems, and the Medstat Episode Grouper created by Medstat. These groupers are designed to comb through administrative claims to create clinically distinct episodes of care. These episodes can vary in length and a beneficiary can have more than one episode open at any given time. For example, a beneficiary can have concurrent episodes of diabetes and sinusitis.

Over the last few months, we've presented a range of findings related to our use of these groupers on Medicare claims. In the next slide, I'll briefly reprise some of what we told you last month and map out what we'll talk about today.

In the November presentation, we presented two analyses. The first analysis attempted to quantify the size of spending on outlier physicians in the Medicare program by specialty.

The second analysis focused on the use of episode groupers to identify outlier physicians and presented information on some of the technical issues that have to be confronted in the use of these tools, such as attribution, the calculation of expected values, and the fact that

because of sample size problems not all of the physicians in a given market are going to be measured.

We concluded with some distributions of overall physician scores for cardiologists and urologists in the Boston MSA where we showed that it was possible to identify both low and high resource use outliers, for example 10 percent of the cardiologists in Boston used 44 percent more resources than average.

Today we're going to focus on two critical issues in the use of these groupers, the ability of the groupers to account for differences in health status between patients, and the ability of groupers to provide detailed information that can show physicians the precise drivers of their resource use patterns.

One of the most important factors that we have to deal with in using episodes of care to assess physician resource use is risk adjustment. From our experience in talking with people who have used these tools in the private sector, a common reaction from physicians is that their per episode costs are higher because their patients are sicker. In order for these grouping tools to have face validity with practitioners, you have to be able to show that the groupers

do not unfairly reward or penalize physicians based on the underlying health status of their patients.

Both groupers employ risk adjustment techniques. ETGs uses an approach known as episode risk groups or ERGs, while the MEG grouper uses the diagnostic cost grouper method, DCG. Using these methods you can calculate a risk score for each episode and eventually build an overall risk score for a physician's panel of patients. In the next few slides, we'll provide some examples of the MEG DCG risk adjustment approach on Medicare claims in the Boston MSA.

We're also conducting analyses using the entrance ERG risk adjuster and expected to have results from that early next year.

One thing I'd like to add here is that risk adjustment systems are only as good as the coding that they rely on. For example, in this process we've documented instances where in certain MSAs, such as Miami, beneficiaries are significant more likely to be coded as having coronary artery disease. Risk adjustment systems will then treat these beneficiaries as having poorer overall health status.

What we wanted to show you with this table is how

risk adjustment techniques can impact a physician's overall score. This is a simple cardiologist in the Boston Metropolitan Statistical Area. If you look at the table you can see that this cardiologist has a total of 250 episodes, the majority of which -- 156 -- are hypertension episodes, with smaller but still sizable numbers of coronary artery disease episodes and arrhythmia episodes.

The expected value in this case is calculated as the per episode average for all hypertension episodes seen by cardiologists in Boston and all CAD episodes and all arrhythmia episodes. Using this averages as our expected value, the non-risk adjusted overall resource use score for this cardiologist is 1.04, meaning this cardiologist uses 4 percent more resources than his peers. However, once you incorporate the effects of the MEG risk adjustment approach, this cardiologist's overall risking use score increases to 1.13, which if you remember our distribution of physician scores in last month's presentation, would place him roughly in the 75th percentile of cardiologists. So high, but not excessively high.

I'd also like to note here that it's the physician's resource use score on hypertension, the 1.76,

that's driving his overall resource use score here. So this physician appears to use more resources than average in the treatment of hypertension, about an average amount of resources in the treatment of CAD, and fewer resources than average in the treatment of arrhythmias.

So what drove the increase in this cardiologist's overall resource use score? It turns out his patients weren't sicker. They were actually healthier than average than other hypertension patients seen by Boston cardiologists. Of this cardiologist's 156 hypertension episodes 141, or 90 percent, fell into the lowest disease stage of hypertension compared to 80 percent of all Boston cardiologists. And we'll talk a little bit more about disease staging and risk adjustment in the next slide.

Yet despite having healthier than average patients, his observed resource use was still greater than his peers.

Before we continue, I'd like to take a moment to talk about the concepts of disease staging versus risk adjustment. The MEG grouper uses disease staging, which classifies each episode into one of three disease progressions. So stage one of a particular condition is

less severe than stage three. Decisions on which stage of a disease an episode is classified into are made based on specific ICD-coding on the claims. Risk adjustment looks at all diagnoses an individual has, an addition to age and sex, in order to create an overall picture of health status for that person.

In the MEG grouper, within each episode disease stage, based on your risk scores, you are assigned to one of five possible severity levels ranging from lowest overall severity, severity level one, to the highest overall severity, severity level five. We'll see some of these concepts in the next table.

This table focuses just on the 141 episodes of stage one hypertension by our selected cardiologist in Boston. If you look at the rows, we present information both on the number of episodes within each severity level and the level of resource use, both for our selected cardiologist and his Boston area peers. The last row on the table calculates a resource use ratio for our selected cardiologist.

What the columns show is the stratification approach employed by the risk adjustment in the MEG grouper,

which further subdivides each disease stage into five different levels of overall patient severity.

As you can see, our selected cardiologist's resource use is higher than his Boston peers across four of the five severity levels within stage one hypertension. If you focus on the severity level two column, you can see that his observed resource use of $660 is more than twice that of other Boston cardiologists who see similar hypertension patients. Remember in this analysis, we've standardized all dollars and that our episode costs are comprised of both Part A and Part B dollars, although with a condition such a stage one hypertension we would expect that the majority of costs would occur in the ambulatory care setting. I'll show you in a table later that that is indeed the case.

The last table is meant to illustrate the ways in which episode groupers can retain detailed claim level information that can then be used to explain to physicians with the drivers of their resource use are. I'd like to stress that this should not be viewed as a report card but rather as a very simple, very specific example, of the type of information that might be appropriate for inclusion on a report card.

So if you look at the first column, the total dollars, the numbers in that column are the same as the numbers in the last column on the previous table. It represents spending for that cardiologist across the different severity levels.

The types of service we examine are evaluation and management, procedures, imaging, tests and other. The previous slide established that our selected cardiologist was above average in his treatment of stage one hypertension. This slide can help us show why.

Overall, the cardiologist has a resource ratio of 1.74, observed resource use of $623 versus $357 for his peers. If you look at the evaluation and management column, you will see that a large proportion of the overall difference is accounted for by E&M dollars with smaller shares accounted for by imaging, tests and other.

It's also important to note here that you have to take into account both the amount of dollars you're looking at when you look at the resource use ratio. For example, the selected cardiologist has a resource use ratio of 0.67 for procedures but procedures count for a very small proportion of overall stage one hypertension costs. We

continue to work on these types of drill down analyses and will present more findings again early next year.

In conclusion, we feel that our ongoing work and the work of others demonstrates that episode groupers can be used as a tool in identifying outlier physicians. We've drawn your attention to several technical issues over the preceding months that may need to be addressed a little further.

Once we're confident that we are actually identifying outlier physicians, a number of policy options could be pursued. These range from confidential feedback and educating physicians in an attempt to change their practice style, to more direct interventions such as the public reporting of physician outlier scores or differential copayments or payment updates for outlier physicians.

Later this morning Kevin is going to talk to you a little more on ways in which this could be integrated with some of the other options that we're looking at.

That concludes our presentation and I'd be happy to answer any questions that you might have.

MR. BERTKO: More of an observation than a question, Niall, and that's just to confirm that that table

that you had, the last one, which shows tests, imaging, E&M, et cetera, has proven -- at least in private sector -- to be a pretty effective tool in displaying the kind of results that come out. A physician would say what do you mean I'm out? When we've shown a tool like this and explained the mechanics behind it, it has worked pretty well.

So again, recognizing that this is only illustrative but still it's pretty useful.

The other observation on risk adjustment, I can't speak to the use of the DCGs as well, but to the ERGs, the Society of Actuaries is now finishing its third study over about a 10-year period. I've seen the draft of it and I would comment to my fellow commissioners that there has been a gradual improvement in the predictability of these, either as measured by R-squareds or by predictive ratios. That will be out soon.

So I'd like to at least acknowledge that while these tools will never be perfect, they're actually getting better as we adapt the systems. And the ERGs will be one of those that are displayed in this study.

MR. HACKBARTH: Niall, over a course of months now, has done a terrific job, for me at least, in terms of

making this more understandable, more concrete. Thanks, Niall, for the great work you've done on it.

John, at various points in the past you've talked about how this tool is applied by private payers, Humana in particular. It would be helpful for you to again, just very briefly, describe how you apply it. In addition to feeding back information, what are the other uses?

MR. BERTKO: The primary use for it is in setting up a tighter network. We call them high performance networks and there is basically three categories of physicians. Two of them are in. There are physicians who we have enough episodes and we say you clearly are inside the network. There are some outlier physicians and those are clearly excluded. And then every physician without sufficient data gets a free pass, and so they remain inside the network here.

We then would go out, as we have say in Milwaukee where we have a big effort underway, and walk through the results in general, the methodology to the physician, hospital and employer community -- usually all mixed up, which is useful. And to the extent that individual physicians may have a question about that, we have produced

something which is very much like that third chart that Niall had. And that's been fairly effective.

Frankly, one of the reactions that I know from the leader of a county medical society was oh, I didn't know that. And I think that's a good implication for the use of information.

MR. HACKBARTH: So feedback, network development. Do you ever use it to alter the amount paid to physicians, either to allow them to somehow share in gains or different unit prices?

MR. BERTKO: No, at this stage it's strictly are you in the network. It's a beneficiary copay then, but not at this stage a differential amount paid to the physician, although we've talked about that in theory.

MR. HACKBARTH: Arnie, in your experience, have you seen it used for purposes other than education and network development? Have you seen it used to set payment rates or penalties for inefficiency or sharing in gains for relative efficiency?

DR. MILSTEIN: Yes, there are some self-insured plans that have been doing this for several years. In addition, the largest of the physician pay-for-performance

programs, which is the IHA California pay-for-performance program, is this year introducing a resource use measure into its formula for P4P.

MR. HACKBARTH: Just say a little bit more about how that works. How do they use it in P4P?

DR. MILSTEIN: The way the California program works is the participating physician organizations are scored historically based on quality only. And now they will be quality and resource use. It's always been left to each participating plan to decide how to weight the different elements of the scores in their P4P formula.

So what they're committed to do is to weight it in their P4P formula, but there will be freedom among the plans as to how much weight to assign, for example to patient experience, to effectiveness, to resource use, and IT adoption.

DR. REISCHAUER: Niall, this is fascinating and once again the further down we dig, the more difficult the solutions become.

I was wondering whether you had done a similar analysis of arrhythmias? We have the case in which this physician, with respect to hypertension, seems to be less

efficient than his peers. But with respect to arrhythmias, it would be quite a different story. And one, of course, doesn't know whether he's underserving, in a sense, not providing significant appropriate care or not, or where the source are. One can just look at this picture of hypertension and come up with hypotheses about why there is so much E&M going on. But if one found, with respect to E&M, he was well below the average then there would be a different set of hypotheses.

When you look across the different severity levels there is a sort of a bizarre pattern in which the lowest costs are associated with the highest severity level in this physician's practice, as opposed to the monotonic rise in costs across severity levels for the average hypertension cardiologist in the Boston Metropolitan Area.

So you think maybe this is a case where we need reeducation and you might get very significant improvement in the quality of care if the average physician is a measure of appropriate quality, and that's sort of a big question in and of itself. But how much you'd save in the way of overall resources is really an unknown.

MR. BRENNAN: Those are all very good questions.

We do have information on arrhythmias. However, it was produced pretty close to the meeting and we haven't had time to fully absorb it. But it is something that we could maybe check and get back to you relatively quickly.

And then also, on the differences in E&M costs, one thing I should have added in the presentation perhaps is we know that it's a utilization component that's driving it. It's an average of 14 visits compared to 11. And then, just on your point on the higher severity level, actually his resource use ratio is less than one.

Again, we're not entirely sure what's going on here but also if you look at the N's in those columns, the N gets lower. And once the N gets lower more noise comes in. He has a sprinkling of patients in stage two and stage three and those N's are even smaller. There would be a lot of information to present on the table and some of them were slightly counterintuitive.

But if you only have one observation in the cell, you can sometimes get strange results.

DR. HOLTZ-EAKIN: Niall, a similar set of questions. In your first table, you showed numbers for non-risk adjustment and then risk adjustment. Is literally risk

adjustment or is that disease staging plus risk adjustment?

MR. BRENNAN: That's disease staging plus risk adjustment.

DR. HOLTZ-EAKIN: So it's everything?

MR. BRENNAN: Yes.

DR. HOLTZ-EAKIN: Because one of the things that jumps out in that table is it's the all other where the big difference is. I was just curious if you had some intuition about what's going on there?

MR. BRENNAN: Off the top of my head, I don't. We could check into it. Again, it's not a lot of episodes. It's only 16 episodes, so it's probably not practice.

MS. DePARLE: My question is kind of related to Doug's. I thought I was following you now in stepping through this. When you get to page nine, which is very interesting, those numbers are risk-adjusted? Or is that a separate analysis?

MR. BRENNAN: The numbers reflect risk adjustment. I guess the best way to describe it would be to go to the preceding slide, on slide eight. In that one, for stage one hypertension, people have been subdivided into their varying risk levels. And then the far right-hand corner presents

the aggregation of that information. So that's the 141, $623, 357 is then the first column in the last table. Because we sort of collapsed it back up again, just for ease of presentation.

MS. DePARLE: Okay.

And then what is other? Because he or she seems to be quite off the chart in respect to the categorization of other.

MR. BRENNAN: Other is hospital inpatient, SNF, non-physician outpatient dollars, not classified dollars. We will, down the road, be able to classify that with a little more precision. Right now we can't.

MS. DePARLE: There's no Part B drugs or anything like that in there?

MR. BRENNAN: No, I don't believe there are. I'll check that.

DR. MILLER: But as a general thing, in the database Part B drugs could be --

MS. DePARLE: When you use the betas, that's --

DR. MILLER: In this particular example is what you're saying?

MR. BRENNAN: I'm almost positive it doesn't

reflect Part B drugs so that the other was zero. That would reflect the cats and dogs that don't fall into E&M procedures, imaging and tests.

MR. MULLER: You almost have an implicit acute adjustment just by seeing how much of it is in E&M. That's the giveaway right there. I'm not sure that's statistically valid, but you can just see it right there, you have such a high proportion right there.

DR. KANE: I think the resource group stuff is very interesting, but is it an outlier analysis? Because we start off defining outlier as sort of the two standard deviations out, 2 percent of the people with the highest -- of course, we don't talk about the lowest -- but the highest payment. And here you're really saying who's off the mean.

So I guess is this responsive to really doing the pluses and minuses of an outlier strategy as opposed to an episode-based resource use? I didn't feel we really, in this paper, described the pluses and minuses of an outlier strategy statistically. Should you just pick the top -- the guy is two standard deviations out on their payments, and try to adjust their payment for that? Here we really much more talk about a tool, which is a great tool, a very

promising tool, and then how people look relative to the mean in their population of specialty and geography.

So I guess overall I didn't know that this type of analysis falls into what we would call outlier, if you mean what you start off in the paper by talking about, this is that you're two standard deviations or one standard deviation out on per capita payment.

I'm just trying to reconcile the use of the word outlier for this type of analysis.

MR. HACKBARTH: In fact, let me pick up on that. This has focused on the tool and basically we've picked up work that has been ongoing now, before the SGR mandated report, focused on the tool and saying the tool could it be applied to the outlier issue.

Indeed, in order to identify outliers, you need some tool, some metric, for saying here is an outlier. But I agree with your basic point that the focus is principally on the tool, as opposed to what you do once you've identified the outliers.

DR. KANE: I think it's also saying that you can't just look at the outliers because they don't mean anything. There's no risk adjustment. Until you do, this outlier

doesn't make a lot of sense.

DR. REISCHAUER: But also you have, this particular individual is an outlier in one area and is an outlier on the downside somewhere else. So don't know if somebody who you don't pick up for the average is really an outlier for certain procedures.

DR. KANE: I think we need to do a little more systematic addressing of the pluses and minuses of the use of the concept outlier. This is a great general education tool that may or may not be hitting outliers but it may be hitting pieces of a physician's practice that aren't in consonant with their area norm. That's not an outlier, certainly at a physician level. And it's really not statistically driven. It's much more here's how you stand relative to your group's norm.

MR. BERTKO: Nancy, let me say it is, as Glenn said, mainly a tool analysis. And the next question is how you use it. But let me confirm, in a group in one city to be not identified, we have lots of cardiology practices. They tend to be small practices, five, seven, 10 folks. And frequently we would have one or two physicians who would show up in a pattern just like this who were unknown.

So if you have any kind of organized payment arrangement, the first step is what we're doing compared to what's going on in California. You give this information and the physicians all look at each other and went oh, Bob, did you know you're doing it? And that's the next step in terms of the budget.

But it is a true outlier and it's a useful tool if someone were to manage their practice more efficiently.

DR. KANE: I just don't think you need to use the word outlier. I think this is a general tool to help people learn where they're efficient and inefficient. There are other issues around the use of the word outlier and the statistical tool that we haven't addressed here. That's my only point.

MR. HACKBARTH: Let me just pick up on what Nancy is saying, because I think I understand where she's headed with this.

What you need in order to have an outlier payment policy, is several elements. One, you need a tool for identifying, and that's what this is all about. Second, you need to make decisions about set points. Where in the distribution are you drawing your line to say who is an

outlier?

And then third, do you need to say what are the consequences of being beyond the set point and being in the outlier category?

On his last slide, Niall had a list of potential consequences, ranging from simply feedback to education, public reporting, differential payment rates, and so on.

I think, to complete the list, based on what John has described the other use private payers had for the tool is exclusion, or putting providers in a nonpreferred tier. So that would be sort of a more complete list of the range of the potential consequences.

One more thought and then you can leap in.

As I look at that range of consequences, they have very different implications in terms of how strong the tool needs to be. Arnie and I have had several e-mail exchanges about this.

Generally, as you move down this list, the stress that the tools are under increases. People are going to resist it more, debate it more, go to their Congressmen more as you move down the list because the consequences get more and more dire. If you add to that risk exclusion, that's

the atomic weapon of Medicare.

So not only do you need a tool, not only do you need set points, you need to think about which use we're applying and how much stress that applies to your tool to have sort of a complete discussion.

DR. KANE: But you're not talking actually about physician outliers so much as particular practice outliers within a physician's practice, too. So as we find with his physician, I don't know if I'd classify the whole person as an outlier, but certainly there are things they do that make them an outlier on their practice.

I'm just worried about the word outlier. I don't think that's appropriately used here. And the word outlier has a statistical significance in the inpatient side that I think we're not using here.

So I just wouldn't call this an outlier analysis. I think I'd call it something else, and maybe a tool to improve overall medical practice across the board, as opposed to some kind of let's hit the weird thing that's two standard deviations out. It's a much broader tool than that.

And then we still haven't said well, should we

really be focusing on the one standard deviation out or two standard deviation out or not. We're not talking about that here. Do we need to or not, to address Congressional concern?

MR. MULLER: As the dialogue that you had with both John and Arnie indicated, insofar as there's a lot of use of this by the private payer community, the data you presented today is on all the Medicare beneficiaries. But how then, in any Boston area, where I assume there's a multiplicity of plans, does a Humana or a Wellpoint or whoever's up there, Blue Cross, use the whole Medicare database? I assume they focus mostly on the beneficiaries that they have. And therefore in the essential subsample, is Niall pointed out, you already have cell size problems in some of these areas.

If you're then looking at it divided by three or four plans and how they may look at that data, in some ways it may not be in the interest of the plans but they probably want access to the whole Medicare database rather than just their subsample of the database, in terms of what you're looking at and if you want to look at individual physician practice.

And therefore anyplace where you have three or four plans, it's going to make the data aggregation or de-aggregation problems much more difficult. So that probably is an argument for using the Medicare full database in conjunction with the database that the plans have, obviously understanding that have the greatest incentive to manage the population that they've signed up.

DR. MILSTEIN: I don't think, in thinking about the readiness of this tool for various intermediate to higher stress uses, I don't think we should regard the fact that physicians vary on how they score by diagnosis to be a problem. I think that if you look at almost any other use of performance evaluation affecting compensation across other professional services, this is the case.

Now whether you're talking about attorneys or investment bankers or baseball players. If you were to, for example, characterize a baseball pitcher that had an earned run average of 2.5 and stratify for how that earned run average is distributed on early, intermediate, and later innings, you would find substantial variation. But nonetheless the compensation, in effect even the retention of the team by the pitcher is based on their aggregate

performance across all hitters, all innings.

So I think that we should absolutely expect that there be variation by diagnosis. I don't think we should regard that variation as evidence of a flaw in the tool. That's first comment.

The second comment is that, following on Nancy's point, I don't know whether it's at this point in the discussion or later, I think we should perhaps elicit more opinion as to given what we know about the flaws and the strengths of this particular tool, that it's using episode groupers to assess resource use, what is our sense as to how far down the list of stressful applications we feel the tool is ready for use?

As I referenced earlier, the private sector is moving ahead with this. It's certainly true that a public program like Medicare, those providers who feel disadvantaged do have a lot more avenues of redress that they may have in the private sector, although John may disagree with that.

But we have a circumstance in which private sector users have moved ahead with this over the last several years, and it has been translated into meaningful

improvements in affordability of health insurance premiums. And that latter result is something that this program obviously is -- Medicare is striving for.

I think, if you were to ask is this conceivably a better approach, granted its flaws, than current SGR, I personally think it is even for higher stress uses.

I mean group punishing all physicians based on the entire nation of physicians not hitting a GDP growth target, that is hard to defend. I think moving to something that's better, even if flawed in a high stress use, is something I personally do feel comfortable supporting, particularly in view of the improvements in affordability that have already been delivered over the last several years by private sector payers using this very approach.

DR. REISCHAUER: On this particular point, these are arranged in sort of order of both severity and possible political backlash. And we don't know anything about what the response would be to each of these. And there's a logical order, I think. You have to do, in a sense, the first before you can do the fifth.

But I would think you would start and begin measuring what the impact is. And you might not have to go

very far down this list before you got 90 percent of the possible response from the provider community. And certainly it would be more harmonious.

DR. HOLTZ-EAKIN: Briefly, Arnie is right about variation. I won't repeat that.

Secondly, in terms of the stress on using this, I think it's important to remember that the tool itself is not static. If you put it into the mix, it will improve as it gets feedback. And so we should remember that. It's not a static entity.

And the last is I would be curious what we can learn from the private sector about what sample sizes seem to be big enough to work. A lot of this focuses on things where you look at the number and you say oh, that's too small and I don't trust it. But I don't have any empirical basis for knowing what sample sizes matter.

DR. MILLER: Niall, you've talked about a rule of time that you've run across, haven't you?

MR. BRENNAN: For aggregating a group of episodes to a single provider, and John can speak to this too, it seems like anything between 20 and 35 -- and obviously people like NCQA have looked at standard errors around

measurement and things like that.

MR. BERTKO: I would agree.

And to Ralph's point earlier, the physicians who practice in Medicare fee-for-service have lots of episodes. And so the 20 of 35 is common in commercial. If you get up to, as I was indicating, 50 you've got the guy or woman nailed in terms of their performance.

Scored appropriately, sorry.

DR. WOLTER: I was just thinking about the possibility over time, as the ability to get into the information improves, of looking at how we could do more innovative approaches to payment that would combine Part A and Part B. Because if we can take congestive heart failure, look at an episode it's longer than an inpatient stay, combine it with the care that then occurs in the outpatient sector before and after, and of course, ultimately the hardest thing is to look at sort of utilization, how many admissions are appropriate, that sort of thing.

But this tool, appropriately refined, might allow us to create something that is more patient centered, follow patients across the silos and over a longer period of time

than just a DRG admission, which often would be the highest cost part of the episode.

So that might be worth plugging in as we continue to analyze and refine the ability to use the information.

MS. HANSEN: This somewhat relates to what Nick just brought up but it's a question really for John.

I know hospitals have tiering kind of copayments. The question is have you used this for tiering of beneficiaries' copayments with the physicians?

MR. BERTKO: We, as my company, have not. But other insurance companies, Tufts in particular I know of, has used something like this. And the sorting which can be done can be done either at the physician or at the hospital level or across both. So the tool is quite flexible in this.

And it goes back to Nick's point here of combining A and B services together.

DR. SCANLON: Quickly, I think that we can learn a lot from essentially what the demonstrations are that are going on in the private sector.

But the question, in terms of moving forward with respect to Medicare, that I think it's important to keep in

mind is that the private sector has the advantage of being able to pick where they're going to have their fights. And not all markets are the same.

That's the difficulty with the national program, it's got to have something that fits into all markets. Maybe not one thing but it has to have a set of thing that's going to be compatible with all markets. That's a big handicap in terms of what we can move forward.

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

Next, continuing on the theme of the SGR report, is a discussion of some cross-cutting issues that apply under multiple or all of the SGR options that we've been looking at.

Jennifer, you can proceed when ready.

MS. PODULKA: Moving from a single national SGR, as the current system is, to a subnational target system, such as those listed in our DRA mandates, raises several issues. Some issues are unique to each alternative and you've heard presentations on those. But others are cross-cutting and must be considered before choosing and implementing any of the alternatives.

Before I continue with the presentation, I'd like

to thank Megan Moore for her data analysis which is reflected in my presentation.

The cross-cutting issues that we'll be discussing today are how to set targets, making trade-offs among multiple goals, attributing beneficiaries and their spending to physicians, possible unintended consequences of subsetting the SGR system, and options for secretarial authority under a system.

Under the current SGR system, spending targets are cumulative and they include GDP as an allowance for volume growth. Possible alternative target allowances can be categorized into three distinct groups. First, are objective defined standards, such as GDP which is used by the SGR and has been a little bit over 2 percent over the past few years.

Secondly are historical trend, as was used under the previous target system, the VPS. For the past six years spending has averaged almost 10 percent while volume growth has averaged almost 6.

And third are targets that haven't been tried yet, such as basing updates on growth in MA plan bids.

Once a target allowance, either objective,

historical trend or other, is selected the next key question for moving to a subnational target system is should the target be cumulative or not? Using a cumulative target, as the SGR does, tends to exacerbate fee cuts if spending exceeds the target. When this happens, the system must both reduce future updates to slow the next year's spending growth and to recoup previous excess spending. The arguments for including a cumulative target are that it serves as a budgeting tool and it allows a target system, when combined with fee cuts, to recoup excess spending over multiple years.

At the bottom of the slide, a non-cumulative target system, like what was used under the VPS, would compare spending in a single year to that year's target and recoup any excess spending in an upcoming year's update. If a non-cumulative target system also limited fee updates, as the SGR does, then excess spending that could not be recouped in a single year would have to be forgiven. This type of system, depending on design, could result in more favorable updates but at the cost of greater program spending over time.

The current SGR system is designed to constrain

spending growth. A subnational system could be designed to measure and respond to different rates of growth in each of the subnational units, geographic areas, types of service, et cetera. Alternatively, it could be designed to address the different initial volume levels in each of the units or a combination of the two.

In a subnational target system, ideally the units that have both low volume growth and low volume level would be rewarded with better physician fee updates. Conversely, units with both high volume and high growth level would be penalized with lower or negative fee updates. It is less clear how the other two combinations, high growth/low level and low growth/high level, should be treated.

For example, in a geographic target system addressing growth solely or primarily, risks rewarding already high-cost areas such as Miami for keeping their rate of growth low while penalizing already low-cost areas such as Minneapolis for potential higher growth rates.

However, a geographic target system that focused only on initial levels could fail to provide an incentive for physicians to control growth going forward and could cut physician fees so deeply in high-cost areas that beneficiary

access could be jeopardized.

One option for addressing these trade-offs is designing a target system to address a hybrid of levels and growth which is each unit's contribution to total growth. To explore the various effects of designing a target system to address growth, levels and contribution to growth, we analyze claims for physician services for 2001, 2002, and 2003 in CMS's 34 prescription drug plan regions. For each area we ranked areas growth, levels and contribution to growth in each of the three years. We then compared these ranks to see how strongly one rank correlated with another.

To illustrate our results, I've included two examples. These are the PDP drug regions of Florida and the large Upper Midwest multi-state region. Before going through the numbers, note that there are a total of 34 regions. On the first two columns of numbers, you can see that the two regions are nearly at opposite ends of the rankings. Florida is ranked relatively high on spending level, both in the first year and in 2003, and the Upper Midwest region is ranked relatively close to the bottom. However, looking at the next column, 2001 to 2003 growth, you can see that the ranking for growth rates are different.

Both PDP regions are ranked at or near the bottom, in terms of growth rate.

And finally, if you compare the far right column, you highlight the impact of measuring contribution to growth. Although Florid is 27th in terms of growth, it moves up to 15th on contribution to growth because the growth rate is added to an already high base level and the Upper Midwest region remains in the same lowest rank.

Some criticize the SGR system because it applies only to physicians. These critics contend that the SGR therefore fails to recognize that physician services may increase as they substitute for other services, especially inpatient and outpatient care. One way to address this concern is to extend an SGR-like target system to payment updates for all Medicare services. To design such a global Medicare target system, several questions must be answered. First, should the global target system apply to all Medicare services or should exceptions be made?

Secondly, how would a global target system fit in with the rest of Medicare's payment update framework?

And third, would a global target system result in different physician updates and targets than the current SGR

system or one of the subnational, physician-only target systems we've been discussing?

For the next part of the presentation, I will focus on the final question here. And for illustrative purposes, we explore how geographic areas compare in terms again of level, growth and contribution to growth under a physician-only target system versus a more global target system. To do so we used our previous analysis and extended this to Parts A and B services for which we had data.

Revisiting our same two example PDP regions yields similar results to the physician-only analysis. One notable difference when we compare Parts A and B spending to physician-only spending is that in terms of contribution to growth, that final column, the Florida PDP region fell from 15th physician-only to 24th for A and B spending.

To summarize the results for our comparison of all areas ranks for physician-only and Parts A and B spending, we found that areas were fairly strongly correlated. In other words. PDP regions tend to have similar spending growth. level and contribution to growth ranks as they do when you measure just physician service only versus Parts A and B only or Parts A and B together.

Moving on to the cross-cutting issue of trade-offs, a subnational target system will have to balance trade-offs among a few key goals, generally alternative systems that use larger units, emphasize administrative feasibility and limiting volatility but do so at the cost of decreased physician accountability. Alternatively. smaller units may be more difficult to administer, introduce greater volatility into the system, but may benefit from more physician accountability.

In each of the five alternatives that we are studying for the report, the number and therefore the size of the subnational units, differed greatly. On the first bullet there, for administrative feasibility, to make estimates for the SGR CMS actuaries must rely on claims that are only partially complete. In a subnational target system, many data items might have to be disaggregated or collected at a subnational unit. This would introduce greater complexity into the actuaries' work and could further hinder timeliness if the subnational units data completed at a different rate.

Replacing the SGR with a subnational target system would require CMS to conduct potentially exhaustive overhaul

the data payment algorithm and other systems. These changes would need to be communicated to contractors, physicians and beneficiaries and new appeals processes would also have to be implemented.

Given the amount and complexity of work that would have to be done, CMS would likely need additional resources to effectively implement a new target system such as the special appropriation they received for the new Part D benefit.

On the next bullet for volatility, the data collection estimation and projection issues also affect the volatility of year-to-year updates. Problems like this would likely be greatly exacerbated by a subnational target system because of the greater empirical volatility associated with smaller units and Medicare-specific issues such as MA enrollment affecting the number of fee-for-service beneficiaries differentially locally.

And finally, on accountability a key shortcoming of the SGR system is it provides no incentive for individual physicians to limit the volume of services that they provide. Ideally a subnational target system would incorporate subnational units that were either small enough

or organized enough for physicians within those units to know their peers and able to encourage them to practice efficiently.

Most of the subnational target system alternatives would require establishing rules for attributing beneficiaries and spending to physicians. Attribution would not be necessary for the type of service alternative because different payment would attach to the services rather than the physicians.

For the other alternatives that create subsets of physicians -- geographic, group practice, hospital medical staff, and outliers -- the system would need to compare the spending within each pool either to a national target or to every other pool. Such analysis requires attributing spending to these pools of physicians. In other words, defining for which spending each pool is responsible.

The simplest option is to hold physicians responsible only for the services for which they bill. However, this fails to capture much of the volume that physicians generate through referrals. Other options for attribution are complex, given that fee-for-service Medicare allows beneficiaries to see any willing provider and many

beneficiaries see multiple physicians.

Here you see a table with a brief description of the attribution rule and resulting issues for each of the alternatives. I won't go through all of these but I will discuss the first one listed.

In a geographic target system, and to varying degrees the other target systems, a significant obstacle to attribution is border crossing. The most extreme example of border crossing are snowbirds. Addressing the issue of border crossing involves trade-offs between fairness and accuracy. Border crosser spending can be omitted entirely, assigned to physicians in a single area, or divided among physicians in multiple areas. For example, CMS can attribute a snowbird's spending to two main physicians, one in each area, but this is somewhat more administratively complex and it would be unclear which physician was responsible for the overall care that the beneficiary received.

Attribution for all of these alternatives raises the companion issue of risk adjustment. Once a circle is drawn around a pool of physicians and their attributed beneficiaries, the target system should use risk-adjustment

to determine to what extent differences in pool's spending is accounted for by variation in their attributed beneficiaries' health status. At that point the target system can be designed to address only the excess spending that can now not be explained by sicker beneficiaries. However, while risk adjustment has improved greatly it cannot account for all variation in spending because not all health care is predictable.

Replacing the SGR system with a subnational target system could have multiple unintended consequences. For example, a type of service target system that reduced payments for one set of services could provide an inappropriate incentive for physicians to substitute other higher priced services.

Secondly, if a subnational target system were to use additional or higher payments to reward more efficient physicians, then policymakers would want to consider how to adjust beneficiary cost-sharing. If they did not, Medicare's beneficiary cost-sharing requirement, generally 20 percent coinsurance for physician services, would penalize beneficiaries for seeing more efficient physicians. In fact, it may desirable to offer even lower copayments or

other incentives to encourage beneficiaries to choose more efficient physicians.

The DRA mandate that calls for our SGR report specifically requires that we identify the appropriate level of discretion for the Secretary of HHS to change payment rates under the Medicare physician fee schedule or otherwise take steps that affect physician behavior.

Under the VPS, the Secretary was required to recommend the Congress each year if the VPS determined physician update should be modified. In other words, although it was never exercised, the Secretary had the authority to recommend a different physician fee update. The Secretary was instructed to confer with physician organizations and consider inflation, changes in the number and age of Medicare beneficiaries, changes in technology, evidence of inappropriate utilization of services, evidence of lack of access to necessary physician services, and any other factors the Secretary considered appropriate.

Secretarial discretion was not included under the SGR. It could be reinstated under an alternative target system. Similar to the VPS, the Secretary could be authorized to suggest to Congress a different target or

update than the one automatically calculated by the system. Of course, the Secretary should consider a list of criteria and consult with physician and beneficiary groups, as well as the Commission. The criteria could be similar to those used under VPS but could also include others, such as changes in the health status of beneficiaries.

The slide includes a scheme for possible options for Secretarial authority. Under the first option, which emphasizes Secretarial authority, there would be no automatic update as under the SGR. Instead, first the Secretary would set an update and then this would become law unless the Congress acted to override it.

Under the second option, which emphasizes the formula under law, the formula would determine the update. Secondly, the Secretary could recommend a different update if he or she choose to do so. And third, there would be no change to the formula unless the Congress acted on the Secretary's recommendation.

And under the final option, which incorporates elements of the two above, the update would also be determined by formula. It would be overridden by the Secretary if he chose to act. And of course, Congress could

always override the Secretary's authority.

In the either or any of these three cases, there could be a requirement added that the Secretary provide a letter to the Congress similar to the letter that they provide to MedPAC detailing volume, growth and breaking it out by the various subnational units.

Thankfully for my cold, that concludes my presentation and I look forward to your comments.

MR. DURENBERGER: I think that was a strong presentation and a strong product, so thank you very much.

My question relates to under trade-offs, and then I think it came up again under attribution, and that is the issues raised relative to data, and the complications in accumulating data. And it really deals with the role that Medicare carriers and intermediaries could or should play in gathering the kind of information. Since they're all basically localized, even though there aren't as many as there used to be, but they're dealing with local practices and making a variety of decisions on the basis of data they accumulate for CMS at that level.

Is that an opportunity within the Medicare system to simplify access to the kind of information that's needed

when we go to targets that are subnational?

MS. PODULKA: That's a very good point. I believe it was in October when Dana discussed some of the vision for other options for physician payment. There is an opportunity right now, given the contractor reform that's going on, to possibly require additional efforts from the contractors to sort through these data and provide reports to CMS.

And then it becomes a policy issue, do you want action at the local contractor level? Or do you want them merely to provide information for CMS to act upon?

DR. SCANLON: You've highlighted some of the really tough points that we need to be thinking about dealing with. Let me add one, to make our lives little more complicated, and that's the dynamics of a system when we're talking about changing the updates.

It comes to me in terms of two questions. One is how much variation in fees would we tolerate? If we have differential updates because we have subnational targets, over time these are going to start to diverge and there is going to be, at some point, it's going to exceed some level and people may get uncomfortable with that. And to build in

some type of a mechanism that puts a control on that and keeps it in balance is something to think about.

The second issue is the dynamics of what might be the accountable groups, particularly when we get down to the lower levels of disaggregation. And the reality that there's going to be a lot of turnover in those groups over somewhat more extended periods of time and there is the potential for good groups going bad and bad groups becoming good. The question is historically how should their historical updates affect their current fees?

In a pay-for-performance context, we're usually looking at the moment and we're saying someone has done well, we're going to reward you. And then we look at the next moment and we make the decision again.

In an SGR or a formula driven update context, we potentially build in baggage from the past. We talked about it in terms of having to pay off a cumulative deficit. It also potentially applies in terms of individuals and whether they've been rewarded or penalized in the past.

MR. HACKBARTH: You can imagine how the payment system itself could start to affect movement across systems.

DR. CROSSON: Just on that point, while I agree

that over time the quality or resource responsible focus of a group could morph, and what Bill brings up is a good point, you wouldn't want to continually reward a group that had been great 10 years ago and how wasn't great by whatever you were measuring, there is another aspect to the choice of whether you use the incentive as an annual reward or whether you create a cumulative reward. And it has to do, I think, specifically with the issue of physician payment.

In previous discussions we've been commenting on the fact that when we're talking about incentives for institutions, like hospitals, numbers like won or 2 percent can make a big difference. If you're dealing with, for example, an institution whose entire margin for the year is 2.5 percent, a won or 2 percent difference seems to have been -- at least in demonstration models -- enough to get significant change.

We've had some concern though that the evidence seems to show that when you're dealing with individual physicians rewards, of that size don't seem to make the same sort of change. And it may be simply that since volume is able to be influenced, let's say, that that 1 or 2 percent difference in payment may not be viewed as the same as it is

for institutions.

So there is a strength to using a cumulative reward system because if you're going to be in the physician payment arena anyway -- and I don't know about what it would be when we link the two, A and B -- but there is a strength in the sense that you can make small changes that over time result in large changes. And when a physician or a practice is looking at that prospectively they may say, in effect, 1 or 2 percent isn't that much. But 1 or 2 percent per year over a decade, based on the pattern that we do or don't adopt, may make very significant changes.

And so you have to trade that off against the perspective that in doing that you might over reward over time or perhaps under reward based on changing patterns.

MR. HACKBARTH: I think the term trade-off is very important. Jennifer used it in her presentation. On a lot of these design issues you're trading off multiple variables, multiple potentially good things and multiple risks. And trying to balance them up properly is, to say the least, tricky. But there's no avoiding the need for trade-offs.

DR. CROSSON: Just one more technical point on

some of these charts, for example on page seven. So the first column is the standing in terms of the level of cost. The third one is the growth over those years. The last column is called contribution to growth. I think that's really contribution to spend; right? It's the product of the level and the rate of growth? Am I missing something?

MR. HACKBARTH: Jennifer, it would be helpful, I think, for the broader audience if you just defined how contribution to growth is calculated.

MS. PODULKA: Sure. Contribution to growth, in the way we calculate it, is you take the change in terms of dollars. So not the growth rate. And you're dividing that by the total growth in terms of dollars.

So because growth rates differ, but the level can also be different, you can have a low growth rate on a high base. So in this instance, let's say Miami. So Miami is towards the top in terms of level, but it may be growing very slowly, but the total dollar change then can be just as great as an area that starts off at a very low level, such as Minneapolis, but may experience very high growth rate.

So in that instance, contribution to growth is picking both growth rate and level.

DR. REISCHAUER: All of this is done on a per beneficiary level.

MS. PODULKA: Correct.

DR. REISCHAUER: So it's a complicated thing when you get to the contribution to growth.

DR. CROSSON: It seems to me then the growth is being used in two ways. One is growth rate and the other is growth in dollars.

MR. HACKBARTH: Contribution to growth focuses on dollar growth as a percentage of the total dollar growth on a per beneficiary basis.

MS. BEHROOZI: Thank you, Jennifer, in particular for pointing out the impact on beneficiary copayment rates. when we think about incenting efficient providers or high-quality providers that's so important that you pointed out that it's then got a really perverse effect in terms of beneficiaries who may then -- particularly people on limited incomes, lower income beneficiaries, who are going to make their choice based on who's the cheaper doctor to see. And actually I will guess that some other people might have had the same question that Jay whispered to me.

But then ultimately they're going to have fewer

visits with that better doctor, that more efficient doctor. But in anticipation of that question or kind of responding to Jay, I would say that for people again on limited incomes, that initial cost is what they're going to look at. They're not going to be in a position to make the judgment about instead of five visits I'm going to have four, so I'm going to save in the long run. It's today, the dollars in my pocket, where am I going to spend it?

So I think you're absolutely right to point out that if we make any recommendations in this area it's got to be in conjunction with recognition that beneficiary copayment should not be impacted in the same way.

DR. SCANLON: On this point I think we also need to remember what's going to be the accountable unit and whether the beneficiary is going to have the choice of going to physicians that are being paid differently. Because if the accountable unit is a geographic area, then everybody within the area is going to be paying the same.

Even if it goes down to being the hospital-based, the extended hospital accountable unit that we talked about before, there are going to be many, many beneficiaries that don't have choices. They're going to be in a situation

where the geographic proximity of the physicians is going to be such that they're all going to be in that one accountable unit. And so their choice on the basis of price does not exist.

DR. WOLTER: It seems like this issue of where decisions get made is an important discussion point because certainly right now there's a lot of frustration that annually some legislation needs to occur at the last minute to address these issues. I'm sure counterbalanced by the fear that in a different situation arbitrary decision-making might be made by a few.

But it does seem like a critical issue, when you look at the complexity of the situation, the complexity of some of the recommendations or the options that we're starting to outline.

I guess I would be interested, for those of you with experience in this area, Nancy-Ann, Dave, others, if you have given any thought to how one might approach the issue of authority and decisionmaking. If I put you on the spot, I apologize.

MR. HACKBARTH: Who wants to go first?

MR. DURENBERGER: I was reflecting, during the

earlier presentation, about the way in which members of Congress make decisions about these sort of things, which is largely in response to an experienced need we substitute a different formula, if you will, for addressing that need and then send the accountability for implementing it to Nancy, which I would like to do right now.

[Laughter.]

MR. DURENBERGER: But in this context, there's a different kind of a dynamic. And I was reminded of the last conversation in 1989, before I turned to Jay Rockefeller and said let's go with the old VPS, of a conversation I had with a former chair of this commission when she was in serving in a different capacity, in which we both agreed that the vulnerability in the implementation of what we thought was a replacement for an inadequate former reimbursement for physicians, the vulnerability was in the volume performance standards because they would discourage accountability basically at the physician decisionmaking level or at the physician/hospital decisionmaking level in terms of the physicians' use of hospital services.

I think we knew that from the beginning. We knew that it would impact on accountability. Because the DRGs,

when you have a large group called a hospital, you give the hospital an opportunity to change its behavior and the authority with which to get rewarded for changing their behavior, hospitals do it. But individuals perform very differently unless they're in groups.

And was also had before us at that time the evidence of the TEFRA risk contracts and cost contracts that were conducted in the mid-80s in which groups, accountable groups or whatever we may call them, in various parts of the country took the opportunity at 95 percent of the fee-for-service payments system to do all of the things we're talking about here, resource use changes, outcome payments, things like that.

And we had that evidence before us, but it didn't come from all over the country. So we were in a kind of a quandary, I guess, as to -- and again, it's the same quandary I sense sitting here -- which is should this be a national system, operated in the same way in every part of the country? Or should it be a national program which holds individuals accountable in ways in which they can be rewarded for good behavior and not for bad behavior?

And that seems to be the essence of where we're

trying to go with this SGR reanalysis and the subnational target. Is that your question?

MS. DePARLE: In answer to your question about the authority, I think I was at OMB, and Mark I think you were there too, during the very brief time period when the Secretary did have some authority around this. And I can remember looking at the proposed rule one year and thinking should we do something, and by then it was too late.

I think you could do this though. And I'm thinking of your comments earlier about you would have a process, and Lord knows they have plenty to do at HHS, but this is important because everything we look at today, the physicians are at the center of driving for it and quality, controlling costs and all of those things.

You would have a series of conversations around the country with data like this and put on the table what should we do and do a proposed rule that might say -- it might do a lot of things. It might say physicians in one area get a lower update. It's sort of whatever you're big enough or have the nerve to put forward. So do a proposed rule and allow everybody to comment.

You could do that. It would take a lot of time.

In a year you would have a group of staff devoted full-time to it, but you could do it.

I guess, I think Arnie you made this comment in an earlier section, it would be hard administratively and all that and messy and probably ugly, politically. But sometimes I think we hold the new thing to a higher standard than we hold the old thing that we've been doing that we all know doesn't work very well.

So I think, in some ways, Nick, physicians would be less likely to receive that. If you really went out and engaged them in a conversation and showed this kind of data, along the lines of what you said John, as an on high, black box, who knows what they're doing in Washington, kind of decision then what they receive now, which is sort of how they perceive what we're doing here. If you really went out and said I have some authority to make some adjustments here, what do you think?

Maybe it's naive but I think some would engage and would begin to understand that.

Even if it's something like the GDP, which I disagree with as the standard, but even if it were that at least they would have an honest discussion of what they were

being judged against.

MR. HACKBARTH: Nancy-Ann, let me just follow up on that.

As a general matter, it seems to me that if you're implementing a new complex, many moving part system, having discussion to override formula is probably a good thing so you don't get driven into very bad corners the way we've been driven into a bad corner by the existing formulaic SGR. So having a stronger secretary with more discretion seems like a good thing.

Although if the path that you want to go is subnational and making distinctions by region or system, that's the sort of situation where it seems to me that a secretary might have the greatest difficulty with discretion. It's one thing to say well, I'm going to ease off a national target for all of physicians. But when the secretary is implicitly saying I'm going to push harder on Miami, not give them any relief, and maybe give Minnesota some relief, politically that is I think tougher ground for a secretary to stand on and exercise reasonable discretion.

DR. REISCHAUER: That is what I was going to point out.

MS. DePARLE: It's probably a second term kind of thing.

DR. REISCHAUER: If we look at the one through three, strong secretary/strong law mix, this is really a question of who's going to be holding the hot potato. And a lot of what's going on here is because of congressional scoring rules. If the Secretary has the potato, there is no scoring problem in the Congressional budget process. What's going to happen? Well, we're probably going to get an outcome much like we had before but with a lot less turbulence, anxiety, uncertainty in the process.

I agree with Glenn completely. You're sitting there in the Secretary's seat and the data seems to suggest the update for the Florida area should be much lower than the average, but the upcoming Senate election in Florida seems to be extremely tight. And no matter how much integrity you as the secretary has, you'll get a phone call, whether it's a Republican or a Democratic administration, from the person in Karl Rove's seat saying you know, I don't think you're looking at the data quite right.

[Laughter.]

DR. REISCHAUER: And we've collected some new

information.

And so we shouldn't kid ourselves. There is the objective argument about the necessity for flexibility but the flexibility is not going to be exercised always in an analytical way.

MR. HACKBARTH: Okay, thank you very much, Jennifer.

Thanks for fighting through the cold. Good job.

Our final SGR item for the morning is on a phased approach to SGR. Kevin.

DR. HAYES: Good morning. We begin this session with a question about the content of the SGR report and that has to do with this idea of a phased approach.

At the November meeting, Commissioners started talking about a way to replace the SGR that would have multiple parts and that would occur over time. It would draw upon different SGR alternatives that are listed in the mandate and it would consider other ideas. From that discussion, we come to this idea of a phased approach.

So the question for the session would be under such an approach, replacing the SGR, what are the specifics? What changes in policy would occur? And in what order?

To outline what could be included in this approach, I will summarize options that were listed and discussed in the paper we sent you for the meeting. We will review a possible timeline, noting links between phases, and we'll list some advantages and disadvantages.

In moving from the current national SGR, the purpose would be to fulfill three goals simultaneously. First, it would address geographic differences in the volume of services. Second, improve accountability. And third, providers would receive information they could act on to change their practice style.

In concept, this approach would apply more pressure in high spending areas; assess spending in all sectors, not just physician services; give feedback on resource use and identify outliers; and reward efficient care.

How would this work? Under this option each geographic area would have a spending target and payment updates for the area would depend on whether the area has met its target. Within each area feedback would be provided to outliers showing how their resource use compares to that of their peers.

Accountable care organizations, these would be entities composed of physicians and other providers, would be able to share savings with the program if they furnished care more efficiently than other providers in their area.

To identify the specifics of this approach, we need some kind of design parameters. In the discussion so far, commissioners have expressed certain themes that could be considered in replacing the SGR. The paper that we sent you goes over these in a little more detail but let me just go through these quickly now.

First, it would encompass all fee-for-service Medicare; apply most pressure where service use is the highest; provide a way to perform apart from the SGR and share in savings; maintain budget control; reward efficient care in all forms of organization; and allow time for data systems and analysis tools to develop.

Let me just pause here for a second and note the budgetary environment in which all of this would occur. As we know, any alternative to replacing the SGR would be very expensive because of baseline spending projections. As with other approaches to the SGR, we're talking here about a way to go forward in a new environment while acknowledging that

there are some very difficult scoring issues here.

This is kind of the timeline in total, and I'll go through each of these items, each phase, one by one. But for now, I would just note a couple of things here. First, we have four phases with multiple policy changes occurring during three of the four phases.

Clearly, replacing the SGR in this way would be complex with some elements of the policy working in concert with each other. In addition, CMS would have to develop necessary infrastructure along the way and there would be some sequencing of steps necessary.

Such complexity is not surprising, however. The goal here is to foster provider accountability in what is now a very fragmented and decentralized system.

We should also acknowledge, just in looking at this timeline overall, that it would be very burdensome for CMS. To do this the Agency would need clear administrative flexibility and new resources. These resources could be identified explicitly the way they have, say, for the new drug benefit.

Just to kind of give you some kind of perspective on numbers here, what we're talking about, CMS has

identified costs of implementing legislation passed previously. For example, they estimated that the Balanced Budget Act cost $77 million. That's in 2001 dollars. The Deficit Reduction Act, more recent, smaller in scope than what we're talking about here, but that was $60 million. And then, of course, we're all aware of the benchmark, if you will, of the Medicare Modernization Act and the $1 billion that was identified there for administration of that law and its provisions.

Moving on now to each of the phases, some of the steps toward using this approach could begin to happen almost right away, as CMS would start to work on the infrastructure necessary for subsequent changes in policy.

Certainly, to reduce the likelihood of multiple years of negative payment updates, there are different ways to set up the target to set its level. Jennifer went over some of that in her presentation, so I won't go into that here.

Also in this initial phase, we could see budget neutral bonuses for meeting quality standards. That could occur also here in the same way.

Moving along to phase II, here the policy would be

drawing on groundwork that had been completed previously. At this point, Medicare would start to differentiate among physicians. The SGR could transition here from a national system to one that has targets in payment adjustments for specific geographic areas. There would be different ways to define these geographic areas, of course, and we talk about that some in the paper.

Rewards and penalties would accrue to physicians and also possibly to hospital outpatient departments. The rationale for including the OPDs would be first off that it would be a step toward adjusting payments for all providers that could occur in a subsequent stage. Also, there's some substitutability among services, physicians offices say versus hospital outpatient departments. Many of the services are provided visits, some imaging, tests, some procedures are provided in both places.

There is a question, though, about what to include in the target. Would it be not just other Part B services but also Part A? And what about Part D?

Moving on to other aspects of this phase, we could see providing confidential feedback to outliers at this stage, using methods of the type that Niall went over

earlier this morning.

It could also be an opportunity for accountable care organizations to emerge and to begin some public reporting of their performance as a step toward them participating in shared savings programs later on.

Phase III could expand upon the policy of adjusting payment rates, adjusting payment rates whether spending has been consistent with the target, but here to include all providers, not just physicians and hospital outpatient departments. Commissioners have discussed the importance of all providers collaborating to make providing care for beneficiaries more efficient and it may be more equitable also to hold all providers accountable for volume growth, given Medicare's problems with long-term sustainability.

Although we have listed this change in policy as occurring in phase III, it's possible that some of what's discussed here could happen in earlier phases, depending upon whether preparations have been made and completed or not.

In phase IV, here is where we begin to talk about the shared savings. Building on groundwork that was laid in

phase II, accountable care organizations could begin to receive shared savings here with the physician group practice demo possibly serving as a model. CMS would be to establish eligibility criteria for entities, criteria that would address such things as IT, care coordination, things that you're familiar with, having responsible compensation programs and so on.

In addition, the size of the accountable care organizations would need to be large enough so that there would be some stability in the measures that are used to judge performance against the criteria.

Shared savings could serve as a way to earn back losses under the SGR and also to receive bonuses. They could also foster organized systems of care.

Beyond shared savings we could contemplate some other changes in payment incentives, ideas that you've discuss previously having to do with things like bundling and gain sharing.

We come now to our advantages and disadvantages of this approach. Overall, the advantage to this approach is that it would allow pursuit of multiple goals simultaneously, the things that we listed earlier in terms

of addressing geographic differences in volume, improving accountability, and providing information to outliers.

The disadvantage of this approach include first, there likely would be some resistance to what could be large redistribution of payments. The complexity of this approach demands more data and would increase the administrative burden for CMS. Smaller spending pools in the nation as a whole could raise concerns about attribution to care and volatility.

Just to close here with a revisit of the timeline, brings us back to our question about what to say about this approach in the report, what specific policy changes to discuss, sequencing of them, and so on.

Thank you and I appreciate your comments.

MR. HACKBARTH: I have no doubt that Kevin would be honored to have this known as the Hayes plan but in all honesty, Kevin didn't go off into his office and work this up by himself. I am the instigator behind this, and let me just say a few words about why.

What I've tried to do was capture important themes, ideas, and proposals that I've heard from various commissioners in response to the question if there is a

formulaic aggregate cost limit of some form, how might that be best structured?

Now I do think this reflects the point of view that I've heard from many of you, both in our public meetings and in individual discussions. But I should be clear that I don't think there is unanimous agreement on any of these things, let alone on all of the pieces.

But from my perspective there are a few key elements where there seems to be fairly broad commissioner support and identification. One is that if Congress decides that there's a limit to how much we can afford to spend and chooses to express that in terms of an aggregate Medicare spending limit, it would make sense to apply that differentially on a geographic basis.

We've got well documented differences in the cost of care within the Medicare program that are not getting smaller over time. They're getting bigger over time. If, as a society, there are limits, those limits ought to be applied in a way that recognizes those differences in the cost of the program. And if there's pressure to be applied, it ought to be applied first and foremost, to the greatest extent, to the highest cost areas. So that's one idea.

A second is that if, in fact, Congress decides we've got a Medicare cost problem, it's a total cost problem. It's not just the cost of physician services, as the existing SGR would imply. It's the total program cost per beneficiary that is of concern.

In fact, in the not too distant past I've heard individual commissioners at least speculate that in an optimal health care system we may, in fact, want to have a higher proportion of spending on physician services, not a lower proportion, to the extent that excellent physician care can obviate the need for some more expensive institutional services or treat illnesses at in earlier stage and avoid unnecessary admissions and the like.

So to have a physician-only system that squeezes only physicians may be, in fact, moving us in the wrong direction in important respects. That's a second idea.

Then the third is that even if you were to go from a national system to a geographically-based system, there is variation within those geographic areas, even if you would go down to something like MSAs. Some are higher cost than others, some are higher quality than others.

One of the fundamental flaws in the existing SGR

is that there's not enough individualized accountability and reward for good performance and penalty for poor performance. So even if you go to a more geographically-based system, you need to have a way to individualize accountability. Hence, you would want to look at options like allowing accountable care organizations or individual practices to get rewarded based on their individual performance and not just getting hit because they're in the high-cost region, for example.

In the abstract, those three ideas I think have fairly broad support within the Commission. In the abstract, they're relatively easy to say and I think commonsensical applying them, operationalizing them though, is a much, much more challenging task. And hence, the notion of a phase-in.

We're talking about capabilities, developing capabilities, new payment systems, new tools like episode groupers that would take time to develop and apply, gain the confidence of providers, not to mention members of Congress, and we should have no illusions that that's not something you would do overnight. We are talking realistically about a process that would unfold over a period of years, and I'm

thinking more like five or 10 years as opposed to next year. That's why it seemed to be important to at least think conceptually about how you might phase it in.

And then last but certainly not least, given the complexity of the challenge we're talking about, it's obvious that we're talking about a huge challenge for CMS, an agency that is already straining under its existing workload, let alone this one. In order to have any reasonable chance of succeeding in such a major redesign of the Medicare system there would have to be a huge new investment in CMS.

To the extent that you tried to do it on the cheap, so to speak, the risk of error, unintended consequence, inequity would greatly increase. And frankly, the risk that we'd find ourselves back in a situation not unlike today's where we are with the existing SGR, trying to dig out of a hole, finding that the system is driving us not towards a better system but maybe in some ways towards a worse one, those risks would greatly increase if you don't invest in the necessary infrastructure.

So those are the real points that I'd like to come through out of the very good presentation that Kevin made

and offer them for further discussion by the commissioners.

MR. MULLER: I think the Hackbarth-Hayes plan is well done, so I commend you for it.

We're not as explicit in here about the role of Medicare Advantage, although obviously an awful lot of this could perhaps even be done faster inside the plans than it can inside fee-for-service. They already have a lot of incentives to move in these kind of directions already.

So I think I would urge that we be a little bit more explicit about that, that in fact those incentives are there, and some other capacity is within those plans. I think a lot of what we, in the sense, committed to in the Modernization Act was by, in a sense, betting on or pushing in that direction, we were counting on their performance being able to achieve certain outcomes that were not as achievable in the regular fee-for-service, the less managed fee-for-service system.

So I don't know whether you want to put this into this language in any kind of way, but thinking about how these kind of goals could also be achieved perhaps in a -- if not sooner but in a more experimental way -- inside Medicare Advantage, I think that is something we should

speak to as well.

DR. REISCHAUER: Yes, I was going to ask to be recognized because the question that this raised with me as if we went down this path for fee-for-service Medicare, what kind of advantage are we giving to private fee-for-service plans within the Medicare Advantage program? We might be shifting the playing field very radically in favor of an option which some of us have questions about its appropriate inclusion in the Medicare program.

DR. KANE: One minor point is that on the face, when we're talking while providing confidential feedback, I would like to change that to everyone rather than outliers. Again, I'm not sure we've convince ourselves that it's just the top 5 percent of doctors who need this information and it's not clear that we can identify them as such. But it makes a lot of sense to have a whole community see their information. Then you get improvement even at the general level of practice.

In England, in Great Britain, they tried to do a similar kind of phase-in of the primary care trust and created a set of criteria that if you could hit those criteria as a provider unit, you got different kind of

payment and different level of accountability and different level of budgetary discretion. And they did it, I think, over a five-year period perhaps.

Instead of seeing it as you have to do this everywhere across the whole nation all at the same time -- granted CMS still has to come up to speed -- but I think the phases could be done differentially, depending on how capable each provider system is to achieving it. And then every time you move up a level of capability you get more accountability and more responsibility for your own costs and more opportunity to save in those. And the ones who can't pull it off stay down there with the SGR either as it is or maybe differentiated somewhat by -- I don't like geography as much as I like service myself. I think it's less politically vulnerable and perhaps -- I don't know. I like the idea of saying imaging gets less of an update than primary care.

But in any case, this notion that you can build the phases to be more oriented towards the providers' ability to hit performance criteria and then they get more discretion, more accountability, more savings. And let it happen differently across the country, depending on where

those different parts of the country are.

It definitely worked in other countries and so I don't think it's -- it's just a different way of thinking of it than some sort of massive national roll-out that you have to achieve all at once.

DR. WOLTER: Just a couple of things. As I've said before, I do hope that we can manage to stay with our past comment that we don't think the SGR as it's currently put together has been effective and, in fact, has put us in a very difficult spot in many ways.

But moving on from that, in the online that we received and in the exec session this morning there's a list called me the Vision of a Physician Payment System, which I assume is going to find its way into the final report, although it's not in today's materials.

Along the lines of your comments, Glenn, maybe that's broader than just physician payment system because some of the things that are there, in fact, include others than physicians and we may want to include some other things that would include payment to other silos.

And I think that as far as the phasing goes, as early as possible there are some things that could be done

that I believe would significantly help us with cost constraint and, to some degree, volume, pricing maybe being at the top of the list. That's pricing not just in the physician payment system but in the hospital payment system, where right now there is so much going on in terms of investment and the drive to increase volume in a handful of services that I think if we could accelerate the DRG re basing, for example, and continue to look at imaging pricing, there are some very, I think, high leverage there that we don't want to wait too long on if we're going to try to deal with the sustainability issue.

Another thing that concerns me greatly, as I've mentioned in the past, right now to me there is an unfortunate coupling of measures, measure reporting, and pay-for-performance with the SGR problem. The reason I think it's unfortunate is there's a great drive to create measures for 40 or 50 physician specialties, most of whom are incredibly ill-prepared to provide the measures. And that is diverting attention away from what could be a focus in pay-for-performance on high-volume high-cost disease states where I think we could achieve much more in a timely manner than the current situation where we're trying to

design measures for everybody but without really a sense of strategy and tactics about what will the outcomes of that be other than it's a way to tie payment to physicians to something.

I think it's really an unfortunate thing that's going on right now in terms of how pay-for-performance is being approached, but it does relate to the SGR, which is why I bring it up now.

And then I think that I'd also move things like bundling and gain sharing from phase IV to a much earlier phase because I think that ties to a focus on high-volume high-cost disease states, and it is an area where we could create both quality and cost gains if we tried to move that along more quickly, recognizing I know there are opponents to that in Congress. But I think it does have a place in what we're trying to tackle.

MR. HACKBARTH: If I may, let me just pick up on a couple of things that Nick said.

Regardless of what path Congress elects in the future, whether it elects to continue the existing SGR or a new SGR along the broad lines described in Kevin's presentation, or repeal the SGR, there are certain things

that need to be done under any of those scenarios. And very high on my list would be what Nick said earlier about continuing to improve the accuracy and equity in our pricing.

I believe, as I know Nick does, that the amount we're paying for certain services is sending very inappropriate signals to the delivery system and producing unproductive unhelpful behavior. And that's true both in the physician payment systems and in the hospital payment systems, and I suspect in all of our payment systems.

That type of work, trying to improve payment accuracy, has been one of the staples of MedPAC and its predecessor commissions. I don't see that going away under any of these scenarios. If anything, my personal sense of urgency is growing about that work, not declining. So I wanted to clearly identify myself with Nick's point there.

The other thing that I wanted to say is I, with Kevin's help, have tried to outline a potential path. What I envisioned, and this is more directed at the public audience, is that this is not the only path, it's not the only path that has some support within the Commission. And I want people to understand that. And what I envision in

our final report is that we will lay out some potential alternative paths that Congress might take.

Here again, I would emphasize that there are some common elements. So if, as Nick proposes, we stick to our traditional MedPAC position that the SGR doesn't work, it ought to be repealed, and formulaic national volume plus price targets are not have a helpful tool, even if you go down that path, I think we all still agree that we need new payment systems that improve accountability for both cost and quality like the examples that Nick alluded to, bundling, the group practice demo model. There are a variety of those potential systems that we have discussed.

I think those are things that you want to do under any of the SGR scenarios and they all are important. They all require resources to take them from concept to operation. And so under any of these scenarios I think a major investment in CMS is going to be required to increase the accountability for performance in the Medicare system.

DR. CASTELLANOS: I think this is just going to expand on some of the topics that Nick just said. Under the Hayes-Hackbarth proposal, you mentioned that you -- and again I'm not trying to beat you up. You said you really

were listening and listening to the commissioners and all of that. But under phase I, I still see we're talking about adjusting the SGR.

Why are we try to expand it? I don't see anybody saying it's working. I agree that you just said let's go by the original MedPAC position, and I certainly agree to that.

MR. HACKBARTH: Thanks for making this more pointed. The traditional MedPAC position has been repeal, as Nick described. That position was first taken four years ago, five years ago, back early in my tenure. The composition of the Commission has changed. We could easily go around the table and identify commissioners who want to keep an SGR mechanism in place. It's no surprise. People aren't concealing that. Over the months of discussion about this, there are a number of commissioners who have said they do not want to endorse a recommendation that the first step is repeal.

And so I don't, in talking about the Hayes-Hackbarth plan, I don't pretend for a second, Ron, that it is the unanimous view. Not for a second. But what I've tried to do is assemble in some reasonable fashion elements that I've heard from a lot of different commissioners.

DR. CASTELLANOS: Thank you.

Again you know, the target system, as we all said, is going to lead to inappropriate substitution. It hasn't worked. What we really need and what we're all talking about is individual physician accountability.

But as we also said this morning, it's not just the physician but it's all providers that need to be held to responsibility.

I like what we've been talking about over the last three months. I think we need to phase in some of these visions that we have had. The accountable care organization, I think is workable. Whether it's the hospital staff, whether it's geographic, whether it's a clinic, I don't know. But where the physician and the hospital are that entity working together.

As Nancy said this morning, we need to get the physician involved. You need to get it done on that level. You don't want to get it done up in Washington because the message never gets out.

I like the outliers. It works in private. And I know it works in my practice, because when I talk about it to my partners, they listen. We all have egos and we're

going to try to do it.

I think we need to start with the private first and then work down that cascade of beating up people for resource use.

We need to go down this path carefully and thoughtfully. As we said maybe the SGR, when we looked at that, maybe we didn't go down it as careful as we should. Maybe we didn't do the right thing or it wasn't done then. We can't cry over spilled milk but we can certainly prevent that at this time.

What we're doing is trying to address the spiraling costs. And maybe you all know it, but I haven't seen any cost estimates or anything like this. I certainly would like to see some cost estimates. I know the staff is busy, busy, busy but maybe they can provide some cost estimates. I think that's a tremendous advantage for looking at that because that's what we're talking about. We're talking about addressing the spiraling costs.

Thank you.

DR. HOLTZ-EAKIN: Glenn doesn't have to carry my water. I'll defend what I believe is the appropriate need for some sort of aggregate cap, which has worked in the

following sense. It has highlighted to the political community and to the medical community and to the U.S. as a whole that this system is not working, period. It delivers inadequate care at extraordinary costs, and it's growing every day.

So I think it's appropriate to use these kinds of caps to provide pressure, not just financial but also for change. What's wrong with this one is it's just on the physician.

So when I look at that phasing, the thing that jumps out at me as if we're going to have an SGR-like mechanism which is what we know inadequate from any standard of perfection but which does provide impetus to change, it should apply broadly. And it should place pressure on all providers to get together and coordinate care and give incentives to get out of the SGR by providing cost-effective care that works.

That's what I think we need to focus the discussion on. That's the value of the cap, I think. It has produced this kind of discussion. It's forced Congress to ask us to come up with some solutions. I think that's all entirely appropriate.

Cost estimates, left unchecked, the numbers are frightening. We've seen the sustainability report. You can do more narrow things with just this SGR. If you waive it, you're looking at $200 billion in a price tag. This is very expensive, and it merits the attention of the community and the Congress to have a cap that doesn't let health care eat the entire federal budget and then gives, underneath that, incentives for better care.

That's the real goal.

DR. CROSSON: Thanks.

I just wanted to compliment you on the choice of Kevin Hayes to carry the standard here, not just because of the quality of his thinking and the quality of the work. But I assumed that since he's the only member of the staff, I believe, whose shares a surname with a former president, that this was actually a very clever way to help us in the future with the Hayes plan or the Hayes-Hackbarth plan.

[Laughter.]

DR. CROSSON: I just might make a couple of comments, and some of it has already been said. I think this is a good direction. I think it potentially provides a way to deal with geographic differences, and you've made

that point.

I also think over time that it may very well lead to the development of whatever we want to call them, but accountable organizations. I think, as Nancy said, we've seen the same development in England and at least so far it seems to be going in a good direction.

I do have the problem with the use of the term SGR. It would be an interesting discussion but I actually would wonder whether or not all of the commissioners don't agree with the previous position, and that is that the SGR, as it now exists, ought to be dispensed with, that it is in fact a bad system for all of the reasons that have been said. The linkage to the GDP doesn't appear to have been the right thing to link it to. And the cumulative nature of it has created the political problem.

But that's a separate issue from Doug's issue, which is to say that if the Congress decides or if the economics of the Medicare program dictates that there has to be some constraint on spending that there ought to be some linkage to volume or linkage to resource use or the like. But those are separate things. And I think we get tangled up now increasingly with the term SGR.

So if you look at slide six, even within the context of our own discussion slide six talks about this path as a replacement for the SGR. But on bullet three it says -- and I think this is in the context of the accountable organizations -- provide a way to perform apart from the SGR and share savings.

Well, we're not talking -- we're talking about a system that would have replaced the SGR. It would be to part from whatever the rest of the universe is that is described in the previous slide that is not within that accountable organization.

So we're getting a little tied up with SGR. And since that carries such political baggage, I think we ought to restate the fact that we think it's a flawed way of going about managing volume or appropriateness of care and needs to be dispensed with and replaced with some other system that doesn't have any of those three letters in its acronym to avoid confusion.

The last one, and I think I would just reiterate points that Nancy and Nick made, and it has to do with the phasing. And I think I would agree that a change of this nature would require phasing. It's going to take time. But

I would like to see, in some way, the incentive aspects of this either not limited to phase IV and included in some ways earlier, or that the timing between phase III and phase IV be very short. Because I think unless the incentives are in place, the dynamics are not going to work.

MR. HACKBARTH: Let me just pick up on that point.

I, not Kevin, my coauthor, was the one who put that in phase IV. It certainly didn't signify that I think that we ought to hold back on doing that. If we could do it tomorrow, those things tomorrow that establish better accountability, better reward, individual performance, if we could do them tomorrow, I would do them tomorrow.

I put them in a later phase simply to signify that I think that while we've got attractive concepts, they are at this point just concepts and they would take time to actually develop and operationalize. And so I wanted to put them later to signify that I, unfortunately, don't think that they're ready to go tomorrow.

But it's not a strategic decision to hold them back or a decision of lower priority. I agree with you, Jay and Nick, that those are among the most important things to do and they ought to be done as early as possible.

MR. BERTKO: I'll be a math person and shorten the timeline to now an H-squared timeline.

The comment would be, I think this last discussion has just noted the usefulness of the timelines themselves. And whether it's one or maybe two or three, having that in the report, I think, is very good because it will allow staff and Congress to perhaps discuss it in the substance of something that's somewhat concrete, while not suggesting that this is the answer.

The second comment is a quick one and it's a lesson. Kevin gave dollar amounts in the budget that were learned from the BBA and the MMA. I think the MMA also has a very good time line one. The two years for implementing something of perhaps equal magnitude, namely the Part D benefit, was clearly -- I mean, people on both sides were running flat out and it was still less than adequate.

So Glenn, you're five-year time frame might be something we might explicit mention in the context of our past experience.

DR. MILSTEIN: Before I comment, one aspect of the plan that could be elaborated on is this idea of phase one, provide performances for high performance. Before I

comment, Kevin, could you elaborate what unit of reward? What measures?

DR. HAYES: This would be a policy oriented toward what the Commission has recommended in terms of pay-for-performance for physicians. That's what my conception of it was, but I might have it wrong.

MR. HACKBARTH: In all honesty, Arnie, it's probably the piece of this I have thought least about. So I'd be open to suggestions.

Basically what I wanted to signify is that even if we extend the existing SGR for some period while we gear up to do something fundamentally different, we may well want to go down the path that Congress has already begun thinking about, well let's exempt people from cuts or provide modest updates for physicians who are doing good things and trying to move us in the right direction.

So that's the concept. Exactly how we operationalize that and define those good things is very much an open question in my mind.

DR. MILSTEIN: Let me make two comments. First of all, I think this plan looks -- I'm very supportive.

Secondly, time is of the essence. We are in an

affordability crisis. By doing nothing, I believe we're just continuing to expose the beneficiaries to more of their Social Security increases going to Part B premiums in the program. That is, for me, the burning platform. And the chunk of Social Security increases that has been going to this use is very sizable.

So for me, I think assuring that this provide bonuses for high performance, even though the bonuses we know initially will be quite modest as a percentage of physician payment, for me it's very important that it encompass not just quality parameters but also the best resource parameters we have, whether it's episode groupers or -- but something that is a reasonable proxy for spending growth.

So that my support comes with a request that the dimensions included in high performance and phase one include resource use, as well as quality.

Secondly, I just wanted to say I may be misreading my fellow commissioners, but I don't think there's need to have question marks in this, whether we want to include Part A, B and D. It's the total spending that is the problem and physicians are in a tremendous position to affect A, B and D

use. So I would hazard a guess that there is, if not unanimity, at least substantial support among commissioners for -- if total spending is what we're after -- including all three buckets.

MR. HACKBARTH: Maybe Kevin and I can answer this together.

I'm not sure why the last question mark is there in that bullet, include Part A and other Part B and Part D in target. I definitely included a question mark about Part D, and I included a question mark because the Part D spending is flowing through a completely different system right now, through a private health plans system, each private plan having its own formulary and rules of the game. And so it's got a different dynamic to it that at least raises questions.

In principle, I absolutely agree, you want all of the expenditures. But how you incorporate Part D, when you do it, seems to me to be a question, given that it is operating through a different payment system altogether.

DR. REISCHAUER: It's technically probably impossible if you're going to include the employer/retiree policy amounts included there.

DR. MILSTEIN: My comment here would be, granted that these technical problems are real. But there are parallel problems in the private sector profiling. Many of the employers carve out pharmacy, have very employer-specific rules as it applies to their formularies and is administered by their PBM. And yet the private plans make do and find ways of bringing that back into the profiling, understanding it does introduce some noise in the measurement.

DR. REISCHAUER: I'm just saying geographically, I don't think we can allocate the resources when we give it to General Motors.

MR. HACKBARTH: This is an important conversation but I don't want it to obscure an even more important point. I think one of the areas where there is a very strong consensus, if not unanimity, among the commissioners is if you have a system like this with formulaic limits, to apply it only to physicians and think that you are meaningfully addressing the long-term cost problems of Medicare is a mistake. And so you want to make it as comprehensive as possible. We're concerned about system costs, not just physician costs.

I think that's a point on which there is substantial agreement.

DR. SCANLON: In response to that, I think that while we do care about total cost we need to also recognize that it's the physician that's the decisionmaker in terms of volume.

So between phase two and three, I see a big distinction, which is in two one might hold physicians accountable for all costs because they are signing the certification that someone uses home health, DME, even prescription drugs.

But when we move to phase three, and if we're thinking about adjusting the payments for all providers, we're talking about a much bigger task because we need to think about the incentives that are already built into the pricing systems that we've got for these individual providers and what they have under their control. Because they don't necessarily have volume under their control. They may have the quality of the service that they can influence.

The idea that they're more efficient, we're back to this national system because we have national rates for

home health and SNF and other providers. So the idea if I become more efficient I'm going to be rewarded in terms of the underlying rate is not the case. So three is a big change in terms of all the payment systems that we have.

MR. HACKBARTH: Your point is well taken. My objective, my hope in this, would be that if Congress were to elect such a path, what you want is for all providers, physicians, hospitals, home health agencies, you name it, to be engaged in the task of trying to reduce total costs while increasing quality, not maintaining it. While increasing quality.

To the extent that the squeeze is applied only to physicians, even if the metric is a total cost metric, I worry that the other providers are going to have less enthusiasm for the task. The hospitals, for example, are going to say oh, reducing admissions is reducing my revenue. No thank you, I'm not going to provide operational support to activities that are designed to reduce hospital admissions and readmissions. It's physicians who are going to get hit with any fee cut, their problem not mine.

So there are lots of very important questions about how you would operationalize it. But the goal needs

to be to get all providers engaged in that conversation, as difficult as that is.

Who else has comments? We are at the end of our appointed time for this, but I don't want to cut off any conversation.

Okay. Thank you, Kevin. Excellent job.

Now we'll have a brief public comment period, with our usual ground rules. Please identify yourself, first of all. And then keep your comments very brief, no more than a couple of minutes.

MR. CONLEY: Thank you, Mr. Chairman. Jerry Conley on behalf of the American Academy of Family Physicians.

I appreciate many of the comments of the commissioners, and particularly one that I think Doug made, as far as using the SGR as a continued pressure point as far as the political and the other kinds of environments that we're dealing with.

It reminds me of the Bowl Championship Series using the bowl series and the bowl playoffs as a mechanism to create pressure on the NCAA to get them finally to a single playoff.

But it is clear, I think, that the SGR has not worked, it's not effective and, in fact, it can be used very effectively as a pressure point for change. It has created a fractionalization and fragmentation within particularly the outpatient health care community. It places, in our view, an insufficient emphasis, because of this fragmentation, on primary care.

Reimbursement is not the only factor, of course, that devalues or diminishes the emphasis on primary care. As you see, throughout the entire sector there is a diminishing selection of primary care as a specialty, from medical students and residents. And this whole deemphasis on primary care we've witnessed in this country, while we are recognizing an emphasis on primary care in other countries, in other countries that have exemplified a higher quality of life, a higher quality of their health care delivery system and a lower cost.

So we would really encourage continued discussion around this SGR replacement or this expenditure target replacement by holding up your decisions to the grid of what effect would those decisions or those recommendations have on the primary care system in the United States?

And with that in mind, then try to reflect on how those decisions would help redistribute or reemphasize that comprehensive care that we have seen be used effectively in other countries where there is higher quality of health care, higher quality of life and decreased cost on health care system.

MS. McILRATH: Sharon McIlrath with the AMA. I hardly know where to start.

Just to talk about what have we accomplished with the SGR. I think one could argue that the payments to physicians, the payment rates today, are lower than they would have otherwise been. You cannot argue that it has controlled volume. Volume has gone up lots more under the SGR than it did before there was one. So then, if you think that the reason to have this is so we can force discussions about the overall spending in this country, I would ask -- I mean, aren't we going to have to do that anyway with the MMA cap?

Then I would say think of the ways in which the SGR has actually hampered what you would like to do. And to follow up on what Jerry said about primary care, just note that on January 1 things are going to change drastically on

a lot of payments for a lot of different surfaces. And keep in mind that actually physicians, the surgeons and everyone else, gave up a lot of money and they gave it to primary care in the last five year review. Some of the primary care services are going up by 37 percent. In order to accomplish that, you had to take a 5 percent hit on everybody else.

What is taking that away is the SGR and the budget neutrality. So when you have the SGR in place, you actually are putting in a lot of incentives that are exact opposite of where you want to go. If what you want to do is pay physicians on an individual basis for high performance, what you have going on today in the discussions up on the Hill, is that in order to pay anybody anything, we are going to next year put people in a position of unless we come in with some other one-year kind of solution that is paid for by making the situation even worse in the following year.

And so what's happening is we're talking about giving people increases if they meet certain reporting standards. And I would pick up on what Dr. Wolter said, those standards are not necessarily being applied in a way that makes sense. They're being applied in a way that makes it possible for everybody to have an opportunity to get at

least some kind of a positive update.

And the price of that is that next year you're looking at, in the formula, cuts of 13 to 10 percent, and you've got the next year to ride in and it will be even lower the next year. So you set up this system where you can't give physicians an update that even makes sense because of the scoring implications.

If you were to change and eliminate the SGR, you could, under the system that you have previously recommended, as you do with all of the others, if you thought that volume was going up too high, if you thought it was going up too much in a particular service area, you still would have the option of making a recommendation to Congress that they gave differential updates or that they cut everybody by a certain amount or that they only gave the update to those that met the reporting requirements.

But if you did that, then you would be creating savings under the system instead of a cost. It is ironic that if you cut the hospitals by 1 percent, you get a huge savings. If you get the physicians even up to a freeze, it's a huge cost. It just doesn't make sense.

On the administrative issues, I would say that is

a huge issue. If you just look at the back of the rule and look at changing the SGR, if you go back two years, just look at the numbers in there and imagine doing that on a regional basis.

But another problem is that some of the things you can't solve with just putting more staff in there. You're making a lot of projections and no matter how many staff you have, you're going to have to make projections.

And I would remind you that in each of the last two years there was a letter that came out in the spring that said this is what the volume increase is going to be. And by the fall, we had discovered that it was still high but it wasn't as high as it had originally been projected to be.

So administratively then, if you're looking also in terms of the scope of the target, I think if you asked physicians to be held responsible and have their pay cut dependent upon what happens in every other part of the health system, then it would be hard to deny them the ability to go off and form specialty hospitals, to increase the number of ambulatory surgical centers, to do the sorts of things and create the kinds of settings where they have

total control. So I think that should be part of the discussion as well.

That's probably enough.

MR. BUSHMAN: I'm Jesse Bushman with America's Health Insurance Plans.

I've been following the SGR issue for a number of years. And sitting here listening to this conversation reminds me of a quip that Dave Barry made that we should all take comfort from the fact that there's no problem in government that won't be solved once the sun explodes.

There were a couple of things that I thought of as I was listening to this idea of creating various geographic regions with distinct SGRs for each one. The number one item was that the target under the current system has been an issue of debate for a long time. There's a lot of argument about what should be included in the target and what not. If we create multiple geographic regions, each with their own target, it seems to me that that problem would just propagate throughout all of these different regions. It would be something that would be a battleground every year if it wasn't carefully designed and agreed upon by the people who are receiving payment and folks who are

making the payment.

Another problem that you would need to think about, it seems to me, is the issue of physician migration to areas where payment is higher. Recruiters do actually use varying levels of physician payments under the GPCI-based adjustments right now. And if the variation in physician payment was increased further than it is right now, it seems to me that that would just motivate physicians to go more to an area where the payment is higher, you get more physicians, you get more services, then maybe that would result in lower payments because of an inefficient use of resources, which would create this kind of yo-yo-effect. It's something to think about.

It could also create the perception of a different Medicare benefit across the country, in the same way it happened with the managed care plans. You had varying payments and then there were political arguments about whether or not the benefit being supplied was different.

It seems to me that you would also get political battles, representatives, senators supporting a system that resulted in high levels of payment in their areas versus those who had low levels, and you would have to deal with

that on a regular basis. That would be a tough thing.

And then, I guess the major point is something that folks on the Commission have recognized, is that even if you have a geographic area that consists of a single state, it still doesn't get to the individual physician behavior. And that really, it seems to me, is what's going to drive a real change. It's individuals seeing how their payment is getting impacted, not their whole state. If it's their whole state, that could be 50,000 physicians. In the larger states it be tens of thousands of physicians. In that situation, the physician doesn't have as much individual motivation to modify his or her behavior.

Speaking as a person who has a health savings account and a high deductible health plan, I would be really interested in seeing the kind of individual level information on physician resource use that I could access as a consumer, not speaking for the organization that I work for. So I would encourage that, any movement toward that. I think that kind of goes along with the administration's emphasis on transparency in pricing.

The last thing is that up until a couple of months ago I worked with CMS over in the Humphrey Building. I came

in one morning and there was a guy with a cart going up and down all of the aisles, and he was taking two light bulbs out of every one of the four light bulb fixtures. So as you think about the resources that you would recommend that CMS get -- and by the way, they never put the light bulbs back even after it got colder. It wasn't just to reduce the electrical usage during the hot spell. So do think about that.

MR. HACKBARTH: Thank you.

We will reconvene at one o'clock.

[Whereupon, at 12:17 p.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION [1:12 p.m.]

MR. HACKBARTH: It's time to get started.

This afternoon we have a series of presentations related to updates. We start with hospitals and then proceed through a series of post-acute care related presentations.

Just as a reminder about the process, of course we must make our update recommendations for inclusion in our March report, which means that we will vote on recommendations in January. In each of the discussions today there will be a draft recommendation presented. The draft recommendation, in each case, is based on our recommendation from a year ago for that particular sector. So it's no more, no less than a repeat of where we were last year.

Obviously, to the extent that circumstances are different this year, we are free to depart from those drafts but we did want to have a starting point for discussion.

With that preface, Jack and Craig, lead the way.

MR. ASHBY: Good afternoon.

This session will address payment adequacy for hospitals, including IME and DSH payments. The IME and DSH

segment, by the way, at the end will only include new material, following up on our presentation from the last meeting. The draft recommendation on uncompensated care data that we developed at the last meeting, we'll hold that until January for further consideration.

Before I start though, I wanted to take just a moment to thank several people who contributed to the numerous set of analyses that we will be presenting on today. That includes Tim Greene and Dan Zabinski, Julian Pettengill, David Glass, Jeff Stensland, Ann Mutti, and Sarah Friedman. We have a cast of thousand here.

One more preliminary matter, and that is that we'll be presenting draft update recommendations today for acute inpatient and outpatient services. But you'll remember that we consider the adequacy of payments for all services that hospitals provide to Medicare beneficiaries taken together. And that includes inpatient, psych and rehab, SNF, home health and graduate medical education.

Following the Commission's framework for assessing payment adequacy, we will present findings on access to care, volume of services, quality, access to capital and payments and costs in the current year, which is fiscal

2007.

So first, in the area of access, we first look at the share of hospitals offering certain services. We've been monitoring a set of 10 specialized services for several years now. These are things from burn care to open heart to MRI. And we found that the share of hospitals offering eight of these 10 services has increased. The share of hospitals offering outpatient services, including emergency room services, rose after the outpatient PPS was implemented in 2001 and then it has remained stable since that time.

Then we monitor the number of hospital openings and closings. In each year since 2002 more hospitals have opened than closed. In addition to that, the annual number of closures has dropped by 60 percent between 1999 and 2005.

A large number of hospitals have converted to critical access hospitals, about 1,100 over the last six years. And for the first time this year, we also identified conversions to long-term care hospitals. We found that we've had an average of 10 conversions a year over the last six years, including 10 more in 2005.

Turning to the volume of Medicare services, growth in outpatient services has been strong but the rate of

increase is falling. It's dropped from about 12 percent in 2001 to 4 percent in 2005.

Inpatient discharges have grown more slowly but following a similar pattern. In 2002, 2003, and 2004 discharges grew faster than the number of fee-for-service beneficiaries but in 2005 the growth rate slipped to 1.3 percent, which is slightly less than beneficiary growth.

Beyond Medicare volume, growth in all-payer discharges also dipped in 2005, as did growth in all-payer outpatient visits, as reported by the American Hospital Association. In a survey of 600 hospitals that we co-sponsor with CMS, it suggests that the slowdown in volume on both the inpatient and outpatient side has continued into 2006.

As the volume growth slowed, we've had larger increases in inpatient case-mix and outpatient service mix. These increases are fully paid for under prospective payment. In other words, a 1 percent increase in CMI produces a 1 percent increase in payments, all else held constant.

The outpatient increases of around 3 percent in 2004 and 2005 were heavily influenced by increases in

observation services which may, in part, reflect a relaxation of coding requirements. We're not sure exactly what has caused the 1.3 percent increase in inpatient case-mix in 2005, but it is the largest increase that we've seen in a decade.

Turning to quality, we have three analyses that together support the conclusion that quality is generally improving. Mortality has declined in most of the conditions we've measured over the last seven years. Performance in delivering recommended care to beneficiaries also improved in most categories in this, the first year that we've had these data available on the CMS Hospital Compare website.

And finally, patient safety results have been mixed. The rate of adverse events declined, that is the performance got better, in seven of 13 available measures over the last seven years.

On this next slide we display the results for the nine most common patient safety measures for you, although we thought we would not spend any more time on the details of this right now.

On access to capital, the most direct indicator of hospitals' access is the level of their actual capital

expenditures. As we see here, hospital construction has increased steadily since 1999 and we've seen by far the largest increase, 30 percent, in 2006.

In addition to construction spending, the growth in taxes and bond issuances has been strong and the value of debt for hospitals with upgraded credit ratings far exceeds the value for hospitals with downgraded ratings.

The median values of several financial indicators that we monitor, things like days cash on hand and a couple of measures of debt service coverage, reached their highest value ever recorded in 2005.

A recent survey indicated that 83 percent of nonprofit hospitals plan to add capacity in the next two years, implying that they expect to have continued access to capital.

And finally, in the for-profit sector, the big story this year is the $33 billion buyout of HCA by a private investment group. Most of the cost of the buyout will be financed through debt, again demonstrating very robust access to capital.

Turning to financial performance, our first chart presents Medicare margins through 2005. Going from 2004 to

2005 the overall Medicare margin declined by two-tenths to minus 3.3 percent. Looking at our to key component measures, the inpatient margin fell by four-tenths while the outpatient margin increased for the second year in a row. This is due primarily to low outpatient cost growth, as we'll see directly in a later chart.

The next slide shows 2005 overall Medicare margins by hospital group. The rural margin is three-tenths higher than the urban margin for the first time. This change is due to several years of increased payments to rural hospitals and to the fact that we've had a number of rural hospitals with low margins drop out to become CAHs.

The group with the poorest financial performance, of course, is non-teaching hospitals, as has been the case for a number of years and I'd like to point out that about 70 percent of non-teaching hospitals are in urban areas. None of the rural subgroups that we monitor had margins as negative as this non-teaching figure.

Our projection for 2007 is for about a 2 percentage point decline in margin to minus 5.4 percent. This projection captures the impact of policy changes affecting inpatient, outpatient and hospital-based post-

acute care services in 2006, 2007 and 2008. It also reflects an assumption about cost growth that I'll explain in a moment. So the projection represents our best estimate of what margins would be in 2007 if 2008 policies applied at the time.

We used the same rate of cost growth for every hospital, so the projection does not reflect any behavioral responses. Unless there are different rates of cost growth between urban and rural hospitals we expect the 2007 margins of these two groups to be about the same.

This next table shows the rate of growth in Medicare inpatient costs per discharge, outpatient costs per service, and a weighted average of the two, all adjusted for changes in case-mix. Even before the case-mix adjustment, the rate of growth in inpatient costs drops over these three years. But with the accelerated growth in case-mix that we saw a couple of charts back, the drop is more pronounced here and the rate of growth also declines, as you can see, on the outpatient side.

In 2005 the combined 3.3 percent cost growth you see in the bottom corner here exactly matches the market basket update for that year.

But unfortunately we have evidence that the rate of cost growth may be edging back up again in 2006. Our survey of 600 hospitals, as well as data from six for-profit chains, suggests that rate of cost growth has written about a percentage point into 2006. This would be either six or nine months into the year, depending on the measure.

These data sources cover all payers and they don't offer a case-mix adjusted result. But if we assume that case-mix will continue to increase in 2006, since we know that it's been increasing for Medicare patients over the last several years, then the increase in the rate of growth will probably be a little less than the 1 percentage point suggested by these data sources.

Of course, we don't yet have a complete picture of what's going on in 2006 but we would cite two possible factors in the higher growth rates. One is capital expansion. The rate of growth in capital costs, that's measured by interest and depreciation, increased by more than a percentage point in 2005 over 2004. And with the record capital investment we showed earlier for 2006, a one-year increase of 30 percent, another jump in capital costs growth rate is virtually inevitable.

The other factor is up with the volume growth tailing off into 2006 the patient volume grew more slowly than hospital employment in the first half of the year. This could be a temporary phenomenon with equilibrium reached later in the year. And if that's the case, then the rate of cost growth may drop back somewhat for 2007.

In our margin forecast we assumed an annual rate of cost growth, case-mix adjusted, of 4 percent between 2005 and 2007. That's seven-tenths higher than what was actually observed in 2005.

Now Craig will present some further analysis of financial performance.

MR. LISK: I'm now going to talk about our analysis of hospitals that consistently performed well or poorly under Medicare. This analysis is consistent with our negative margin analysis that we've presented with you in the past, but here we have altered the analysis to base it on adjusted overall Medicare margins. By doing this we remove IME and DSH payments over the empirically justified amounts. This means that these payments are not a factor in determining who consistently performs well or poorly under Medicare. Hospitals get in the bottom or top group if their

adjusted margins were in the bottom or top third every year from 2002 to 2005. 18 percent of hospitals fall into each of these groups, in terms of in the top and bottom groups here.

In general, what we see is that hospitals with consistently low margins have had smaller declines in length of stay and higher cost growth than those with consistently high margins. From 1997 to 2005, Medicare length of stay fell on average of 2.3 percent per year in the low-margin group compared to 3.1 percent in the high-margin group. From 2002 to 2005 annual growth in Medicare costs per case was a percentage point higher for the low-margin group, 6.3 percent compared to 5.2 percent for the high-margin group.

So what may contribute to this disparate performance? Hospitals with consistently low margins do not appear to be under as much financial pressure as hospitals with consistently high Medicare margins. The non-Medicare ratio of revenues to cost, a measure of financial pressure, is very different for these two groups of hospitals. This ratio stands at 1.16 for the low-margin group compared to 0.99 for the high-margin group. The low-margin group may face less pressure to control their Medicare costs as non-

Medicare revenues greatly exceed costs and they can rely on these excess revenues to offset their Medicare losses.

These hospitals also have a large private self-pay share of cases, 39 percent compared to 29 percent for the high-margin group. Moreover, along with their higher cost growth, the low-margin group has actually seen revenues grow faster, another sign that this group faces less financial pressure to control costs.

In contrast, the ratio of the high-margin group is only 0.99, which means that these hospitals are almost breaking even on their non-Medicare business and that they need to do well under Medicare in order to perform well overall. The low ratio could come from uncompensated care, low Medicaid payment rates, or some other factors, but it does appear that these hospitals have responded to this pressure with smaller cost increases and bigger reductions in length of stay than other hospitals.

And this difference that we observed on a previous slide translates into bigger differences in costs between these two groups of hospitals. Here we use a measure of standardized costs to compare facilities' Medicare costs per case. Our standardized cost measures, standardized costs

for case-mix, patient severity, outliers, wages and teaching intensity. What we find is much higher standardized costs for hospitals in the low-margin group. As you can see here -- I'm sorry.

What we find here is much higher standardized costs for hospitals in the low-margin group, $6,200 compared to a little over $4,500 for hospitals with consistently high Medicare margins.

If we compare these hospitals to their neighbors, we see that those in the low-margin group have higher costs than their neighbors, $6,200 compared to $5,700 for their neighbors within 15 miles. In contrast, hospitals with consistently high margins had lower costs than their neighbors, $4,500 compared to $5,100 for their neighbors within 15 miles.

We also see that hospitals with consistently low margins have other hospitals closer by than the higher margin group.

We also examined how overall Medicare margins would change if we exclude hospitals with consistently high costs. For this part of the analysis, remove from the overall Medicare margin calculation hospitals whose

standardized Medicare costs per case were in the top third each year from 2003 to 2005. Excluding these high cost facilities from our margin calculation, we find that the overall Medicare margin in 2005 would be 3 percentage points higher, or just about at zero. About 20 percent of hospitals fall into that group of hospitals to be excluded.

MR. ASHBY: We now turn to our update recommendations for inpatient and outpatient services. To start the conversation we have put the same recommendation the Commission made last year, an increase of market basket less half the expected increase in productivity for both inpatient and outpatient services.

These recommendations though might represent an appropriate balancing of our findings for this year, as well. On the one hand we have positive outcomes in our assessment of payment adequacy. We have access to care appearing stable, volume of services increasing although at a somewhat reduced rate lately, quality of care generally improving and access to capital reaching new highs.

On the other hand, while hospitals' margins under Medicare were fairly stable this year they do remain low, which is cause for concern. The rate of cost growth rising

again in 2006 is also a concern, but at the same time the potential for escalating cost inflation emphasizes the need for some degree of constraint and we continue to believe that providers should be able to achieve at least a small improvement in productivity as other sectors of the economy have done.

As you know, our standard for expected productivity growth is the 10-year average in total factor productivity in the general economy which currently stands at 1.3 percent. So the recommendation would be market basket minus 0.65 percent. The budget implication is a decline relative to the current baseline and we expect this recommendation to have no major implications for beneficiaries or providers.

Now we turn to IME and DSH.

MR. LISK: I'm going to move on to review a couple of charts related to our IME and DSH analysis. This chart that's up here now, you saw at the last meeting, shows overall Medicare margins by teaching status and show how it changes under different scenarios.

As you can see, as we move from the baseline margin, baseline policy, current policy, to reducing the IME

adjustment to the empirical level, the margins converge. A difference of 12 points narrows to 10 points with one point reduction in the IME adjustment. It narrows further to a 5.5 percentage point gap if the IME adjustment is reduced to the empirical level.

This next chart was requested at the last Commission meeting and it shows how teaching and non-teaching hospitals are affected by the DSH subsidies included in the current payments. Essentially what we show here is that the DSH subsidies are not a major factor in explaining differences in financial performance between major teaching and non-teaching hospitals.

Here we see only a small narrowing in the gap in margins between major teaching and non-teaching hospitals from reducing the DSH adjustment. A one point adjustment in the DSH adjustment would result in only a 0.3 point narrowing of the difference in margins between major teaching and non-teaching hospitals.

If the DSH adjustment were reduced all the way to the empirical level for urban hospitals over 100 beds, the difference in margin narrows but only 1.5 percentage points, so there would still be a 10.5 percentage point gap in

performance here.

Thus, DSH payments over the empirically justified about are not a major factor giving teaching hospitals their higher margins. The major factor contributing to the difference in Medicare margins between major teaching and non-teaching hospitals are IME payment above the empirically justified amount.

As you can see on this chart, from the last set of points to the right, the difference between major teaching and non-teaching hospitals narrows to 3.4 percentage points if both the IME and DSH adjustments were brought down to their empirical level.

We have also included in the chapter a discussion of potential uses of IME payments that are above the empirical level. We discuss three potential uses of these funds. One is returning them to the base rates to improve payment equity across all providers.

A use is to use the funds to support pay-for-performance initiatives for hospitals.

A third potential use of these funds is to help support innovations in residency training. This might include funding special fellowships to train a new

generation of physician faculty, or rewarding specific curriculum innovations such as benchmarking, integrating geriatrics training into curriculum, and reengineering.

Given the results of our analysis, which finds that IME adjustment is set substantially above what is empirically justified, and that this contributes substantially to large disparities in financial performance under Medicare between teaching and non-teaching hospitals, and also that teaching hospitals will benefit from impending implementation of severity adjustments, the following draft recommendation is presented for your consideration.

The recommendation reads with the implementation of severity adjustment to DRGs, the Congress should reduce the indirect medical education adjustment by 1 percentage point to 4.5 percent in fiscal year 2008. The funds obtained from reducing the IME adjustment should be used to increase the base rates for all hospitals.

Spending implications under this would be none, as the proposal is budget neutral. Beneficiary and provider implications, it would reduce payments to teaching hospitals and increase payments to non-teaching hospitals, improving the equity of payments across providers. No effects on

beneficiaries would be anticipated.

With that, we will conclude and we can discuss the recommendations and other things in the other chapter.

MR. MULLER: In terms of the draft recommendation, we've had this fall a series of discussions about not just increasing the base rates but also funding pay-for-performance and, on page 21, rewarding innovations in residency training. I would prefer to have a different rank order if we're going to do this adjustment.

If you could go to 21 please.

The recommendation ranks the base rates. I would probably rank them in the other order, with rewarding innovations in residency training. Arnie and others and Jennie have spoken over the last few months about the need for either -- some people want to focus on primary care. Other people want to look at collaboration among physicians. Rather than reprising all of the arguments, given the shortness of the time this afternoon, I would prefer that we put the money either into the rewarding of innovations or -- this Commission has a long history, three or four or five years now, in P4P recommendations. So if we increase the pool of funds, I would kind of rank order them in that order

rather than the base rates.

I think in the base rates we've had, with the growth of critical access hospitals, a lot of protection for the sole community providers and so forth. So I prefer the ranking be done in that order.

DR. MILSTEIN: I would very much like to support Ralph's last suggestion of flipping the order. I think, again, going back to our sustainability chapter and the notion that long-term what we need is a health care system that can innovate quickly enough in generating new efficiencies that we can have a prayer -- perhaps stabilizing health care spending as a percentage of GDP while raising quality of care.

I think the only way you get there is if you take the subset of health care professionals that have the most leverage on how health care works, which is physicians, and begin to train them in the disciplines that they're currently missing.

I would, in addition to geriatrics, lean towards process reengineering and health care informatics because that's what, in our testimony from the IOM Committee on Reengineering and Virginia Mason we heard, has the most

opportunity for not just one time but dynamic ongoing increases in the rate at which efficiency is captured by our health care system year in and year out.

It's only through such a dynamic change that you can hope to stabilize spending as a percentage of GDP. So this is, I think, our single highest leverage investment that we can make and hear's some of what appears to be some discretionary funds to work with.

So I want to second Ralph's suggestion of reordering the recommendations.

DR. CROSSON: On this point then, it seems to me as we go through the logic of the presentation that one of the points of doing this, it's not necessarily linearly related to the fact that there's overpayment based upon the empirically justified amount. It's can we use this as a tool to narrow the gap that appears to exist between the profitability of teaching hospitals and the profitability of other hospitals?

So if that's the logic, then I could see the argument for perhaps taking the second bullet point and making that the first bullet point because that would apply to all hospitals; right? Pay-for-performance for all

hospitals could be open to all hospitals and it's something that we've been in favor of, at least in some ways.

But I don't understand the logic for elevating the third bullet point, because that applies only to hospitals that have residency training programs. So it seems to me that that doesn't follow from the purpose of the policy change we've argued for.

DR. REISCHAUER: After hearing Ralph and Arnie, I thought I would just offer the counter argument. The counter argument would be after we took the 1 percentage point away, we would still be overpaying -- based on the empirical level -- teaching hospitals and it would not be unreasonable to say for that excess payment we should get something for not cutting it still further. And then ask what social values do we want to pursue with the 1 percent that we took away? I could go for either raising the base rates or a pay-for-performance system.

DR. WOLTER: I'd actually fall on increasing base rates with this recommendation. The reason I say that is when you look at the margins, the differential is pretty striking. We already have 2 percent of a base rate that's tied to performance measures and that could evolve over time

to some sort of more performance.

But when you look at the negative margins in the other teaching and non-teaching, you wonder about the ability for organizations to invest in the infrastructure to improve quality and costs and those kinds of things.

If I'm remembering the history of IME, the dollars were taken out of base rates to start with. To me there would be a great amount of logic in following the recommendation as it's outlined here.

DR. BORMAN: On this specific point, I would support the reversal of order that Ralph has outlined and pretty much agree with him for all of the reasons that he's mentioned to you and the things that Arnie has said.

As we link this, and the counter argument has been or part of the contentions on the other side would be that linking this, there will be adjusted DRGs coming which will return some percentage, presumably disproportionately in favor of the teaching hospitals because of their acuity.

And for that reason, I would couple -- whether or not we do this -- I would also advance the notion that the draft recommendation should start out assuming the implementation of severity adjustment DRGs rather than with

the.

I'm very concerned that these two things will get disassociated fairly quickly. I recognize that it may be a fine semantic point. I would like to see us be on record that we have some stronger linkage there.

MR. HACKBARTH: On that specific issue, I agree with your point. Let's not try to wordsmith the language in the recommendation itself. Maybe concurrent with is the way to put it.

But in addition to the wording of the recommendation, we will make that connection clear in the following text, so that's unmistakable.

Who else on the issue of either the recommendation or the particular point of how to use the funds?

MR. DURENBERGER: Just to restate a comment that I made the last time we covered this, if we're talking about access for beneficiaries to adequate Medicare services, I'd vote for an option that isn't up there, which is reduce it either to the empirical level or to 4.5 percent period. And then the rest of that money would get spent not on medical education but it would get spent on accessing beneficiaries to services.

And again, to restate the fact that Medicare is the only third-party payer, public or private, that is contributing except Medicaid -- not even Medicaid, I guess -- contributing to medical education. And that at a time when we are reducing payments in general, my preference I stated. And so I would support the draft recommendation.

DR. KANE: I just wanted to weigh in for having any reduction go to the base rate because the way the non-teaching hospitals make up for this is by raising their charges to the private sector. And we're just making the affordability problem worse. And it shows up actually a little bit in your hospitals with the low margins trying to cost shift, as well.

So I think there are broad social goals and yes, it would be nice to have the right residency trainings.

But I think the way to do the residency training incentives is really to make the payment system more accurate, create the incentives for people to go into primary care and into geriatric care because there's an income stream there that's attractive. Right now all of the innovation in the world isn't going to get what we want if we can't create the accuracy in the payment system to

attract people into the residencies that we want.

So I would vote for trying to stop the non-teaching hospitals from taking their losses on Medicare and putting them into the private sector and making insurance that much less affordable in the private sector.

Actually, I have one other question. And that is there is a different coefficient empirical level for major academic health centers versus minor teaching hospitals. And I notice no one's mentioned that.

But it's a fairly significant difference. I think we should be discussing that as well, whether there should be an adjustment differentially for the academic health center, the major ones that have a much higher -- a 2.6 versus a 1.5 empirical rate for the cost impact of teaching.

So I would rather that we went after some of those differentials than an across-the-board reduction.

DR. REISCHAUER: I just want to know where you're going to put the money Nancy?

DR. KANE: Back into the base rate.

MR. HACKBARTH: On using the money to achieve changes in medical education, there's a lot of that that I find appealing, although it seems like if you really believe

it, to link it to this almost diminishes it. And say well, what we ought to do is 1 percent worth as opposed to a broader effort.

I think this is what Bob was suggesting. If you really believe that we need to affect those changes in the types of physicians we're training and what they learn, why link it to this? Why not take that on as a separate initiative in its own right and appropriately fund it or appropriately apply leverage to it?

It's the connection that seems weak. The connection that seems most logical to me is either the base rates or pay-for-performance. And that's not to diminish the significance of the medical education points. It just doesn't seem like the logical nexus is as strong to me.

DR. REISCHAUER: Why shouldn't it be tied into the GME payment, as opposed to the IME?

MR. HACKBARTH: Right.

MS. BEHROOZI: To the extent that there are people in Congress or wherever who think that it's really about the accountability factor -- I mean, that's a factor that we've talked about here a lot, that that's one of the problems with the above the empirical value portion of the IME. I

guess that's where there's some attraction to tying it to the type of medical education. Then you address accountability. Maybe redistribution is harder to achieve.

So I think it's worth keeping that in the mix.

MR. HACKBARTH: That's, to me, also part of the rationale for pay-for-performance. There you're putting it into an accountability fund. Teaching hospitals or other hospitals that achieve at high levels would be eligible to get the money.

MS. BEHROOZI: I agree, but then you'd have more redistribution, in terms of being able to address each of the concerns separately. I agree that pay-for-performance is absolutely a valid use of the money, as well.

MR. HACKBARTH: We're going to need to leave this particular topic in just a minute. The last word on this one, Jennie.

MS. HANSEN: I thought that since I've been certainly one of the ones who has brought up the whole aspect of accountability for the IME, I too have thought about and talked actually with Glenn about the GME side of this.

But I just know that the idea of having a separate

pocket to address this big issue, because it is about the reimbursement. So if the primary care isn't getting reimbursed or the geriatricians, there isn't the endpoint incentive to go into it even if you have the education.

As I guess my statement is that I just would like to figure out how to put a perimeter around all of this because it does fall in different pockets and it is about the workforce in the future with process innovation and using that to achieve the pay-for-performance.

So if I were to weigh in on those three options, I probably would use the more generic pay-for-performance on it over the other, even though I know I've expressed strong feelings about the educational accountability.

MR. HACKBARTH: So let's, for a moment, set aside the IME recommendation and go back to the broader topic of the hospital updates.

Comments or questions on that?

DR. REISCHAUER: I have a question for Craig on this analysis of hospitals with consistently high and low margins.

I'm just wondering what fraction of the beds in America are we talking about here in these two categories?

And are we placing too much emphasis on this? You have to be high or low, in the top or bottom third, four years consistently. And then I'm looking and I'm seeing that one is, on average, seven miles away from another hospital and another is 12. And I'm thinking none of these could be in the core areas of any major metropolitan area.

So we're talking about not, I think, what many people here are thinking about in the way of hospitals; right? Ex-urban, semi-rural kind of hospitals.

MR. LISK: There's a distribution around here, so this is the median -- we're showing you the median values. So you're seeing kind of the distribution is a little bit different. So they are in the different locations in terms of --

DR. REISCHAUER: What fraction of the beds --

MR. LISK: -- we haven't looked at the core --

DR. REISCHAUER: What fraction of the beds would be in the consistently high or the consistently low?

MR. LISK: I'd have to get back to you.

DR. REISCHAUER: We count hospitals, but...

MR. LISK: There's not really any disparity for this group on terms of number of beds that it has, I don't

think, but I can get back to you folks on this.

MR. MULLER: You said it was 18 percent of the hospitals?

MR. LISK: 18 percent in each of these groups.

MR. MULLER: That's out of the 4,000? This is after the critical access; right?

MR. LISK: No, critical access hospitals are not in here.

MR. MULLER: So it's a 3,800 number, 18 percent of that twice is one-third of that?

MR. ASHBY: Out of 3,400 that we have now --

MR. MULLER: So one-third of that. So about 1,100. And then the question is how big are they, compared to -- I had the same sense that Bob did --

DR. REISCHAUER: It's not a third. You have to be in it every year, in the bottom third or the top third. So some would fall out.

MR. MULLER: What's the 18 percent then?

MR. LISK: 18 percent of hospitals are consistently in the bottom third or consistently in the top third.

MS. DePARLE: The market basket that we're looking

at here, what cost report is it based on? Is it 2003 or 2002?

MR. ASHBY: The market basket doesn't really come from the cost report. The market basket is a separate phenomenon.

In which area are you talking about?

MS. DePARLE: I guess I just mean the cost report data. Which year are you using for that, for the hospitals?

MR. ASHBY: The basic information we presented was 2005 and then we projected to 2007, a two-year projection.

MS. DePARLE: I had the impression that the data that we were using was very lagged when it came to understanding hospitals' costs and incorporating new technology and innovation. So do you think that the data that you have adequately captures the expenses they have?

Because I think some of the charts you showed would have indicated that those costs are rising.

MR. ASHBY: One of the key things to remember is that the technology is in the base. So our 2005 information by all means represents the cost of all technologies that are applied to acute inpatient care and it includes the payments for new tech, approved new technologies in that

year, which came out to about two-tenths of a percent that year.

Now it varies from year to year because technologies come in and out but it, by all means, does respect the cost of technology

MS. DePARLE: There is an issue though, isn't there, with weighting of it? Because I had the impression that some of the newer things are probably underweighted just because of the lagging of the data.

MR. ASHBY: You're speaking of the market basket right?

MS. DePARLE: Yes.

MR. ASHBY: Yes, the market basket weights are fixed for five years. It's a statistical concept, a fixed weight market basket.

We've looked at that in the past, though, and found that reweighting more often than five years would have a very, very small effect. And in fact, CMS did an analysis of that and put it in the rule last year. They moved from five to four years as they were required to do so and it made very little difference.

MS. DePARLE: I guess what I'm struggling with,

Glenn, is whether or not our recommendation adequately takes into account the costs that hospitals are truly incurring, the concern that some of this data may be lagged, and that they are bearing the brunt of incorporating new technologies without really being -- you know, we're making a recommendation for a year from now based on data that, I think, probably doesn't reflect some of these new technologies.

I think MedPAC used to specifically account for technology in its recommendation and we quit doing that.

MR. HACKBARTH: And one of the reasons for doing that is Congress made a series of changes that basically liberalized payment for new technology both on an inpatient and outpatient basis.

And so thinking of it as an add-on, if you will, in the update seemed to be overtaken by events when Congress adopted a different approach to encouraging new technology, which was special payment adjustment.

MS. DePARLE: Yes, although I think one could argue about whether -- with respect to certain things, yes, I think there has been some liberalization really by CMS. I don't know that I think that the new technology add-ons on

the inpatient side have had that kind of an impact. Outpatient, at the beginning I think maybe it did but I'm not sure it does on the inpatient.

But at any rate, I'm not sure that we adequately take that into account. And therefore, we recommend market basket minus one-half of productivity factor. And I guess now is as good a time as any to discuss why we say one-half of the productivity factor.

MR. HACKBARTH: Before we turn to that, it might be helpful, Jack, for all of us if you would briefly describe the payment policy changes directed at new technology in recent years.

MR. ASHBY: The new tech payment, there's an approval process where technology has to be major. It has to have a major cost effect, if you will. It has to be what amounts to a quality improving technology. And they are approved on an annual basis so there are new ones coming in and old ones coming out each year.

But for each approved technology there is a unit payment paid in addition to the basic DRG rate, and it is not budget control. This is additional money that comes in.

MS. DePARLE: How many of those have there been?

MR. ASHBY: I believe that this year there are two and the number varies from year to year.

MS. DePARLE: My understanding is it's been a very small number. Now that may be appropriate. I don't have that granular knowledge. And it also may be what Congress intended. But by sense is that it does not fully account for the cost of those new technologies, both because it's a pretty difficult filter to get through by design; and secondly because I think some of the data is lagged.

DR. REISCHAUER: The market basket is basically an estimate of what input prices will change over the year. So what you're talking about is really a level issue, the level upon which this inflationary adjustment is imposed is wrong. The year-to-year change in technology would be infinitesimal change, in a sense, in the level for this.

So if there is a problem like this, this isn't, I think, the place in which you should go to try and fix it.

MS. DePARLE: I disagree a little bit because it's my understanding it's based on -- and I think I said this the wrong way but it is based on 2002 cost reports. So that is not just year-to-year, that's four years.

DR. MILLER: 2005.

MR. ASHBY: What is based on 2002?

MS. DePARLE: The market basket.

MR. ASHBY: The market basket weights you're speaking of.

MS. DePARLE: The weights, yes.

DR. REISCHAUER: The weights of it. It's like the Consumer Price Index, you have the weight for food, for clothing, whatever. And then you apply expected increases in the price of those, adjusting for quality improvement.

MR. LISK: In that last point that Bob said, adjusting for quality improvement, it's holding the same set of products constant. So the market basket has never been intended to measure changes in product. It's holding product constant. It does reflect changes to the input prices over time, every single time. If pharmaceuticals are going up at twice the other things, the pharmaceutical weight is automatically rising. But if you're having certain pharmaceuticals that are costing twice as much, the market basket -- that are new, the market basket doesn't reflect that type of change.

MS. HANSEN: Mine is actually a question on the aspect of technology, not just individual devices but the

whole cost of the information systems. Is that built into this formula as kind of part of the average?

MR. ASHBY: Information systems are not included in the new technologies for which we make specific payments. Of course, the thought is that over time they will have a return in improved quality and decreased costs and hopefully will, in essence, pay for themselves.

MS. HANSEN: Actually then that does segue. Does that still fall under capital? Or is capital really bricks and mortar?

MR. ASHBY: No, those would be capital expenditures, as well. The cost of them are paid for as any other capital item would be.

DR. REISCHAUER: To the extent technology would be in the market basket, you would hope that it wouldn't be, because its price per constant quality has been falling like a stone.

MR. MULLER: Not information technology.

DR. REISCHAUER: Overall.

MR. MULLER: Not in this area. The things that we've been urging in other discussions around electronic medical records, all the stuff that Arnie and Jay and John

and others have been talking about, that Leapfrog has been pushing in terms of order entry, those are very expensive tickets. The benefit is obviously to the general health.

DR. REISCHAUER: The question is they're very expensive, but what's the price next year? Is it cheaper than it was this year for a software of equal capability? And if it's like every other piece of software available, it's falling like a stone.

MR. MULLER: A lot of the costs have to do with reengineering. They are very expensive line items. I don't know if we're going to get into this right now. It would be very hard to say the cost of these are going down. And the benefit of that doesn't necessary accrue to the hospitals' cost structure. It may accrue to the general health of the population, et cetera, and so forth. But I can assure you it's not going down.

DR. KANE: I just have a quick question. To what extent does recalibrating the DRGs based on costs now incorporate new technology? And how fast does new technology get put into the recalibrated weights?

MR. ASHBY: The weights are recalibrated every year and, by all means, they would reflect the cost of any

technology that was part of spending for the previous year.

DR. KANE: So one year.

MR. ASHBY: Yes. There's basically one year's lag in the process.

DR. BORMAN: I have two questions. One is in the productivity section we reiterate that the target is equal to the BLS, a multifactorial 10-year item. Do we have any separate analysis that would allow us to say in retrospect that the assumption that that is a good measure of health care industry productivity is correct?

MR. HACKBARTH: The productivity adjustment has never been an empirical adjustment or an estimate of change in hospital productivity, but rather a policy adjustment, an objective if you will, an expression for some of us at least that it's reasonable to expect that health care providers paid under Medicare will strive and achieve improvements in productivity much in the same way as the taxpayers who finance the program are under relentless pressure to improve their productivity.

So it is not an estimate.

Now more specifically to your question, obviously to the extent that actual productivity improvement lags,

costs will be higher than projected and it will ultimately be reflected in the margins. So margins, if we're consistently off on that and the hospitals are not achieving productivity gains, our costs will be higher. And as we look back, we'll see actual margins are less than we might have projected for that year.

DR. BORMAN: I think the other piece potentially being -- I understand the linkage to the mechanism of funding, and sort of the philosophic piece of that. I guess the other implication could be that, in fact, even the productivity gains are higher. But obviously, the margins provide the answer to the question over the long-term.

My other question would be in looking at -- you've made a very convincing set of arguments about the access to capital and the boom that does appear to be going on.

Is there any reason to believe that that capital access is better or worse for the IME or DSH hospitals, particularly the major teaching hospitals? I think it would go a little bit like this, in that we have both operating and capital adjustment. And if everybody can get to capital, then maybe the capital adjustment is a piece of what's less equitable, malaligned or whatever it may be, as

opposed to perhaps the operating. Do we have any information that would speak to that?

MR. ASHBY: The short answer is that we don't have any information that would speak to that. I'm not aware of a breakdown in the literature that we follow out of Wall Street that way. And of course, they are by and large not responding only to the Medicare situation anyway. They are responding to the broader picture.

MR. HACKBARTH: Just to leap into the queue here, and to pick up on Karen's initial question, the big question in the room this year and every other year is what is Medicare's role in setting payments? One view of that might be what we want to do is set payments so that we properly account for new technology and accurately account for real productivity gains, not policy adjustment factors, that we accurately track increases in hospital costs. And ultimately the goal is to stabilize margins or hit some target margin or be within some range of margins. That's sort of one general mindset about this.

Another very different approach is to say Medicare has some serious long-term financing issues. As a society we've got big issues with health care costs. And not only

what it means in the budgetary sense but what it means in a real-world sense for workers paying payroll taxes into the system who are not necessarily getting increases in their compensation that anywhere near match the increase in their health care costs. Workers are losing their jobs.

And if you adopt that view, the objective for Medicare, and private payers as well, is not to track the increase in hospital costs but to change the cost trend and continue to apply pressure as long as is necessary to induce change in the trend.

So there are two very different mindsets that one might bring to the table on this.

When I first came to MedPAC six years ago, more than six years ago now, I think the first was predominant. That we had a pretty detailed, some would say arcane, approach for trying to calculate all of these different adjustments that you would make off of a market basket to try to get as precise as possible, new technology add-ons and deletions for this and that, to try to track what hospital costs were and the pressures they faced.

As the years have gone by, I've undergone my own personal migration here, and I'm probably moving more

towards the second view. Maybe that's because we're now six years closer to the retirement of the baby boom generation and all of these -- and me, right, my retirement. All of these things somehow seem much more immediate than they felt six years ago.

So at the end of the day that's the real debate not just for us but for Congress, which of those things are you about? Are you about accommodating cost increases or changing cost trends. That's just an observation of my five year or six year experience.

DR. CROSSON: Now you've got me thinking that I'm three years from being a beneficiary, so I'm not sure about my question.

What I was going to ask what is, I think, on the same topic, because I've been asked this question myself. I think I heard it in the point that what happens if, in creating the market basket, we really miss the technology piece? But the more fundamental question is that when we are talking about market basket here and whether we should be at it, above it or below it, we're talking about a projected market basket. And so we're now talking about the payments in 2008.

And if, in fact, at the end of 2008 the actual market basket turns out to have been different is that something that we learn about, consider or should consider in terms of thinking about subsequent updates? At least I don't think I've heard that in our previous deliberations.

DR. MILLER: I think part of that answer goes back to some of the other discussion on productivity. What you end up with in the margin is if the performance of the hospitals, for whatever sets of reasons, because the cost was estimated wrong, because some new technology hit it that somebody didn't anticipate two years later, or because the market basket estimate was wrong, then our margins are going to generally look worse and we're going to drive our decisions off of that. I think that's at least part of the answer.

DR. CROSSON: So if markets are deteriorated, it's become a proxy to that.

MR. HACKBARTH: If I remember correctly, Jack, we used to have a correction for forecast error as one of the many adjustments in the update framework.

MR. ASHBY: Yes, at ProPAC they used to consider forecast area in developing their recommendation.

DR. CASTELLANOS: My comment was a comment about 10 minutes ago and it's about to Bob's answer about the cost of IT.

I can tell you in the physician's office, we had hoped that that was going to be, it was going to go down. But we waited and waited and waited and it went up and up and up. I can tell you the costs in a physician's office for IT and EMR is still going up.

DR. WOLTER: I do also worry a little bit about the technology issue, I will say. I think this is expensive. It's kind of a long-term implementation and the operating expenses, in addition to the initial capital expense, are significant. And I think the productivity return from it, there's a gap between implementation and when that productivity return occurs.

Some of the productivity return is initially in lower paying positions, certainly. And so I think there's something about all of that that we ought to at least recognize, whether it's the right thing to do a different approach to technology adjustment I guess can be debated. But I don't think the current system is maybe capturing what some people believe is really an important issue in health

care. And there may be significant barriers to some institutions in adopting technology solutions as well.

So I think that's a reasonable concern at least to raise.

I'm also personally a little bit concerned about the productivity adjustment. I understand the philosophy certainly. This year it jumped up quite a bit from previous years also, even though it's a rolling 10-year average. I worry about an industry that is so labor dependent, and in some states even legislative staffing ratios and those sorts of things. Having said that, I understand the philosophical commitment to it but I do worry about it.

And then I wanted to say I really was fascinated by the analysis of the top one-third hospitals and the bottom one-third margins. I guess one lesson from that is it's nice to live in a market where you have a nice private payer mix, which would be obvious. But it does leave other institutions under a fair amount of pressure.

I guess when I see that after we exclude the top one-third cost hospitals, which is 20 percent of hospitals I think you said, we still have margins down around zero. If there was a year when you might argue for a full market

basket update, this would certainly be one, at least based on the data, recognizing that the sustainability issues and the cost issues remain significant.

MR. HACKBARTH: One quick point about the technology issue, as I'm sure is evident to people, I'm a believer in clinical information technology. I think it's critically important. When I ran a group we invested heavily in it because we believed in it.

Having said all of that, a higher update is a very crude tool for promoting that since people will get the update regardless of whether they choose to invest in the clinical information technology or not. They can just as well use the funds to go out and buy another scanner which will have maybe an even more attractive return on investment.

And so I agree with the goal. I'm not sure that this is the appropriate policy tool to advance the goal.

MR. MULLER: This morning we had the Hackbarth-Hayes theory on SGR and this afternoon we have the Hackbarth simplicity theorem on how to look at these margins.

I think all of us have evolved in bit in terms of how to think about payment updates, obviously from where we

were a number of years ago where we looked at payment adequacy and we kind of massaged that, perhaps endlessly.

It seems to me we've moved now towards these categories of the hospitals -- I want to call them worthy and unworthy -- but the ones that have the higher and lower margins and there seems to be some characteristics of the ones that are performing less well.

I think if we're going to keep going in that direction we need to put a little bit more flash on the description of those kind of hospitals. We can all kind guess based on mileage or size and so forth as to what they might be.

With so many critical access hospitals now, up to 1,300, it seems to me we've taken a whole segment of hospitals that many people are worried about and have kind of put them in a more protected status.

So the question is really what is left here, the ones that are lower performing. I think intuitively if hospitals have low occupancy and have higher cost increases than others, one tends to think perhaps they're not either managing as well or they have less fortunate circumstances and so forth. But I think we need to flesh it out a little

bit more. I'm not saying we're going to do this by next month. But if we're going to go in that direction, as opposed to the where we used to be on payment adequacy, I think we need to get a better sense of what they are.

I think the projected margin that we're looking at for next year is going down another basically minus 2 percent; is that correct?

So to have a 2 percent drop in the margins to negative 5.4, it starts getting to be a serious number. And I think, like Glenn I haven't been on the Commission as long, but it strikes me that's the biggest drop we've projected in all those years, in terms of year-to-year drop in projected margin.

So I, like the other Commissioners, are very sensitive to the taxpayer and the overall sustainability of the program but I think I would want to note that this is probably the biggest drop, if I'm accurate in that, that we've projected in all of these years, in terms of a margin.

To just say that there are some hospitals that have less occupancy and higher cost curves, and that's what it is, if we're going to come to that conclusion I would like to flesh it out a little bit more and say that's what

it is, as opposed to just kind of inferring at that.

I do think the point I tried to make earlier about information technology -- and this builds also on what Nancy-Ann was raising earlier -- a lot of technology investments that happen in our siloed system, the benefits of it get reaped elsewhere. They get reaped either by the taxpayer, they get reaped by health plans, they get reaped by beneficiaries. Those are good things. But they are incurred at a hospital level.

So I agree with Bob that while in general maybe iPods and desktops are getting cheaper, but information technology in hospitals is by no means getting cheaper. The drug prices are still what they are.

And so we do capture it a year or two later, but given that this Commission has been on record over the last few years of really encouraging investments in information technology, that benefit the general health system, I think we should be sensitive and try to get a better estimate as to what that really is doing to the cost.

If it's a trivial number, then we should say it's a trivial number and it doesn't make that big a difference. If it's a more substantial number, as I suspect it is, then

I think we should try to get a better handle on that rather than just saying it's a small number and get caught up in the cost curve two years later and then recapture it.

Because we are really asking now, especially in light of -- whether it's what CMS is asking, whether it's the Leapfrogs and the British Excellence Programs are asking, there's more than 100 reporting systems out there right now that are asking hospitals. An awful lot of what they're asking us to do is make major investments in information technology so that we can do both the process measures and the outcome measures the people all want to do as part of pay-for-performance.

So I would say there is a heightened expectation of investments in technology that we're down to the benefit of the health system. I think that's a very substantial number that we're being asked to bear, and I think we should probably not guess at it and try to get a better estimate of what that might be, especially if it lags a number of years.

It may just be that maybe teaching hospitals and the critical access hospitals can afford to do it and nobody else can. I would think in general we would want to have hospitals be able to make those kind of investments in

information technology.

MR. HACKBARTH: As I say, I agree with the importance of the investment. The issue, to me, is the best way to reward appropriate investment. As this Commission has discussed in the past, I think a better approach, as opposed to a higher update, is the avenue of pay-for-performance. Let's create a return on investment for improvements in quality and efficiency, for which investment in clinical IT may be a tool. And let's create an incentive that's targeted to the results as opposed to updates for everybody.

MR. MULLER: Can I go back to where I started history this thing about a half hour ago. Your recommendation was increasing base rates. Then why don't you put it into pay-for-performance?

MR. HACKBARTH: As I said in my response to that, I can see the argument for pay-for-performance. The one that I stretch most with is the medical education one. So I could easily switch to the pay-for-performance use of the dollars.

MR. MULLER: That's why I preferred the way I ranked it, but still I see the pay-for-performance as a

clear second ranking.

DR. HOLTZ-EAKIN: One more time with the economists on technology, and that is these investments in technology are one-time expenses that are quite large. We know that. But if you wait one year, all the evidence is you will get a lot more for your money the next year. They are going down in cost, correctly adjusted for what these systems can do year by year. There's no evidence against that.

They are embedded in what we're doing because the margins include some allocation of the fixed costs, so they're built into the margins. And as they get embedded into the market basket, they're correctly caught there as well. It would be wonderful if we saw such a broad adoption of new technologies so that a year-to-year change in the market basket was dramatic and we're missing it. But that's not happening or we wouldn't be talking about incentivizing investments. So I don't think there's a big problem here in missing technology costs.

I do think it's worth just being realistic about the whole business of projections and margins and things like that, because it comes with the turf. We're going to

be wrong. You can't project anything using the data that are a year old two years out. It's part and parcel of the business, including projecting margins. So I don't think projecting a 2 percentage point drop in margins means that there's a 2 percentage point drop in margins. It tells you something about trajectories and not the actual outcomes.

With that in mind, when I look at what was put together here, I think it was a nice effort to use a bunch of indicators, a broad swath of indicators, about access which seems good, quality which seems to be not deteriorating or even improving. And in the industry where everyone wants to get in. That suggests things are in pretty good shape.

In those circumstances, you might want to ask why can't they do as well as the rest of the economy?

MR. MULLER: Total margins, because that's what's driving that, not the Medicare margin.

DR. REISCHAUER: Let me just try this one more time. What is the market basket trying to do? To do a hospital, you have some labor. You have some equipment. You have utilities. You have drugs. You have other inputs and IT. The market basket is asking to buy the same things

that you bought to do a hospital this year what will it cost next year? What percent increase will it cost?

It's not saying well, we should change this and expand our technology or improve the kind of care we give. It's saying to produce the same thing we produced this year.

All of these things are objectives which I agree with you, but they're different from what this exercise is trying to do. That's all.

MR. MULLER: If that's the argument on the market basket, then in the question is what's in the underlying costs that get updated year-to-year and lagged and so forth? And if it's showing that those costs are now running at a minus 5 percent, that's telling you that it's not capturing all of those costs.

If you're saying that those costs -- I know with the economists lined up there, I'm going to be over my head pretty fast.

DR. REISCHAUER: It might be telling you that you're improving each year by providing a different kind of product in a different kind of way. Or it might be telling you you're becoming increasingly inefficient. It could be doing all sorts of things and you don't want to, in a sense,

reward people without knowing what it's telling you.

MR. HACKBARTH: Okay, having resolved that --

[Laughter.]

MR. HACKBARTH: We will have to move on and proceed to our next presentation, which is the first of a series on post-acute care. We're going to start with an overview of post-acute and then proceed to the individual types of facilities.

MS. CARTER: Medicare pays for post-acute care, that is services furnished by home health agencies, skilled nursing facilities, inpatient rehab facilities and long-term care hospitals using separate payment systems. The Commission has previously noted that these individual silos do not function as an integrated system in which a comment patient instrument is used to assess patient care needs and outcomes and where payments reflect the resource needs of patients and not the site of delivery.

While CMS envisions an integrated system, it is years away from implementing one. Several barriers inhibit the integration of the current systems, undermining the program's ability to purchase high-quality care in the least costly PAC setting. These include the lack of adequate

case-mix measurement, data on the care needs and outcomes of services furnished, evidence-based standards to identify which beneficiaries need how much post-acute care and the incentives for PAC providers to treat beneficiaries in the most appropriate setting.

These same barriers also limit our ability to understand differences in financial performance across providers. We do not know, for example, if low costs reflect efficiencies, patient selection or stinting on care. Within each PAC setting we have found considerable variation in Medicare margins across providers, with some performing consistently better than others.

Today I'm presenting work done to better understand these differences. We examined whether consistent financial performance, as measured by unit costs and Medicare margins, was related to resource use and cost growth. We examined each PAC setting separately and then compared our findings across the four settings. These analyses are similar to the ones done of the acute care hospital sector.

Within each PAC setting, we found that providers with consistently better financial performance used fewer

resources than other providers, had much lower unit costs and had slower cost growth. Now let me back up and walk through how we did this and the specific findings.

Because a provider's performance can vary from year to year, we examined consistent performance over multiple years as listed in the slide. We defined consistently low cost as having been in the bottom quartile of the cost distribution for each of the years studied. Consistently high cost providers were in the top quartile of the cost distribution each year.

Similarly, high and low margin providers were in the top and bottom quartile respectively of Medicare margins for each year in the study. All analyses were done using a cohort of providers with valid data for every year in the study

The costs were standardized for wages and case-mix, and we also adjusted the costs for long-term care hospitals for short stays. And in examining SNFs and home health agencies we looked at freestanding providers.

To assess if there were different patterns within each of the industries, we examined separately hospital-based and freestanding IRFs, hospitals within hospitals and

freestanding long-term care hospitals, and rural and urban SNFs and home health agencies. Generally, we did not see different patterns across these subgroups.

One way providers with consistently low costs -- and those are the ones in the yellow -- achieve their cost position was through their more sparing use of resources within the episode or discharge. On average, home health agencies with consistently higher costs provided 22 percent more visits per episode than low-cost agencies. Likewise stays at consistently high cost IRFs and long-term care hospitals were 22 and 9 percent longer respectively than their low cost counterparts.

We found a different result for SNFs. SNFs with consistently low costs had longer stays. This result is consistent with the incentives of their payment system, which pays on a per day basis. Longer stays increase a facility's Medicare margins and lower their unit cost by spreading their fixed costs over more days.

Looking at occupancy rates for the whole facility, consistently low cost IRFs and long-term care hospitals also had considerably higher occupancy rates compared to consistently high cost providers. For these two settings

the occupancy rates are driven by Medicare, which makes up about 70 percent of their days.

We did not see this pattern in SNFs. Low and high cost SNFs both had quite high occupancy rates. And here Medicare is a fairly small share, about 12 percent, of SNF days. Their occupancy rates are primarily driven by Medicaid.

We also looked at differences in margins for these providers. I want to remind you here that the groups of providers are very different from the groups that we typically report on. Here we're looking at providers with consistent unit cost performance over multiple years and the providers in these groups are a select group. For example, in the home health analysis the consistently high and low cost groups included about 250 facilities in each group. So the margins that you see here will not be the same as any of the margins we've presented in other analyses.

With that in mind, you can see that the differences in 2004 Medicare margins between providers with consistently low and high costs were considerable. While providers with consistently low costs had aggregate margins in the 20 to 30 percent range, providers with consistently

high costs had aggregate margins that were negative, sometimes quite negative. High cost IRFs had aggregate margin in 2004 of negative 16.3 percent.

As might be expected, we found similar relationships between Medicare margins and resource use. For example, consistently high-margin home health agencies, IRFs, and long-term care hospitals also used fewer resources within the episode or discharge.

Next we looked at unit costs for providers with consistent Medicare margins. We see that providers with consistently high Medicare margins had considerably lower unit costs. Unit costs for consistently high margins were generally half to two-thirds of the costs of consistently low margin providers. For example, SNFs with consistently high margins had daily costs of $199 compared with $320 for SNFs with consistently low margins.

We also looked at SNFs and their competitors. We compared the daily costs of SNFs with consistently high and low margins to the daily costs of SNFs with which they compete. We defined here competitors as within 15 miles of the references SNF. We found that consistently high-margin SNFs had daily costs that were 18 percent lower than their

competitors and, in contrast, we found that consistently low margin SNFs had daily costs that were 20 percent higher than their competitors.

We did not do this analysis for other providers. Many markets do not have multiple IRFs or long-term care hospitals in them, while home health agencies have more fluid markets because the care is furnished in the beneficiary's home.

Last, we looked in cost growth. Except for home health care, unit costs grew more slowly for providers with consistently high margins. For example, costs per discharge for IRFs with consistently high margins annually grew at one-third the rate of IRFs with consistently low margins. The difference in cost growth between consistently high and low margin long-term care hospitals was even larger, a 1 percent decline compared to a 7 percent increase. And even for home health agencies, the difference between agencies with consistently low and high Medicare margins was small. It was 1 percent.

In conclusion, in recent years PAC providers with consistently better financial performance had lower resource use, lower unit cost and generally slower cost growth.

Before concluding that low-cost providers are efficient, we need to know if they attained their financial performance without compromising quality of care or selecting certain types of patients.

Because of the limitations I outlined at the beginning, broad PAC reform that is favored by the Commission is years away. In the meanwhile, Medicare is likely to continue to pay for PAC services under the respective prospective payment systems. Within each setting then, the program must ensure that payments are adequate.

With that in mind we now are going to turn to the assessment of the adequacy of payments in each of the settings. Kathryn is going to start with SNFs.

MS. LINEHAN: In our March report, we will be making an update recommendation for skilled nursing facility services for fiscal year 2008, and I'm going to review the latest data on payment adequacy to inform your recommendation.

SNF spending grew 8 percent between 2004 and 2005. This was slightly lower than the average rate of growth of SNF spending between 2000 and 2005, which was 11 percent per year. But that growth was variable, and the variation

larger reflects a number payment changes, including several temporary payment add-ons that went into effect and some of which expired during that period.

Volume also contributed to spending changes during the period, and was also variable from year to year. During this period, volume grew as much as 14 percent between 2001 and 2002 and as little as 5 percent between 2003 and 2004.

Case-mix increase also contributed to spending growth, as I'll discuss just a bit later.

First, we'll look at the supply of facilities. Change in the overall supply of Medicare participating SNFs was nearly flat between 2005 and 2006, and it's been nearly flat since 2000. The most recent data show a net decrease of 0.1 percent facilities.

As in previous years, and as we discussed at last month's meeting, the number of hospital-based SNFs declined and the number of freestanding SNFs participating in the program increased since the implementation of the PPS. This means that the share of all SNFs that are freestanding has increased and they now make up 92 percent of all facilities.

Last month we presented information from site visits about hospital-based SNFs reasons for remaining in

the program given payment reductions under the PPS and consistently negative average margins for hospital-based SNFs which are minus 85 percent in 2005. We found that hospitals' decisions were generally a function of the SNFs role in carrying out their acute care mission, things like their ability to shorten the length of stay in acute care hospital. And for those that closed, they cited costs but also a more profitable alternative use of space.

Now turning to access, the latest IG study on access to SNFs found, based on interviews in 2004 with hospital discharge planners who oversee the placement of patients, that Medicare beneficiaries appear to have little or no delay in accessing SNF care, especially if they need rehabilitation therapy. 84 percent of discharge planners in their sample could place all Medicare beneficiaries who needed SNF care. This was a statistically significant increase from the share in 2000, the last time they did this study.

In addition, continued growth in the volume of SNF services, as I'll show you in a minute, suggest access to care for benes. Medicare patients are also considered financially attractive patients for nursing homes that

generally treat a largely Medicaid population.

However, beneficiaries with certain condition or needs may experience delays that mean they stay longer in the hospital. The IG also reported that Medicare patients were harder to place if they need IV antibiotics or expensive drugs, wound care, vent care or have certain behavior problems. Several of these services are non-therapy ancillary services long identified as costs for which the SNF payment system was not designed to allocate payments. These same services were also identified as high costs in our interviews with hospital-based SNFs.

Last year we showed you volume data through 2003. Looking at volume of services, we see that Medicare beneficiaries had 2.4 million SNF admissions in 2004, which is an increase of 1 percent, and the number of covered days increased 5 percent. The average length of stay has increased only two days between 2000 and 2004.

We hope to have 2005 data finalized for you in January. I ran the data for 2005 and found a pretty big increase, bigger than we've seen in past years, in the number of covered days between 2004 and 2005 and it made me a little nervous so I wanted to verify the result with CMS,

since we've used their data in the past to establish this time series.

But the latest data suggest that volume is growing, even without looking at the 2005 data.

While volume is growing, the volume of days has increased at different rates among case-mix groups, known as resource utilization groups or RUGs. Just a note here, you might wonder how I can have days for 2005 but not have it in the previous slide. This is from a different data source. This is from cost reports, so that's the explanation.

We see two changes related to case-mix in freestanding SNFs. First rehab RUGs make up a large and growing share of total Medicare days. Second, we see a greater share of rehab days in the two highest categories of RUGs, ultrahigh rehabilitation and very high rehabilitation, and reduction of the share of says in all the other groups. Together the ultra and very high rehab RUGs represent about 42 percent of SNF days in 2005. This is an increase of 14 percentage points from three years earlier.

As a result of these shifts toward a greater share of days and higher rehab case-mix groups, the average therapy case-mix has increased and the average nursing case-

mix has declined slightly among freestanding SNFs. Overall, the program still spends more on nursing than therapy, but a growing share of the program's skilled nursing dollars is going to therapy payments.

Now turning to quality, our two measures of SNF quality, discharge to the community and a composite of potentially avoidable rehospitalizations, show that between 2000 and 2004 quality has gone down. These measures are risk-adjusted facility rates and are measured within 100 days of admission to the SNF.

The decline in the average facility rate of community discharge between 2000 and 2004 means that slightly fewer beneficiaries were discharged from the SNF to their home, assisted living, or other non-institutional setting immediately following their SNF stay. But the decline seemed to have reversed just slightly in 2004.

The increase in the rate of potentially avoidable hospitalizations means that a greater share of benes are being rehospitalized from the SNF at some point during their stay for one of five conditions. We are pursuing additional research to get behind this trend and see, for example, if trends are different for different categories of facilities

or if they're related to facility characteristics.

Now looking at SNFs' access to capital, when we talk about access to capital for skilled nursing facilities we're really talking about nursing facilities that provide long-term care to most of their patients.

Evidence suggests that access to capital for this sector is good this year. For-profit chains report new acquisitions in construction financed by debt and private equity investors have been investing in this sector. The National Investment Center, a nonprofit that provides information about business strategy and capital formation for the senior living industry, reported that key financial and operational indicators showed continued strength in senior housing, including SNFs.

Loan volumes for all the sectors they track was highest in the second quarter of 2006 than any time since they began collecting the data in 1999 and loan performance has been strong.

Overall, the NIC reported this year that it's a good type to be a borrower in this sector but they were cautious moving forward because of interest rates, obsolescence of physical plants and some labor issues.

We spoke with industry analysts who reported that several factors are making this industry attractive to investors. Among these were SNFs being well positioned to be the beneficiaries of Medicare's efforts to rationalize the provision of post-acute care and provide such care in the lowest cost setting, increasing demand for short stay SNF care as a result of the aging population, and nursing facility properties have attracted investors who are interested in the real estate component of the nursing facility business.

They also noted that they've seen what they described as stability in the reimbursement environment including a RUG refinement that took place on January 1st, 2006. Some chain providers have reported faring better under RUG refinement than they had estimated and they're seeing increased Medicare payments under the new system as a result of shifting towards higher acuity cases.

They also noted improving state fiscal situations that mitigate the prospect of Medicaid rate cuts, although one note to this is the threat of the reduction in minimum provider taxes that flow back to nursing homes under Medicaid payment systems in several states.

Medicare payment is undoubtedly an important source of revenue for these providers and a factor in their access to capital, but Medicaid is the biggest payer of care in nursing facilities. The nursing facility industry has reported to the Commission that Medicaid rates are too low and has been arguing that the Commission should consider the total margin, including Medicaid, in our Medicare payment adequacy analysis. But the Commission has held that increasing the Medicare payment rate to subsidize Medicaid rates is an inefficient way to target subsidies.

Now we're going to look at financial performance. We see in fiscal year 2005 that the aggregate Medicare margin for freestanding SNFs was 13 percent. We continue to see some variation across facilities. Margins are much higher in for-profits than for nonprofits.

I just wanted to note that the margin for the small share of facilities in the government categories is difficult to interpret because of subsidies that may affect their incentives for efficiency, and therefore this might not be a good indicator of payment adequacy. But overall, based on the 2005 cost report data, we estimate that the 2007 aggregate Medicare margin for freestanding SNFs is 11

percent.

This estimated 2007 margin is the function of payment changes including a full market basket update in 2006 and 2007, changes due to RUG refinements, and the accompanying elimination of add-ons, plus a policy change that makes 70 percent of bad debt reimbursable for non-duals starting in 2006.

We also considered cost growth in recent years when modeling future costs. Cost growth, and this is unadjusted for case-mix for all freestanding SNFs accelerated from 2004 to 2005. But some of this is undoubtedly due to case-mix changes, as shown earlier. Cost growth has shown different trends in for-profit and nonprofit facilities between 2002 and 2005 with the rate of growth declining in nonprofits but increasing in for-profits.

In addition, based on Carol's analysis of the consistent cohort, average ancillary cost growth has been greater than routine cost growth, suggesting that facilities are spending more on rehabilitation services, which is also consistent with shifting case-mix towards higher intensity higher payment therapy case-mix groups.

So to summarize what you just heard, the number of facilities providing SNF care to Medicare benes remained almost constant between 2005 and 2006. Benes have good access to SNF care, although those who need certain services may experience delays. Volume increased modestly in 2004 as measured by SNF stays but days increased 5 percent. Data in 2005, that I didn't show you but I will show you next month, suggest a sizable increase in days.

Two outcome measures show facility rates of avoidable rehospitalizations increased and discharge to the community declined.

SNFs have good to access to capital and their Medicare margins are estimated to be 11 percent in 2007.

To start our discussion on the recommendation, last year we recommended no update to SNFs. This year it would decrease spending relative to current law but providers should be able to accommodate cost increases in the next year without an increase in the base rate for SNFs. And this should have no major implications for beneficiaries.

Before I turn it over for questions, I wanted to raise two topics that I touched on in the paper and that the

Commission has raised before.

Although RUG refinement increased payment for some patients with high non-therapy ancillary costs if they qualify for the new RUG, the payment system still does not allocate payment based on the need for non-therapy ancillary services. Consistent reports of differences in access for these patients suggest that facilities may select against these expensive patients or that facilities who treat these patients may be disadvantage. We're continuing to look at refinements to the case-mix system to improve this.

On a related note, the case-mix weights underlying the current system, as we noted, should be based on more current data, and CMS has undertaken the collection of these data for the first time since the implementation of the PPS.

And second, increasing use of therapy still adds another reason for measuring the value of these services, which the Commission has previously recommended measuring functional status at admission and discharge to assess whether patients' functional status is improving with this therapy.

As the Commission has previously recommended also, given the evidence of declining quality, the program may

want to consider improving data on nursing costs and staffing to facilitate evaluation of the relationship between nursing costs, staffing levels, turnover, experience and quality of care.

This concludes my presentation and I'll take your questions now.

DR. CASTELLANOS: Just a quick question. I see you have financial performance for freestanding and costs for freestanding. Do you have any data on hospital-based?

MS. LINEHAN: No, we don't have cost growth for hospital-based SNFs calculated separately. The margin for 2005 is minus 85 percent.

That's an improvement over last year. It was minus 87 percent.

DR. CASTELLANOS: Is there a reason why you don't have it?

MS. LINEHAN: This issue has a long history with the Commission.

DR. CASTELLANOS: We can talk about it later.

MR. HACKBARTH: The challenge in the hospitals, many hospitals have multiple lines of business, the inpatient care, the SNF care, home health agency, and so on.

And so there's a question about how you allocate costs across those different lines of business within a single enterprise.

Now there are cost allocation formulas used in the cost reports but we've had some reservations about how accurate those individual line of business numbers are. So actually, when we do the hospital update and look at the hospital financial performance, as we just did a few minutes ago, we're looking at the aggregated financial performance for all of the hospital-based lines of business, including the hospital-based SNF.

And so when we get to this particular group, to the skilled nursing facilities, here we're focusing on the freestanding as opposed to the hospital-based.

DR. KANE: On my page seven, which I think is also yours, on the quality measures, the rehospitalization, I would assume that means they go from the SNF to the hospital?

MS. LINEHAN: Yes.

DR. KANE: Did something change in the way Medicare pays for a bed that's occupied by someone in a SNF who gets moved back to the hospital? Did they started

paying to hold the bed? Because that would encourage rehospitalizations. And I know in some markets I've heard something like that.

MS. LINEHAN: I don't think Medicare has a bed hold policy. Medicaid does in some states. I can look into this, but I don't think so. I don't think Medicare has that kind of policy.

DR. KANE: I think it may have, in some markets because I think in Massachusetts we started seeing more --

MS. LINEHAN: I see what you're saying.

DR. KANE: I'm just wondering if there isn't something in the --

MS. LINEHAN: You're saying it's a state policy that applies to any facility, regardless of the payer?

DR. KANE: No, I thought it was a Medicare policy, so I'm not sure why it happened. But I know my group started seeing an increase in rehospitalizations because the nursing home is being paid to hold the bed, whereas in the past they weren't.

MS. DePARLE: I think it's Medicaid.

DR. KANE: This affects Evercare and Evercare is Medicare only.

MR. BERTKO: Evercare, I believe, is duals.

DR. KANE: No, they have Medicare.

MS. LINEHAN: I can little look into it and answer the question.

DR. MILLER: We can run this fact down.

MS. HANSEN: Thank you for the point about the continuity of care of staffing issues, because I think that would be an interesting aspect that I think you're planning to plumb.

My question is also then about the whole challenge of people who have more complex issues, such as IV therapy and other areas. I found that this issue was not only for the SNF, it was one of the other post-acute care access points, as well, it seemed.

MS. LINEHAN: I think Evan mentions that in the home health.

MS. HANSEN: But with that in mind, just how we deal with that -- because it seems like, of course, if you have a therapy diagnoses coding then you get in. It's just some of these areas that require more nursing skill, these kind of complex medical issues, which represent a fair number of patients I would imagine. So this brings to me

the question of access and payment.

MS. LINEHAN: In looking at some of our case-mix refinement work going forward, we're going to be dealing with this issue and hopefully have some kind of solution.

DR. SCANLON: Just to follow up Nancy, if it's Evercare, then as a Medicare Advantage plan they can choose to do this on their own and it would only be that particular instance, not a Medicare policy. Does that make sense?

DR. KANE: What they're finding is people don't sign up anymore for the Medicare SNP because of the fact that now they get the bed hold paid for by regular Medicare. But I'll get the details.

DR. SCANLON: I was going to say I think you gave us an incredible amount of information and leave us not in a gray area in terms of recommendations. It seems that things are pointing pretty much in one direction.

I would say, though, as we make comparisons here to other sectors, that we have to be careful because our data here reflect organizations that are in two businesses. One, the Medicare business, which is to provide care to people in a post-acute setting; and another which care is a part of their business but sort of residential environment

and long-term living is another part of that business. I don't think we have the data we to capture all of the things that might contribute to higher or lower costs for that other business.

It's kind of like if you think about single-family homes, and if the only thing you knew about single-family homes was they had three bedrooms it doesn't tell you much about why prices vary for those homes. I think that's our problem with skilled nursing facilities, is that they're really in this separate business which we've never ever really captured what's the cause of variation.

Fortunately, I say we're not in the gray area where we really need to worry about interpreting that.

MR. MULLER: This may be for Carol. Where you are showing the lower cost higher margin facilities, is that largely a function of occupancy, so therefore just by dividing fixed cost by high occupancy you get lower costs and therefore better margins?

MS. CARTER: It could be occupancy. We also looked at volume. And we also saw that low-cost facilities had higher volume. So it would probably be both of those things, which I suppose are different aspects of the same

phenomenon.

MR. MULLER: And a question, are we going to speak to the hospital-based SNFs at all? Is it just captured in this? I mean, at minus 85 you probably can't do too much to change that but are we going to speak to that at all?

MR. HACKBARTH: The chapter does discuss the research.

MR. MULLER: I meant in recommendation.

MR. HACKBARTH: We'll be more specific then.

MR. MULLER: I mean, we're saying that we're recommending zero update for SNFs, so I assume that applies to freestanding and hospital-based? Or not? What does that apply to?

MR. HACKBARTH: The zero update -- help me Mark, I'm getting confused. The zero update applies to the hospital-based SNFs.

DR. MILLER: That's correct.

MR. MULLER: Minus 85 is overwhelming so we figured we won't deal with it? It can't be all cost allocation.

MR. HACKBARTH: Probably not.

The reason I'm hesitating, Ralph, is my mind is

working slowly and I'm trying to access the file that has our discussion on this last year where we had, as I recall, quite a bit of discussion about the idea of a separate update for hospital-based SNFs.

MS. DePARLE: I thought we did that.

MR. HACKBARTH: We did a number of years ago and you'll be able to correct me, Mark, in just a minute. We did several years ago, maybe even four years ago now, actually recommend a separate update for hospital-based SNFs. We have not repeated that recommendation since.

The last couple of years we've tried to do some research understanding the dynamics of hospital-based SNFs, why people go into the business, why they exit from the business and so on. The piece that I can't remember, Mark, is exactly why we decided not to resurrect, if you will, the separate update last year. We talked about a lot.

DR. MILLER: There's a couple of, I think, three things to keep on track here, and Kathryn help me out.

We had some of these conversations, and there is the allocation issue, which I know is not completely satisfactory. There was sort of a pushing and pulling on that. There was also, we couldn't quite determine whether

these hospital-based facilities were treating really different patients that might explain some of that difference.

So we have three things that we set in motion to start to try and answer that question. The first was the research that was reported out -- I want to say in the last meeting or the meeting before, maybe it was the last meeting -- in the last meeting, which then talked about this two or three different models that people could pursue in hospital-based SNFs. Explicitly, at least one of those models was it was viewed as a way to make the hospital operation more efficient. There were a couple of other models that I'm sure Kathryn could detail.

A couple of other things that we have going on is Kathryn has a bunch of work, which she just referred to in response to Jennie's question, going on on further refinements in the SNF case-mix system because we also think that there are certain costs that are not being covered well -- and this is were I want to be careful -- which may impact this issue that we're talking about here.

MS. LINEHAN: Some of the work that's been done previously showed that hospital-based SNFs

disproportionately treat patients with high cost care needs that the payment system doesn't reimburse well.

DR. MILLER: Is that the non-therapy --

MS. LINEHAN: Yes.

DR. MILLER: So we're taking a look at that to see if that may be part of it.

And then also another analysis that we're trying to get ginned up in the midst of everything else that's going on is looking at their margins, their indirect margins.

MR. MULLER: Maybe sometimes they take care of patients that nobody else will care and there's not the supply. I just find it difficult to say that in between cost allocation on the one side or saying that the hospitals do it because it allows them to open beds for acute care -- it just makes it difficult for me to explain 85 percent that way.

I think sometimes you have to do it because you can't get anybody else to take care of the patients. And therefore, if that's the case, then it would be interesting to see what kind of evidence we have towards that. If there's evidence of lack of supply of other freestanding SNF

sin the area where the margins -- like we did on the hospitals just now, are there other freestanding SNFs around there and so forth, then there might be some indirect evidence of that. Because if there's no place else to put them -- and I've had my own experience of that -- then you just have to do it as a way of protecting your patients because you have no place else you can put them.

DR. REISCHAUER: Can I just ask whether the RUG-III adjustments were thought to disproportionately help hospital-based SNFs?

MS. LINEHAN: In the impact analysis that CMS did with the proposed rule, it did disproportionately help hospital-based SNFs. But not enough to overcome a margin that negative.

DR. MILSTEIN: In forming an opinion about this, if it hasn't been done it would be very helpful the next time we discuss this to have some perspective in this comparison of low cost and high cost, in this case, SNFs, whether when segregated that way there's any systematic difference between the two groups with respect to either -- I guess you'd call it rehab creep because there certainly seem to be a very major move in that direction -- and our

two quality of care measures.

Coming up with a more rather than a less stringent recommendation update, for me, would partly depend on feeling reassured that the low-cost operators were not achieving their low cost through either rehab creep or reductions in either of the two quality of care measures that you brought to bear.

Maybe you already know the answer to that and, if so, it would be helpful to know that now.

MS. LINEHAN: I don't know the answer but we're looking at that question. We're looking at a lot of differences in these quality measures by facility characteristic and cost growth is one of them.

DR. MILLER: The only thing I was going to say is that what gets complicated in these situations is being able to truly adjust for differences in the mix of patients. And Kathryn says all of the time when we have these conversations internally, you have a case-mix adjustment system for SNFs but it's too gross to capture what we think are the actual differences of patients who might be going -- hospital-based, freestanding, but even just from facility to facility if you're trying to measure.

So we are doing this work but it's not as straightforward as oh, you just drop the case-mix adjuster in there and then you've got it. It's a little more complex than that.

That's all fair; correct?

MS. LINEHAN: The same thing that makes pricing in this sector difficult, having a good case-mix system makes adjusting for case-mix in any analysis difficult.

MR. HACKBARTH: Any other comments or questions on SNFs?

Okay, thank you.

Next is home health.

MR. CHRISTMAN: Good afternoon.

Next, we're going to go through the most recent data on home health as it relates to the Commission's update framework.

Before we begin, I just wanted to remind everyone that this work includes important contributions from Sharon Cheng here and Sarah Friedman.

The first issue we're going to turn to is access. For access to care we asked two questions. Do communities have providers? And are beneficiaries getting care? This

map provides a graphical answer to the first question. It shows how many providers operate in each ZIP code inhabited by a Medicare beneficiary in 2005.

As you can see, most beneficiaries have at least one provider and many have two or more. 99 percent of beneficiaries lived in a ZIP code with only one provider and 97 percent lived in a ZIP code with two or more. This map generally suggests that access to care in most areas is adequate and in many areas beneficiaries have access to multiple providers.

In addition to this map, we can look at surveys of beneficiaries to measure their access to care more directly.

A quick review of two surveys suggests that access to care is generally adequate. Last year we shared data from the 2004 CAHPS survey with the Commission. This data showed that about 90 percent of beneficiaries that needed home health had little or no difficulty accessing it. And then another review of access was conducted by the IG in 2004. As a part of their study, they surveyed discharge planners and 79 percent of discharge planners reported that they could place all of their beneficiaries that needed home health in a typical month. We would note that this is a

decrease relative to the 2003 number, where that IG found that 89 percent could be placed in a typical month but still pretty high at 79 percent.

Next, we're going to take a look at the supply of providers. The table on this slide shows that the number of agencies in Medicare continues to grow. It's still below the 1997 peak of 10,900 agencies, but it's been growing rapidly in recent years. Most of the new agencies, about 90 percent, are for-profit. Though the growth is robust, we'd also note that it's pretty concentrated. About 70 percent of the new agencies are in Florida and Texas and, in contrast, many states have seen little or no growth. For example, since 2002 41 states have seen a net gain of 10 or fewer providers or a decrease. These growth numbers generally also suggest to us that home health agencies have good access to capital for expansion.

In our next section we'll review trends in utilization and intensity. This table displays the recent trends in episodes per user and visits. I think it's similar to what you've seen in recent years. For the first three measures -- episodes, users and episodes per user -- they continue to increase. And the exception to the upward

trend has been visits per episode, which has been slightly decreasing since 2002. and we see that trend here between 2004 and 2005. This suggests to us that home health agencies have been able to control costs and reduce the number of visits they provide even as volume has increased.

Next we're going to take a look at quality.

This table shows risk-adjusted quality measures for the home health benefit. And with a few notable exceptions, the table shows that the quality trends have gradually improved.

For the first five measures, the yellow lines, those are measures of a beneficiary's functioning. What you can see is that year-over-year the number of beneficiaries who showed some improvement on that measure of function at the end of their episode of home health has increased. If you look at the two lines at the bottom, the blue lines, those measure rates of adverse events, hospital readmissions and unplanned ER use. You can see that those lines are straight. They have not declined. The rate of hospital readmission and unplanned ER use has not fallen, even as the other measures we've seen improvements on.

CMS is planning a quality initiative next year

with the home health area to address those two measures at the bottom and try and work with home health agencies to reduce the rate of readmission and unplanned ER use.

I'd also note really quickly that last year the Commission discussed process measures such as fall prevention to complement these measures in the future.

Next, we're going to take a look at financial performance. This table shows margins for different categories of providers. The top row shows the margins overall for the industry. For the freestanding providers in 2005 it was 16.7 percent.

I just want to note, it's important to remember that there is a lot of variation in the margins that providers experience and the second and third line shows some of that variation. The second row you can see that the home health agency at the 25th percentile in the distribution of margins had a margin of 2.3 percent, whereas the home health agency at the 75th percentile in the margin distribution had a margin of 27.2 percent.

If you look below, you'll see tables on geography and type of control and the trends there are unchanged from what you've seen in previous years. Under geography

agencies that served both urban and rural areas, referred to as mixed on this table, had the highest margins of 17.7 percent. And then the rural providers, they had the lowest margins. Those margins were 13.7 percent.

Under type of control, the story is the same to what we compared to previous years. The private providers, the for-profit providers, have the highest margins of 18.2 percent and the government providers have margin of 10.7 percent. These margin estimates are our starting point for estimating margins for 2007 and next I'm going to walking you through the changes to payments and costs.

For payments, the first two lines are the major changes for 2006. One is that the home health agencies were held at the 2005 rates for a year in 2006. They got no market basket update.

The second change in 2006 was there was a temporary add-on of 5 percent to every episode provided to a beneficiary who lives in a rural area, and that's in effect for one year, as well.

The key changes for the upcoming year are there's a new pay for reporting requirement. Medicare can reduce the market basket update of any agency that does not report

quality data in 2007 by 2 percentage points. However, CMS opted to use data that agencies are already required to submit to satisfy this requirement. So we expect that few, if any, providers will be affected by the reduction.

Also in 2007, home health agencies will receive a 3.3 percent market basket update.

The next section takes you through costs, and it's very similar to what we've shown you in recent years. The first line, cost growth again is 0.7 percent and that's consistent with what we found in previous years.

We would note that this is below the inflation suggested by the market basket in 2005, which was 3.1 percent. Again those two factors, it's very similar to what we've seen in previous years, where the cost per episode has been under 1 percent and the market basket inflation has been between 3 percent and 3.5 percent.

Really quickly, I just want to summarize what we've gone through. We found that access to care is generally good. Communities have providers. Quality is improving. More providers are entering the program. Volume is increasing. Cost growth is less than 1 percent. The home health agencies will get a full update in 2007. Based

on this information, we project that margins in 2007 will be 16.8 percent.

Next I want to show you a draft recommendation for 2008, and this is based on last year's recommendation.

The Congress should eliminate the update to payments for home health care services for calendar year 2008. The spending implications is this would decrease spending relative to current law. For beneficiary and provider implications, we don't think there would be a major impact.

Before I finish, I just want to outline a few future issues that we may be bringing. CMS is planning to issue a rule next year that will refine the case-mix and other aspects of the PPS. We plan to review this rule to see if it addresses the issues previously identified by the Commission.

Also, we note that the growth in the number of providers underscores that Medicare's rules for certifying new agencies are critical for safeguarding the interests of beneficiaries in the Medicare program. We plan to take a look at this issue as well to better understand the growth in the program.

That completes my presentation.

MS. DePARLE: Thanks. I'm interested in the data that you mentioned about the changes in the supply of agencies and wondered whether there have been some changes in the Medicaid law, I think, in the DRA that made it easier for states to -- or maybe required them to pay not just for nursing home care but for more home-based care. Is that part of what's driving the increase in home health agencies? I may not have it exactly right about what the change in policy or law was.

MR. CHRISTMAN: I don't know specifically. I'm aware of that change, but I don't know that we have any data that we can connect that to the change in the trend of providers. It's kind of hard to tell because a lot of states require Medicaid certification as a part Medicaid. So we can't tell.

The number of agencies that are Medicaid only agencies is very small, it's like 100. We can take a look at that.

MS. DePARLE: I'd be interested in knowing what the utilization is. I know this isn't exactly part of our job, but I'm kind of interested in whether the change in

Medicaid has had any affect on utilization of home health, what the trend is in Medicaid and whether that would be part of what's happening here.

And you said 70 percent of this new -- what's the number of new agencies?

MR. CHRISTMAN: The number of new agencies, I believe it's increased by about 1,700 since 2002. About 70 percent of those have been in Florida and Texas.

MS. DePARLE: It's interesting, because having been here before, these are the ones that left or we were never sure whether they left or they sold or closed down branches. It was always hard to get a handle on it. But it's interesting that those states and then Louisiana and Illinois.

DR. MILLER: When he told me, I had the same reaction, that it was the same states.

MS. DePARLE: Oklahoma was big, too. It's just interesting to note.

DR. SCANLON: Relating to this, in terms of my understanding of the DRA provision, it is to give states the option to offer home and community-based services not only through a waiver but as part of their regular program with

some more flexibility there.

The reality has been that the home and community-based, even though the waivers were required, has increased dramatically. There's about 900,000 people now being served through those waivers under Medicaid, compared to about 1.1 million being served in nursing homes.

Over 25 years, actually nursing home use overall, when you take into account the changing age-mix of the population and the number of elderly, has declined by about 30 percent, the utilization rate. So even though people still talk about institutional bias, there really has been an incredible rebalancing of how long-term care is financed by public programs.

MS. DePARLE: Is it your sense that those people are getting care from home health agencies or is it personal care attendants?

DR. SCANLON: I think the more typical model is the agency will be a home care agency, not necessarily a home health agency. Before we had the Medicare home health PPS, there was certainly the effort on the part of states to Medicare maximize. Dave's not here, but Minnesota had a law which they called the Medicare Maximization Law, and other

states had similar efforts either in law or through policy efforts on the part of their Medicaid programs.

DR. CASTELLANOS: Again, the naive question, I just see freestanding. I know there are hospital-based. You've got to understand, I'm new on the Commission and I don't have history.

MS. CHENG: As we mentioned during the SNF presentation, the situation is similar in this case as well. We look at the freestanding home health agencies as a model of the efficient provider because they don't have costs allocated to the hospital side of the house. And so we do use freestanding cost reports to make our estimate here.

So the similar caveat, we don't have the cost growth for hospital-based home health agencies, but the margin in 2005 for hospital-based home health agencies, our current estimate is that it's negative 1.5.

MR. HACKBARTH: In the respects that Sharon just mention, this is the same as the hospital-based SNF, but it seems to me that it's potentially different in an important respect. There is at least some reason to believe or fear that the hospital-based SNF patients might be different and we've got a problem with accuracy in payment.

I think there's less reason to believe that the hospital-based home health agency patients are different. In each case, we're talking about people who have been deemed ready to go home and they're being served by a provider. The only question is whether they're affiliate with a hospital or whether they're freestanding. So I think the risk that we've got a payment error mixed into this problem is somewhat less.

If hospital-based home health agencies simply have higher costs because of overhead or some other factor and freestanding agencies are systematically able to do it at a lower cost, you wouldn't want to increase Medicare payment to cover the cost of less a efficient provider.

But as I say, the hospital-based SNF issue is potentially a little bit different because we have this uncertainty about whether we're really comparing apples to apples.

DR. SCANLON: On this point, and I don't have facts to dispute what you just said, but let me set up a potential hypothetical, which is that given the problem in terms of the Medicare standards of what it takes to be a home health agency, you can imagine in some areas we have

very minimally qualified home health agencies. And you juxtapose that with the complex cases that some home health agencies deal with, particularly in terms of wound care, there would be a concern that people may end up back up in the hospital because there isn't an adequate home health agency to deal with them in a community.

I don't know to any degree what the extent of that problem might be.

MR. MULLER: I have some concern about, we have this long-running debate about the spreading of overheads, to all of a sudden call that -- therefore, they're less efficient providers. I mean, to go to that, I have some objection to that.

The fact is if there's overhead in these hospital-based home care or SNFs doesn't mean necessarily mean they're a less efficient provider. There's case-mix issues and so forth.

So I wouldn't want to necessarily want to immediately concede that the freestanding ones are the example of the more efficient provider.

MS. CHENG: With all the caveats about the strength of case-mix systems throughout these settings, we

have consistently over previous years compared to case-mix of home health patients in freestanding and in hospital-based agencies and we don't find substantial differences in the case-ix. So it does appear, at least from what we know about the assessment of the patient once they're admitted to home care, that they appear to be very similar patients.

DR. MILLER: I think the other point that you were making was what is it about running a home health agency out of a hospital versus a freestanding one that would inherently make the overhead costs higher? She may have used a shorthand by saying the word efficiency, but I think in this instance it is also a little bit different than what we were talking about a minute ago. And I think that's really the point that she was driving at, if I'm getting you right.

DR. WOLTER: My comments really are more aimed at rural. And on our map, at least in the West, why would there be fewer home health agencies in rural areas in the West than in certain other rural parts of the country? I don't know the answer to that.

I do know that the home health agencies in my state have pulled back a bit. There's a bit less service

than there had been in the past and they feel that it's very, very hard for them to travel the distances and that sort of thing that goes on in rural areas.

It does look like rural providers have been successful with these add-ons in Congress. So it might be worth our while to see in the future if we can learn a little bit more about why, in the Intermountain West, there does seem to be a little different pattern in terms of availability than there is elsewhere in the country.

MR. HACKBARTH: Although the piece of that geography that I know best, the Oregon/Northern California/Northern Nevada, that blue area where there's zero, there are very few people in those places either. It's very sparsely populated.

MR. MULLER: Montana is all blue and he's sensitive to that.

MR. HACKBARTH: I don't know about the other parts.

DR. WOLTER: I saw in one of the lists here that something like 12 percent of home health agencies are rural and I think more than 12 percent of the population is rural, if I recall. So there may be some patterns there worth

looking at. That's all.

MS. CHENG: One of the things that you have to try to keep in the back of your mind also, and with this map as well, one of the things that we can't capture when we do a head count of home health agencies is their capacity. It's been something that has bedeviled our understanding of this for a long time. But we don't know whether one agency is 10 times the size of another agency, and we do know that there's a wide variety of the size and the capability in terms of staff from agency to agency.

So we'll certainly try to get a better description but we're going to be a little limited by just our ability to quantify the capacity of home care.

DR. MILLER: To the point on the 12 percent is that you're referring from this table here. The other thing here is that there's 25 percent who are mixed who, if I understand, they serve both urban and rural; right?

MS. CHENG: Right.

DR. MILLER: So I don't know that 12 is quite the -- it's the rural only number. But I don't know that that means that's all that's serving rural areas.

MS. CHENG: No, all of the agencies in the mixed

category serve some rural beneficiaries.

MR. HACKBARTH: The other take we have on this issue is the beneficiary survey, where we ask beneficiaries in rural areas -- now admittedly, it's a sample and it's not covering every part of that map. But the beneficiary reports in rural areas are that they do have access. And as I recall, I think even higher access from a beneficiary perception standpoint than urban beneficiaries. Is that right; Sharon or Evan?

MR. CHRISTMAN: That's right. I think it was in the mailing materials. According to the 2004 CAHPS data, 84 percent of rural beneficiaries had no issue with access, compared to 77 in urban. And then we also mentioned the IG survey, and they also in their work did not find any significant differences between urban and rural access.

MR. HACKBARTH: Undoubtedly there are some issues in some places, and quite possibly in the West. But in terms of the bigger picture, it looks like access is pretty good.

MS. HANSEN: I'm just really pleased that we cover next time, perhaps, the standards for entry. But just generally speaking, aren't they fairly low? That's one

question in terms of generally what we know. I know you'll go in further depth. That being number one.

And number two is with this degree of margin, at the 75th percentile of the 27 percent. Again, whether there is some correlation with the ease of entry to obviously the availability for the kind of rapidity of growth that's starting up again with these kind of financial incentives seemingly in mind.

This is just something that is a noticeable pop-up trend, as compared to all of the other sectors we look at.

MR. CHRISTMAN: On the standards for entry, I don't think we're in a position to say that Medicare standards for home health are any lower than other providers. What I could say is different is that there's no bricks and border investment you have to make when you want to start a home health agency. So there are other barriers to entry that are present in the home health area.

And then on entry, the correlation between whether an agency is relatively new and it's margins of entry, we haven't taken a look at that but that's definitely something we could look at.

DR. MILLER: Can I ask you something, Evan? Am I

forgetting this? Didn't we have a conversation on something about in order to get in you actually have to provide some care for a period? Was that here, home health? Or did I confuse one of the other parts?

MS. CHENG: That's correct. You have to have served patients for some period of time before you will be certified for Medicare precisely because of the bricks and mortar problem. There has to be something for us to measure during the survey and certification process.

MS. HANSEN: I recall from last year when we looked at it, you had an array of all of the different kind of home health agencies. If we could tuck that back into this next report, just as a reference point as to what the spread is relative to the size. And then also by the ownership type again. That was a previous area.

MR. HACKBARTH: Any other questions or comments?

Okay. Thank you. Good job.

Next is inpatient rehab facilities.

DR. KAPLAN: The third post-acute care sector we're going to assess for payment adequacy is rehabilitation hospitals and units, also known as inpatient rehabilitation facilities. I also called them IRFs. We will be looking at

the most recent data available for our assessment.

The IRF PPS began in 2002. What you will see throughout this presentation is a period of growth after PPS began in volume of cases and payments, in particular, and costs per case declined.

CMS modified the 75 percent rule which requires IRFs to have 75 percent of admissions with one or more of a specified list of conditions. As the new 75 percent rule phased in, starting in 2005 you'll see volume of patients admitted to IRFs and spending declined and the trends changed.

IRFs provide intensive physical, education and speech therapy on an inpatient basis. Intensive therapy is generally defined at three or more hours of therapy a day. Medicare paid $6.4 billion for IRF services in 2005 and Medicare pays for about 70 percent of IRF patients.

To be paid as an IRF, facilities must meet a number of conditions of participation like those on the screen. To be admitted to an IRF, patients generally must be able to tolerate and benefit from three hours of therapy a day.

75 percent of all patients must have specific

diagnoses. At the end of your slides are a list of the conditions. The 2004 change to the rule means that most hip and knee replacement patients are not appropriate for IRFs. This was the largest category of patients IRFs treated prior to 2005.

IRFs out of compliance with the 75 percent rule are declassified and paid acute hospital rates for all Medicare patients. The rule is phased in according to the schedule on the screen.

The 75 percent rule already has had an effect. As you can see on the screen, in 2006 stroke became the top diagnoses while joint replacement dropped to second. Hip fracture also increased its share from 2004 to 2006. Cardiac, another category not included in the 75 percent rule, also dropped during this period.

About 80 percent of IRFs are hospital-based, the red dots on this map. As you can see, IRFs are generally located where the population is located.

The number of IRFs increased slightly after the PPS started in 2002, at 1 percent per year. Between 2004 and 2005 there was a net increase of four IRFs. Rural IRFs, however, have had a different pattern. The number of rural

IRFs increased more than 4 percent a year after the PPS started. Between 2004 and 2005 growth was even faster at almost 7 percent. This growth is consistent with a 21 percent payment adjustment for rural inpatient rehabilitation facilities under the PPS and critical access hospital's ability to have IRF units starting in October 2004.

Between 2002 and 2004 the volume of cases and Medicare spending increased rapidly while average length of stay decreased. Spending increased 16 percent per year during this period because of market basket updates and coding improvements.

In 2005 the story changes, as hospitals had to make sure that at least 50 percent of their cases were compliant with the new 75 percent rule. Spending fell almost 3 percent and case-mix increased. This case-mix increase is inconsistent with the length of stay increasing.

Cases compliant with the 75 percent rule have a much higher Case-Mix Index than those that are not compliant.

The decrease in cases is difficult to interpret from an access perspective. We don't know where

beneficiaries who needed rehabilitation were treated, nor do we know their outcomes. For example, CMS assumed patients not treated in IRFs would be treated in SNFs. There are indications that access has become more limited in some areas where IRFs closed and less limited where IRFs opened. This is difficult to interpret because IRFs do not exist in every community.

The number of unique beneficiaries using IRFs is another indirect measure of access. After PPS, this number increased almost 7 percent per year. After the new 75 percent rule went into effect, the number dropped 9 percent.

To assess changes in quality of care for these facilities, we use a measure commonly tracked by the IRF industry. These scores represent a slight gain in functioning from 2004 to 2006. The thing to remember is that a higher score is better.

The scores represent the difference between discharge and admission functioning using the functional independence measure known as the FIM, which is incorporated in the assessment tool for inpatient rehabilitation facilities. The FIM measures physical and cognitive functioning.

We are interested in whether the scores are stable, indicating no change, an improvement and increase in the difference, or deterioration, a decrease in the difference.

To compare quality on a national basis, we used the average difference in FIM at discharge versus admission for all Medicare patients and for Medicare patients discharged home. These scores suggest that quality has improved slightly from 2004 to 2006.

They are not adjusted for case-mix.

As I said before, 80 percent of IRFs are hospital-based. Hospital-based IRFs have access to capital through their parent institutions. As you heard in the hospital presentation, hospitals' access to capital is quite good.

As far as freestanding IRFs are concerned, a new chain plans to open 36 IRFs, suggesting that freestanding IRFs also have access to capital.

After PPS, starting in 2002, payments per case increased rapidly. Costs started to accelerate in 2004. In 2005 the new 75 percent rule went into effect and costs per case increased 10 percent. What we saw in 2005 is consistent with the assumptions we used to project margins

last year. We estimated a 10 percent decrease in volume between 2004 and 2005, that 90 percent of IRFs patient care costs would disappear but that there would be no change in their indirect costs or overhead for the loss in patients.

In 2005 the aggregate Medicare margins for IRFs was 13 percent. IRFs at the 25th percentile had a margin of negative four. IRFs at the 75th percentile had 22 percent. As you can see, for-profits have a margin twice that of nonprofits. Government IRFs have few Medicare patients and don't operate under the same constraints as other facilities.

We've estimated a margin of 13 percent in 2005 and a margin of 2.7 in 2007. This latter estimate assumes a 20 percent reduction in cases going to IRFs as a result of the new 75 percent rule phase-in. We also assume IRFs will be able to eliminate the majority of patient care costs but will not be able to eliminate overhead. These are reasonable assumptions and, as I just said, they are consistent with the first year implementation of the 75 percent rule. If we vary those assumptions, the margin would be between 5.5 percent and 0.5 percent.

To sum up, we see that supply is stable, although

there have been rapid increases in rural IRFs. Volume and spending declined in 2005. Access is difficult to assess, although there has been a decrease in the unique beneficiaries using IRFs. In quality indicators, there was a slight improvement. And IRFs have access to capital. The estimated margin in 2007 is 2.7.

To kick off your discussion, last year's recommendation is on the screen. The update in law is market basket, so the implication of this recommendation would be a decrease relative to current law.

That concludes my presentation.

DR. REISCHAUER: I thought I would preempt Ron by asking if we didn't want to consider hospital-based home health and SNFs, what are they doing here?

DR. MILLER: I think Craig is probably best to give this answer in detail, but you may remember about a year ago we went through this and we did a specific analysis where we went through and tried to look at the effects of the overhead here and found that we did -- well, maybe I should let you.

MR. LISK: Basically, we went through an exercise to look at the differences in the costs and looking at the

overhead contribution here for the IRFs. And we didn't find that overhead allocation was necessarily an issue here for this sector.

The other thing to remember in this sector is over 80 percent of the facilities are hospital-based and over 50 percent of the patients are in those facilities, as well. I think it may be 60 percent, I can't remember. So a substantial portion of the facilities are hospital-based.

Eventually, if we get to psych hospitals and units, we'll face the same issue again for those in the future.

DR. MILLER: This is what I'm having a real hard time dragging up because this was fairly complex. We started disaggregating things like direct and indirect costs. We were looking at freestanding and hospital-based. We weren't finding large differences. And then we did some comparison with skilled nursing facilities, I think, and you found very big differences there when you compared them but not on these.

And then there was something about when these got created and came into the process that played into this argument, too.

MR. LISK: That's right. Basically, these guys have historically been part of it. One of the things we did look at was the people who came in after versus before, to see if there was any cost allocation issues as well between those who came in earlier verses later. We found basically no differences there.

Whereas on the SNF side, we actually did find differences, some differences.

MR. MULLER: If we have such a big change in margin due to the implementation of the 75 percent rule, I don't see why going to a more conventional thinking about that it's appropriate to have an update doesn't apply here, being we have -- from 15 to 2.7. So probably the hospital-based ones are roughly around zero. So since the freestanding ones are 2.5 times that.

So I don't understand why -- this might be a place to both consider some kind of update recommendation, since we've already had a lot of the course correction through the 75 percent rule. The number is in here, I just forgot it.

DR. KAPLAN: The margin went from 13 percent to 2.7, is our median estimate.

MR. HACKBARTH: Just as a reminder again, the

draft recommendation was a repeat of last year. And Ralph is making, I think, a legitimate point that in this area, more than perhaps any other, there was a dramatic policy change with a corresponding effect on the margins, projected margins, which probably all adds up to a case that just doing what we did last year in this instance may not be the right thing. We need to have a clean slate.

Just one other observation. We've got sort of three different profiles out there now. We've got the hospitals that we began with today, where we have negative margins that have been gradually going down. We've got home health and SNF where we've had consistently high margins. And now we've got a different case where we've got a pretty abrupt change based on a policy change.

And so I think those are cases that we need to think differently about.

DR. CROSSON: In terms of the recommendation, I was thinking pretty much the way Ralph was. But I just had a question on a slide 12, if you could put that up.

If you were trying to make the case ever that payment pulls costs along with it, this slide would make it. So the question is, to get back to your point earlier about

pressure or whatever you want to call it, in projecting the 2.7 percent margin, what would the point on this cost curve then look like that led to that calculation?

In other words, is there already pressure on the costs? Or are we just simply, in doing what Ralph said, would we be just rewarding cost growth that seems to come along with added opportunity?

MR. HACKBARTH: This doesn't capture the change in the 75 percent rule.

MR. LISK: The 2005 number captures part of the change. Do you see that cost growth --

MR. HACKBARTH: Part of it, the beginning of the phase-in.

MR. LISK: The beginning of the phase-in. So you see part of the cost increase is related to change in case-mix. This is cost per case. And you saw a fairly large increase in case-mix. It was due to the shift in cases and taking out the cases that were -- the hips and the knee were the lowest weighted cases. And so they were removed. The cases that remained were higher weighted cases. And you also had a drop in volume, so you had overhead costs that had to be allocated across fewer cases.

MR. HACKBARTH: So there are some things going on in this that makes it so it's not a neat illustration of costs following payment.

Although I remember last year when we talked about post-acute care, we had some similar graphs. And Nancy pointed, as we went to PPS systems, payments went up and cost tended to follow. And there we weren't talking about situations where the data were contaminated by case-mix change, but they were, I fear, an illustration of your point, Jay.

But this one is a little bit different because of the implementation of the rule and the resulting case-mix shift.

And then we get to the 2.7 by projecting outward to 2007 and they're coming together or converging.

DR. SCANLON: It seems like there's a lot of things going on here and many of them end up being disturbing. When we come down to the margin and we look at the margin and we say okay, we potentially need to think about a different recommendation, we have to juxtapose that with what Sally mentioned, that the overhead costs are unlikely to change a lot. That's going to be a major

driving force behind the margins.

So then we have to ask ourselves about the efficiency of these providers that we're going to maintain thorough a higher update.

Nothing is against the providers. Maybe our problem is, in some respects, the 75 percent rule and what brought us to the 75 percent rule. We have an industry here than, in some respects, is dominated by Medicare. And we worry about the incentives that our payment policy creates and how the industry burgeons because of the incentives that we've created.

The 75 percent rule gets us out of that directly by moving people away from this sector. But is that the best way we should have responded? Or should we have adjusted our payment rates so that we were serving more people in these facilities at the right rates and potentially getting the right outcomes?

Part of this goes back to the fundamental question which Carol started with earlier, which is we don't really have a good understanding of these different post-acute care providers and how they should be distinguished in terms of who they serve, how well they serve them, what outcomes we

can expect. So we have all of this uncertainty in these variety of areas and it's leading us to the point where we're now going to potentially make a recommendation that says they've become inefficient because of our policies. But we've got to increase our payments to them because of that.

That's the box that we're in because we lack the kinds of information about post-acute care that we really need. And we should be moving in that direction as well. And I think we should be making that point in what we do.

MR. HACKBARTH: If I remember last year in our report we had a similar conversation to this and expressed concerns about these payment systems collectively and whether we had payment systems that encouraged appropriate and efficient care and expressed many of the same concerns that Bill just outlined.

I thought we included like a preface to the post-acute update chapters expressing that and saying we really need -- Medicare really needs to look at this whole sector in a much more holistic way with common assessment instruments and develop tools that will allow us to better increase are confidence that the patients are going to the

best facility and the lowest cost facility for their given needs.

I think those ideas are every bit as true today as they were a year ago. So we may want to think about lifting that language from last year and reintroducing it into this year's report.

MR. MULLER: If I could just speak to Bill's point. The 75 percent rule, in part, is a policy direction that takes some of the lower acuity cases out of rehab and says perhaps do them in home care or do them elsewhere. And therefore on average, other things being equal, it raises the average acuity, and therefore the cost.

I wouldn't necessarily call that that they've become less efficient. They just have a higher acuity population for roughly the same payment.

DR. SCANLON: But I think, from what Sally said, they are less efficient because we have a higher proportion of the costs are overhead, as opposed to direct care costs. And what I was basically saying is we can afford to have a lower acuity level, as long as we're paying for lower acuity level. That is potentially our problem. We were paying for a higher acuity level and we said we didn't have it there.

So we're trying to create that by the 75 percent rule.

I think instead, if you target the payments to the acuity level that you've got -- I mean this question of what happens with someone with an ordinary joint replacement, do they really always do better or as well in SNFs and home health, as opposed to a rehab facility? I don't know if that's the question. And that's a big part of the populations that's being affected by this.

MR. MULLER: I don't disagree with the point you made first, which is that perhaps the 75 percent rule went too far as a way of getting the lower acuity cases out of the IRFs into other settings and perhaps into alternatives. So I agree with your point that perhaps another way of doing that was to modify the payment on that, as opposed to just driving the cases out through the 75 percent rule.

That being said, when we have a high acuity mix, calling that less efficient is something I have concern about.

MR. HACKBARTH: For our next meeting, if you could pull out that language from last year so we can all take a look at it and see if we think it's still appropriate for this year's report, that will be hopeful.

DR. KAPLAN: There also is a little bit of hope on the horizon in that the Congress mandated a demonstration for post-acute care with a unified assessment instrument and that contract has been awarded. So hopefully by -- I believe it's 2008 or 2009 -- there will be some hope on the horizon that we might get toward at least being able to measure things similarly across post-acute care settings and measure and compare quality from the different settings.

MR. BERTKO: Two quick questions, Sally. I think I heard you say that your margin assumptions at the 2.7 percent included no change in the fixed overhead?

MR. LISK: In terms of fixed overhead, our assumption to get us to 2.7 percent was in fixed overhead no change in that. And that the direct costs related to the care of the patients that left, 90 percent of that would go away.

If we said let's say 25 percent of fixed overhead was reduced and 100 percent of the direct costs went away, that's where we get the 5.5 percent margin estimate. So that's the way we get the upper end.

MR. BERTKO: My question would be for next month's meeting, when I guess we're voting on this, is it possible

to call a couple of these facilities or chains and see how much they can move it? I'm looking here at your 9 percent reduction in volume in one year is a pretty big change and people generally don't sit still when that happens.

And then a related question is do they expect more change or no change as they ramp up to the 75 percent phase-in? Is there another 9 percent drop that's going happened?

DR. KAPLAN: It's basically 10 percent per year for each year after that. In 2005 we found a 10 percent decrease in volume. For 2007 it was 20 percent, which is 10 percent a year. And then there's another year in the phase-in.

MR. BERTKO: Where does that number come from? From talking to folks or your assumptions?

DR. KAPLAN: Basically the 10 percent came right off the cost reports, in the volume.

MR. BERTKO: But the next 10 percent is the question.

DR. KAPLAN: Basically those are projections that have been done that show what it will take to reach the level of the 75 percent rule at that point.

MR. BERTKO: You don't think that most of the

cases fit under that? That is, the effect doesn't happen all at once.

DR. KAPLAN: The compliant cases, there's limited ability to replace noncompliant cases with compliant cases, and that's part of the issue. So as far as how are they adjusting, we can call and find out how they're adjusting.

MR. BERTKO: I know your workload.

DR. MILLER: Also, some of it is what you expect to hear. There is that.

There is some adjustment. I thought you were saying that there was more stroke patients going to the facilities.

DR. KAPLAN: Exactly, yes. The percentage of stroke patients has gone up.

DR. MILLER: But has the number of stroke patients gone up? I guess that's what I was asking.

DR. KAPLAN: That number is not going to me right now. I'd have to answer that question later.

MR. HACKBARTH: Any other questions or comments?

Okay, thank you.

We are now to long-term care hospitals, which is the last one for today.

DR. KAPLAN: We're going to end the day with long-term care hospitals.

We've seen a lot of growth in this sector, which has raised questions about the role of these facilities. MedPAC has studied long-term care hospitals for several years and recommended that CMS implement new criteria to define these facilities and their patients. Although CMS has made several payment policy changes, the Agency continues to review our recommendations.

Long-term care hospitals must meet the conditions of participation of acute care hospitals and, in addition, have an average length of stay greater than 25 days for Medicare patients. Medicare spending for long-term care hospitals was $4.5 billion in 2005 and Medicare pays for about 70 percent of these patients, of long-term care hospital's patients.

On the screen are the top 10 long-term care hospital DRGs. Only one DRG, respiratory system with ventilator, accounts for greater than 5 percent of cases. Half of the top 10 LTC-DRGs are respiratory related and they're shown in yellow on the screen. Although there's been no change in the DRGs that are in the top 10, there has

been increased concentration of cases in these DRGs. Last year the top 10 made up one-fourth of cases. This year they make up almost one-half.

As you can see, long-term care hospitals are not distributed evenly in the nation. The red dots represent long-term care hospitals that entered the program before October 2003, while the stars are those that entered in or after October 2003. As you can see, there are a lot of stars close to or on top of dots. That indicates that long-term care hospitals are not always opening up in new markets.

The number of long-term care hospitals has grown rapidly since 1990 when there were fewer than 100 hospitals. Growth has accelerated under PPS, especially for hospitals within hospitals.

Actually, it's surprising to see continued growth in hospitals within hospitals, considering the implementation of the 25 percent rule in 2005. I'll discuss this rule in more detail later, but it seems clear that we have not seen a slowdown in growth yet. Exactly the same number of long-term care hospitals entered the program in 2005 as in the previous year.

The number of cases increased 10 percent per year under PPS. Medicare spending increased 29 percent per year. I've already talked about case-mix change with the consolidation of cases in the top 10 DRGs. Length of stay went down 1 percent per year.

How did beneficiaries' access to care change under the long-term care hospital PPS? Although we have no direct indicators of access, the number of long-term care hospitals increased and the volume of unique beneficiaries using long-term care hospitals increased, both of data at 10 percent per year.

From these increases, we conclude that beneficiaries' access to long-term care hospitals increased under the PPS.

We used four different indicators of quality for long-term care hospitals and we found mixed results. The rate of death in the long-term care hospital improved by 4 percent from 2004 to 2005. The rate of death within 30 days of discharge improved 1 percent. Readmissions to acute care hospitals got worse by 3 percent.

We also used four AHRQ patient indicators or PSIs, although we removed from the analysis the long-term care

hospital patients that had these conditions in acute hospital before transfer to the long-term term hospital. Three out of four of the PSIs worsened between 2004 and 2005. One PSIs improved during the same period.

Long-term care hospitals appear to have access to capital. Private equity firms have invested over $3 billion in long-term care hospitals between 2004 and 2006.

How have payments per case compared to costs per case for long-term care hospitals? Under TEFRA, which is the part over on the left of the chart, a cost-based system, costs were slightly higher than payments for three out of the four years before the PPS began. Payments have increased significantly under PPS, and as payments went up, so have costs. The increase in payments has been driven by observed case-mix. However, almost two-thirds of the case-mix increase were coding changes.

The growth in hospitals within hospitals resulted in CMS establishing a new policy to ensure that hospitals within hospitals don't act like hospital-based units and that decisions are made for clinical and not financial reasons.

The new rule limits to 25 percent the share of

cases a hospital with a hospital can admit from its host hospital. For cases greater than 25 percent, hospitals within hospitals will be paid by IPPS rates. The phase-in will be complete in 2008, the year for which we are recommending an update. There are some exceptions to the rule. Hospitals within hospitals in rural hospitals located in the only hospital in an urban area or in a hospital that is dominant in its city have a 50 percent threshold instead.

CMS may not have the tools to enforce this policy at this time.

There are also a lot of possible ways to respond to the rule. For example, hospitals within hospitals can take a larger share of outliers from the host hospital, which are not included in the threshold. They can make arrangements to take a greater share of patients from hospitals other than their host, including trading patients. Hospitals within hospitals can become freestanding long-term care hospitals. Or there can be other arrangements that can make hospitals within hospitals willing to take a financial hit on patients over 25 percent.

The 2005 Medicare margins are on the screen. Hospitals within hospitals and for-profit long-term care

hospitals are more likely to have positive margins. Government long-term care hospitals are few in number, they have Medicare patients, and they operate under different constraints than other long-term care hospitals.

For purposes of projecting the 2007 margins with 2008 policy we modeled the changes on the screen. As you can see, there are a number of policies to include in the model.

There was a net increase in payment in 2006 and a net decrease in payment in 2007. The big question is whether behavior will change in response to the 25 percent rule?

With these payment changes, we estimate that the Medicare margin is between zero and 2 percent, depending on hospitals within hospitals' response to the 25 percent rule.

To sum up, we see no indication of a slowdown in growth. We've seen that long-term care hospitals are able to control their costs. They are very responsive to payment changes. Long-term care hospitals have a large amount of discretion over the patients they admit.

The zero percent margin assumes that every case over the 25 percent threshold is paid at the lower rate and

there is no behavior change. Alternatively, the 2 percent margin assumes that hospitals within hospitals change the mix of patients and there are various ways to do that, as I've discussed.

To start the discussion, last year's recommendation is on the screen. Before you start discussing, I'd like to give you several reasons for staying with this recommendation this year. Long-term care hospitals have been earning 9 to 12 percent margins for two years and we estimate that the 2006 margin will be at least as high.

Long-term care hospitals have shown themselves to be nimble. Their costs appear to be under their control and they are responsive to payment changes. Then also select their patients. There are several ways to change behavior to avoid the 25 percent rule.

These are all arguments for staying with this recommendation for one more year to see how hospitals within hospitals behaviorally respond to the 25 percent rule.

That concludes my presentation.

MR. BERTKO: Sally, can you go back to the map?

I'm a Westerner. Having said that, I guess the

question that I really have is is it more expensive to pay for the same kind of admission in a state with long-term care hospitals, the whole episode, than it is in one essentially without? Does it cost Medicare more or less?

And secondly, and I have to ask this, and maybe Ralph is the right guy. But clinically, are these necessary? I'm asking out of total ignorance.

DR. KAPLAN: CMS is doing a study that may give us some insight on the episode of care. We really have not looked at episodes of care post-PPS. I can tell you what we found in the study that we did that we published in June 2004, which was pre-PPS. What we found was that for most patients for an episode of care long-term care hospital patients cost Medicare more money.

However, if they focused on the very sickest patients, it basically was a statistically insignificant difference.

MR. HACKBARTH: That was the factual foundation for our recommendation that there ought to be patient and facility criteria developed for long-term care hospitals to determine when they're appropriate for Medicare.

But, as Sally reported at the outset, we're still

not there. There are now beginning to be some proposals about what those criteria might look like. But they're not in place at this point.

So from my perspective, and I think I'm coming from a similar direction as you, we've got a rapidly growing type of new facility. There are parts of the country that seem to do perfectly fine without it. And we ought to, while we develop appropriate criteria that focus access on the patients who most need this intensive high-cost service, until we have those, we ought to keep a tight rein on the payment and not allow it to go up as a way of slowing the expansion of the industry until we get some better, more focused, rules in place.

I think that's what Sally was alluding to in her statement that we may want to continue last year's recommendation for another year.

MS. DePARLE: In addition to continuing last year's recommendation, what has it been, three years since we said there should be criteria other than greater than 25 days average length of stay? To me, it's crazy for the kinds of practices that Sally talked about to be going on, which we've all heard about, and the growth to be continuing

without any criteria around who is an appropriate patient for this kind of facility.

I think we spent time, and Nick and Pete DeBusk went out and looked at these. And I became convinced at the end of it that yes, there is a legitimate place in the continuum for this kind of care. But lets define it.

Maybe it's silly to make the same recommendation again but I think we need to because it doesn't seem to be getting any action.

MR. HACKBARTH: Sally, in your presentation while I was out, did you talk you know about the status of trying to get criteria place and what's happened?

DR. KAPLAN: Basically, yes, I did. CMS has put a lot of these payment policy levers in place where they've change the short stay outlier rule. They gave a zero update. They basically have implemented the 25 percent rule for hospitals within hospitals.

They contracted with RTI to do a study on the feasibility of our recommendations, and reportedly that study should be out fairly soon. But I don't have a firm date. I would say hopefully by the first of the year or shortly after the first of the year.

MS. DePARLE: Is the idea that that will have some proposed criteria in it?

DR. KAPLAN: Yes. And that also will have things like a more up-to-date episode, an analysis of the cost of these things post-PPS, which ours was pre-PPS and that would be post-PPS.

DR. MILLER: So we expect that to have proposals in it?

DR. KAPLAN: Let me also say that the industry -- there are two associations affiliated with this industry and they have both proposed criteria. They're not completely mutually exclusive but they pretty much are very different, but they are a starting place for criteria.

MS. DePARLE: I think they did that two years ago.

DR. KAPLAN: I can't say.

MR. LISK: They've only recently come close to finalizing what they think the appropriate thing is. They started working on these after the Commission made the recommendation. So they're just kind of putting those final things out to the public now though, I think.

MR. HACKBARTH: I think the basic message of the chapter is something like this: from our prospective it's

much better to deal with the rapid growth and escalating costs through criteria on the patients that are appropriate for this intensive type of care.

The approaches that have been done instead of criteria, like to 25 percent rule or limiting updates, are inevitably cruder tools. You do crude when you can't do more sophisticated. But the longer you do the crude, the more problems you're going to generate, the more gaming behavior, and the more legitimate institutions and legitimate patient needs are going to go unmet. So there is some urgency about getting on with a more focused approach.

But in the meantime, we've got to keep a tight rein on the payment.

MS. HANSEN: Along with the criteria, going back to page eight, which was the quality of care factor, I just wonder if we could really shine a light on that because this is not a robust way to keep a system going when there are readmissions that are worse, as well as three out of the four safety indicators are worse.

Just intuitively, it just doesn't feel right to support a growth when their quality indicators are not positively robust.

So it is an area I just would like to make sure gets highlighted.

And then a final comment is going back to the fact that home health agencies and other resources exist elsewhere. Is the CMS study such that it is trying to compare it on characteristics of beneficiaries period, regardless of what resources there are? Meaning home health agencies, long-term care hospitals as well as IRFs.

I know that their core foci may not always be the same, but using a comparable sample to say what difference does it make in terms of their getting better or getting good quality of care? Does it matter? If you don't have any out West, what happens if -- I think I brought this up last year. If you don't have the facilities, do you still get better?

That's a fundamental question. When you have a broken hip or you have a COPD, what happens to you if you live in Wyoming? That is, to me, a fundamental question about the characteristics of the beneficiary.

MR. HACKBARTH: Part of what happens is that the capabilities of home health agencies and SNFs in the community may be altered by the presence of a long-term care

hospital. If that alternative doesn't exist, then the SNF and home health capabilities may be more robust because they know they need to care for some patients with a lot of needs.

MR. MULLER: That's the minus 85.

MR. HACKBARTH: Exactly.

DR. REISCHAUER: Compare Louisiana with Oregon.

MR. HACKBARTH: These are dynamic systems. I think Bill made that point last year. What you've got in a given community, in terms of capabilities, it's not uniform. Agencies aren't uniform. Skilled nursing facilities aren't uniform. This is a tough area, the post-acute care.

DR. CASTELLANOS: My question was answered about quality, but it was answered already.

DR. KANE: I think part of what was bothering me last year and continues to bother me about these update issues is not just looking at any one silo on its own but the cross-sectoral equity of this. And I think it really bothered me last year and continues to bother me this year they we're looking at a negative update for physicians, acute hospitals have been pretty much losing money, looking at a market basket minus productivity factor.

And then historically the post-acutes have all gotten market basket, if you look at what's actually happened, even though we recommend no update.

I guess, given the level of their profits compared to all of the other sectors, except physicians -- other than looking at their incomes, I guess we're not looking at their profits. It just seems inconsistent to do anything but no update, given what's going on with the other recommendations we've made, even though we get overruled as soon as it goes to Congress anyway.

MR. HACKBARTH: Other comments? Thank you.

MR. HACKBARTH: We'll now have a public comment period, with the usual ground rules. Please keep your comments to no more than a couple of minutes.

MS. COYLE: Carmela Coyle, the American Hospital Association.

My apologies, I have brief comments but on four different areas addressed since lunchtime.

First of all, on the indirect medical education discussion, the Commission's discussion seemed to be about the best place to reallocate some of the IME dollars that were discussed in terms of reducing the IME adjustment by a

percentage point. And that discussion seemed to be about where to place it, but perhaps without resolution.

We would urge the Commission to thoroughly think through and then articulate where those dollars should go before taking it away, before making the cut.

And to suggest perhaps a somewhat different approach. Since we don't yet know how CMS is actually going to implement the severity adjustment, the Commission -- since you're considering linking it to the implementation of that severity adjustment -- may want to consider directly suggesting that whatever the increase is that that is then the amount that may want to be taken from the IME adjustment. We just don't have any idea how that might ultimately be phased in, but just so there's a more direct connection.

A second issue on the issue of the update, and specifically on the issue of technology, there seemed to be some confusion and at least perhaps an unintended error in some of the information shared that I just wanted to clarify.

That the new costs that are experienced by hospitals when information technology or other clinical

technologies are adopted are not, with few exceptions, included in the Medicare payment system and are not included in the Medicare market basket. They are not covered in the new technology payment adjustments that are part of the inpatient payment system with the exception of only seven new technologies that have been improved in the last five years.

They are not, in fact, captured in the DRG weighting system. Recall that the DRG weights for any one DRG where technology may be employed may go up, but that it's all done relatively and it's all done in a budget neutral manner. So that all the other weights for the other DRGs go down. There is no new money that goes into the system as a result of that DRG weighting system.

That increased adoption of IT is also not captured in the market basket. As was suggested, I think it was clarified by the Vice-Chair, the market basket is just a year-to-year increase in the price change of that technology. It does not capture an increased adoption by the hospital field.

And unfortunately, it's not well captured in the market basket itself. The price proxies don't capture

hospital purchases of technology. It's broader technology in the economy, which includes many, many things.

We would suggest that a specific adjustment to the market basket to take this into account been made, as MedPAC did for years. An upward adjustment for the market basket, it was suggested, may be crude given that some hospitals may be adopting at a faster rate. I suppose one could argue that a downward adjustment for productivity may suffer from the same problem, given hospitals have different rates of productivity.

But if the update recommendation is going to reflect both inflation and a policy target in the area of productivity, an update recommendation could also include inflation plus a policy target in the area of information technology.

And one last issue, a question was asked about the forecast error. The market basket has been under estimated for seven of the last eight years to the cumulative tune of about 3.8 percentage points or a total of about $4 billion, that this Commission recommended and that Congress recommended be paid that was never received.

A third issue, very quickly, on skilled nursing

facilities, a negative 85 percent Medicare margin for hospital-based skilled nursing facilities is really impossible to ignore. We would urge the Commission to consider a separate hospital-based update in that area.

And finally, in the area of rehab facilities, also encourage a full update given the data, given the 75 percent rule. Policy changes have been made. Now it's time to go back to an inflationary concept, an inflationary adjustment in that area.

Thank you.

MR. CALMAN: Good afternoon. My name is Ed Calman and I'm General Counsel to the National Association of Long Term Care Hospitals. I have just two brief comments for you.

The staff recommendation today did not mention that CMS policy and rules require a one-time adjustment to the standard amount in 2008. We expect to see that in proposed rules that will be proposed in January. That should be a negative amount, a reduction to the standard amount.

Our own research has shown that with the cuts that took place last year, in 2007, that margins are about zero.

They're a positive 2 percent for proprietary hospitals, zero for not-for-profit hospitals, and for some reason in the West there's significantly negative margins. And public hospitals have the worst margins.

So when you come to your final recommendation, our request would be that you make an assessment of the effect of the 2007 cuts, an assessment of the one-time adjustment which you may see in proposed form before the next meeting.

Secondly, we are very concerned that CMS has not moved forward with criteria. As an association, we have endorsed most of the recommendations of the June 2004 report that was made by this Commission. And we feel that it is inequitable to patients to subject them to rules that percentage thresholds which provide incentives that they not be admitted to hospitals.

We have developed clinical criteria which we have shared with all policymakers. But I do agree that you should put a very strong statement in your chapter that CMS -- I'll put it this way. It's been two-and-a-half years since your recommendation and it's time for CMS to act in a way that provides for continuity of care, access, and safety for patients.

Thank you.

MR. HUNTER: Chairman Hackbarth, Executive Director Miller, ladies and gentlemen of the Commission, Justin Hunter with HealthSouth. I am Vice President of Government and Regulatory Affairs for our company. We own and operate 92 freestanding inpatient rehabilitation hospitals across the country, 10 LTCHs.

I will be very brief and say, first and foremost, that the comments with respect to the concerns and observations over the effects of the 75 percent rule on patients and providers is appreciated. It's very real. There's no question about it.

I wanted to, and I know that a lot of data discussed relative to IRFs -- or excuse me, rehabilitation hospitals. I'd like to point out the latest findings of an independent study that was commissioned by the American Hospital Association, the American Medical Rehabilitation Providers Association and the Federation of American Hospitals entitled Utilization Trends in Inpatient Rehabilitation, updated through Q2 2006, revised edition.

The report was prepared by the Moran Company, Don Moran and his colleagues. I will read one bullet point from

the executive summary. In program year 2006, caseload in our sample was 292,677, which is down 12 percent from program year 2005 and by 18.4 percent relative to program year 2004. Since our sample comprises approximate 75 percent -- coincidentally enough -- of all Medicare IRF discharges, we estimate that total Medicare caseload declined by 88,053 cases over this two-year span.

Clearly this rule is having an impact.

There is another issue that was not discussed in today's presentation relative to rehabilitation hospitals that I think merits a mention for the Commission to consider in your deliberations, and that is the impact of what are known as local coverage determinations or formerly known as local medical review policies.

I'm getting down into the granular aspects of the Medicare program here. What I'm talking about is essentially medical necessity. There are a number of medical necessity review activities that are occurring within the rehabilitation hospital and unit space, resulting in a material number of medical necessity based denials. It is a legitimate and serious problem and issue that is affecting rehabilitation hospitals and patients. It is

discouraging, in some instances, admission of certain types of patients. After a while, when you see certain types of denials being repeatedly sent to you, you begin to wonder look, is it really worth the admission? And that has serious potential implications on access to care long-term, and it's worth considering.

I appreciate your attention and thank you for this opportunity to make these points.

MS. KENDRICK: Good afternoon. My name is Marty Kendrick. I represent the American Medical Rehabilitation Providers Association, and on behalf of AMRPA, I just wanted to express appreciation to MedPAC for your continued interest and diligence and the competence with which the MedPAC staff have consistently addressed inpatient rehab issues.

I want to underscore our support for a full market basket. It is absolutely critically needed, given the fragility and instability of this sector. The combination of the 75 percent rule, the impact of LCDs, the RAC reviews, and a number of other factors have significantly effected access to Medicare patients to inpatient medical rehabilitation services in a very negative way.

The actual capacity of the field is seriously jeopardized at this point in many geographic areas of the country, not necessarily showing up as direct closures but staff reductions, conversions of beds and a real undermining capacity in this sector. It's not going to be easy to reinvent in the future.

So we thank you for your independence and for your work and contributions and we just would plead that you stay in the forefront in the competent way that you have in the past.

Thank you.

MR. HACKBARTH: Okay. We are adjourned and reconvene tomorrow at nine o'clock.

[Whereupon, at 4:38 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, December 8, 2006.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 8, 2006
9:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
MITRA BEHROOZI
JOHN M. BERTKO
KAREN R. BORMAN, M.D.
SHEILA P. BURKE
RONALD D. CASTELLANOS, M.D.
FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
DOUGLAS HOLTZ-EAKIN, Ph.D.
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
WILLIAM J. SCANLON, Ph.D.
NICHOLAS J. WOLTER, M.D.

P R O C E E D I N G S

MR. HACKBARTH: It's time to get started.

Good morning. We have three sessions planned for today. The first of them is the final discussion of our mandated report on the impact of the changes in payment for Part B drugs. We will have a vote on that.

And then we have two update-related presentations, one on physicians and the other on dialysis.

So Joan, would you do the Part B drugs?

DR. SOKOLOVSKY: Thank you. Good morning, everyone.

Today, I am bringing before you for the final time the Congressionally mandated report on the impact of changes on Medicare payments for Part B drugs provided to Medicare beneficiaries.

We have given you a draft report and, as you've seen, we've tried to respond to your comments. So for example, there is a more extended discussion of both least costly alternative and CAP program.

At this meeting, I will present a draft recommendation for your consideration.

I just want to briefly remind you of the mandate.

This study is the second of the two Congressionally mandated reports. Last year we studied the effect on the payment changes on chemotherapy services for Medicare beneficiaries. This year we studied the effect of the changes on other specialties that provide physician administered drugs.

We focused on the experiences of urologists, rheumatologists, and infectious disease specialists. We also continued to meet with oncologists and beneficiary advocates to track access to care for beneficiaries needing chemotherapy.

We found that the payment changes resulted in savings for the Medicare program and its beneficiaries. Beneficiaries continue to have access to drugs and the volume of drugs provided, in general, has continued to rise. However, because of a change in practice patterns, fewer beneficiaries received drug treatment for prostate cancer in 2005 compared to 2004.

The payment changes appear to have had an effect on where some beneficiaries receive care. Interviewees told us that beneficiaries without supplemental insurance are more likely to be treated in hospitals than other beneficiaries.

We also found that there are few common measures available to determine of quality of care has been affected by the payment changes.

In the past few months we have talked about a particular issue connected to ASP. Some manufacturers make discounts of one of their products contingent on the purchase of one or more other products. The way in which manufacturers allocate these bundle discounts in calculation of average sales price can affect the accuracy of the ASP payment methodology.

That leads us to the draft recommendation. The Secretary should clarify ASP reporting requirements for bundled products to ensure that ASP calculations allocate discounts to reflect transaction prices for drugs.

The ASP payment method has resulted in substantial savings for the Medicare program and its beneficiaries. Medicare payment systems are based on averages and no payment system is expected to be totally accurate. In order to maintain the close to accuracy of individual ASPs, discounts should be allocated to ensure that ASP reflects the average transaction price for drugs.

The spending implications of this recommendation

are indeterminate. Reallocation of bundled discounts could increase the payment rates for some drugs and decrease it for others. This recommendation would support access to drugs for beneficiaries and providers by ensuring the integrity of the ASP payment system.

I welcome your comments.

MR. HACKBARTH: Thank you, Joan.

MS. BURKE: Joan, I think you've done a terrific job of capturing, I think, the concern that we had. And I think that you've also captured the concept that bundling isn't good or bad, which is an important concept for us to underscore. We're not trying to presume that, in fact, the history here and the direction that we've tried to go, which in some cases bundling makes sense in terms of an array of services.

But rather, in this case, I think what we want to make sure is clear is that the allocation of the discounts are, in fact, quite clearly directed to the product for which they were intended, that there is a clear indication there and that they are not lost, and as a result have this skewing in terms of how people ultimately are choosing drugs.

That, in fact, there is an intention here that the clinical opportunities for physicians are left quite clear, that they are able to make decisions based on the right kinds of decisions but that, in fact, to the extent there are discounts, they are directed and are clear in terms of what the product relationship is.

I think we are, in fact, having said this, making it very clear that we're not neutral on this topic. We are quite clear that this is an important thing for us to clarify. And that again I think that bundling in and of itself is not bad. The question is whether or not the result of it skews the decisionmaking in any way or skews the knowledge we have about the actual ASP in a way that's not clear.

So I think you've done a terrific job and I appreciate it and I appreciate the work the staff has done and the materials that support it. So well done, and well said.

DR. REISCHAUER: Just with respect to the wording of the draft recommendation, and this may not to be needed or an improvement, given the text around it. But where it says ASP calculations allocate discounts to reflect the

transaction prices for drugs, I wonder if we shouldn't say reflect the true or actual transaction prices for individual drugs.

The way it's worded now is a touch squishy.

MR. HACKBARTH: But true, as I recall, was in the first draft and we deleted that because of some questions about exactly what true meant.

DR. REISCHAUER: I gave you a choice of actual or true, but you might say what is actual?

MR. HACKBARTH: The other thing that you did was for individual.

DR. REISCHAUER: For individual drugs.

MS. BURKE: I agree with the direction that Bob is going, that it's allocated to the product for which it was intended essentially. But make it quite clear.

DR. SCANLON: Since I was the one that confessed that I didn't know what true meant, I think that inserting the word individual drugs or each drug or something like that takes care of that ambiguity. I don't know what the adjective in front of transaction price would mean.

DR. MILSTEIN: I thought we had developed this concept of conditionality. That is, if you get a 5 percent

discount on drug A but that discount goes to 10 percent if you also buy drug B, that the incremental 5 percent was conditional on --

MR. HACKBARTH: That's certainly what the accompanying text will explain. The issue is how to capture that in the much brief language of the recommendation itself.

DR. MILLER: Also, in that conversation, and Bill I think you will remember this, also in the text it will describe other ways to think about allocation. But certainly the one that you just said, the incremental difference is described in the text.

MS. DePARLE: I think this has been in earlier versions and I think it will be at the text but I want to, I think, echo what Sheila said, in that I want to be sure that this specific example is one that we've chosen to highlight because it was in the proposed rule discussion and we've heard about it.

But that we want to make sure that the Secretary is being vigilant about anything that might be going on to undermine the integrity of this new ASP system. Because I'm sure there are other things that could be going on, as well.

And that we're taking a stand that this is one that we're concerned about, but that we also want to make sure that other things -- other things ensure the integrity of the ASP payment system.

You put that in here in implications, but I'd like to see some language like that in the text, too.

MR. HACKBARTH: If I recall, it is in the text. That is sort of the focal point of the rationale for this, is that it's important to maintain the integrity of the payment system.

MS. BURKE: Can we just go back to Bob's point? Are we modifying the language to reflect the actual drug? I want to finish that.

DR. MILLER: I was letting it play out a little bit further, just to see if anyone else had comments. But what I took from that exchange, if everybody's on board with that, is that the word each would be put in front of the last word of the recommendation, for each drug.

And we would obviously make it singular in that instance.

But I took that from that, but I was going to let it play to see if anybody objected.

DR. CASTELLANOS: Joan, I just want to continue the comments that Sheila made. I think you did a very good job.

And I really appreciate what you've done to go out into the provider community, the medical community, and to talk to patients. Because I think that's what we need to do. We need to get down on that level sometimes to find out what's going on. And I think you did a great job.

There's no question that ASP is much better than what AWP was for the Medicare system and I'm glad we did that. Is it a perfect system? No. Can it be improved? Yes. There's a competitive acquisition program that gives us a backup on that, and I would just hope that maybe CMS would improve that program for the provider community.

Thank you.

DR. HOLTZ-EAKIN: I want to echo the comments before on the quality of the draft and also the particular recommendation, I think, is exactly right.

There was one other issue that came up which I'm not sure the status of, and that was those narrow circumstances in which you've got a very cheap drug and the 6 percent doesn't cover things like shipping. Are we going

to say anything about that? It seems like -- I don't know how pervasive it is. It just seems like something no one thought of at the time, when they did the ASP plus 6. We want to make sure that these things actually cover the costs of getting cheap drugs. That would be a bad thing to not have happen.

DR. SOKOLOVSKY: Aside from mentioning it, we haven't talked about a solution to it. There could be language in the text that would say that one possible way of dealing with this would be sort of a fixed price below which we wouldn't pay.

I don't know, there wasn't enough commission discussion on that.

DR. HOLTZ-EAKIN: The reason I raise it is it's the one example that's very concrete, where just saying you want ASP plus 6 to work well doesn't solve the problem, because even if it works right you don't get the costs covered. So I just didn't know if we wanted to get into territory where this wasn't working. That's the real issue.

DR. MILLER: Consistent with Joan's comments, we didn't come away with enough to feel like we had a strategy on that. But, like all of these issues, we're not done with

this. If there is enough interest, we can continue to pursue that. Joan and I have had some conversations about that. There are sort of fees that you could think about using there.

The nut to crack there would be how you define a drug when it falls in that category and then how you define it in a way that people don't have an ability to kind of get drugs into that category.

But Joan has a lot of free time, on her weekends.

[Laughter.]

DR. HOLTZ-EAKIN: I think we need a draft recommendation to fill her free time.

DR. MILLER: This is work that we can continue to pursue. There are issues in this payment system that have to be chased down further, and we can put that on the agenda.

DR. SCANLON: There was a second issue which also seems to be troublesome and actually may be even more pervasive, and that was the states that have sales taxes. Given what sales tax rates are these days, it's easily seen that they would use up the plus 6. And that goes for drugs of any price.

DR. REISCHAUER: I thought there were only two states that imposed -- no?

DR. SOKOLOVSKY: No, I gave examples of two but nobody has collected for all 50 states. And sometimes it's not the state, it's the city, which makes it even harder to collect everything that's going on.

DR. MILLER: On that one I thought, and I may be just dreaming this. But I thought I remembered some conversation and a concern about action here, that if you try and take that into account, if you do it on an averaging basis it doesn't help anyone. And if you fix it in the specific market, you just encourage the state and the city to step in and actually generate revenue.

So I felt, at least Joan and I, I think, walked away from that conversation that the Commission didn't feel there was a place to go. But we definitely have the problem.

Joan, I'm correct, it is spelled out in the text of the report; correct?

DR. SOKOLOVSKY: Yes.

MS. BURKE: I think, to your point, I think this is something we're bound to come back and get a better

understanding of. To Doug's point, as we get more information and see what happens, I think we may want to continue to look at whether this works.

I think the critical thing is that CMS gets a clear message from us, this is something important, this is something that needs to be fixed. And this recommendation needs to be dealt with and moved in this direction. But I think this is something we're going to continue to want to look at to whether or nit, in fact, it achieves the results we want it to achieve.

MR. HACKBARTH: Any others?

Okay. We're ready to vote then the recommendation as modified. So that concluding passage will be to reflect transaction prices for each drug.

All opposed to the recommendation? All in favor? Abstentions?

Okay. Thank you, Joan. Good job.

Next is payment adequacy for physicians.

MS. BOCCUTI: Good morning. I'm going to mention just a brief note before we start that, as you know, our annual payment update recommendations will be sent to Congress and released publicly at the beginning of March,

which is the same time as the SGR report that you've been discussing over the last year.

The SGR report will reflect your discussions on ways Medicare's physician payment system could include incentives for physicians to provide better quality of care, to coordinate care, and to use resources judiciously.

But however, for our annual update analysis, also required by law, we recognize that the current payment system is based on a single conversion picture for now and that updates across all -- that that conversion factor updates across all services and all physicians.

So our approach for recommending updates for 2008 adheres to that context and we first consider payment adequacy from the most currently available data and then assess the factors that are going to affect efficient providers' costs in the coming year.

With that said, first I'm going to present an assessment of payment adequacy for physician services using the indicators that we typically use, which are listed on the slide. And then I'll review expected cost changes for 2008. And finally, we can discuss the draft recommendation.

This year MedPAC sponsored a physician survey,

which was conducted over the summer by NORC at the University of Chicago and the Gallup organization.

The survey included 934 nonfederal office-based physicians who spent at least 10 percent of their patient time with fee-for-service Medicare beneficiaries. Physicians with closed practices, that is practices that are not taking any new patients of any insurance type, were excluded from the survey.

The first topic on the survey which I will discuss relates to physician willingness to accept new patients. Our survey found that the majority of physicians, or 96 percent, accept at least some new Medicare fee-for-service patients, but a somewhat smaller share accept all or most. Only 3.3 percent of physicians indicated that they were not accepting any new Medicare fee-for-service patients. Acceptance of new Medicare fee-for-service patients compares very favorably, as you can see, to Medicaid and HMO patients but it's a little lower than for private non-HMO patients.

For comparison, I want to mention right here that these numbers are very similar to two other national surveys, namely the NAMCS and the HSC physician surveys, both of went though only go through 2005. But there is

similarity in the 2006 numbers here.

So on the last line on the slide, it's regarding referral difficulty. Physicians more frequently reported difficulty referring Medicare fee-for-service patients than private non-HMO patients, 7 and 3 percent comparatively. But referring HMO or Medicaid patients appeared more difficult that Medicare fee-for-service patients.

Acceptance rates of Medicare fee-for-service patients varied by physician characteristics, and I've put some of those characteristics on the slide. But this variation generally corresponds with physicians' overall patient acceptance across insurance types. So compared to urban physicians, a lower share of rural physicians reported accepting at least some Medicare fee-for-service patients, that's 97 and 93 percent comparatively. But note, however, that for almost all payers, rural physicians were less likely to accept new patients compared to their urban counterparts except in the case of Medicaid.

Similarly, non-proceduralists such as primary care physicians were less likely than other types of physicians to accept new patients by each given insurance type.

In our survey, the majority of physicians

indicated that they were very or somewhat concerned about reimbursement levels across patients of all insurance types. Specifically, 53 percent of physicians were very concerned about reimbursement levels for their private non-HMO patients. 62 percent were similarly concerned for their non-Medicaid HMO patients, and 72 percent for Medicare fee-for-service, 78 percent for Medicaid.

Physicians also reported concern regarding administrative burdens imposed by insurers, namely billing and paperwork, listed on the slide. For private non-HMO patients and Medicare fee-for-service patients about half of all physicians reported being very concerned about this issue. Again, rates for Medicaid and HMO were a little higher.

Another factor we surveyed, which is not listed on the slide, is physicians' concern about the timeliness of claims payments. Across all insurers, physicians appeared less likely to be anxious about this issue relative to the two others on the slide.

Many physicians reported recent changes to their practice to increase revenue or streamline costs. Specifically, 70 percent of physicians reported that they've

increased the number of patients they see in the last year. And about 27 reported that they expanded in-office testing and lab services, 19 percent reported expanding imaging services, and approximately 38 percent reported changes to the mix of personnel they have in their practice. These findings are similar to those found by the Centers for Studying Health Systems Change. Those results are a bit more dated.

Perhaps related to efforts to increase patient caseloads, another survey question we asked but is not shown on the slide found that almost half of the physicians reported that in the past year they had increased the number of hours they worked per week.

Our survey also asked physicians about the factors that affect their individual compensation. Most, 80 percent, reported that their own productivity, typically measured by their service volume and even RVUs, was a very important determinant of compensation. Other factors include patient satisfaction, quality measures, and resource use. But those factors were considerably less likely to be determined as a very important indicator.

As you recall, MedPAC sponsors also a phone survey

for beneficiaries. So we're switching now from the physician survey to beneficiary survey. These were both conducted during the previous summer. We do this, as well, to obtain the most current beneficiary information possible for our update analysis. In our last three rounds, we've surveyed both Medicare and privately insured individuals aged 50 to 64 to assess the extent to which any access problems are unique to the Medicare population.

This year's survey found that most Medicare beneficiaries and privately insured people did not regularly experience delays getting an appointment due to scheduling issues. Rates across the survey years have remained steady, with Medicare beneficiaries reporting delays less often.

So in 2006, among those who tried to schedule a routine care appointment, 75 percent of the Medicare beneficiaries and 69 percent of privately insured individuals reported that they never experienced delays. As expected, for illness and injury, timely appointments were more common for both groups.

MS. BURKE: Can you define for me what's delay?

MS. BOCCUTI: The delay is -- there's a bit of subjectivity to it in the sense that we ask did you have to

wait longer than you wanted to get the appointment? So if they wanted to be able to schedule the appointment that week, but they couldn't get an appointment until a week or whatever longer. But it is up to the beneficiary and the individual to say what is longer than I wanted.

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

So among those looking for a new primary care physician, almost the same share of Medicare beneficiaries and privately insured individuals reported that they experienced no problems. That is 76 percent of Medicare beneficiaries and 75 percent of privately insured individuals.

Although access appears good for most beneficiaries on finding new physicians, we continue to monitor the increasing number of beneficiaries reporting a big versus a small problem relative to private individuals.

And so then, on to specialists, we found that access to new specialists was generally better than access to new primacy are physicians. However, I will note that in 2006, from this past summer, we see a significant dip in beneficiary access to specialists. This is the first year we saw this change, and we'll be monitoring it closely.

We're unable to confirm these results with other surveys because there aren't any that are this up to date.

CMS did not conduct the CAHPS fee-for-service survey in 2005, so I'm going to quickly review the 2004 findings, which generally found that Medicare access, or their report of access to physicians, is generally good and it's consistent with responses from the MedPAC Beneficiary Survey.

Specifically, more than 90 percent of beneficiaries reported either no problem or small problems accessing a specialist. Also, the majority of beneficiaries reported being able to schedule timely appointments for routine care, either always or usually.

We also compare payment rates between Medicare and two large commercial insurers. Our analysis shows that the difference between Medicare and private fees is steady over

the last several years. Averaged across all services and areas, the 2004 ratio of Medicare payments to private rates was essentially at the same level as it was in 2004, with Medicare rates at about 83 percent of private rates.

Within a given market area, of course, or for a given service, the difference between Medicare and private payments may vary substantially, but this is averaged across all services and across all areas.

It's important to note for our MedPAC payment adequacy analysis that the research by HSC has found that in areas where Medicare fees are closer to private fees, beneficiary access is not measurably better than in areas where the fee differential is greater. So this suggests that other factors are playing a role here, more than just say payment reimbursement levels.

To examine physician supply, we include only physicians who saw at least 15 Medicare patients in the year. This removes from our analysis physicians who don't regularly see Medicare patients, and perhaps they only saw a few to fill in for a colleague.

So the numbers inside the table give you the number of physicians per 1,000 beneficiaries. So among

physicians who regularly see Medicare patients, we continue to see that physician supply has kept pace with beneficiary enrollment.

We also examined supply trends for physicians with large case loads. We found that the number of physicians per 1,000 beneficiaries continued to grow, even for physicians with large Medicare caseloads. Indeed, the higher the caseload, the faster the growth rate between 2000 and 2005. Incidentally, we found that a little more than half of physicians billing Medicare had caseloads of at least 200 Medicare patients.

So the supply numbers that I just reviewed prompts me to step away just for a moment from our update analysis. I want to mention that in future meetings we plan to analyze differences in access and payments among physicians, with particular attention to private care providers. Specifically with the aging of the baby boom generation, we plan to examine workforce issues of physicians and non-physician providers, a topic we don't generally consider in our update analysis.

Consistent with the Commission's work over the last couple of years, we may recognize and discuss ways that

primary care providers would take a role in care coordination and medical home policies, as well as performance measurement, often heavily weighted by primary care providers.

We may also examine the alternative methods of calculating the work RVU that may consider additional components not currently captured in physician time and effort studies. For example, some procedures have grown rapidly, which may indicate that physician productivity for that procedure has also grown rapidly, and thus the work RVU may need to be reassessed.

Primary care providers may contribute especially to episode efficiency and their services may be valued differently and grow at different levels. So we'll keep watching that. I just wanted to mention that.

So back to the payment adequacy analysis, we looked at claims data through 2005. When we look at these data, we do not see decreases in per capita volume, at least among broad categories of services which are shown in this chart. Rather across all services per capita volume grew 5.5 percent between 2004 and 2005. This growth includes increases in both service and intensity.

I should note that it is a little bit lower than it was for 2004, which I think was about 6.2 percent.

So looking across the years, you see that imaging continues to have a high growth rate, in 2005, 8.7 percent per beneficiary. But volume in the other procedures is close behind at 8.5 percent.

Overall we only saw a couple of instances for specific services of volume decreases. For those, they are usually explained by general trends in practice patterns.

The cumulative impact of these annual increases in volume is shown in that dark line that's upwardly sloping. In a recent report, GAO also found growth in both the share of beneficiaries using services and the volume of services they used. GAO concluded that increases in utilization and complexity of services may demonstrate that beneficiaries are able to access physician services, but does note that these utilization trends have implications for the long-term fiscal sustainability of the Medicare program.

As we did last year, we examined the quality of ambulatory care through a claims-based measure set, which we call MACIEs. Those are derived from the ACE-PROs, which were developed nearly 10 years ago by RAND. MACIEs are

designed to reflect basic clinical standards of care for common medical diagnoses, and they focus on two types of measures. First, the percentage of beneficiaries who received clinically necessary services for these diagnoses. Those can be considered process measures, such as lipid testing for people with coronary artery disease. The second type of measure is the percentage who had potentially avoidable hospitalizations directly related to their diagnosis.

So here are the results, and I'll take you quickly through the table. The table tracks change between 2003 and 2005. The numbers in the table refer to the number of indicators within each medical condition that showed improvement or stable or worsened. As you can see, most of the indicators we measured were steady or showed small improvements between 2003 and 2005. Among 38 measures, 22 showed improvement and 13 were stable.

We found that for several conditions declines in potentially avoidable hospitalizations occur concurrently with increases in the use of clinically necessary services for the same condition. So for example, for diabetes we see lower rates of amputations and diabetic coma, with higher

rates of lipid and hemoglobin testing.

In only three out of 38 measures did we find a decline in quality and all three of these were related to breast cancer, for which we found small declines in mammography screening and imaging for women with a history of breast cancer. But we do note that these slight declines are consistent with ones recently found by NCQA in HEDIS reporting measures.

So for the second part of the adequacy framework, we look at changes in costs for 2008. CMS's preliminary forecast for input price inflation is 3.3 percent. As you know, within this total CMS sorts the specified inputs into two major categories. That is physician work, which is expected to increase by 3.3 percent, and physician practice expense, expected to increase by 3.4 percent.

I'd like to note that these input cost forecasts on the slide exclude productivity adjustments that are integrated into CMS's publicly released MEI, so they are higher than the MEI that comes out in public.

Our update framework requires an examination of input costs for each sector separate from productivity adjustments, and that's why we pull that out. Calculated

from BLS statistics, our analysis of trends and multifactor productivity suggests a goal of 1.3 percent.

In sum, the indicators I've reviewed today do not suggest current payment adequacy problems for physician services. We cannot, of course, analyze data for 2007, which currently and technically is slated to include a negative 5 percent update.

I'll mention again that the Commission's update recommendation will be sent to Congress at the beginning of March, the same time as the SGR report, which will reflect your discussions of late.

So for your discussion, here's the draft recommendation that you've seen from last year. The Congress should update payments for physician services by the projected change in input process, less expected productivity for 2008.

So drawing on the numbers from the previous slide, we would have a preliminary update of 2 percent for 2008.

I'll be happy to take your questions.

MR. HACKBARTH: I'd like to remind people, in the audience in particular, that the draft recommendations that are being presented are simply a reflection of what we

recommended for each of the groups a year ago and don't reflect any new analysis, new thinking. So take them for just that. Obviously they are subject to change.

Before we begin the discussion, it also may be worthwhile to call people's attention to this document, which reflects the conference agreement that's now pending before Congress, including in particular the Medicare provisions on physician payment. Basically, what that boils down to is a proposed freeze in the rates except for physicians who comply with reporting requirements, who would get a 1.5 percent increase.

DR. MILLER: There's also a third provision that establishes a fund to promote payment stability and physician quality. A lot of this is very fluid. The best we can figure out is that fund looks like it's about $1.4 billion for 2008. But I've got to say, these facts are very much in motion.

MS. DePARLE: What does that mean for payment stability?

DR. MILLER: I don't know.

MR. HACKBARTH: That's why I didn't mention it, because I had no idea what it meant.

DR. MILLER: It's not clear how this money gets out, from what we can see in this legislation but there's an amount of money allocated from the Part B Trust Fund, it looks like, of about --

MS. BURKE: [Inaudible.]

MS. DePARLE: I thought it was a contract for MedPAC to do more work.

DR. MILLER: We're trying to get that in. So there's some more money floating around. Exactly how it gets out to physicians is not clear.

MR. HACKBARTH: At this point I don't think it's productive for us to focus on the conference agreement. It's uncertain whether it will become law. And if it does, it will become law hopefully before we need to make our final recommendation in January.

The problem that we've often faced with the physician update in recent years is that we're asked to make an update recommendation for a future year when we don't even know what the rates will be for the current year, which is at least a difficult task. And hopefully that much will be clarified before we do need to vote in January.

MR. DURENBERGER: My question relates to the issue

of productivity and trying to get a little help to understand it in the physician context as opposed to the way we talked about it yesterday with regard to hospitals, and particularly because -- I think it's on slide six -- physicians report practice changes and compensation factors for the past year. In the second section there is a reference to physicians' own productivity, and it says 80 percent.

I'm not real sure exactly what that means. But since they expressed it, perhaps you can help me understand that. Then I want to follow up.

MS. BOCCUTI: Yes. The term productivity has a dual meaning here in some respects, though clearly related.

The productivity on the second section of that slide, think of it as the physicians' productivity in the office, perhaps relative to their peers. It's often measures in RVUs. So at the end of the day, the end of the week, or the end of the year, their counts of RVUs would be a measure for the office as to that physician's productivity. So given a certain block of time, how many units were they able to produce?

We also consider, when we're looking at

productivity, there's more elements within the office to be able to help physicians increase their productivity, with technology and physician extenders and other issues like that.

So that's kind of a little bit more of the BLS productivity in sort of efficiency gained over time in doing services.

MR. DURENBERGER: That is the second part of this question. On the valuing primary care providers section logically and importantly there is a set of future research or ongoing research, one on workforce and then other issues. I guess the question that I had or where it would be helpful to me to understand it is specialty physician, particularly surgeons and so forth, radiologists and so forth, may look at productivity one way because technology substantially enhances productivity unless it happened to be controlled by the hospital. Then in the wrong site of hospital setting it may not, and so they seek other ways in which to enhance their productivity like a setting up their own system.

On the primary care side, generally again, and I'm sure there's a crossover in here someplace, what you call physician extenders and I might call -- and I don't know if

they're the same or different -- but ancillary health professions, everything from the physician's assistants to a variety of other professionals, are really a very, very important part of whether we call it physician productivity or enhancing the quality of the care for the patient, that I wonder if you wouldn't speak just briefly to how this future research will tie with our ability to use productivity as part of a compensation adjuster, if you will.

MS. BOCCUTI: Yes, I have two relevant points to that to make, one on the nonphysician staff. I think I mentioned when I was speaking that when we think of primary -- and I was careful to put primary care providers, not primary care physicians, in the sense that many staff can really provide primary care services. And so I hope that when we're looking at this issue, and if we focus on primary care, that we conclude how the nurse practitioners et cetera are able to provide that service.

I think in many models that increases the availability of primary care services. So I hope that we're able to include that in the analysis.

The other part you mentioned about productivity, I think that hits a little bit in the alternative methods of

calculating work RVUs. In some sense, what are the physicians -- primary care physicians for this example -- what are they able to do with their time and effort? And what constraints do they have on them with regard to that? And how could potentially that be a factor in measuring their work RVUs? So if there are other items like their ability to do more, which may be more constrained for the cognitive services. Potentially the work RVUs may address that issue, that you need physicians' time right then, right there and sometimes that's all you can do and you can't increase their abilities to produce more at that moment.

Is that where you're going?

MS. BURKE: I want to talk a little better about the indicator relating to cancer and the decline there.

But Dave, to your point, on behalf of the nurses of America, physician extenders always makes me think of Hamburger Helper. So I think nonphysician providers works, nurse practitioners, but stay clear of the physician extender thing.

Going to the cancer indicator, and your indication that it appears to be related specifically to mammography as it relates to patients that have been treated in the past,

do we know anything more? I know it's a little off the specific topic we're talking about, but it's a trend that would certainly concern me.

Do we know, in the course of the work, what the nature of the problem is? Nancy-Ann and I were sort of having an off-line conversation. Is it a function of the payment rates? I can't believe that it is a change in the pattern of behavior with respect to the recommendation for follow-up screening as a result of someone who has been treated the past.

I wondered if it's something that we needed to discuss separately as a unique set of circumstances. Because it was so off track with all of the other indicators that are moving in the right direction in terms of behavior, is it a physician behavior? Or is it, in fact, the failure to pay adequately for the service and therefore people aren't doing it or they are not offering it?

MS. BOCCUTI: Because NCQA found in their HEDIS performance measures that same drop, and that's going on in private insurers, it's not necessarily a reimbursement issue for Medicare. While our measures are for Medicare fee-for-service that we're seeing the same finding in the private

insurance population, either it would be a reimbursement across-the-board. But we can't just say it's a Medicare reimbursement issue.

But NCQA also noted that there's been some public debate on the effectiveness of mammography and that could be a contributor to confusion for the patients on seeking the treatments. And that they're actually thinking that that is affecting the screening. So there seems to be a need for coordination of public education efforts.

I think that the data that we show, it covers a long period of time. And to the extent that that is an issue that has gone away, and maybe we're moving back towards realizing that regular screening, particularly if you've had a history of breast cancer, is a good thing, that maybe once we get the old data out we'll be able to pull in the newer data and see that.

But that's what NCQA was thinking may be a contributor.

MS. BURKE: It's something I'd like to keep an eye on and track as we get more information and I think get some better understanding. If it is, in fact, not a reimbursement or if it's a combination of reimbursement and

the story being told or people's lack of understanding. But it's certainly a worrying trend that I'd certainly want to comment on if it had anything to do with either the way we are talking about it or the way we're paying for the service.

DR. CROSSON: Just a note on that, and we've noticed the same phenomenon in our program. In fact, in the last couple of years, in all eight of our regions, slippage of a few points in mammography screening. Of course, it's not related to payment.

We're not actually sure what it is. But the sense we have is that it is due to increasing resistance. So we've been able to move the numbers back up, but it just simply has required more encouragement, more follow-up, more hectoring of people to get it.

The sense we have is that it is, in some way, related to increasing resistance on the part of at least some people to the test.

MR. HACKBARTH: Two other comments on this specific issue, Bill and Karen.

DR. SCANLON: I just wanted to make a comment but also a question, which is I thought you said that the

changes were small. And I was wondering what small might mean?

MS. BOCCUTI: Across all indicators or for the breast cancer?

DR. SCANLON: For the breast cancer; right.

MS. BOCCUTI: That numbers I don't know, but they are enough to be statistically significant, otherwise they would have been in the no change. But we're probably talking about a percentage point.

DR. SCANLON: But in working with claims data, when we have so many observations, statistically significant can mean a small number.

MS. BOCCUTI: Oh, I thought you meant percent decline.

DR. SCANLON: Yes.

MS. BOCCUTI: Yes, about a point. But there's so many patients that this indicator qualifies for it.

DR. SCANLON: It makes it significant, I know. That was one question, what are we talking about.

The second one was a question of whether, when we compared this to other indicators, that we've actually had more success with respect to these indicators and it's

harder to maintain success than it is necessary to move up from a very bad situation.

MS. BOCCUTI: If it's not in the paper, I'll note the exact numbers for you and get back to you, and for you too, Sheila.

DR. BORMAN: One other factor you might recall is that probably one of the higher risk areas in radiology, relative to professional liability, is failure to diagnose on mammography. And that may, in fact, also be playing a role here.

MR. HACKBARTH: Going back to our original list, Bob.

DR. REISCHAUER: First, Cristina, let me just say that each year this analysis has become increasingly sophisticated and useful. And I applaud you and your colleagues who worked on it. This is really good stuff. And now I'm going to suggest maybe an additional cut for next year, if it's not available this year.

My comment really is motivated by the findings of Elliott Fisher and Jack Wennberg and others about supply sensitive services that seem not to have huge impacts on or any impacts on health outcomes. And that is can we take the

various measures of patient satisfaction here or ability to get an appointment, et cetera, et cetera, and look at them by hospital referral districts or whatever, those that in Elliott's scheme of things are very parsimonious in their use of services and those which are very generous, and see if there are huge differences in ability to get appointments satisfaction.

Because I think a lot of this then plays into how you view this workforce issue going forward. And if it turns out that those areas where there are fewer supply sensitive services available that people seem to be as satisfied, then we're talking really about changing expectations and behavior, not sort of denying people care. And it will, I think, reflect on that.

So the real issue is can we, if not this year next year, sort of oversample certain areas and try to get a geographic cut on some of these dimensions?

MR. HACKBARTH: I vaguely recall that, in fact, they have looked at that and looked at access to care and patient satisfaction to access to care. And it's the other direction, that in the intensive areas satisfaction is lower and access is --

DR. MILSTEIN: Satisfaction is equal and quality is lower than the high standard area.

MR. HACKBARTH: I think there is some work on this.

MS. BOCCUTI: In some literature there's been findings. I'm not sure what time frame that's referring to.

The CAHPS fee-for-survey is very, very large and we would potentially be able to look at that in different areas. Our beneficiary survey, we'll have to work very hard to get a sample size that we could split up by region. But the point and we'll see about a --

DR. REISCHAUER: Just oversample a handful of hospital referral districts.

MS. BOCCUTI: We'll look into that. I think it's a good idea.

DR. MILLER: To take another pass on this, if you're not concerned about -- the thing about our beneficiary surveys is it's relatively small but very timely. As she said just a minute ago, you can't even compare what we're finding because it's pretty out in front. But if you are willing to fall back a year or so, then we might be able to divide this up using larger surveys.

MS. BOCCUTI: Right, it's just that the CAHPS fee-for-service wasn't done in 2005. So if they do it, and I'll find out about that, that's easy. We'll CMS and see. But we'll look at other literature and see what we can do.

DR. MILLER: I was going to say, HSC sort of looked at this about a year or two ago.

MS. BOCCUTI: Their household survey will probably be the field about 2008.

DR. MILLER: But they had also looked at this issue a year or two ago and then there's Elliott's stuff. And we can look into oversampling on the bene survey, but there's always a cost issue that comes along with that.

MS. HANSEN: Thank you, Cristina, also for I think even the fuller section on beneficiaries this year that I certainly feel and notice.

My comments actually corroborated both Dave's and Sheila's relative to the other primary care providers. Since there's such an issue of primary care as a field, and given the discussion I just wonder if we could -- and I think you're planning to do this with the whole area of the other primary care providers; i.e. for example, the nurse practitioners to kind of see the fullness of that. Because

I believe some states allow nurse practitioners now to do some billing under some protocols and to provide the primary care. So that actually can probably be seen more visibly in terms of their role to primary care.

So I'm taking a look at this as access for primary care for beneficiaries.

In the larger sense, in addition to physicians, if we're having a very hard time recruiting and doing this, I know that there is an increased supply coming actually of nurse practitioners, and even specifically geriatric nurse practitioners, because of scholarships in that area. And just to begin to see how that trend may have some future impact or considerations on access.

MS. BOCCUTI: We will want to follow up with you about those reports about who's coming into the field from these scholarships. That will be interesting. I'd like to learn more about that.

DR. BORMAN: Cristina, analogous to what Mark was saying earlier about Joan's free time, I need to reserve just a little piece of your free time to have you walk me through one of the calculations about volume and units of service and that kind of thing.

A couple of philosophical comments and some very fine here that triggers them. As you mentioned at the beginning, we have a lot of comments on the SGR report that sort of interdigitate with things that are in here. And I would like to hope that we can kind of maintain the appropriate emphasis here on the physician payment piece for the here and now, and indicate where it folds in but perhaps avoid reprising everything we're also going to say in the SGR chapter.

Coincident with that, I think that the work on SGR perhaps should stimulate us to think about do we need to do a little bit of out-of-the-box blue sky thinking in terms of the RBRVS. I think a couple times ago Bill Scanlon made some comments about resource inputs and are we really reflecting that. And we can say that well, perhaps in our idealized world the RBRVS will go away. I'm not sure it will. Maybe Part B FMS goes away, but I'm not sure that an RBRVS goes away in terms of we've created bigger pots of money but the distribution of those pots may still require some sort of relativity relationship.

And so I think maybe some more blue sky thinking about the RBRVS is in order. I don't know, maybe we have

another chapter in which it's appropriate to say that. But it would seem to me maybe here might be the case.

MR. HACKBARTH: I agree with that, Karen, and we talked a bit about that yesterday, as I recall. Even under the various SGR options that we've been talking about, they assume that there's still going to be a traditional Medicare program and you need a method for paying physicians and hospitals and all the other providers.

As Nick pointed out during that discussion, our past work indicates that there are real issues in how those prices are set and whether they're accurately set and whether the distortions in the prices are causing behavior that we may not want in the Medicare program.

So even if magically there was a new SGR apparatus put into place, that agenda would be still very important to pursue. And so the comments that Bill has made in the past and you have made in the past about looking at that are still on the MedPAC agenda.

DR. BORMAN: I was very intrigued by your comments yesterday in framing the issue of accuracy of each input versus a general philosophic kind of step back and sort of say what the drivers should be and the tension maybe between

these. I think this is an area where that tension comes forward very directly.

Just an example, CMS has stated in one of the rules or one of the NPRMs, I can't remember which, that practice expenses are not being covered to the tune of a third to two-thirds of the total that it believes may be there. We can slice and dice that to some other number, but those are pretty real numbers.

So that kind of input starts to make the accuracy piece look a little bit more cogent then just sort of setting a philosophy and I think we need to be sensitive to the multiplicity of changes that are going on both in RVWs and in practice expense at the same time.

There is a very large shift going on to E&M services in the 2007 fee schedule, as everybody here knows, and the time lag problem or the advance time problem we have, I think, will be very important to monitor that piece of it. I would just sort of say as a prospective item, the $4 billion that's moving into E&M is more than the combined allowed charges of general surgery, vascular surgery, colorectal surgery, plus neurosurgery and CT. And I think we would all agree that general surgery, vascular surgery

and colorectal surgery certainly have a lot of nondiscretionary services in the geriatric population.

I was going to make a comment about nonphysician providers, but it's already been said very well.

I would support wholeheartedly the workforce piece of access. And I understand some of the historic reasons about not looking at that, but I think we're at a time where the costs of training and the kind of things we need to accomplish, maybe the planets are in the right houses that it's time to do that.

Just a brief comment about coordination of care. One of the things that major service global packages do is combine kinds of services and sites of services in one payment. You can make the argument that it doesn't include Part A or Part D, but it is a microcosm of some of the combination payment we've been talking about. And I would point out that major procedures are growing at a good bit smaller rate. And whether that is a valid test of the hypothesis about combining payments could be debated, but that could be one interpretation of that.

I think, however, a lesson from that is that when you start to cross sites of service types of service,

defining a meaningful global quality measure becomes enormously harder. And so if we're going to move simultaneously in the direction of combined payments and more specific quality measures, I think we're going to have to remember that tension.

MR. HACKBARTH: It gets harder and more important as you move to bundles of services that span sites.

DR. BORMAN: With regards to coordination care, I would point out to you that coordination of care is a defined element of evaluation and management services and just some crude first pass calculations with some assumptions about pre- and post-service work would suggest that anywhere from 5 to 25 percent of current E&M payments or projected E&M payments for 2007, or something on the order of $2 billion to $12 billion, is indeed being expended currently for coordination of care, although it doesn't parse out as a line item.

And so I would say that we do need to be very careful about making sure we know what we're spending and what we're getting for what we spend in that particular arena.

I think I'm going to stop there. Thanks.

DR. MILSTEIN: Following up on Karen's metaphor of alignment of planets, and also reflecting on our discussion yesterday in which we made a recommendation on allocation which went so far as to indicate in what pool we thought a particular allocation should go, I would like to raise for consideration whether or not in this year's update factor we offer a recommendation with respect to how the update should be allocated to the base versus P4P pool.

We're at a point in history now where the Secretary has had a limited P4P voluntary program for physicians up and going. It has relatively limited subscription because the amount, I believe, among other things, the amount of dollars in play are not large enough to attract interest.

And so might this be the first year in which we pair our recommendation on the update with a recommendation with respect to its allocation between P4P and base, understanding that that recommendation would only apply to the range of medical specialties for which the Secretary had adopted quality measures, which at this point is not all specialties.

MR. HACKBARTH: Several people have mentioned that

connection between updates and pay-for-performance and let us think about how to bring that into the January discussion. I think it spans multiple provider groups.

DR. CASTELLANOS: Just a few comments. I agree with you about the finance. It's much too early to talk about that. But there are some mandated cuts under DRA, imaging and, as Karen said, the direct practice expenses.

The survey data, that's interesting. It depends on where you look and who you're looking at and who's doing the survey. But I think the important thing here is we're beginning to see some cracks, especially with the availability this year of maybe not getting a specialty referral.

I know when I call and try to get somebody into an office when I'm seeing a patient, sometimes I can't get the person that I would prefer to do. I send it to somebody else or the third one down on the list. So maybe we also think about maybe we don't get always the right person.

The issue of Medicaid, I know that's not our domain, but it's really kind of pitiful to look at what's happening with Medicaid. Under the law they should have equal access to care, and they don't. I don't care what

anybody says, they do not have equal access to care.

I don't know if this commission can do anything about that or make any statements about that, but this is one of the most vulnerable aspects of our care, the pregnant females and the children.

As far as the workforce goes, I totally agree. One of the things that I would also like you to look at on there is the aging of the workforce. I know in Florida 40 percent of the primary care doctors are 60 years old and older. So it's not just the number of doctors, it's the aging, especially with the oncoming of the baby boomers.

As far as the nonphysician providers, Sheila, if I ever called them Hamburger Helper, I would be decimated. I think that's cute though.

But that also, also involves the specialty practices and I couldn't have my practice if I didn't have these providers.

My only saying is maybe some of the newer -- you don't have access to care problems they say, but maybe they're seeing an extended care provider rather than a physician. And 75 percent of the people say they don't have any problems. I think we need to put it in perspective that

25 percent do. And 25 percent of the Medicare population is about 12 million. If that was one of us, I think we would be upset.

Thank you.

MR. HACKBARTH: Let me just pick up on Ron's initial comment about what the data say, the access data.

As Cristina indicated in her presentation, there are a couple of numbers that -- I think the term that you mentioned was something like bear watching because they represent a little different than we've seen in the past. And in at least some of those cases, we're talking about very small sample sizes, so it's in particular when we're talking about patients looking for a new physician, since that's a subset. And so we need to be cautious in interpreting those. But I agree that they bear watching.

The other point that I think is essential is that we are looking at national averages in all of these data. On occasions where I've testified before Congress on this, often individual members will say this doesn't match what's happening in my community, your data are wrong. And I think that it's easy to reconcile. These are the national trends and they're important to watch. But what's happening in any

given community could depart from this. For example, where I lived in Bend, Oregon, I think there are significant and growing issues with access to primary care for new Medicare beneficiaries moving into the area. It's regularly on the front page of the local newspaper and I've heard anecdotally of similar situations in other communities.

The question then becomes how much of that is attributable to Medicare and Medicare patent policy versus broader dynamics in the community? I won't pretend to speak for all communities in this situation, but I think part of the problem where I live is that we have a rapidly growing community where the population growth is outstripping growth in physician supply.

And in fact what you see is it's not just Medicare beneficiaries having problems finding a new primary care physician, it's much broader than that. And I suspect that that's true in a lot of places where we're seeing a very acute problem with Medicare access to primary care. It's not just a Medicare phenomenon, it's a broader issue. So just that observation.

MS. HANSEN: Just to that point as well, I wonder because I note in the report, Cristina, CMS is taking a look

at 11 communities in particular. I just wonder if we could define what those community are in the text.

MS. BOCCUTI: Name the communities?

MS. HANSEN: By name.

And also, I think the Census data is starting to show that there are new -- more quickly defined. I don't know how they crosscut with these 11 communities that CMS has defined. But it his this whole phenomenon of certain communities that are not your usual growth centers, but have become major growth centers. If we could kind of geographically get a sense of the demographic Census components.

And a third component of it that has to do with just also the area of diverse population growth, there's a whole component of health disparities from the IOM reports that we haven't really kind of crosscut in some of the areas of access in a more refined way.

So that may not be for this immediate period. But since the population trends are also changing and the Medicare beneficiaries will start to look more diverse, if we could begin to take a look at the trend as well.

MS. BOCCUTI: Are we planning for the June chapter

to be looking at trends in beneficiaries for the 21st Century?

MS. THOMAS: That is something we've talked about. I'm not sure if we had really wanted to necessarily drill down on the access question. We did several years ago do an analysis of access by different groups, and it may be time to revisit that. We can certainly share with you the findings, which I don't think you would find surprising.

MS. BOCCUTI: And the changes in the diversity that you were mentioning about the population to come, I think is something -- the demographic issues I think we are tracking.

DR. CROSSON: Just a point, the NORC survey, does that have more cells in it than what we have here? In the future could we get down to more geographic information? Or is this summary information pretty much what they put out?

MS. BOCCUTI: It's a pretty comprehensive survey and I do have it beside me, so we can get a look at it together if you want. It does separate by region, but the significance than drops a bit. But we can look at sort of the base and the raw numbers that we see by region, gross regions like Central, Northwest, that kind of thing.

We'll look into that. That's the physician survey.

DR. BORMAN: A quick comment to this point. Cristina, I know the IOM report about access to emergency care, and certainly the American College of Emergency Physicians and other organizations have some similar studies.

All of these things ask about or sort of circle around can you get an appointment. And I think there is a category of care here that probably is not preference sensitive service that we're not perhaps biopsying to see where there are issues in that arena. That would be things for acute conditions or exacerbations of chronic conditions and also acute conditions like appendicitis or acute things that might require a craniotomy or something like ruptured aneurysms, some of those kind of issues.

And if not necessarily in this particular cycle, if we could start to look for a vehicle that does sample urgent care access. Because I think we all know our EDs are overcrowded and I think we need to understand a little bit more about that urgent care sector.

MS. BOCCUTI: The MCBS does look at some more

emergency room indicators, but that would be a beneficiary survey. So we'll look into that and I have some results.

DR. CASTELLANOS: On that point, when we looked at specialties and increased volume, if you look the highest one was ER, the emergency room. When we looked at the specialty categories for increased volume, I think it was last month. If you look at that carefully, you'll see that the emergency room was largest increase in volume.

MS. DePARLE: This analysis excludes Medicare Advantage because we're only looking at the physician payments under fee-for-service Medicare. But it made me think this is the time of year that we look at these beneficiary indicators. I can't remember the last time we looked at it for Medicare Advantage, the CAHPS information. When we look at Medicare Advantage, do you present that, Scott?

DR. HARRISON: We haven't presented in lately.

MS. DePARLE: It's been a while since I've seen it. It's a little off point of the purpose of why you're doing this, but at some point I'd like to at least see the most recent CAHPS information for Medicare Advantage and how that's going.

MS. THOMAS: We did take a look at this and I can't remember exactly what the finding was. But I think it was the year that we made the series of recommendations. One of the recommendations was actually to do more comparative studies between MA and fee-for-service. We do have a few measures of access, and I can go back and find those and get those to you.

MS. DePARLE: I'm not even necessarily looking for comparisons. I just don't have a baseline anymore. I know it started in Medicare Advantage. They've been doing CAHPS for 10 years now. I'm just interested in seeing some data on how it's going.

MS. THOMAS: It would be no problem to get that data together.

MS. BOCCUTI: I do have to caution, technically the beneficiary survey that MedPAC has sponsored doesn't really weed out the Medicare Advantage patients.

MS. DePARLE: I wondered about that. So do you ask that as a threshold question?

MS. BOCCUTI: It takes too many questions to get that accurate. And for beneficiaries to really know in this kind of large omnibus survey --

MS. DePARLE: I wondered if you're able to just ask them if they knew what plan they were in.

MS. BOCCUTI: Many surveys have showed that it's not reliable to ask a couple of questions, are you in a Medicare Advantage? They're just not going to know and not going to know the difference. So we always have to footnote the beneficiaries.

So the comparison is going to have -- if it's 17 percent of beneficiaries in Medicare -- there is going to be some difference. But if you have only Medicare Advantage, you can certainly see how it relates to the survey at large. I just needed to say that for full information.

MS. DePARLE: That could dramatically change the way I would interpret these results.

MS. BOCCUTI: Depending on the share of them in the survey.

MS. DePARLE: Depending on the plan, in some plans I think they have great access. In others they might not. So that's an interesting fact.

MS. BOCCUTI: In fact, it could have something to do with the access to specialist issue, where these surveys are or something, but we don't know and we can't really

parse that out. But we could compare it to a Medicare Advantage only survey and see what comparisons there are.

MS. DePARLE: We're getting into some cans of worms here. I'd at least like to know as a baseline how that program is doing. I have a feeling that it's doing great but I just would like -- I think if this is the time of year that we look at it, we should look at it for Medicare Advantage, too.

DR. MILLER: When we did the managed-care stuff, Sarah was all over that a while back. And we'll just bring that back up and make sure that you guys get it.

MS. BEHROOZI: I was originally thinking of this question in the context of types of service, but maybe it's also relevant to look at it regionally. And it's got to do, I guess, with implications for the future, the study of workforce issues going forward.

On slide five, where you look at physicians' concerns about levels of reimbursement, that kind of jumped out at me, that fee-for-service Medicare looked like Medicaid -- as you say, Ron -- in terms of physicians being very concerned about the levels of reimbursement.

Obviously up until now I guess it hasn't had the

kind of impact that you might worry about, but maybe it has implications for the future, especially in terms of what areas of practice physicians go into or in which regions they choose to practice.

So I wonder if you have that drill-down information, if you have it broken out by areas of practice or specialties or primary care or whatever? Or as I said, maybe it's relevant regionally, as well.

MS. BOCCUTI: We do and we'll provide that to you.

DR. WOLTER: I just wanted to urge extreme caution on the idea of recommending that we tie pay-for-performance measures to the physician update. The reason I say that is in the voluntary program currently in place, a very small number of physicians are participating, many of whom are being added into the numbers simply because they're in the group practice demonstration project.

I've talked to no physician group that feels it's going to be easy to supply measures. I think, even in my own organization, which is extremely committed to patient safety and quality, our quality resources staff are pulling their hair out about the number of staff we need to add to do chart abstraction.

I think, as I've mentioned before, we're in grave danger at this moment in time around pay-for-performance of trying to graft a series of measures onto a bunch of fragmented silos and the opportunity right now to think strategically and tactically about how pay-for-performance could create true improvement in quality and cost is present. But we are, I think, in a dangerous direction on it right now and I really worry about that.

It will be a very interesting test case to see what happens if the current bill goes through with that 1.5 percent update to physicians being tied to measures. First of all, do all specialties have measures? And secondly, for a small office is a 1.5 percent incentive going to cause you to add the staff required to do chart abstraction?

So I think we just have to be really thoughtful about how we want pay-for-performance to unfold as we look at updates.

DR. CASTELLANOS: I'd like to comment on that, too. Right now it's a voluntary program where a physician does not get paid. We have an electronic medical record. To change our computer system to comply with the voluntary program, it would have cost my practice about $20,000. I

don't have that excess money to contribute to a non-compensated fund and I would have to look at the 1.5 percent to see if it would work out.

MR. HACKBARTH: I have mixed dealings on this. When we did our pay-for-performance work, I think our reports show that we recognized that doing pay-for-performance for physicians was both very important and very difficult, and in some ways much more complicated than doing it for some other provider groups. Not that it's easy for any of them.

But when we approached the issue, we said that Medicare Advantage plans would be a good place to start. ESRD, because there is fairly strong consensus about appropriate measures of quality. Hospitals.

Not that in any of these cases they're perfect or that they deal with some of the issues that both you and Arnie have raised about where we want to go in the long-term with pay-for-performance.

But I can readily imagine how we could be taking more aggressive steps in Medicare advantage and ESRD and the hospitals. But the way the political process has unfolded it seems like physicians, one of the more complicated areas

has become sort of the rate limiting step. We can't move on any front until we figure out how to do physicians, and physicians are, I think, inherently complicated for a bunch of different reasons, including the fact that we have small units with not a lot of informational infrastructure, a higher degree of specialization, we can go on and on about that.

But I would like to see us, I would like to see the Congress more importantly, make progress in some of the areas that are somewhat less complex and not have the whole process at a standstill until we figure out how to deal appropriately with physicians.

MR. MULLER: Just on that point, and I agree with all that. I think reiterating, at the same time, some of our support for bundling, some of our support for gainsharing, and some of our support for payments across the silos which we discussed in SGR and other vehicles yesterday, that could be helpful in that context. It has to be seen in that context in order to put those together.

Certainly, as our numbers indicate, the number of solo practices and the points that both Nick and Ron have just made about the lumpiness of these costs in order to

comply, tend to cause people to not make those investments.

It's going to be a long time before you get over that lumpiness. So unless they are part of larger accountable units and there's a way of doing the gainsharing across A and B, et cetera, and so forth, you're not likely to secure the compliance one wants in P4P in this sector.

DR. WOLTER: I just wanted to clarify, I'm all for aggressively getting going. But I would really prefer it if we could focus the initial efforts in the high-volume high-cost areas because I think there's so much return that can come here. And how to do that in a way that people don't feel left out, et cetera, of course is important.

But if we could really get going on congestive heart failure and diabetes and hospital infections and some of the areas where there are currently good evidence-based practices, good measures are available, we could make so much progress, as opposed to thinking that if we have a measure for every specialty that's going to be the fix to the SGR.

It's just strategically, I don't believe, well thought out.

DR. MILSTEIN: Clearly, whether you are on the buy

or sell side of health care greatly effects whether one sees the measurement cup as half full or half empty. Obviously, I'm on the buy side and so I see it as half full.

I would make a couple of comments here as we think about whether or not our update recommendations ought to routinely include a recommendation with respect to allocation between P4P and base. First, I think it was Senator Bennett in Joint Economic Committee hearings last spring, who said that he had recounted, in thinking about this issue in relation to both physicians and other health care provider performance, that he had spent a fair number of years of his life trying to defend the food industry against food labeling using many of the perspectives that are valid perspective that have been shared about are the measures good enough and how much would it cost to do this.

His comment was, in retrospect, he was way off base and that had it begun earlier in an even more imperfect fashion, the good things that subsequently happened would have happened sooner. It's simply one perspective from someone who was on both sides of the equation, first being on the side of the group being evaluated when they felt measures were not really ready. and then later from more of

a public interest.

Secondly, I think we have to again link back to our comment in last year's report on sustainability that one of the only ways one can imagine getting a reasonable progress on performance lift on the efficiency domain that Bob's earlier comment related to, as well as quality, is to think about better synchronization between Medicare and private purchasers. I think the last time I looked there were over 100 private payer physician P4P programs listed in that compilation that RWJ, I think, has paid Leapfrog to do.

But we are not as far along as any of us would like to be, but the situation is not as impossible as some might portray it.

MR. HACKBARTH: Thank you, Cristina.

Our concluding session is on dialysis.

MS. RAY: Good morning.

There are more than 320,000 dialysis patients in the United States. Most of these patients are covered by Medicare. Thus, how Medicare pays for outpatient dialysis services is quite relevant to their care.

My presentation on outpatient dialysis is composed of two parts. First, I will provide you with information to

help support your assessment of the adequacy of Medicare's payments for dialysis services.

Second, I will present a draft recommendation for you to consider about updating the composite rate, that's the payment rate for each dialysis treatment, for calendar year 2008.

Here are the six payment adequacy factors that we will be considering. These are the same factors that you've seen for all of the other provider groups.

Moving to beneficiaries' access to care, it appears to be generally good for most beneficiaries. There was a net increase of about 79 facilities between 2004 and 2005. The number of dialysis stations is keeping pace with the growth of the patient population.

There seems to be little change in the mix of patients providers treat. For example, the demographic and clinical characteristics of patients treated by freestanding facilities did not change between 2004 and 2005.

With respect to facilities that closed, some of what we found is intuitive. Facilities that closed are more likely to be smaller and less profitable than those that remained in business. We also see that African-Americans

and dual eligibles are overrepresented in facilities that closed.

In conclusion, we will keep monitoring patient characteristics for different provider groups but again, based on all of the evidence, access appears to be generally good.

Dialysis patients received care in about 4,500 dialysis facilities. Most providers are freestanding and for-profit and, in particular, 60 percent of all facilities are affiliated with two national publicly traded chains, and I'll refer to these two chains as the large dialysis organizations.

This slide shows that the large dialysis organizations operate in most states. The red dots are the LDOs and the yellow dots are all other facilities that include hospital-based, freestanding associated with a smaller chain, and then freestanding not associated with any chain.

Moving on to volume of services, we have looked at a number of pieces of information about the changes here. First, we see that the growth in the number of dialysis treatments has kept pace with the growth in the patient

population. However, spending patterns have changed. Expenditures for composite rate services increased while payments for drugs decreased between 2004 and 2005. Why did this happen? Because of changes in the MMA.

Very briefly, the MMA changes increased the payment for the composite rate, that's the payment for each dialysis treatment, by about 8.7 percent through an add-on payment, while it decreased the drug payment rate for separately billable drugs. CMS paid dialysis providers the Average Acquisition Payment in 2005, which lowered the drug payment rate. CMS did update this add-on payment in 2006 and 2007 to account for the increase in drug expenditures as mandated by the MMA.

This figure shows the change in spending patterns. What you see here is the trade-off in payments for drugs and composite rate services. The MMA moved some of the drugs' profits to the composite rate through the add-on payment.

Overall, spending grew more slowly between 2004 2005, by about 4 percent. Previous year growth averaged about 10 percent per year. Between 1996 and 2004, drug payments grew 15 percent per year. Between 2004 and 2005 payments fell by 10 percent, drug payments fell by 10

percent.

So how did the volume of drugs change between 2004 and 2005? And how are patients' outcomes affected? First, we looked at the aggregate volume of drugs and we held price constant in 2004 and 2005. And here we see modest increases in the aggregate use of erythropoietin, which accounts for about 70 percent of dialysis drug spending, as well as all other drugs.

We also for erythropoietin, because it is the dominant drug here, we looked at the dose per treatment between 2004 and 2005. And here we found that it stayed about the same in 2004 and 2005.

In GAO's report that was just released this week, they also show that it remained stable between 2004 and 2005, and they looked at the first six months of 2006 and show a slight increase between 2005 and 2006.

We also looked at the quality of care using the claims data. Providers are required to report patients' adequacy of dialysis and their anemia status on the dialysis and epo claims. Our analysis of the claims data suggest that the proportion of patients receiving adequate dialysis and with their anemia under control remained stable between

2004 and 2005.

Two stories to keep in mind when considering the growth in dialysis drugs. First, clinical guidelines recommended their use. At the same time, Medicare's payment policy promoted their use. Medicare pays according to the number of units given. And drugs are profitable, even after the MMA's changes, which you will see later on.

Moving on to dialysis quality, it is improving for some measures. The proportion of patients receiving adequate dialysis and patients with their anemia under control has improved. At the same time, there has been concern about the rising erythropoietin dose per treatment. It has increased between 1991 and 2004. And that information is in your briefing paper.

Again this raises the concern about whether paying for drugs on a per unit basis promotes efficient behavior from providers. One policy option the Commission can think about evaluating in the future is bundling drugs as an interim step until CMS bundles both composite rate services and dialysis drugs, labs, and other commonly provided services. A dialysis drug bundle might be one step towards addressing the potential incentive for overuse.

We also looked at the nutritional status of patients and that measure shows little change over time. One strategy that Medicare might consider is collecting information about patients' nutritional status on hemodialysis claims. This type of information could be used in Medicare's quality improvement efforts. We don't collect this information for all patients like we do patients' anemia status and adequacy of dialysis.

CMS and researchers have shown how valuable this information has been, the anemia status and dialysis adequacy, to monitor care, to pay for care and to try to improve care.

Moving on to access to capital, indicators suggest it is adequate. There is an increase in the number of facilities, providers have access to private capital to fund acquisitions. The four largest chains merged into two chains. That was financed in large part through private capital. And that occurred in 2005 and 2006. Analysts are positive about the large dialysis organizations and their stock prices have generally increased over the last two years.

So let's move to our analysis of Medicare's

payments and providers' costs. We looked at providers' Medicare allowable costs for the most recent year that data is available. For this analysis, I used 2004 and 2005. Costs per treatment grew about 2.8 percent annually between 2000 and 2005. And you see that there is some variation here. This annual cost growth approximates the 2.9 percent annual growth in input prices estimated by CMS's market basket for dialysis services.

Let's move to our audit correction. Our margin analysis is based on the costs being Medicare allowable. That is why we have considered and continue to consider how CMS's audit efforts affect the level of costs. The BBA mandated that CMS audit facilities' cost reports every three years. The 2001 cost reports provide a sufficient sample of audited cost reports to analyze. We find it reported costs are about 5 percent than audited costs. Therefore, we determine the Medicare margin by applying this audit correction to the costs of composite rate services for facilities whose cost reports have not yet been settled by CMS.

Here is the Medicare margin for both composite rate services and dialysis drugs. It has increased since

2003, which we predicted to be to 4 percent in 2007. I'd like to remind you of a couple of points to consider as you look at these margins. First, on average, drugs were still profitable under the Average Acquisition Payment, that is Medicare's payment policy for drugs in 2005.

Two, part of the drug profit moved to the composite rate in 2005 through the add-on payment. So even though aggregate drug spending fell, aggregate composite rates spending increased.

Providers also received an update to the composite rate in 2005 and 2006, and an update to the add-on payment in 2006, and they will also receive one in 2007.

Finally, the drug costs per treatment decreased between 2004 and 2005.

You can see here that the Medicare margin varies by provider type. It was larger for the large dialysis organizations than for everybody else. This difference stems from differences in drug's profitability between these provider types.

The second part of our update process is to consider cost changes in the payment year we are making a recommendation for, that is 2008. CMS's ESRD market basket

projects providers' costs will increase by 2.7 percent in 2008. As is the case with other provider groups, we consider the Commission's policy goal to create incentives for efficiency. So I would like to start your discussion with last year's recommendation, that is to update the composite rate by the ESRD market basket less half of productivity growth. Again that productivity growth goal is 1.3 percent.

There is no provision law for a composite rate update, so this would increase spending. And beneficiary and provider implications is that no effect, we expect on their ability to furnish care.

Before I turn it over to your discussion, commissioners could consider raising some concerns about the payment method for composite rate services. We already raised the first two items in our June 2005 report when we recommended that the Congress combine the composite rate and the add-on payment and eliminate differences in paying for composite rate services between hospital-based and freestanding dialysis facilities.

Also, commissioners this year could raise concerns about the MMA requirement that CMS update the add-on payment

based on the growth in drug expenditures. Updating based on such an approach is not consistent with the Commission's approach for developing payment policy.

I look forward to your questions.

MR. HACKBARTH: Nancy, could we just go back to the slide with the margins on it? I just want to connect that to the draft recommendation. As we've discussed, the draft recommendations are simply a carryover of what we recommended last year.

When we made this recommendation last year, we talked about making it consistent with the hospital recommendation, which was the same. We thought that that made sense because last year when we were projecting the dialysis margins, we were looking at either zero or slightly negative projected margins, whereas now these numbers are quite different.

I think it might be useful for you, Nancy, just to explain why these numbers are different than what we were looking at last year at this time.

MS. DePARLE: You're saying last year, but 2006 isn't up there.

MR. HACKBARTH: I'm talking about last year when

we were making our recommendation for 2007.

MS. DePARLE: But shouldn't we have a number?

DR. MILLER: What we were doing last year -- and let me sure this is right. What Glenn is referring to is last year we were projecting 2006.

MS. RAY: Right. Last year we were projecting -- this year, like the hospitals, we are working from 2005 cost reports. We don't have -- neither do hospitals -- have 2006 cost reports.

But last year dialysis was projecting 2003 to 2006 because we did not have a sufficient sample of 2004.

This year you've seen now 2004, which shows the increase from 2003, as well as the 2005.

DR. MILLER: I think there was another piece of why we were thinking zero at that time. In addition to working with 2003 data because we not gotten the 2004 at that point, we were making more conservative assumptions about what was going to happen with drugs. And two things changed dramatically. Do you want to pick up the storyline there?

MS. RAY: I think we were very conservative in estimating drug's profitability last year, moving from 2003

to 2006, whereas what we have seen here is at least for the large dialysis organizations separately billable drugs are quite profitable in 2005.

DR. MILLER: And the add-on.

MS. RAY: And then in addition to that, the add-on payment represents the excess profits that used to be paid for drugs before the MMA took into effect. So now providers are receiving this add-on payment. In addition to that, the add-on payment was updated in 2006. So our projection reflects that, as well as the update to the composite rate in 2005 and 2006.

DR. MILLER: Which at the time we did the estimate last year, we didn't know what they were going to update the add-on by. And this I'm a little hazy on, that's basically an administrative decision.

MS. RAY: Right. We knew what the add-on was going to be. It was the update to the composite rate. Because that's not in law. So that's just a slight clarification.

DR. CROSSON: Just one question about the difference between the allowable costs and the audited costs. Is that a surprise? And is there any specific

finding that causes that? Or is it just sort of an observation across multiple types of entities and multiple types of costs?

MS. RAY: Actually, the difference in costs -- and I can get back to you with more specific information. But there tends to be a bigger gap between the general administrative cost category versus the other categories of labor, costs and the other direct costs.

This difference between audited costs and reported costs we have, as you see, looked at it for 2001. Looking back though, we previously analyzed 1996 cost reports and also found a difference there between audited and reported costs. And our predecessor commission, ProPAC, used earlier cost report claims from I believe either the late '80s or the early '90s and also found a difference between audited and reported.

So there is some history in looking at the difference. And again my analysis indicates that there tends to be a bigger difference in the administrative and general cost category.

MR. HACKBARTH: Nancy, for the benefit of the new commissioners, you may want to just say a few more words and

explain why we have the audit adjustment here and not in other provider groups.

MS. RAY: The BBA requires that CMS audit dialysis provider cost reports once every three years. I'm not aware that there is a similar statutory requirement for other provider groups. I think what we said last year is if we had this information for other provider groups we would consider it as well in our updated analysis.

MS. BURKE: Nancy, at the bottom of slide three you note that dual eligibles and African-Americans are overrepresented in the facilities that closed, in particular with respect to African-Americans, they tend to be higher risk population in terms of the presence in the dialysis population.

In the text of the report, you had noted that your prior analysis had shown that patients treated by closed facilities in 2001 were being treated in newly opened facilities in 2002, that there were similar populations, the presumption being even though they were in the area of closed facilities that they were being taken up.

This issue is one that continues to concern me, and I wonder, there is no discussion in the text about

whether this is, in fact, a growing problem or, in fact, presents a particular set of circumstance. And that is whether or not this population, that are particularly vulnerable, likely to be low income, certainly predominately African-American, if in fact there continues to be this trend of the closing of facilities that service and therefore in those areas, whether they in fact will get adequate care.

They also tend to have higher rates of noncompliance and dietary issues and a whole variety of things.

DR. HOLTZ-EAKIN: Sheila, can I interrupt. do we know if this is driven by Katrina in any way? I'm worried about the 2005 drop.

MS. RAY: I did look at that. Actually, I looked at the states that facilities closed. And it does not appear to be driven by Katrina, no.

MS. BURKE: So my question is are we able to determine or are we going to looking at going forth whether or not this particularly vulnerable population is going to be put at additional risk because there is this disproportionate closure of facilities in these areas?

Again, we looked back in 2001, but circumstances are radically different than they were in 2001. I don't think we can assume that because they were served in places that were closed that they're necessarily going to be picked up by the additional beds in some of these other areas.

MS. RAY: Right. I think this is important area. We will continue to monitor this. We will look at it again next year.

I do want to note that the proportion of patients treated in facilities that remained open in both years, 2004 and 2005, treated about 40 percent -- 40 percent of their patients were African-American, which is the same share in the general dialysis population.

But again, this is a point which we will note in the text that we will continue to monitor this.

I also want to make the point, when we looked at the share of African-Americans treated by provider type, by the large dialysis organizations, by the freestanding facilities, that did remain constant between 2004 and 2005. And I think that's also another way to just keep monitoring this same point.

MS. BURKE: It is. Query whether or not -- and

that was going to be my other question -- whether there was a predominant population treated by hospital-based facilities. It appears that that's not the case, that they're fairly widely distributed, as are the other populations.

But again, I don't want to presume that if, in fact, you see a predominance of closures in a particular geographic area, that they are naturally going to get just picked up. Although you see distributional effects are similar, I think we need to keep a close eye on it.

MS. BEHROOZI: I might have misread something and I'm trying to find it now.

Had you said something in the paper about, in terms of the proportionate share of African-Americans and low-income patients, that they were more likely to be seen -- maybe a steady level over the years, but more likely to be seen in the freestanding facilities rather than the chains?

MS. RAY: There are more likely to be treated by freestanding than hospital-based. That we do see.

DR. CASTELLANOS: To this point, the illegal immigrant and the high, high risk patients are seen in the hospital setting rather than the freestanding setting. If

you look at that, you'll see -- I happen to be involved in dialysis. But we have a preponderance of illegal immigrants where we live and we have high preponderance of high-risk patients. And these patients are kept in the hospital setting versus the freestanding setting.

A separate concept, and I would like perhaps Dr. Milstein and Jay to comment on this. Dialysis is the only part of Medicare right now under pay-for-performance. Not the nephrology, but the dialysis. And we have two large organized chains today. We have a lot of freestandings, but predominantly two large chains that control the dialysis market.

In my conversation with other nephrologists, one of their concerns is that the dialysis units seem to focus in on the quality issues that they get paid for rather than some of the other indicators. And I think you very carefully stated that today. You mentioned that the quality issues of hemoglobin, which they look at very adequately, and the adequacy of dialysis, which they look at carefully. But you also mentioned maybe nutrition they don't.

This is the nephrologists telling me, and I think this may be a little small snapshot of what pay-for-

performance will be in the Medicare group. I'm mentioning this because this is what the nephrologists tell me. And I'd like any comments from you concerning this, and perhaps as a snapshot for us to look at pay-for-performance.

MR. HACKBARTH: When you answer that, Nancy, could you just clarify for me whether there's payment connected to these measures at this point or whether they're just measuring?

MS. RAY: For providers paid under the fee-for-service program, payment is not linked to performance yet. The anemia information and the adequacy of dialysis information is collected on dialysis claims and epo claims but there is no P4P yet under the fee-for-service system.

There is a dialysis demonstration going on and for those providers participating my understanding is there is pay-for-performance there but not in the fee-for-service.

DR. CASTELLANOS: That's the group I'm looking at, the ones in that demonstration project.

DR. MILSTEIN: There is evidence on the question you've raised, which is the question of whether or not within broad clinical performance category performance rises across all facets of performance, not just those that are

being measured and rewarded. The best published research on this is from the VA, which has had pay-for-performance programs going for a while. And they've actually published a paper in which they address this issue directly.

The bottom line is that which gets measured and paid rises the most. That which is in clinical areas related to that which is being measured and paid rises significantly less. And then domains that are not being measured at all rise the least or rise not at all.

There is a slight halo effect, as it were, within a clinical area associated with P4P, but it's not as robust as one might hope.

DR. CROSSON: I would just reiterate a little bit about what Nick said later on, which is that some thought needs to be given to prioritization, even within a laudable area called pay-for-performance. Because, as Arnie just said, you will get activity in things that you pay for, more than activity in things that you don't pay for.

DR. REISCHAUER: But at the same time, we don't have the counterfactual, which is what if you don't pay-for-performance at all? What happens to these various measures? Some increase in some places might be better than no

increase anywhere.

DR. MILSTEIN: I don't want to get too far into this but there actually is a difference piece of research that Judy Hibbard has published, which sheds some light on the rate at which performance is getting better and getting worse in the United States, absent any pay-for-performance. The answer is it's going nowhere and we know what the baseline levels are which are not anything anyone would like to defend.

MR. HACKBARTH: Any other comments?

Thank you, Nancy.

We'll now have a brief public comment period. As usual, I ask you to keep your comments no more than a couple of minutes. And please begin by identifying yourself.

MR. CHIANCHIANO: Good morning. I'm Dolph Chianchiano from the National Kidney Foundation and I'd like to relate the first and third presentations.

There's been a lot of interest in the last month or so about anemia therapy for dialysis patients but anemia doesn't begin with the onset of dialysis in chronic kidney disease. It starts in stage three of chronic kidney disease.

There is evidence that dialysis patients have an easier time in having their anemia managed if they have received anemia therapy before the initiation of dialysis.

So my question to the Commission is whether you might be interested in exploring the impact of the changes in payment from the Medicare Modernization Act on the access to anemia therapy before dialysis in the physicians' offices?

Thank you.

MR. DeJESUS: Good morning. My name is Pavel DeJesus and I'm with the Office of the Governor of Puerto Rico here in Washington, D.C.

And I just want to come and register our concern regarding the move to decrease the wage index floor. Our dialysis providers in Puerto Rico are very concerned that this is going to have a disproportionate effect on their ability to render care.

This is particularly the case given the difficulties that they have, our patients have in getting access to care in Puerto Rico, and an apparent above average need for care in Puerto Rico in this area.

So we would ask you to revisit the issue of a

suspension, and we would make you aware that we've provided materials to staff members on this issue and that we are available to work with you or answer additional questions.

Thank you.

MS. TROOP: Good morning. My name is Becky Troop and I am an oncology nurse at a local hospital here. My role is a patient educator and advocate for a local cancer program.

I want to thank MedPAC for discussing the bundling issue and applaud you for your positive proactive recommendations to the CMS to address how bundling distorts ASP.

I came here with prepared concerns about it but I know that you have voted to address the issue, and for that I am very grateful. So all I wanted to say, on behalf of myself and my patients, is thank you.

MS. PECK: Barbara Peck with the American College of Surgeons.

On the issue of access, I just wanted to point out that we are really seeing a lot of access issues in the most vulnerable areas. Most, like Dr. Borman said, in acute services. I think the IOM studies that came out earlier

this year really point to that, that there is access problems, and that the Medicare payment policies that you set affect this because physicians are being driven back into their offices because their reimbursements are being cut and their office is really the only place where they can generate revenue. So they're not taking call because they can't take the risk of either not being paid for treating patients or being paid less. And the office is the place they have to go.

So I think the IOM study is a place you could look for more statistics on that.

And then second, it sort of seems like the Commission views the physician world as primary care and everyone else. Really that group of everyone else is really variant. And I think the issue of workforce is a good example of that, where there's a lot of residency programs in the everyone else that have very similar numbers to primary care but they're not filling their residency programs. Actually the number of physicians in their field is dropping. And they're very similar to primary care and it can't really be viewed as just one big group of people.

I think we would just urge the Commission to look

at things with a broader scope and not just two groups.

MS. McILRATH: Sharon McIlrath with the AMA. Just two really quick questions.

One is I don't think you should necessarily be surprised that things in Medicare and the private sector do not look so very different. 75 percent of the private carriers in the last survey that we did also use the Medicare conversion factor and just tie to that. So to some extent what is happening in Medicare is being replicated everywhere else, as well.

The other comment is if you're going to really get into productivity more and, in effect I think it sounds as though the way you're going is perhaps a double productivity adjustment for certain physicians or certain procedures, then I think you need to be sure that the one that is applied to the MEI is adequate.

There was a conference that CMS where they looked at the possibility of a physician-specific productivity adjustment. Also at that conference was a group that has done one on just a health sector productivity factor. So you might want to look at that.

One other point is that this is being applied to

what a physician office looked like in 1973, and there are a lot of differences in the staff makeup and that sort of thing in an office today than in 1973.

MR. HACKBARTH: Thank you. We're adjourned.

[Whereupon, at 11:13 a.m., the meeting was adjourned.]