MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, April 25, 2002
10:07 a.m.*

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

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

2 MR. HACKBARTH: I'd like to welcome our guests in the
3 audience.
4 This morning we have a series of topics related to
5 reports to Congress, mandated reports to Congress, on coverage
6 of non-physician practitioners, payment for non-physician
7 practitioners, and beneficiary access to hospice care.
8 And then we will have, as is our custom, a brief
9 public comment period. For those of you who plan to participate
10 in that public comment period, I ask you to keep your comments
11 brief. And to the extent possible, avoid redundant comments.
12 If somebody before you has already said what you plan to say,
13 once is enough, because we do have some time constraints. I'd
14 like to give as many people as possible an opportunity to come
15 to the microphone.
16 Then after lunch today we turn to our June report on
17 the Medicare benefit package and potential options for modifying
18 the benefit package.
19 So first up is Marian on coverage of non-physician
20 practitioners.
21 MS. LOWE: Good morning. Today we're going to
22 continue our discussion started in March regarding Medicare

1 coverage of certain non-physician practitioners. As you'll
2 recall, Congress directed MedPAC in the Benefits Improvement and
3 Protection Act to study whether the following non-physician
4 practitioners should be allowed to independently bill Medicare
5 for their services: surgical technologists when they're
6 functioning as a first assistant at surgery; several mental
7 health providers, marriage and family therapists, pastoral
8 counselors, and licensed counselors. And finally, we had an
9 additional request from Congress, to address whether Medicare
10 should cover clinical pharmacists for collaborative drug therapy
11 management services.
12 As is the case for so many of the issues you're
13 addressing today, this report is due in June. With the Chair's
14 indulgence, I'm going to present these issues in reverse order
15 to try and knock off the easy ones first, and save a little bit
16 of additional time for the first assistant issue.
17 At issue here is whether Medicare should cover
18 clinical pharmacists who provide drug management services,
19 essentially assisting physicians with medication management,
20 including services ranging from patient education to ordering
21 and interpreting medicated related laboratory tests.
22 In your discussion last month you talked about several

1 basic issues, that drug management may improve quality of care,
2 especially for beneficiaries managing complex conditions with
3 multiple medications, that the benefit should balance physician
4 and pharmacist roles, but that the cost of such a benefit in
5 Medicare is largely unknown.
6 Several important conclusions emerged from this
7 discussion. In short, that this was an idea worthy of
8 exploration, that the work necessary to determine optimal
9 strategies for implementation of drug management services should
10 begin sooner rather than later, as this may help inform the
11 design of an outpatient drug benefit.
12 That said, we have brought back the following
13 recommendation for your consideration to encourage continuing
14 progress on this front. That recommendation, that the Secretary
15 should assess models for implementing collaborative drug therapy
16 management services.
17 I'm going to pause there and try and do the discussion
18 for these, and then we'll move on to the mental health next.
19 MR. FEEZOR: I guess just reading this and then
20 reading where we talk about the fact that care management
21 services need to be covered, and yet we're talking about a
22 program that ostensibly doesn't pay a lot for at least

1 outpatient drugs, and we're urging study of the coordination of
2 that.
3 I just wonder if it doesn't need to be offered in the
4 broader context, as studying for ways of collaborative drug
5 therapy management services as a part of care management
6 services, just to raise the question.
7 MR. HACKBARTH: So, Allen, you're proposing just to
8 add those additional words to the recommendation? Not everybody
9 heard them, so would you repeat them?
10 MR. FEEZOR: I guess the suggestion would be that
11 collaborative drug therapy management services, as a part of
12 larger care management services that might be considered. But
13 if that takes us too far off, given the time, I'll withdraw it.
14 MR. HACKBARTH: When we take up the afternoon
15 discussion, one of the potential benefits that we've been
16 discussing is some sort of a care management benefit, but it's
17 not yet part of the program, not yet a foregone conclusion that
18 we would recommend to make it part of the program. So
19 introducing it here may be putting the cart before the
20 proverbial horse.
21 MR. SMITH: Maybe then we should wait and revisit this
22 recommendation. Certainly, the emphasis that we're likely to

1 place, and was reflected in the March meeting on care management
2 more comprehensively would suggest we're headed down that road
3 properly, I would think. And it would seem to me maybe we
4 should put this aside, have that conversation, and then revisit
5 this recommendation with Allen's amendment.
6 DR. LOOP: This is all ambulatory or outpatient; is
7 that correct? Because it wasn't entirely clear.
8 MS. LOWE: The discussion that we're considering here
9 is basically in regard to outpatient drug benefit, management of
10 outpatient drugs.
11 DR. LOOP: There's one statement that you make in the
12 text establishing a structure for the benefit in the absence of
13 outpatient prescription drug coverage, seems unlikely to produce
14 the necessary integration. Aren't those two distinct issues, a
15 drug benefit package and this collaborative management services?
16 Do we have to tie that together in the text?
17 DR. ROSS: The reason we bring them together is --
18 they are distinct in the sense that you probably wouldn't do
19 this in the absence of an outpatient prescription drug benefit.
20 But if you were going to consider looking at the collaborative
21 therapy management, that might influence the nature of the drug
22 benefit you'd offer and how you offered it.

1 That was sort of the gist of why might you be looking
2 at models for this now, so you'd have a knowledge base if and
3 when Congress gets around to doing the drug benefit.
4 DR. NEWHOUSE: It's not clear to me that you'd have to
5 be linked with an outpatient drug benefit. I didn't read it
6 that way either in our discussion. I read it as it could be
7 linked, but it could also stand on its own.
8 MR. HACKBARTH: My understanding was that was the
9 context for the request. They asked us to evaluate this before
10 a drug benefit had been enacted, which implies that it could be
11 done separately.
12 DR. NEWHOUSE: Also in terms of the afternoon
13 discussion, this is a separate report, as I understand it. So
14 it's not as though this would be in the same report as the June
15 benefit discussion.
16 MR. HACKBARTH: Let me just pick up on the connection,
17 or perhaps not a connection between the two. The broader issue
18 of care management is one of the topics we've been discussing
19 under potential revisions in the benefit package. As we have
20 discussed, we do not, at this point at least, plan to make
21 specific recommendations in that report. It is an educational
22 document, as opposed to a recommendation document, the way our

1 March report is.

2 If we include language here that says the Secretary

3 should do this in the context of a broader care management

4 benefit, we have now said we're going to start to make

5 recommendations about revisions of the benefit package, which

6 takes us into an area where we said we were going to stay out

7 of.

8 So that is my reservation about adding that language

9 that you suggest, Allen. Am I misunderstanding your intent? I

10 know you disagree with me, David. Do you want to articulate

11 your disagreement?

12 MR. SMITH: I'm not sure I disagree. It would seem to

13 me we could do precisely as you suggest and respond to Congress'

14 request by saying the Secretary should, and then another

15 sentence that says particular attention or the Secretary should

16 also consider ways in which drug management programs could be,

17 should be integrated with overall care management.

18 I think it's sort of goofy not to say that if we're

19 going to make that point as clearly as I think we intend to make

20 it in the June report.

21 MR. HACKBARTH: I wouldn't have any reservation about

22 saying that outside the bold-faced language, that if you do this

1 it might be logical to look at it not just as drugs but in the
2 broader context. But having bold-faced recommendation language
3 for a care management benefit, I think goes through a door that
4 we said we weren't going to go through.
5 MS. ROSENBLATT: I'm concerned about what is in the
6 bold-face. I think we were asked to look at should there be a
7 drug management program now, without there being outpatient drug
8 benefits. I almost think we need two recommendations, one
9 particularly geared to that. And I would say I don't see how
10 you can do that when you don't have the data on drugs. So I
11 would say no, there should not be a drug management program in
12 the absence of outpatient drug benefits.
13 The second piece of the recommendation is if
14 outpatient drugs are introduced to the program, there should be
15 a drug management program along with the introduction of those
16 drugs. That's how I would do it.
17 MR. MULLER: Though our data indicates that of the
18 beneficiaries who have need for drugs, they use quite a bit of
19 them and it's pretty high out-of-pocket costs. So I think an
20 argument can be made that giving them some assistance in
21 managing that, even though it's not a direct Medicare program
22 right now, is a reasonable argument. And I think, in some ways,

1 waiting for drug coverage to occur which -- like other people,
2 we're always told it's around the corner but it may not be
3 around the corner for quite a while.
4 But obviously the assistance that a segment of the
5 beneficiaries, a sizeable proportion of beneficiaries use a lot
6 of drugs and they need some help in that. So I do think it can
7 be separated and would be with those people who think it doesn't
8 necessarily have to be linked to adding prescription drugs to
9 the program.
10 MR. HACKBARTH: Murray reminds me that I may be trying
11 too hard here, and that the actual draft recommendation is one
12 that we should assess, as opposed to an actual recommendation
13 that we do some sort of drug therapy management benefit. If we
14 are talking about the Secretary ought to assess it, then putting
15 it in the context of well, assess it in the context of broader
16 care management services may not be a problem.
17 We're off to a very deliberative start but probably
18 we're not using our time wisely.
19 DR. NEWHOUSE: My comment was along the lines of your
20 last comment, which is the operative sense in the text for me
21 was at the bottom of page five, the Secretary should start now
22 to develop and test models, direct management models -- there's

1 a type there -- because this might help inform the design of
2 future benefits.
3 That sounded to me like we were looking toward a
4 demonstration of a sort, as opposed to a benefit. That's what I
5 thought I was going to vote on.
6 DR. REISCHAUER: In some sense that was my problem
7 too. I had a difficult time with the word implementing because
8 implementing is something very different from demonstrating the
9 effectiveness and the way which this might be coordinated with a
10 larger benefit.
11 I would also just say that I'm concerned about a
12 discussion of benefits that raise serious equity issues. I
13 would say that while they are separable, to provide a benefit
14 like this before we've covered drugs raises a significant equity
15 issue, because those without prescription drug coverage tend to
16 be lower income, tend to be more vulnerable groups. Not the
17 very poorest, because they're covered by Medicaid.
18 DR. NEWHOUSE: But they still use drugs.
19 DR. REISCHAUER: But you're talking about managing
20 something that some people don't have an ability to access. And
21 I think I would spend whatever marginal resources I had trying
22 to provide the basic input, rather than the management of it.

1 DR. NEWHOUSE: Why can't they access it? I assumed
2 you were providing this benefit for everybody, irrespective of
3 whether they had insurance to cover the cost of their drugs.
4 MR. HACKBARTH: Potentially the people who have the
5 fewest resources maybe are in the greatest need of help in
6 making sure they're not taking duplicative, inappropriate drugs.
7 DR. REISCHAUER: They tend to take fewer drugs and
8 more often don't take the drugs that they need. I'm just saying
9 if I were allocating my resources, this wouldn't be higher on
10 the list than providing the basic drug benefit itself.
11 MR. HACKBARTH: Before we leave, Bob, do you have
12 specific language, Bob, that you would use to replace
13 implementing? Models for collaborative drug --
14 DR. ROSS: -- assessing and implementing. Strike
15 that.
16 DR. STOWERS: Mine was the same thing, not to be
17 redundant. I was going to add something like before adding a
18 CDTM benefit to Medicare, the Secretary should assess models.
19 Because the way, with the word implementing, I think we were
20 saying that it should be implemented and it should be a benefit.
21 And what I think we need to get across here is before we would
22 recommend adding that benefit to Medicare there should be this

1 assessment done, I think is much more clear in our intent.
2 Because from this we could say we think it should be
3 added and we just need to pick which model. I think that's what
4 this inferred. So I think we need this before implementing or
5 before adding or whatever, or somehow explained if not directly
6 in the recommendation, for sure in the text.
7 MR. HACKBARTH: I propose what we do is say, the
8 Secretary should assess models for collaborative drug therapy
9 management services. And then in the text we make Ray's point,
10 make it clear that we're not assuming the benefit but we're
11 looking at ways that it might be done if the benefit were added.
12 And then also in that text, make Allen's point that
13 there's a broader issue here of care management services and
14 drugs is just one facet of that bigger problem.
15 DR. NELSON: I know you want to end this but the basic
16 question was whether we open a new category of practitioner to
17 directly bill for Medicare services. Apart from whether there's
18 a drug benefit or not, you could have a drug benefit and still
19 say that pharmacists can't bill for patient care.
20 And so don't fuzz it up in the text in a way that
21 prejudges that issue.
22 MR. HACKBARTH: Help me. Was there something that I

1 was saying that would fuzz it up in an inappropriate way?

2 DR. NELSON: No.

3 MR. HACKBARTH: So the draft recommendation on the

4 table is the Secretary should assess models for collaborative

5 drug therapy management services. Are we ready, do you want to

6 vote on those now or just vote on all the recommendations at the

7 end?

8 DR. ROSS: Let's do it now.

9 MR. HACKBARTH: All opposed to the draft

10 recommendation, raise your hand?

11 All in favor?

12 Abstain?

13 You had no idea, Marian, that it would take that long,

14 did you?

15 MS. LOWE: Up next, Medicare coverage of non-physician

16 mental health providers.

17 Once again, we were asked to assess whether or not

18 Medicare should extend coverage and allow those providers to

19 bill independently for their services. As we discussed at the

20 last meeting, each of these practitioners provide viable

21 services to their communities. However, we have some very

22 limited data to assess the ability of whether these providers

1 are able to fulfill unmet needs of Medicare beneficiaries in the
2 areas in which they practice.
3 Second, that these providers, in some cases, are not
4 licensed in all -- in the case of all of these providers, none
5 of these are licensed in all 50 states, as is the case with the
6 other non-physician providers currently able to provide mental
7 health services under Part B.
8 And also, this is likely to cost additional money
9 either by fulfilling current unmet needs or by expanding
10 additional capacity in urban areas. One of the points of our
11 discussion last month led to the issue that the barriers to
12 access mental health services that cut across both urban and
13 rural areas are both financial and cultural. Certainly the
14 financial barriers is the area in which Medicare policy can
15 address those issues. And that has led us to bring back the
16 following recommendation.
17 That Congress should not allow marriage and family
18 therapists, licensed professional counselors of mental health or
19 pastoral counselors to bill Medicare independently for mental
20 health services, noting in the text the Commission's sense that
21 reducing beneficiary cost-sharing offers greater potential for
22 improving access to mental health services than does covering

1 additional providers.

2 DR. WAKEFIELD: I'd like to make a few comments on
3 this recommendation, but the comments that I'll make actually
4 derive from some of the statements in the text because the text
5 leads us to this recommendation as its currently framed.

6 Let me just start off by saying I put my bias out on
7 the table. I don't support this recommendation and how the vote
8 goes is probably a different outcome. But I want to share why
9 that is the case and, as I said, make a few points.

10 According to this text, the existence of mental health
11 professional shortages is doubtful. We cast it carefully,
12 saying it might exist, not sure, not a lot of precision around
13 that conclusion. Part of the issue for me is that this is
14 really caught up in a much bigger issue. Medicare doesn't own
15 this problem. That is, if the problem exists, access to mental
16 health services, it's not just unique to Medicare. That's
17 frequently the problem that we get into, that Medicare can't
18 solve the much bigger woes of the world. So I want to
19 acknowledge that right up front, that the comments I'm going to
20 make I recognize are cast in a larger context.

21 Nevertheless, I think it's worth noting that according
22 to the HHS office of designations, health professional shortage

1 designation areas, as you know, we've got designations for
2 primary care health profession shortage areas, for dental, and
3 for mental health. And we've got about 50 percent of our
4 counties that, applying that definition -- which is not a
5 perfect definition but it's the only one that I'm aware of at
6 the federal level for mental health.

7 Applying that definition, we have a lot of counties in
8 the United States that have mental health profession shortage --
9 that are designated as mental health profession shortage areas.
10 And in those counties we have about 40 million people residing.
11 And of those 40 million people, no doubt some of them are
12 Medicare beneficiaries.

13 So cast in that broad a context, and I think that my
14 read on this chapter takes me to a slightly different place,
15 which is a little bit too much of a caveat built around the
16 notion of whether or not shortages exist.

17 When the federal office determines whether or not a
18 health profession shortage area exists, they look at the
19 population-to-provider ratio. They've got about five categories
20 that they incorporate in that population-to-provider ratio.
21 Those categories are psychiatrists, psychologists, mental health
22 nurses, social workers, marriage and family therapists. Those

1 are the categories that the government counts, including
2 marriage and family therapists.
3 If you look at that designation, about 95 percent of
4 Wyoming is in a mental health shortage area. When I was out
5 with Senator Baucus and his staff about three weeks ago in
6 Montana, I believe there is no psychiatrist, for example, east
7 of Billings. There are some rural Medicare beneficiaries who
8 reside east of Billings, for example.
9 So it's just that broader context of how we're casting
10 this issue of access that I think I've got a slightly different
11 take on it than how it's represented in the text.
12 I'd also say that in the text we talk about a lot of
13 different barriers. And I think everyone recognizes that there
14 isn't one single problem that drives shortage to mental health
15 benefits. And the text does a nice job of saying there are lots
16 of multiple barriers. But I think that even if we address some
17 of those other barriers, like payment policy, if we've got basic
18 fundamental access to health care provider problems it can
19 change co-pays. And if there's isn't a provider out there to
20 meet that need you still have a problem, I think, with access.
21 And I also say that on the HHS report that was cited
22 in the text, from 2001, there are points from that report -- and

1 I know we've got to be concise here -- but points from that HHS
2 report that weren't cited. That report from HHS specifically
3 speaks to access to workforce and says, just for the record, the
4 section on workforce says -- here's the challenge: more
5 geriatric mental health professionals and paraprofessional
6 personnel are needed in the fields of medicine, mental health,
7 and social services. They state it specifically in that HHS
8 report. Then they identify strategies. Expand the pool of
9 mental health personnel and training opportunities, and they go
10 on from there.
11 In that same HHS report, we don't pull that data into
12 this read. But in that same report it says many older persons
13 do not recognize their own mental health needs, don't know how
14 to access and use the service delivery system. Older persons
15 who live alone, are geographically isolated, frail or physically
16 disabled have particular difficulty accessing services which
17 tend to be in short supply.
18 So we've got sections of the report that I think would
19 be useful to help frame our thinking when we're talking about
20 this particular issue.
21 The last point I could make, because I could go on and
22 on and I won't. But one of the last points I make is we've got,

1 for example, a comment in this document -- and I didn't go back
2 and take a look at that particular reference -- but it says non-
3 physicians basically -- a citation from the American College of
4 Physicians, American Society of Internal Medicine, that says you
5 don't see non-physicians wanting to practice in underserved
6 areas.

7 And yet in our next document, behind the next tab,
8 we've got data that says use of non-physician providers, NPs and
9 PAs are higher in rural areas. And in the Hartley study that
10 was just done they say, in fact, you've got a higher use of
11 social workers in rural areas than in urban areas.

12 So there's just lots of information here that's kind
13 of hard to cull out. But I don't think this text goes -- I
14 think this text could move more strongly, at least in
15 acknowledging this broader context of problems around access,
16 from my perspective, around access to care.

17 And in all honesty -- the last point, I promise, to
18 make here -- is that the statement and text on this draft
19 recommendation as I look at it, reducing beneficiary cost-
20 sharing offers greater potential for improving access to mental
21 health services. That was in our text, as well, that we
22 reviewed. I'm not exactly sure where the evidence for

1 positioning the first change against the second is. But what
2 I'm fairly sure of is that there isn't one silver bullet that's
3 going to address all of the problems with ensuring that Medicare
4 beneficiaries get access to adequate mental health services.
5 I can tell you, based on CDC data released last year,
6 when they cut their data rural versus urban, we've got a much
7 higher rate of suicide, for example, in rural areas. And the
8 more rural you get, the higher those suicide rates go. That's
9 not just for Medicare beneficiaries. It's for the rural
10 population.
11 So I think it's an awfully difficult problem, I think.
12 But at the very least, I'd see reimbursement in underserved
13 areas, in health profession shortage areas, for these providers
14 to at least assure that level of access. I recognize cost is an
15 issue that all of us are concerned around the table, and the
16 cost to the Medicare program. If we're meeting unmet needs of
17 access, it's probably going to cost something. If we're
18 substituting a marriage and family therapist for a social
19 worker, that substitution is probably not going to cost anything
20 in addition.
21 But I recognize cost is an issue. And I think if we
22 frame this, and we're concerned because of costs, maybe we need

1 to state that more strongly. If we're framing this because
2 there's really not an identified access problem, or these people
3 provide different services, I don't think that the graph that's
4 provided bears that out. There's a lot of overlap in the
5 services provided.

6 So, I'll just stop there.

7 MR. HACKBARTH: How do you want to proceed? Do you
8 want to offer an alternative to this, that you would ask people
9 to vote on?

10 DR. WAKEFIELD: My alternative to this would be to at
11 least consider health profession shortage areas for
12 reimbursement of this category of provider.

13 DR. NEWHOUSE: I thought about that issue in the text
14 too, partly because there are some data that these people are
15 where psychiatrists aren't. But in my view, Mary stated out by
16 saying the HPSAs were imperfect. My own view is that that's an
17 understatement, and it's enough of an understatement that I
18 would be reluctant to actually base policy on it, although we
19 have precedent for that in Medicare, but I would support it.

20 Part of the problem is the HPSAs generally are based
21 on counties and counties are not a natural market area. You may
22 cross a county line and get to another provider. The no

1 psychiatrist east of Billings is a real issue, that's not an
2 artifact of the HPSA definition. But to then carry it into
3 basing payment for all of these providers, if they're in HPSAs,
4 is further than I at least am willing to go. And I don't see
5 any step short of that. That is, I don't see any alternative to
6 using the HPSA to address the problem.
7 DR. NELSON: Marian, on chapter two, page 2, you
8 indicate that professional clinical counselors, marriage and
9 family therapists, and pastoral counselors may bill Medicare for
10 counseling under Medicare's incident to physician services. Is
11 that something that is widely used? And if so, how does it
12 work?
13 That is, will clients avail themselves of services on
14 a weekly basis over a spell of time? How does it operate?
15 MS. LOWE: My understanding, based on how the claims
16 are received by Medicare, when it's a service provided incident
17 to it's very difficult to determine who is actually providing
18 that service. So it's hard to tell how often this mechanism is
19 being used.
20 As far as the course of treatment goes, I'm really not
21 able to speak to what that service looks like. But my
22 understanding is conceivably it's something in a group practice

1 where there are other non-physicians working in the same office
2 as a psychiatrist.
3 DR. NELSON: Can I pursue it just a little?
4 MR. HACKBARTH: Yes.
5 DR. NELSON: Do the trade groups that represent, for
6 example, these categories of clinicians indicate that oftentimes
7 pastoral counselors work in conjunction with a physician and
8 bill incident to? I mean, I don't know whether this is a way of
9 dealing with the access, with the shortage problem or not. I
10 don't know whether out in the areas where there aren't any
11 psychiatrists, whether or not any other mental health clinicians
12 are working with the family practitioners and provide services.
13 That's the reason I'm trying to get a hold of.
14 MS. LOWE: I would think out in the areas where
15 there's very limited access to psychiatrists, that the ability
16 of a non-physician to bill incident to is likewise extremely
17 limited. And I don't have any data to suggest how closely the
18 non-physician mental health providers are working with primary
19 care physicians in those areas.
20 MR. HACKBARTH: As I recall from our discussion last
21 time, I think Ray was pointing out that under the incident to
22 there's no requirement of physical proximity and being in the

1 same practice location, is there? There simply has to be some
2 sort of a relationship established, relationship between the
3 physician and the non-physician provider; is that right?
4 So conceivably you could have a physician connected
5 to, in some fashion, these non-physician providers of mental
6 health services in shortage areas.
7 DR. STOWERS: Yes, I think that would especially be
8 true, only be true that I know of, like in the rural health
9 clinic thing, where they allow them not to be in the same
10 facility in several states.
11 My question is not only physicians but are the other
12 mental health workers that are paid directly, are they able to
13 be the sponsoring individual in an incident to, or is it only
14 for physicians? Like can a psychologist that can get direct
15 payment work with a marriage and family therapist and still use
16 the incident to type? Could that type of a team be used in a
17 rural area?
18 MS. LOWE: It's my understanding that the incident-to
19 policy is in reference to a physician only.
20 DR. REISCHAUER: One comment about something which was
21 in the text which suggested that resources devoted to raising or
22 lowering the coinsurance might have a bigger impact on access

1 than this would. I'm just questioning whether we know enough to
2 say that. Medigap policies pick up coinsurance and employer-
3 sponsored ones do. So lots of folks out there really don't have
4 huge coinsurance out-of-pocket costs because their supplemental
5 is doing what Medicare isn't.
6 And so I'm a lot less sure of that. And if I had to
7 just pull out of my pocket one thing that would be better, in a
8 sense, it would be covering pharmaceuticals that are associated
9 with mental illness, rather than changing coinsurance.
10 I listened to Mary and I think a lot of what she says
11 is quite compelling, but it strikes me that these three sets of
12 potential providers that we're talking about here are not
13 necessarily equal in worthiness. And we're treating them in a
14 way as if they are. You see that clinical counselors are
15 trained in schools of education. That makes me a little uneasy.
16 Pastoral counselors are yet a different kind of fish. And
17 marriage and family therapist, it strikes me, are the closest to
18 the medical model that we all cover.
19 So if we were going to go away from the draft
20 recommendation, I would want to split the recommendation with
21 respect to the providers that we're being asked to consider.
22 Because at least I don't know enough to be comfortable that they

1 all would deserve the same kind of access to Medicare.

2 MR. HACKBARTH: Here's how I'd like to proceed. First

3 I'd like to get people's reactions to Bob's statement about the

4 statement in the text here that -- what I hear you saying, Bob,

5 is you're not really sure that the evidence supports the

6 statement in text. I saw at least a couple of other heads

7 nodding in agreement with that.

8 Any alternative point of view to what Bob expressed on

9 that issue?

10 DR. REISCHAUER: That's just a modification in the

11 text. It could remain and say there are other things, too.

12 MR. HACKBARTH: The reservation that I had about--

13 DR. NEWHOUSE: You can say may offer, and you can cite

14 the drug example.

15 MR. HACKBARTH: I don't want the whole argument to

16 turn on just this one point, so it can be one of several things

17 mentioned. And I would feel comfortable with that.

18 DR. WAKEFIELD: On Bob's point, I don't know enough

19 about educational background, et cetera, of each of these

20 providers, either. And so it's hard for me to stand in judgment

21 of what any one of them offers that might be somewhat different.

22 What guided me a bit on this was it seemed to me on

1 the table that's provided at the end of this chapter, when you
2 look at the services that are provided by these different
3 groups, it didn't seem like there were marked differences in
4 terms of the services provided. So you're taking it from the
5 educational side and what drew my attention, that left me with a
6 little more of a leveling of the playing field, was on the
7 services provided side.

8 And if I could just say, I agree with Joe on the point
9 about health profession shortage areas. It's not an ideal
10 formula by any stretch of the imagination. Nor are a lot of the
11 formulas probably embedded within Medicare. They are sort of
12 what we've got to work with, for better or worse. So I
13 acknowledge the point but there's just nothing else.

14 MR. HACKBARTH: That's the second point that we need
15 to take up, Mary, whether you want to offer alternative language
16 to this that we would vote on.

17 DR. WAKEFIELD: Why not, Glenn?

18 MR. HACKBARTH: Now having said that, you've got to
19 tell us the precise language that you want us to consider.

20 DR. WAKEFIELD: The Congress should allow marriage and
21 family therapists, licensed professional counselors of mental
22 health and pastoral counselors to bill Medicare independently

1 for mental health services in federally designated health
2 profession shortage areas.
3 MR. HACKBARTH: Let's have all opposed to Mary's
4 alternative recommendation raise their hand?
5 All in favor?
6 Abstain?
7 Okay, now we'll proceed to the draft recommendation up
8 on the screen.
9 All opposed?
10 All in favor?
11 Abstain?
12 And we're finished with that one.
13 MS. LOWE: Last but not least, the question of
14 Medicare coverage of certified surgical technologists when
15 functioning as first assistants.
16 The next slide here is just very briefly, to refresh
17 your memory, an overview of how the Medicare program pays for
18 first assistant surgery services at this point. I've added to
19 there basically the surgeon who gets their surgical fee. If co-
20 surgeons are performing a procedure, they equally divide 125
21 percent of the surgical fee.
22 The providers of first assistant services range across

1 the board as far as their educational background as well has how
2 the Medicare program pays them. Physicians and other surgeons
3 bill 16 percent of the surgical fee. The non-physician
4 providers, physician assistant, nurse practitioner, and clinical
5 nurse specialist bill at 85 percent of what the first assistant
6 physician would be paid.
7 Residents are not paid separately by Medicare because
8 their costs are recognized in graduate medical education
9 payments. Surgical technologist and registered nurse first
10 assistants, who constitute the bulk of the other folks providing
11 this service, their costs are considered included in the
12 facility payment bundle.
13 As you will recall, there's a lot of different ways
14 that we can consider payment for first assistant services. In
15 our discussion last month we talked about the virtues of
16 bundling and unbundling these payments and who to include in
17 those bundles or who to leave as independent billers of the
18 Medicare program.
19 Basically, I wanted to lead us through a discussion of
20 whether to bundle or unbundle, which will bring us down to
21 considering either three options or two. I want to start with
22 the issue of bundling and just go through the pros and cons very

1 briefly and move on to unbundling and do the same.

2 Basically, if you bundle, there are several advantages
3 to this approach. You eliminate inconsistencies in the current
4 payments that, from the hospital perspective, favor the use of
5 those first assistant service providers who are eligible to bill
6 Medicare Part B directly.

7 Secondly, you encourage the recipient of the bundled
8 payment to use the least expensive type of personnel consistent
9 with surgical quality. And three, you certainly simplify
10 Medicare claims administration for Medicare carriers and fiscal
11 intermediaries.

12 On the disadvantages to bundling, there are several
13 different things that can be considered here. One,
14 redistributing the costs of first assistant service providers
15 paid under Part B, currently that's a little less than $200
16 million, across all hospitals performing -- that is
17 redistributed across all hospitals performing surgeries,
18 regardless of who performs the first assistant service.

19 In that case, payment to teaching hospitals able to
20 use residents as first assistants will see an increase in their
21 payments without incurring any additional costs. On the other
22 hand, community hospitals, in contrast, would get the same level

1 of payment increase but would also incur the additional cost of
2 paying the physician or non-physician provider who functions as
3 a first assistant, who they had previously been not having to
4 compensate those people because they are paid under Part B.
5 Second, on the disadvantages, this may reduce the
6 independence of surgeons to utilize a specific individual or
7 type of practitioner as a first assistant by establishing a
8 financial incentive for hospitals to use the lowest cost
9 provider. And third, we're looking at potential disruption of
10 current employment arrangements between surgeons, first
11 assistants, and the facilities where these procedures are
12 performed by changing how we make those payments.
13 Moving over to the unbundled side, that would leave
14 you with two basic options, which is maintain current law or
15 reconsider the list of providers eligible to bill Part B
16 independently for first assistant services. When you look at
17 the advantages of the system that we now have or the slightly
18 modified system, certainly unbundling fosters maximum autonomy
19 for the surgeons to select the most appropriate practitioner to
20 serve as a first assistant. It allows flexibility in employment
21 relationships for independent contractors and employees or
22 associates of surgeons.

1 And third, kind of as a function of this policy, we
2 have in place a system that promotes opportunities to learn
3 procedures or gain experience with new technologies for new
4 surgeons or established physicians while working as a first
5 assistant.
6 The disadvantages of unbundling payments is that you
7 have no incentive to use lower cost providers in situations
8 where doing so would be consistent with surgical quality, that
9 expanding eligibility to bill the program, in terms of the
10 number of practitioners able to bill independently, may result
11 in increased cost growth. And third, that additional providers
12 would increase the complexity of the provider enrollment process
13 that Medicare contractors use to verify these practitioners'
14 qualifications, especially in the case of some surgical
15 technologists where in all but one state -- Texas -- these are
16 unlicensed practitioners. And so there is no state regulatory
17 agency to fall back on to designate a scope of practice or some
18 baseline verification qualifications.
19 If I could pause there and ask for some discussion of
20 the virtues of bundling and unbundling, then we can move quickly
21 into the remaining options, depending on which approach you
22 take.

1 MR. HACKBARTH: Comments on the issue of bundling and
2 unbundling?
3 DR. LOOP: The problem with bundling is whether it's
4 the physician or the surgical technician who assists, they are
5 often not in the employ of the principal surgeon, and that makes
6 distribution of the payment difficult. For example, in option
7 B, which is to bundle the payment for all non-physician first
8 assistants with the Part A facility fee, this would mean
9 essentially that these people would have to be employed by the
10 hospital. So that's the biggest problem with bundling.
11 MR. HACKBARTH: My personal take on this was there's
12 some conceptual appeal to bundling; i.e., that it would create
13 an incentive to use the lowest cost clinically appropriate
14 provider of the services. But there needs to be a compelling
15 reason, in my view, for requiring a reworking of employment
16 relationships. If the payment mechanism does not match the
17 existing way the world works, you need to have a compelling
18 reason to say well, we're going to force the world to adapt to a
19 new payment policy.
20 I'm not sure that the gains from bundling, in this
21 case, are so great as to require the rest of the world to
22 accommodate to this payment policy.

1 DR. NEWHOUSE: I'm sympathetic to that point of view
2 but I wasn't clear as to why it required employment. That is,
3 why couldn't the person work as an independent contractor with
4 the hospital?
5 DR. LOOP: Isn't that fee-splitting then?
6 DR. NEWHOUSE: It would be fee-splitting with the
7 surgeon. It's not clear it would be -- in a sense, it is fee-
8 splitting, but bundling basically implies that.
9 Again, the game may not be worth the candle. I'm very
10 sympathetic with that. But I don't think we can premise what
11 we're doing on saying we don't want to require an employment
12 relationship, because I don't think bundling implies an
13 employment relationship.
14 MR. HACKBARTH: To me it's not that we require an
15 employment relationship but we've got a variety of different
16 types of relationships between the assistants and the hospitals
17 and physicians, independent contractors. And to try to require
18 changes in that existing institutional framework, I think is
19 something that you do if you think there's a really compelling
20 reason to do so. I just don't think the gains from this
21 bundling of the payment are going to be so great as to say
22 everybody adjust to us.

1 DR. NEWHOUSE: I agree but it's not clear how much
2 adjustment is being required. That's what I'd like some
3 discussion of anyway. Couldn't these various relationships
4 flourish anyway?
5 DR. REISCHAUER: I want to know who makes the decision
6 that an assistant is necessary, because in theory that is -- if
7 there's bundling, it should be bundled with the decisionmaker.
8 I don't know the answer.
9 DR. LOOP: The surgeon makes the decision whether they
10 need an assistant and what type of assistant, and it varies by
11 location. I'm sure there's fewer assistants out in far rural
12 reaches than there are in urban areas. So you have a different
13 -- probably in rural areas, you'd have to ask Mary this, but
14 you'd have more physician assistants. And in urban areas, you'd
15 have more surgical technologists.
16 But it depends on the type of case. There's a huge
17 spectrum of cases, too, that require assistants.
18 MR. HACKBARTH: One other issue about the bundling
19 that's at least pointed out in the text is that, at least some
20 of the bundling options imply a significant redistribution of
21 payments among, for example, the hospital bundling option.
22 Given that the residents that serve as the assistants in many of

1 the urban hospitals are totally out of this equation, if we say
2 we've got a new hospital-based bundling policy, there's a
3 redistribution of dollars that occurs, as well as potential
4 changes in the institutional relationships.
5 I think again, for the policy gains from bundling
6 here, to go through redistribution and changes in institutional
7 relationship, I just don't think it's a prudent step to take.
8 That's my own personal view.
9 DR. NELSON: Just to say that I agree with you. Last
10 month I said, all assistants are not the same, patient needs
11 aren't all the same. In rural areas, it may well be that
12 there's one surgeon and half a dozen general practitioners or
13 family practitioners. And the proper kind of additional hands
14 during a surgical procedure would suggest that the referring
15 physician, general practitioner, may very well be the best first
16 assistant. And bundling that fee into the surgeon's fee and
17 requiring then a payback to the referring physician is fee-
18 splitting.
19 There's just a whole host of complexities that we
20 don't need to take on. That's the reason why I think...
21 MR. MULLER: I echo your thoughts as well. I think
22 undoing this gets very complicated. I think the text covers the

1 issues very well. The discussion has added to that. The gain
2 to be had doesn't seem to be sufficiently there to make it
3 worthwhile.
4 I think both Floyd and Alan have spoken to the
5 varieties. Let me just mention the area I'm more specific with,
6 they're not just residents. They're also our assistants in
7 these big hospitals. So it's not just that it's all just a
8 substitution effect, for the reason that Floyd has mentioned,
9 the complexity of the cases. So until somebody articulates a
10 reason as to the gain we would get from, this, is strikes me
11 going back to bundling just raises a host of issues that
12 probably are even greater than we can enumerate at this moment.
13 DR. REISCHAUER: It would have been nice, and maybe
14 the data isn't available, to look at a series of procedures and
15 the incidence of having an assistant and the type of assistant.
16 Because my guess is that what Floyd said is right, that it
17 varies all over the lot. And with bundling we, in a sense,
18 create an incentive to stint where an assistant maybe should be
19 used. What you're doing is providing an average across -- it
20 could work the other way. You're overpaying some and
21 underpaying others, is the problem.
22 I don't know how we could have been so misguided in

1 our discussion at the last meeting.

2 MR. HACKBARTH: So we've had our bundling discussion.
3 It appears that we're unbundling.

4 MS. LOWE: So we would like to consider options D and
5 E; is that what I'm hearing?

6 MR. HACKBARTH: Yes.

7 MS. LOWE: We'll flip forward to the last slide in
8 your packet then, since we chose unbundling payment. This
9 leaves us with two options. Option D, which is essentially to
10 maintain current law, that we believe a list of providers
11 eligible to bill Medicare for Part B for first assistant
12 services should not be modified. Or option E, that Medicare
13 should expand the list of providers eligible to bill Medicare
14 Part B for first assistant services to include certified
15 surgical technologists.

16 I'll just leave it at that and let your discussion
17 continue.

18 MR. HACKBARTH: Comments on options D and E?

19 MR. MULLER: Not a strong feeling, but I think the
20 argument in the text that Mary has articulated, about there
21 being less oversight, less licensing, less education on the part
22 of these technologists is fairly persuasive therefore for not

1 adding them in. It just seems to me more variation than one
2 would want to bring into the program as independent.
3 In the current somewhat bundled fee, the institution
4 can make a judgment as to if they want to take the risk of
5 taking on a person that may not be fully appropriate and so
6 forth. But I think having an independent status for them, given
7 the variation of licensing requirements and so forth, strikes me
8 as not worth getting into at this point.
9 MR. HACKBARTH: Help me understand the decisionmaking
10 process a little bit. To me, in this case, the principal
11 quality control is not coming from the licensing of these people
12 or the lack of licensing, but rather whoever chooses then to be
13 at the operating table, whether that's the surgeon or the
14 hospital.
15 MR. MULLER: The surgeon does, as Floyd indicates.
16 But the kind of liability the institution may take on if the
17 person is not licensed can be greater. I fully agree that the
18 surgeon will make that judgment. The kind of quality control
19 apparatus of the institution may say don't take on those kind of
20 people because of something goes awry and the person is not
21 licensed we get hit.
22 MR. HACKBARTH: So what I'm getting at is, if people

1 are practicing independently, out there in the community, but my
2 way of thinking might be a little more dependent on the
3 licensing bodies and the certification bodies to assure the
4 quality.

5 Here you've got lots of other people making sure that
6 only appropriate people get to that operating table, and
7 potentially liability of the wrong people get there. So I'm not
8 all that worried about whether there's great licensure or not,
9 in this case, as I might be in some other cases.

10 MS. LOWE: As far as the decision as to who serves as
11 the first assistant in the current setup, your issues about
12 licensing as a quality check, I think, are minimal. From the
13 carriers' side and from the Medicare enrollment and processing
14 and knowing who to send the check to, and being able to verify
15 one's credentials to be able to enroll them in the program and
16 bill independently, in a sense we may be asking the carriers to
17 function as credential verification agencies in the absence of
18 state licensure. And not having a defined state scope of
19 practice, the carriers having very little guidance as to what
20 services can and should be performed based upon one's
21 qualifications.

22 DR. LOOP: This may be stretching our mandate, but

1 although it's well stated in the text, I think we could make a
2 plea for uniform standards and better credentialing. There's
3 only a few states that have any standards and the licensing is a
4 hodgepodge. And then you have, at the bottom of this, the poor
5 orthopedic assistants that are hanging out there with little or
6 no reimbursement. If we could tighten up standards and
7 credentialing, licensing, whatever you want to call it, I think
8 if we could say it, that would be doing a service.
9 So I am against independent billing because there are
10 no standards and few thoughtful credentialing.
11 MR. HACKBARTH: Other comments?
12 So option D and E, we have mutually exclusive options.
13 Why don't we choose to vote on option E, which was the question
14 before us. Should we expand the list to include these certified
15 surgical technologists?
16 All opposed to option E?
17 All in favor?
18 Abstain?
19 Okay. Thanks, Marian.
20 Next up is payment for non-physician practitioners.
21 Craig?
22 MR. LISK: Good morning. At the last meeting we

1 discussed the first draft of this report on Medicare payment to
2 non-physician providers and came away with some general ideas
3 for what direction you wanted to go in terms of recommendations
4 and conclusions. We've incorporated those into this draft of
5 the report, which we'd like you to review.

6 At this meeting we need you to approve the current
7 draft report, and also to vote on -- we have currently one
8 recommendation in that report, and vote on that recommendation
9 and discuss those.

10 As you can see here, though, from the slide, we have a
11 change in the report title to help us separate the report that
12 Marian was just discussing. Because this report is really
13 basically looking at advanced practice nurses and physician
14 assistants, we've titled the report Medicare payment for
15 advanced practice nurses and physician assistants, although we
16 are not looking at nurse anesthetists in this report, who is the
17 other category of advanced practice nurses.

18 So that is what we were planning to do, but if you
19 want to change back for some reason we can do that. We thought
20 that the type of providers we're talking about in these reports
21 were different so we wanted to indicate it with different report
22 titles.

1 To briefly review the Congressional mandate, the
2 Congress mandate requires the Commission study the
3 appropriateness of the current payment rates for four different
4 non-physician practitioners, certified nurse midwives, nurse
5 practitioners, clinical nurse specialists, and physician
6 assistants.
7 As part of the study, the Commission was also required
8 to examine whether orthopedic physician assistants also should
9 be paid separately, and whether current payment rates for these
10 and other non-physician practitioners would be appropriate.
11 Again, this study is due in June of this year.
12 I think the report contains information on who each of
13 these providers are and what they do. I'm not going to go back
14 over that again.
15 What I do want to go to next is to just briefly
16 describe the payment rules governing these providers. We
17 basically have three type of issues that we're going to be
18 looking at here, direct reimbursement, incident-to billing, and
19 the issue of payment for the OPAs.
20 Under direct reimbursement, certified nurse midwives
21 are paid at 65 percent of the physician fee schedule for
22 services that they independently bill. In contrast, nurse

1 practitioners, clinical nurse specialists, and physician
2 assistants are paid at 85 percent of the physician fee schedule.
3 Part of the reason that this probably came about, in
4 terms of lower reimbursement for nurse midwives, was that the
5 BBA expanded payment for these other practitioners, there was
6 more restrictions on their reimbursement and the settings and
7 locations where they could be directly reimbursed. And nurse
8 midwives did not face those same restrictions. They could
9 independently bill in all different settings for the services
10 they provided previously. That's one of the reasons the BBA
11 expanded payment for the nurse practitioners, clinical nurse
12 specialists, and physician assistants.
13 The other payment that is of issue is incident-to
14 billing. Here, the supervising physician is paid at 100 percent
15 of the physician fee schedule for services provided by these
16 non-physician practitioners in an office or clinic setting.
17 Incident-to billing does not apply to the hospital inpatient or
18 outpatient settings. And incident-to rules require that the
19 supervising physician be in the office suite and immediately
20 available for consultation in order to bill incident to.
21 The physician must also have provided direct and
22 personal and professional services to initiate the treatment of

1 that patient. So if the patient is coming in with a new
2 diagnosis, in order to bill incident to, the physician must see
3 the patient in those cases. Otherwise, if the physician doesn't
4 see the patient, then the nurse practitioner would bill at the
5 nurse practitioner rate or the same case applies to a new
6 patient, as well.
7 On incident-to billing, though, the physician is not
8 required to see the patient alone very visit. Unfortunately, we
9 don't have any indication of the amount of incident-to billing
10 that goes on, because there's no indication on the Medicare
11 bills to that. You'd have to go to the patient record in order
12 to look at that.
13 Finally, on OPAs, OPAs are not reimbursed for their
14 services by Medicare, in terms of direct billing of their
15 services.
16 One other consideration on the incident-to billing is
17 that there is higher reimbursement than when these other non-
18 physician providers provide those services. One of the issues
19 that does come up with incident-to billing that you had
20 mentioned is the tension or pressure that that puts on the nurse
21 practitioner or those other non-physician practitioners for the
22 practice to bill at the higher reimbursement rate.

1 I think that's one of the concerns that the nurse
2 practitioners have with incident-to billing, is that the
3 pressure that they are under to bill at 100 percent versus 85
4 percent when, in fact, maybe in their eyes, the case does not
5 meet incident-to services. And in that case, the physician's
6 involvement may be very minimal in some cases. So that's one of
7 the issues that has been brought up that I just wanted to
8 mention to you.
9 The next slide provides our analytic approach that we
10 had on the direct reimbursement. Basically, if the inputs used
11 to provide non-physician practitioner services are the same as
12 physician services, we might conclude that there should be no
13 payment differential.
14 But if, however, we conclude that they are different
15 we need to look at what is different. We looked at work,
16 practice expense, and professional liability insurance. Within
17 the work component, we see that there is difference in terms of
18 the input to the education and potential perceived value of that
19 education to the patient that the longer physician education may
20 have.
21 We also know that in professional liability insurance
22 there are large differences in malpractice insurance rates

1 between non-physician practitioners and physicians, although for
2 certified nurse midwives, their professional liability insurance
3 is much higher than other non-physician practitioners
4 professional liability insurance. In fact, their professional
5 liability is equivalent to other internists or even, in some
6 cases, higher than internists and family practitioners.
7 The next slide, in terms of from your discussion, we
8 came to this recommendation for conclusion on the direct
9 reimbursement. The text is a little bit changed from what you
10 have in your report because we have to have an actor on here.
11 So the recommendation reads the Congress should increase
12 Medicare payment rates to certified nurse midwives to 85 percent
13 of the physician fee schedule. The conversion factor for
14 physician services should be adjusted so that the change is
15 budget neutral.
16 You talked, at the last meeting, about any changes we
17 made here should be done budget neutral, and we have dealt with
18 that.
19 The amount of services that nurse practitioners
20 provide is so small that the amount of change would be
21 essentially trivial. It would be at the fourth decimal place in
22 the conversion factor, so it's a very small change. In effect,

1 because if you raise the rate you may have a little bit less
2 incident-to billing, it may actually not cost anything,
3 depending upon how it was scored. I just wanted to bring up
4 that point.
5 So with that, I'd like to discuss this and then we'll
6 move on to the incident-to discussion and conclusion on that.
7 DR. STOWERS: I just had a minor point. When you said
8 that their professional liability was more than a family
9 physician or internist, is that a family physician that's doing
10 obstetrical care?
11 MR. LISK: No, that would be --
12 DR. STOWERS: I think we need to be real careful here
13 because it's an apples and oranges kind of comparison.
14 MR. LISK: What I had indicated in the text is --
15 well, I had said gynecologists and I can put in there family
16 physicians who do not provide obstetrics care.
17 DR. STOWERS: Because I just want to make sure that
18 we're not comparing the lowest category of services done by a
19 family physician to a family physician.
20 MR. LISK: No, these are all physicians who are not
21 providing OB services.
22 DR. STOWERS: Which is kind of still an apples and

1 oranges thing to me.

2 MR. LISK: But if you're looking at the portion or

3 type of services that are being provided, in terms of evaluation

4 and management...

5 MR. HACKBARTH: Any other comments on the

6 recommendation? Do you want to go ahead and vote on this? Or

7 do you want to talk about the other pieces?

8 MR. LISK: You might as well go and vote on this. The

9 others are going to be conclusions, rather than recommendations.

10 MR. HACKBARTH: Okay. All opposed to this

11 recommendation raise your hand?

12 All in favor?

13 Abstain?

14 Okay.

15 MR. LISK: As we discussed on incident to, there's a

16 discussion in the chapter on incident-to billing. Basically,

17 this is a summary of the conclusion that we have in the report

18 is that services provided by non-physician practitioners that

19 are billed incident to should continue to be reimbursed at 100

20 percent of the physician fee schedule.

21 That comes, again, from your previous discussion. If

22 that seems to be okay, but if you have any comments and

1 discussion, now is the time to --

2 DR. WAKEFIELD: It's a little bit on this point. At
3 what point could I make a few comments about the text, Glenn?
4 Would now be the time, or can I just reserve my right? I'm a
5 little bit on this one, but I want to make some other contextual
6 comments.

7 MR. HACKBARTH: Why don't we stay on this one right
8 now, Mary, but we can come back.

9 MR. SMITH: Craig, can I take you back to something
10 that you said in passing, that some of these providers have
11 institutional pressure to bill at 100 percent, regardless of the
12 actual involvement of the physician, whether or not she's onsite
13 or not.

14 If the world works the way it's supposed to work, the
15 recommendation makes perfectly good sense. If the world doesn't
16 work the way it's supposed to work, then without any knowledge
17 but a healthy degree of skepticism that it works that way, I'm
18 concerned about the sort of invitation to deceit, but I would
19 solve it by going to 100 percent in both cases, rather than
20 current law. It seems to me that the principle that ought to
21 guide here, assuming that clinical integrity is maintained, is
22 that the same service ought to be reimbursed at the same rate

1 and that the artifice here that results in the 15 percent
2 differential is not very convincing.
3 You raised it, I suspect we don't know very much, but
4 what we do know would help me out, to the extent we know
5 anything.
6 MR. LISK: I think some of that is the discussion --
7 you had a lot of that discussion actually at the last meeting
8 where you were conceptually appealing to pay 100 percent for the
9 services but there were some for the services, and that brings
10 that even on the incident to, as paying the same regardless.
11 I think you had a lot of discussion. I think that's
12 why we put in the paper, in terms of the text, that it was
13 conceptually appealing to pay the same for those services, and
14 we probably could put something in the text at that point
15 regarding incident to, but then there's these other issues about
16 what incentives does that create for providers and who they use
17 or the incentives for people to pursue a physician education,
18 and people's potential perceived values of the physician
19 services compared to a non-physician practitioners services,
20 because of that additional education, may have some additional
21 value. That's the rationale where we came to the previous
22 recommendation, which was focused on the certified nurse

1 midwives.

2 I don't know, that's a large part of the discussion

3 you folks should have.

4 MR. SMITH: I'm not sure I found the incentive to

5 pursue a medical degree, as opposed to a PA, not very

6 convincing. To the extent that that incentive works, and to the

7 extent that it's entirely financial, it has to do with all of

8 the things that none of the non-physician practitioners can do

9 anyway. In the instance where we're talking about the same

10 service, it seems to me you're right, it's conceptually

11 appealing, but we also ought to act to remove the incentive to

12 distort and remove the pressure that you said some of the nurse

13 practitioners raised, being encouraged to bill as if something

14 happened that didn't.

15 MR. HACKBARTH: I just want to pick up on David's

16 point. The discussion on the top of page 18, which lays out

17 potential problems with paying the same amount for the non-

18 physician practitioners as for physicians, to me felt a little

19 bit strained. I think, consistent with the logic of the RBRVS

20 system, there's really only one acceptable rationale for paying

21 different, and that's if they're offering a different service.

22 In everything else, it's just sort of make weight arguments.

1 Similarly, with the incident to, the only reason you
2 would pay 100 percent there is it's a different product that
3 you're buying with the physician's supervision. And there are
4 admittedly problems in assuring that, in fact, there is
5 physician supervision involvement that makes it a different
6 product. But that's the only acceptable rationale for having
7 differential payments.
8 I think all of the other stuff muddies the waters, as
9 opposed to strengthening the argument.
10 DR. REISCHAUER: Glenn preempted me. When I read
11 through this I thought, between the lines, 85 percent was about
12 right for one group, but the incident to should probably be
13 about 95 percent. And it's really because it's a different
14 service and the different service might just be the insurance
15 value of having the doc somewhere in the vicinity for this. But
16 I can live with our conclusion, in large measure because we seem
17 to have not a lot of knowledge about what's going on.
18 I was wondering if we could include a statement that
19 says it would be nice if we collected some information on how
20 much of certain things are incident to, as opposed to being
21 provided by the physician. Maybe we will discover that 97
22 percent of these activities are incident to, and then you might

1 rethink the relative value scale, I would think, on some of this
2 stuff.
3 DR. NELSON: I just want to point out that direct
4 supervision also means that the physician is accepting
5 responsibility for what happens, and if things go wrong in the
6 middle of the night, presumably he or she is the one that gets
7 the phone call. So it is a different service with respect to
8 the incident two portion. It involves the responsibility
9 clearly being assigned to the physician.
10 MR. DeBUSK: My question is to Ray, is to his thoughts
11 on this, because this is something you deal with on a daily
12 basis, right?
13 DR. STOWERS: I just would echo what Alan says, it's
14 definitely a different service with that responsibility being
15 there and the after hour call, the liability. There is so much
16 importance put on the requirement of incident service to those
17 first visit where the diagnosis is established. It is required
18 under this, the medication is set up. There's a lot of
19 difference in the original planning and diagnosis and care
20 planning that takes care than what usually happens in these
21 where you're monitoring them the diabetes or the blood sugar or
22 whatever.

1 You can't just look at one follow up visit here,
2 because incident-to service with the initial requirement of
3 evaluation and treatment makes it more of a team approach and
4 obviously both parties here are a part of that team. But it's
5 not the same package. That follow up visit is not the same
6 service when it's being supervised and working together as a
7 team.
8 I think what we're paying for here is the team
9 approach of having the two work together. And I think
10 throughout Medicare we need to be paying for that team approach
11 and I think the incident to is one way that that's occurring.
12 So I think to drop this to 85 or go the other way
13 around, and I look at this as part of the 85 versus 100, as
14 we're going to discuss later, we're going to have to decide in
15 Medicare whether we're going to pay for this kind of
16 collaboration and working together to increase the quality of
17 care.
18 In our place, that's the way we make it work and it
19 does work the way it's supposed to with being in the building
20 and working together and talking on the difficult cases and
21 consulting with each other takes time and effort out of a
22 practice to do that, and I think it ought to be compensated.

1 So I think it ought to stay at the 100 percent, just
2 like it is.
3 DR. WAKEFIELD: A couple of comments. One on David's
4 comment earlier. I thought in the text also it was interesting
5 that we've got text that talks about the fact that -- to take a
6 quote out of the text -- those who employ physicians and non-
7 physician providers would likely have a far greater incentive to
8 higher the lower cost provider if the reimbursement received was
9 the same.
10 It seems to me that historically we have tried to
11 allow the market to determine who was or what was the most
12 qualified, cost-effective provider. That almost, that text
13 almost takes me to the point where I'm thinking we're building
14 in a market advantage for a type of provider. So that was my
15 take on that language. I didn't feel comfortable with that
16 particular piece of language.
17 The second point I wanted to make is on the incident
18 two piece of this, I'm okay with this conclusion but I would say
19 that I don't think that we've got -- well, two points. One, in
20 terms of whether or not the care is the same or different, I
21 think a lot of us would recognize nuances and differences of
22 care and maybe clear some types of differences.

1 But right now, a nurse practitioner who's looking at
2 an elderly patient with an ear problem is going to be held to
3 the same standard of care that a physician does or a family
4 practice doc does in the legal system, and that an ENT doc is
5 held to. That standard of care is the same.
6 We can talk about differences in that service
7 delivery. I don't see anything in the literature, but somebody
8 else might, that speaks to any kind of different outcomes when
9 these different providers are providing the same set of
10 services, whatever that set of services is.
11 So the standard of care, which I think is about the
12 only thing I can have that's sort of objective out there,
13 doesn't vary based on who's providing that service. And if
14 they're providing the service, they're all licensed to provide
15 that service or they're going to be in a lot of trouble when
16 they try to claim reimbursement or anything else for having
17 provided the service. That's just a second comment.
18 A third, on the 100 percent of the physician fee
19 schedule, I think that Bob's recommendation is probably a good
20 one. I do think there's value to the fact that there is a team
21 there to provide services. But it's a little bit odd to me to
22 put somebody inside of a building, a bricks and mortar of a

1 building, a physician, or put them outside of it. And the
2 service that's provided by that nurse practitioners, that
3 service where it may only be that NP for example, seeing that
4 patient on that given day and the next two or three subsequent
5 visits, the payment can be the same depending on if you're
6 paying through incident to or you're paying a direct
7 reimbursement at 85 percent.
8 So I think there's value at having access to a
9 physician. I would be clueless whether that value is 92 percent
10 or 87 or 99. I don't think we know. So we're sort of coming in
11 behind something for which there doesn't seem to be much data.
12 We're also talking about differences in practice by different
13 practitioners for which I don't know of any outcomes that would
14 illustrate that. But I do know about standards of care that are
15 equally applied to different providers.
16 So those are some points. And I'm concerned about how
17 some of this reads in the text. So I'm not disagreeing with
18 what we have up here, but I would have some of these
19 perspectives that I'd really want to have you consider when
20 we're looking at the text, which do not follow this logic.
21 And the education piece, the last point on this, I'm a
22 little concerned about where -- I think it's fine to identify

1 differences in education. I'm still looking at patient outcomes
2 where we can and services delivered. But if we look at
3 education, and all of a sudden we're going to build a lot of our
4 rationale -- which is the way this text to me currently reads --
5 around education, we are now introducing a new factor, in a way,
6 that wasn't part of the initial development of RBRVS where
7 different types of physicians, for example, were not provided
8 with different payment amounts except when you're providing a
9 higher complexity of care in which case, and rightly so, that
10 orthopedic surgeon is paid at a higher rate for providing a more
11 complex piece of care than his or her family practice
12 counterpart.
13 And that's where I think those distinctions ought to
14 be drawn. Thanks. And so different concerns about the text,
15 from my perspective, on some of those issues.
16 MR. HACKBARTH: That was one of the concerns that I
17 had is that I don't think the rationale can turn on educational
18 differences without us getting sort of crosswise with the basic
19 theory of RBRVS. So it needs to be characterized as a
20 difference in product as opposed to difference in education.
21 As someone who's used a lot of nurse practitioner and
22 physician assistant services personally, I think that the

1 quality of service, at least in my personal experience, has been
2 great. This is a bit of a dilemma for me. Certainly for the
3 services that I've used, I don't see any discernible difference
4 between the non-physician practitioner and an M.D.
5 But again, if we go back to the logic of RBRVS, if you
6 say it's the exact same product, I think that leads you to the
7 conclusion that you level down to the level of -- the payment
8 would go down for physicians to the level of the non-physician
9 practitioners, as opposed to saying well everybody ought to be
10 pulled up to the M.D. level. Then that gets into a whole
11 another set of problems.
12 That's a place that I'm not prepared to go based on
13 the available information and data.
14 MR. LISK: What I was trying to convey in the text
15 though is some of that discussion you had last time. What I'd
16 like to know is what is the product difference that you would
17 identify for a difference? That's what I was trying to convey
18 is the potential value of that education is what may be
19 providing a difference service, in terms of the value of
20 education and the experience that goes into that is part of it.
21 And then those other incentives that did come up in some of your
22 discussion, because a lot of the discussion at the last meeting

1 was leaning to coming to the conclusion of not paying different.
2 But you came down to a vote that came down to basically
3 maintaining a differential, based on some other discussion that
4 occurred about some of the incentives that had occurred, and
5 also some of this in terms of the value of the physician
6 education.

7 Not saying that we're talking about the economic
8 return to the physician's education, but the value of the
9 physician providing that service versus the NP service and what
10 the education might bring to that individual service, is what
11 we're trying to convey.

12 I'd like a response back in terms of how people feel
13 on that.

14 MR. HACKBARTH: I understand the challenge that you
15 face in writing it. I'm not sure that the best way to handle
16 this specific wording is to try to write the language here. But
17 your point is well taken, we need to be very careful about the
18 language when we review the draft.

19 MR. FEEZOR: Just we've got enough swamps that I don't
20 want to make another one, but I think we are on the edge, if
21 we're not already, of probably needing to put some study or some
22 future study around the term incident to, given current

1 technologies and communication and telemedicine and even
2 robotics. I think that's something we're going to have to
3 probably come back and visit within the next year or two.
4
5 MR. HACKBARTH: A couple more minutes then we need to
6 move on.
7 DR. WAKEFIELD: Actually that's a good point, Allen,
8 especially when you look at how services are provided in rural
9 areas or with rural health clinics, for example, and the
10 designations of who you must have onsite and who you don't, but
11 who you must have access to at distance and how you transcend
12 that distance using technology, et cetera. I think you raise a
13 very good point and I hadn't thought about that much before.
14 In terms of your comment, Craig, about the text, I
15 just think it's worth looking at. From my perspective, there's
16 no data in this text that said to me that when these providers
17 give comparable services there's any difference in the work.
18 The studies that were cited say, in fact, outcomes seem to be
19 about the same.
20 So I don't know why we go down that road very far, as
21 the text is currently configured. I can see your point, where
22 you're trying to capture some of the dialogue from the last go

1 round, but I think some of those areas, especially when we get
2 very far into anything beyond saying there's a difference in
3 education, I think is fraught with problems.
4 So I would be looking at that very carefully in terms
5 of what conclusions are drawn that aren't supported by evidence
6 in the text. In fact, the evidence in the text may take
7 somebody to a little bit different conclusion, based on the
8 studies cited.
9 MR. SMITH: Glenn, I'll try to be very brief. I think
10 the text can't enter the issue of level up, level down. I agree
11 with that and I think the paragraph, Craig, in the middle of
12 page 18 needs to be rewritten to reflect it.
13 But just to comment on it, Glenn, again the 100
14 percent was supposed to be the cost of providing the service.
15 Not the cost of getting educated to provide the service, not the
16 appropriate economic return to the investment in education. So
17 if there's an argument for leveling, it has to be a leveling up
18 argument.
19 We're not ready to reach that yet, but we certainly
20 shouldn't conclude, based on this conversation, what we appear
21 to conclude in the text.
22 I agree with the recommendation, as I said earlier.

1 DR. NEWHOUSE: David, that's actually not -- we've
2 said the opposite with our SGR discussion. We've said SGR
3 delinks 100 percent from the cost of services. So we can't
4 really argue that 100 percent is the cost of services.
5 MR. SMITH: Right, but we have argued that there is an
6 appropriate payment for the service. Whether or not the current
7 SGR system gets us there is a different issue.
8 DR. NEWHOUSE: But it may be 90 percent, it may be 110
9 percent.
10 MR. SMITH: But the difference is not -- we will not
11 determine whether it's 90 or 100 or 105 by discriminating among
12 the providers of the service. We need to get the price of the
13 service right, and then we ought not to discriminate among those
14 who provide it.
15 DR. NEWHOUSE: Yes.
16 MR. HACKBARTH: Okay, I think we need to move on here.
17 For the two conclusions, we're just going to leave those as
18 conclusions, no votes required on those?
19 MR. LISK: Yes. The conclusion on the orthopedic
20 assistants, in terms of the last slide here, is that orthopedic
21 physician assistants should not be recognized for separate
22 reimbursement. Some of that is similar to conclusions when

1 we're talking about the surgical technologists who serve as
2 first assistants, is that there is very limited recognition at
3 the state level of licensing of these folks, even though they
4 may be providing very valuable services to patients.
5 MR. HACKBARTH: Here we'd be talking about them acting
6 independently --
7 MR. LISK: Acting independently.
8 MR. HACKBARTH: -- where I think lack of state
9 oversight is a bigger issue.
10 DR. LOOP: I'm somewhat sympathetic to the plight of
11 OPAs. I think that if the state certifies OPAs then they should
12 pay at 85 percent, because they add a lot of value to orthopedic
13 practices. They're just hanging out there by themselves.
14 I think that if they're really certified and there are
15 some uniform training standards, then we should pay them.
16 MR. HACKBARTH: Other comments on OPAs?
17 MR. LISK: Did you want to pursue that as a
18 recommendation or you're just bringing that up, Floyd?
19 DR. LOOP: There's not a lot of data on, except for
20 your statement in the text, there's not any information on OPAs.
21 I mean, it's a scattered group.
22 MR. HACKBARTH: Refresh my recollection, it's what,

1 two states that currently --

2 MR. LISK: There's a few states that have some form of

3 recognition. Tennessee, I think, is the one that has broader --

4 California recognizes those that graduated from programs in

5 California. So in that narrow window that there were certified

6 programs, California recognizes those. And in New York, they

7 recognize them as first assistants at surgery. But that's the

8 extent of it.

9 There used to be some recognition in Minnesota as

10 well, but I don't believe that's current.

11 MR. HACKBARTH: So, Floyd, are you asking for us to

12 consider a recommendation that in those particular

13 jurisdictions, or in states that do recognize OPAs, that

14 Medicare pay for them?

15 DR. LOOP: If they're recognized, they're certified by

16 the state, then I believe that they should be paid. Do you want

17 to say certified or licensed?

18 MR. LISK: Certified is national. They have a

19 national certifying exam. But then, the state level is

20 licensure for the other practitioners.

21 DR. NEWHOUSE: I'm worried about the consistency of

22 what we did before. I mean, there were a number of licensed

1 mental health practitioners that we just said we didn't think
2 should be paid. So what is the argument for paying here?
3 DR. LOOP: Joe, I don't have a good answer. The
4 mental health area is a little more diffuse. This is fairly
5 easy to quantify what they do. That would be my answer.
6 DR. REISCHAUER: Am I right that these assistants
7 don't have bachelor's degrees even, or the equivalent of a
8 bachelor's degree necessarily?
9 MR. LISK: It varies.
10 DR. REISCHAUER: And they have no formal training
11 program.
12 MR. LISK: Currently there is no formal schools that
13 provide it. It's an apprenticeship model to be able to get the
14 training for new folks. It's an apprenticeship model, working
15 with an orthopedic surgeon for five years, I believe, that has
16 to be certified by that orthopedic surgeon.
17 The other route are people who are physician
18 assistants or nurse practitioners. They will, of course, get
19 reimbursed who can be recognized as an OPA. But basically the
20 other training mechanism is through apprenticeship model with an
21 orthopedic surgeon.
22 DR. REISCHAUER: I'd be very hesitant to move forward

1 to classify these individuals as professionals who can get
2 separately reimbursed.
3 MR. DeBUSK: Looking at the history of the orthopedic
4 physician's assistant or however you want to classify this,
5 there were schools, then there wasn't schools. Then apparently
6 the American Academy of Orthopedic Surgeons took a different
7 stand on that profession. And now it appears, from what I'm
8 hearing, that they want to get back into it.
9 I think if they're going to move forward with this
10 type of assistant in the future, which is very beneficial, the
11 specialty training is certainly there, perhaps I'm asking you if
12 the Academy of Orthopedic Surgeons came back with a plan or
13 something that led to this certification or licensing, as Floyd
14 addressed there, perhaps this is something that we could
15 consider in the future, if that came together, right?
16 DR. REISCHAUER: Absolutely.
17 MR. HACKBARTH: Okay, so we'll leave it at that. I
18 think that's it for you, Craig. Thank you very much.
19 Now we're turning to access to hospice care.
20 DR. KAPLAN: Good morning. We're going to briefly
21 review our findings from the hospice study and the draft
22 recommendations. Murray told us that this would be the last

1 commissioner review. He didn't want me to say I said, so...
2 In BIPA, the Congress requested we study access to and
3 use of hospice, paying special attention to the delay in the use
4 of hospice and urban and rural differences in use.
5 We used two indicators of access, beneficiaries' use
6 of services and supply of providers. We also hired a contractor
7 to interview individuals knowledgeable about hospice to
8 determine if there were access problems not detected by these
9 two indicators. All of the data in your mailing material has
10 been updated to 2000.
11 As you can see from the figure on the screen and in
12 your handouts, the number of beneficiaries using hospice tripled
13 from 1992 to 2000. During this time period, the number of
14 hospices almost doubled. In 2000, 23 percent of Medicare
15 decedents used hospice. In that same year, cancer patients
16 using hospice accounted for 60 percent of all beneficiaries who
17 died of cancer.
18 Some individuals expressed concern that short hospice
19 stays are an indicator of access problems. The fraction of
20 hospice patients dying within one week of admission increased
21 from 21 percent in 1992 to 30 percent in 2000. We're not sure
22 what this increase means, given the change in the population

1 during this period.

2 The main causes of late referrals, however, appear to
3 be difficulty in making prognosis, beneficiaries' unwillingness
4 to give up curative care, and the greater availability of non-
5 toxic therapies.

6 We conclude that Medicare payment policy is not a
7 major contributor to short stays. We also conclude that the
8 rapid growth of hospice in the 1990s indicate that overall
9 beneficiaries do not appear to have difficulty accessing
10 hospice. To preserve access without financially overburdening
11 beneficiaries or taxpayers, however, Medicare payment rates must
12 be adequate.

13 The rapid growth in providers and service use suggests
14 that rates are not too low on average. However, concerns have
15 been expressed that rates are too low. Therefore, the rates
16 need to be reevaluated. Because of changes in hospice care
17 since the 1980s, on which the rates are based, this evaluation
18 should be more than just looking at margins on cost reports.
19 The cost-base needs to be reevaluated to ensure that the
20 efficient costs of providing high quality appropriate hospice
21 care are covered, including new pain medications and other
22 palliative treatments.

1 Therefore, the first draft recommendation is the
2 Secretary should evaluate hospice payment rates to ensure they
3 are consistent with the costs of providing appropriate care.
4 Do you want me to go on, I assume? I think it's best
5 to go on and then come back and discuss them briefly.
6 Staff extensively discussed the issue of how to word
7 the second draft recommendation.
8 MR. HACKBARTH: You chose the long version.
9 [Laughter.]
10 DR. KAPLAN: Yes, that's why it's so concise.
11 We feel that research is needed to determine what type
12 of payment system is feasible for hospice.
13 We also feel that the high cost outlier policy for the
14 current system and for case-mix adjusted system, if such a
15 payment system is feasible, is needed. So that's why we worded
16 this long recommendation.
17 The Secretary should research differences in the care
18 and resource needs of hospice patients and determine whether a
19 case-mix adjusted payment system for hospice care is feasible.
20 He also should study ways to establish a high-cost outlier
21 policy. The research on outlier policies should include both
22 methods that can be implemented with existing payment policy and

1 methods that might be used with a case-mix adjusted system.

2 DR. NEWHOUSE: I first want to try to clarify what I

3 think is an ambiguity in the second draft recommendation, which

4 is whether we're talking about a payment system that is per case

5 or episode. There's a sentence there saying a different unit of

6 payment, such as episode, may be more appropriate than per diem.

7 Or whether we're talking about case-mix adjusting the per diem

8 and an outlier policy that applies to the per diem.

9 I infer that this discussion is in the -- that the

10 staff, at least, is thinking of this in the context of a case

11 payment or an episode payment rather than a per diem.

12 DR. KAPLAN: Not necessarily. I don't think that we

13 basically said a per diem versus a per episode. I think we

14 thought that would be part of the research.

15 DR. NEWHOUSE: Let me say where I come on this. I

16 would actually like the sentence taken out of the text that even

17 refers to pain by per episode. I would not want to contemplate

18 per case payment partly on the ground that to me that would just

19 further encourage a lot of last ditch referrals to the hospice

20 to collect the per case payment.

21 I do think we ought to study a case-mix adjusted per

22 diem and conceivably a per diem -- I think we should study also

1 a per diem outlier policy. If you have a lot of expensive pain
2 meds, that could bump up the per diem considerably.
3 But at a minimum, we need to be clear about whether
4 we're talking about adjusting a per diem or adjusting a per case
5 payment. As I say, I would prefer that the notion of a per case
6 payment disappear from the entire chapter.
7 MR. HACKBARTH: I think Joe's point makes sense. This
8 is a different sort of service, different than the ones where we
9 typically use a per case method of payment. The entry point is
10 so variable and subjective.
11 MS. RAPHAEL: While I think that you have very strong
12 data showing increases in the number of hospices, the number of
13 beneficiaries using hospices and utilization rates, I still am
14 not comfortable with the conclusion that Medicare policies,
15 there's no relationship to the increase in short stays.
16 What would account for an increase in short stays from
17 '92 to 2000? The fact that people have difficulty foregoing
18 curative care has not changed. The fact that it's difficult to
19 prognosticate six months or less of life has not changed.
20 The only thing that has changed from the factors you
21 list is there are more therapies available. That is the one
22 thing that has changed.

1 Now while it is true that Medicare policy, in fact, I
2 don't think is a major barrier to access, the way it has been
3 interpreted has definitely affected the increase in short stays.
4 And there are a number of things that I think come into play
5 here.
6 One is that there has been a period of regulatory
7 scrutiny of people in hospice. Whether this is accurate or not,
8 there was a sense that you were in regulatory difficulty if your
9 patients ended up living beyond six months. And we know that,
10 in many cases, physicians tend to overestimate and in only 20
11 percent of the cases is the estimate accurate.
12 That has really led to a lot of reluctance on the part
13 of providers to admit cases. I know in my own hospice, it's
14 really disheartening to me that right now, finally, of every two
15 patients who are referred we only accept one. Because while
16 there's been some regulatory rollback, it takes a long time for
17 this to filter through an organization and among practitioners.
18 And there still is a very risk averse conservative approach to
19 entry into hospice by both physicians and clinicians in the
20 hospice program.
21 So I think that has had an effect. What happens is
22 you don't allow people in and then they're in crisis. I looked

1 at my numbers before coming here and I was astounded by the
2 number of people we're admitting on Friday who die on Monday.
3 And that number, the distribution has really gone up. I checked
4 with a few others who are seeing a similar pattern.
5 I think also, Medicare policy doesn't recognize
6 completely the fact that there isn't a clear demarcation between
7 curative and palliative care. You can use radiation therapy to
8 ease someone's pain, and you can use it for aggressive therapy
9 and it's not always clear. I think that that also has been a
10 problem.
11 And lastly, I think that this is unfortunate but true,
12 that hospices are sometimes reluctant to admit high cost cases,
13 because the payment does include drugs, the cost of drugs has
14 gone up beyond some of the trend factors. And so I think that
15 people in hospices make a calculation and therefore that also
16 affects access to the hospice benefit for some subset of
17 patients.
18 So while overall I think you've done a very good job,
19 in terms of using data, and I don't think we can say that
20 Medicare has been a major barrier here, I don't think it's
21 accurate to make a blanket statement without recognizing some of
22 the other variables that are affecting the increase in short

1 stay and what's happening in the distribution of lengths of stay
2 and admission rates.
3 MR. SMITH: Just a question. On the top of page 5 the
4 draft suggests that particularly frail beneficiaries or
5 beneficiaries without a competent caregiver may also have access
6 difficulty. I was struck by that because it wasn't clear to me
7 that that was a cost phenomena, although it may be. But I
8 wondered to what extent --
9 MS. RAPHAEL: It's a cost phenomenon and it's really
10 ironic that frail elderly, who tend to be alone, are the ones
11 who are most likely not to be admitted by a hospice because they
12 need aide service and they often need it around the clock. And
13 that's a budget buster for many hospices. Therefore, there the
14 ones who are sort of on the list most likely not to be admitted.
15 DR. WAKEFIELD: Just a quick question. Will you
16 remind me how supply of providers was measured? On the bottom
17 of page two and the top of three, no hard evidence of access
18 problems. And we say the two indicators, use of services and
19 supply of providers. Will you remind me how supply of providers
20 was measured, Sally?
21 DR. KAPLAN: Supply of providers itself was measured
22 by counting the number of entries and exits from the hospice

1 program. So supply of providers alone, that's how it's
2 measured. And they almost doubled.
3 We also looked at -- not for 2000, but to 1998, we
4 looked at the increase in providers in rural and urban areas.
5 And if I remember correctly, the statistic is 121 percent
6 increase in rural areas, which is greater than the increase in
7 urban areas.
8 DR. WAKEFIELD: If I could just follow up and comment
9 on that. I queried a few of our hospice providers in my home
10 state because it just didn't gibe with what I had heard earlier,
11 which was we do have access problems in the state. That's why
12 the measurement becomes so important. They gave me some data.
13 Basically what they were saying is yes we have, in
14 every single county -- using this one state as an example --
15 agencies that are licensed in each county. It doesn't mean they
16 provide services there at all. So if it was a measure like that
17 that we were looking at -- as a matter of fact, they said, in
18 fact, we choose not to provide services, when our staff have to
19 drive 90 miles it's just not going to happen, though we are
20 licensed to provide services in that area.
21 So that's the reason why I raise that question about
22 what the measurement was on access.

1 DR. KAPLAN: I think you have the same problem with
2 hospice as you have with home health care, that you can't
3 determine what a market area is for hospice because it is not
4 bricks and mortar. It is a professional or a paraprofessional
5 going to the home or a nursing home to provide services.
6 So coming up with a market area is something that you
7 cannot do. So you have to use what's available. Basically what
8 our contract researcher did was do a count of the number of
9 hospices in 2002 compared to 1998. Also looked at the
10 difference between rural and urban for 1998 versus 1992. And he
11 also looked at counties not served by hospices.
12 DR. WAKEFIELD: I would just say I think it merits a
13 caveat in the text that explains what some of the problems are
14 with the potential interpretation of that, because I think
15 that's potentially misleading. That's just a very important
16 distinction.
17 DR. REISCHAUER: On this point, could you look at how
18 many counties had a beneficiary that accessed hospice care
19 within the last three years?
20 DR. KAPLAN: That was done.
21 DR. REISCHAUER: That would give you a different
22 count.

1 DR. KAPLAN: That was actually done.
2 DR. REISCHAUER: It would certainly be a bottom limit
3 to what availability was. I mean, it would be higher than that.
4 DR. WAKEFIELD: This particular group, by way of
5 example, had collected that data, too, Bob, to see how many
6 decedents out of a county, who got hospice service and who
7 didn't. And those numbers do not track in parallel. They are
8 not the same.
9 DR. REISCHAUER: Sally, I was wondering if there is
10 information and you could put it in a paragraph or so on the
11 nature of this industry, how much of it is non-profit, how much
12 of it is for-profit? Of the growth over the last decade, has
13 ever of it been in the for-profit sector? Which then would tell
14 me something about the adequacy of payments.
15 And what is the relationship between hospice agencies
16 and home health and SNF? Are any of them subsidiaries? This
17 will tell you a lot about this, which I think it's sort of like
18 they're out there by themselves and it isn't clear what they
19 are. Just a little description might add to the chapter.
20 DR. KAPLAN: Just for your information, the largest
21 growth in hospices has been in for-profit hospices, and also
22 large hospices.

1 Part of the problem that I've discovered recently is
2 the only way you can tell whether a hospice is affiliated with a
3 nursing home, with a home health agency, or a hospital, is that
4 they self-report that on the form that they file every year,
5 what's called the OSCAR file.
6 The difficulty with that is that if they're attached
7 at the corporate level but they're not actually based out of a
8 nursing home or out of a home health agency, you may not know
9 that there really is that affiliation. And maybe some pressure
10 from on top that you aren't going to see when you see that
11 somebody's home health agency based, you might get a different
12 perspective, or nursing home based, or hospice based.
13 I can give you -- it's based on the 1998 data, I can
14 give you that, but I'm not sure you get a real true picture of
15 what's happening out in the hospice area from that.
16 MR. HACKBARTH: We've fallen a little bit behind
17 schedule here, so please keep your comments brief.
18 DR. NEWHOUSE: I was just going to underline Carol and
19 Mary's comments and say that both my experience gibe with them,
20 and that I think it rises beyond a caveat. The example of the
21 expensive pain meds, the difference in costs between caregiver
22 there and no caregiver there, the travel differences all argue

1 for trying to develop some kind of adjustment system and, in my
2 mind, an outlier system since there's never going to be a
3 perfect adjustment system.
4 I think, in fact, the rationale for saying this should
5 be studied.
6 MR. FEEZOR: I just want to echo Joe's comments and
7 then just a quick question either for Sally or perhaps Carol.
8 I was struck by the text about the observation that
9 those who have Medicare supplemental coverages seem to be one
10 that are underutilized, or at maybe do you have some difficulty
11 -- Medigap, excuse me.
12 Individuals without supplemental insurance.
13 DR. KAPLAN: Without supplemental insurance. And we
14 don't really know how to interpret that because there's almost
15 no copay. I mean, there's a 5 percent copay on drugs with a
16 maximum of $5. There is, I believe, a 5 percent on respite
17 care. And interestingly, the MCBS shows zero copays for hospice
18 users in 1999.
19 That's a very hard thing to interpret, which is why we
20 said maybe it is an issue of looking at the data that -- it's
21 picking up something that's not being measured.
22 DR. LOOP: I don't see why we need two

1 recommendations. It seems to me if you're going to change the
2 payment methodology -- and I like Joe's idea about the per diem
3 DRG -- you would take into evaluating the hospice payment rates
4 now which probably haven't kept up with new treatments, notably
5 drug treatments. There are now very expensive drugs that
6 stabilize bonelytic lesions. there's a lot more people
7 receiving expensive drugs for the treatment of heart failure in
8 hospices. None of that is compensated for.
9 So I would say change the way we pay and while you're
10 figuring out how to do that you also evaluate the payment rates
11 completely, to see whether they have kept up with new
12 treatments.
13 It would be part of the same study.
14 DR. KAPLAN: Excuse me, but I think we said that. In
15 talking about reevaluating the rates, we're saying don't just
16 look at margins, the relationship of cost to payment, but really
17 look at the cost of providing appropriate care. And then in the
18 discussion we talk about the fact that there are lots of new
19 drugs and there are new palliative treatments that might not
20 have been considered. So we actually did include that in the
21 discussion.
22 But then we felt that -- we want them to reevaluate

1 the rates like ASAP. But then we want them to do research on a
2 case-mix adjusted system to basically say okay, maybe one per
3 diem rate for a patient no matter what the patient looks like is
4 okay. We're saying eventually we'd like to see something that
5 is more where the resources are targeted to the individual's
6 care more.
7 MR. HACKBARTH: So in keeping with how we've
8 approached payment rates for other providers, we look separately
9 at issues at the level of the payment and then the distribution
10 of the payment. And so the reason for having two
11 recommendations here is let's look at the level of the payment
12 ASAP, but then let's also study whether the distribution of
13 payments is appropriate and whether there ought to be some case-
14 mix.
15 I think there's a compelling reason for having two
16 distinct recommendations then.
17 DR. STOWERS: I just wanted to make sure -- I really
18 appreciated this chapter, especially talking about the frail and
19 then what Carol had to say. But are we for sure going to
20 remove, like at the top of page six we conclude that Medicare
21 payment policies are not a major contributor? And then we go
22 down and list the policies as being some of the main barriers.

1 I think there's kind of a disconnect there in what
2 we're saying. And then that kind of negates the need even to
3 have the recommendation. So I think that spirit of the text has
4 to not let them off the hook.
5 DR. ROSS: There's a couple of moving parts here, and
6 I noticed in perusing this again quickly that in the text we say
7 Medicare payment policies. In the cover sheet we said Medicare
8 policies.
9 I continue to believe that the statement referring to
10 payment policies is true, that payment policies are not what is
11 driving short stays. Carol, you raise the issue of IG and other
12 kinds of things, and that's fair enough.
13 I guess the question on the table for the Commission
14 is whether even saying payment policies alone is being too
15 sweeping.
16 DR. STOWERS: I think that's what I'm trying to say is
17 I agree with they are not in any way alone responsible for that.
18 But I think, as a practicing physician that has to sit with a
19 patient and declare that six month rule, or some of those kinds
20 of things in which payment policy are factors -- although I
21 don't think they're the only factors. So I think those all need
22 to be looked at, too, as time goes on, and not just these

1 payment issues.

2 I think to not say they're a factor and then turn
3 right around in the text and name them is somehow a disconnect
4 in what we're trying to say there. I think if the layperson
5 reads that, that could be misunderstood pretty easily.

6 MR. HACKBARTH: So, Murray, trying to distinguish
7 between Medicare policies and Medicare payment policies could be
8 confusing. Is the six month rule a payment policy? If we
9 consider that to be a payment policy, what the IG is doing is
10 interpreting the six month rule, so they're interpreting a
11 payment policy and engaged in enforcement actions that Carol
12 reports are influencing and increasing the number of short
13 stays.

14 DR. ROSS: I think there's two issues here. Ray says
15 that we go through and list things, the pieces that immediately
16 follow the statement about payment policy refer to reasons for
17 late referral, difficulty of prognosis, unwillingness to give up
18 curative care, and availability of new therapies that weren't
19 previously there.

20 But that's, to me, a separable issue from saying we do
21 think you should reevaluate payments in general, to see if the
22 level is about right, and explore case-mix. But that's separate

1 from the short stay phenomenon.

2 DR. STOWERS: I'm okay if we separate that if that's

3 what you're saying, but I'm not sure if the text says that.

4 MR. HACKBARTH: We do need to turn to draft

5 recommendation one.

6 DR. KAPLAN: The Secretary should evaluate hospice

7 payment rates to ensure they are consistent with the cost of

8 providing appropriate care.

9 MR. HACKBARTH: All opposed?

10 All in favor?

11 Abstain?

12 DR. KAPLAN: The second recommendation --

13 MR. HACKBARTH: You don't need to read the chapter on

14 the second one.

15 DR. KAPLAN: The long recommendation.

16 MR. HACKBARTH: All opposed?

17 All in favor?

18 Abstain?

19 Okay, thank you, Sally.

20 DR. KAPLAN: Thank you.

21 MR. HACKBARTH: Public comments. We are running

22 behind schedule so I will, if necessary, intervene to make sure

1 that your comments are brief and to the point. Thank you.

2 MS. HARRIS: Thank you very much. I am Louise Harris,
3 associated with the Sanctuary Hospice House. I am an oncology
4 nurse who has been on the front lines in rural areas of America.
5 And I can tell you, in talking of inpatient access, there is
6 practically none in the rural areas of America.

7 We, for instance, Tupelo, Mississippi, have to send a
8 patient -- if we can get one admitted, there is one inpatient
9 hospice facility in the state of Mississippi, and it is three-
10 and-a-half hours away.

11 In addressing that cause, I and a group of other
12 people, interested community leaders and medical practitioners
13 sought to develop an inpatient hospice house, raising the funds
14 ourselves, providing the service for an inpatient facility for
15 those individuals who right now are not being serviced, because
16 they either have no able caregiver or they have an unable
17 caregiver.

18 We started raising the funds. We said we can do this
19 in our community. And we are well on our way to achieving that
20 goal.

21 But in looking at the reimbursement issues for rural
22 America, we are blocked by the 80/20 rule. And so we have

1 introduced legislation in both the Senate and the House, H.R.
2 3270 and Senate Bill 1840, which simply very narrowly defines
3 for rural areas that where a group of non-profit, independent,
4 free-standing, paid for individuals who want to provide a
5 complementary service to the hospice agencies existing in our
6 area, there are 10 in a 17 county area. They have such a small
7 census in those 17 counties that none of them are able to
8 provide an inpatient facility.
9 We just want to complement, not compete, with their
10 services and have them refer their patients to us. And when we
11 sought to get a provider number, we saw that we could not do
12 that because of the 80/20 rule.
13 So our bill addresses lifting the 80/20 rule in very
14 narrow circumstances, whereby there's less than 20 beds, a non-
15 profit organization, where the community has come in to serve
16 those people, their dying neighbors, in their community.
17 We hope that you can see a way to provide that
18 service, because right now what happens in our community -- and
19 I've had several relatives, including my sister, die of cancer
20 in our area -- is if you get into an acute crisis situation, the
21 only option is to pick up the phone, dial 911, get an ambulance,
22 and go to the hospital, which is a much higher rate of

1 reimbursement.

2 We will succeed in Tupelo, Mississippi. But what we
3 want to address, because we saw this was happening all over the
4 country in rural areas, we want to facilitate other groups who
5 are willing to work as hard as we have for two years to raise
6 the bricks and mortar. It will be at no expense to the
7 government or anyone else. We just hope to be able to include
8 those people who either have no insurance or who are on Medicare
9 and receive reimbursement directly.

10 If we should have to contract for that services and go
11 up under those 10 agencies, we would have a nightmare of
12 servicing those terminally ill patients. We will provide the
13 staff, we will have the social worker and all the care they
14 need. Thank you.

15 MR. HACKBARTH: Thank you very much.

16 MR. GALLAGHER: Good afternoon. I'm Christopher
17 Gallagher with the American College of Surgeons.

18 At the beginning of the week, the College joined with
19 the AMA and a large group of organizations representing
20 physicians, nurses, physician assistants, and practice
21 administrators in a letter to express our deep concern about the
22 Commission's recent deliberations over Medicare reimbursement

1 policies for physicians and others who serve as assistants at
2 surgery.
3 I know the College and these groups are extremely
4 pleased that the Commission has recognized that currently there
5 are not enough compelling reasons to go down the road of
6 bundling payments for assistants at surgery services, be it with
7 the hospital or the surgeon. The bundling approaches that were
8 on the table carried with them a number of disadvantages and
9 potential negative impacts for quality of care, not to mention
10 issues as to how Congress would resolve how payments and
11 allocation of funds for these new approaches would be shifted
12 between Parts A and B of the Medicare program.
13 Again, the College just wanted to say they're very
14 thankful that the Commission took these considerations into mind
15 since their deliberations in the March meeting. Thank you.
16 MR. HACKBARTH: Thank you.
17 MR. McCAMBRIDGE: Peter McCambridge. I just wanted to
18 follow up on some points from the March meetings and from this
19 morning's meetings.
20 The current educational standards for first assistants
21 is a bachelor's degree. And to say that that's less significant
22 using licensure and certification is just not accurate.

1 We're not licensed. We're 2,000 people. To think
2 that each state could license that few people is not realistic.
3 That doesn't mean that we're not regulated. So what I'm saying
4 is licensure does not equate into not being regulated. We're
5 regulated by every state and by the Title 18 in the Social
6 Security Act. It's very much regulated.
7 What the Commissioners did today, by not including us
8 in the list, has cost $18 million, which I can validate that by
9 each time a physician serves as a first assistant and a surgical
10 first assistant does not work in that function, it just costs
11 the program money and it cost them $18 million last year.
12 So I'm very disappointed with this decision, and
13 hopefully Congress will set it straight. That's all.
14 MR. HACKBARTH: Thank you.
15 MS. NYE: I'm Janet Nye with the Hospice Association
16 of America. I wanted to thank you for all of the effort that's
17 been put into the study because hospices are in need.
18 My concern is something that was brought up by one of
19 you. Are you going to change the language that says the
20 Medicare policy does not affect the access? I understood you
21 were looking at it, but did you say that you were going to
22 change that?

1 My concern is if Congress gets your recommendation
2 saying that Medicare policy does not affect the short length of
3 stay, they might not take action on trying to change the way the
4 Medicare benefit is reimbursed.
5 MR. BARSTOW: My name is Scott Barstow and I'm with
6 the American Counseling Association.
7 While we're understandably disappointed by the
8 Commission's vote earlier this morning, I just wanted to take a
9 moment to address the education issue that was raised regarding
10 licensed clinical professional counselors.
11 As you may or may not know, the counseling profession
12 had its genesis in the 1950s, and that was mostly in the area of
13 guidance, rehab, and education related services. Beginning in
14 the 1970s the practice of mental health counseling as a separate
15 and distinct clinical specialty within the counseling profession
16 started to develop. But given the profession's history, you
17 have still to this day many master's programs in counseling,
18 including mental health counseling, counseling psychotherapy,
19 that are housed in departments of education within universities.
20 However, you have more and more grad programs housed in
21 departments of health and some are even being established in
22 departments of medicine.

1 Regardless, across the board, there is a lot of
2 overlap in graduate programs in counseling with coursework that
3 graduates in obtaining an LCSW degree or a degree in marriage
4 and family therapy get. And in a lot of cases, you have
5 students in separate tracks attending the same classes and going
6 through a lot of the same coursework.
7 Thank you.
8 MR. HACKBARTH: Thank you. Okay, we will adjourn for
9 lunch and reconvene at 1:30.
10 [Whereupon, at 12:23 p.m., the meeting was recessed,
11 to reconvene at 1:30 p.m., this same day.]
12
13

1 AFTERNOON SESSION [1:31 p.m.]

2 MR. HACKBARTH: Next on our public agenda is assessing

3 Medicare's benefits. Julian and Jill?

4 MR. PETTENGILL: Good afternoon. The first chapter of

5 this report attempts to set up the report as a whole, addressing

6 widely recognized limitations in Medicare's benefit package,

7 raising the question of why it's important to think about that,

8 what implications it has for beneficiaries access to care and

9 out-of-pocket spending, how beneficiaries attempt to address

10 those consequences, and the degree to which their adopted

11 remedies are effective.

12 The Congress will ultimately have to decide how to

13 address these problems, and they will have to do so against the

14 backdrop of the longer term problems facing the Medicare

15 program, which are really two-fold. One is the set of well-

16 known demographic changes coming down the road; that is, people

17 like me retiring, and in large numbers. The other is the

18 continuing rapid pace of technological change where we have new

19 things we can do to people. We start by doing new things to a

20 few good candidates and then we spread to doing them for

21 practically everybody, including the old-old. That turns out to

22 be quite expensive.

1 The demographic problem is primarily a problem of
2 financing the covered population relative to the population as a
3 whole or relative to the working population, who pay taxes to
4 support the program, is mushrooming in size. But the technology
5 problem I think is not entirely a problem of financing. It's
6 also to some degree a question that one should think about a bit
7 in thinking about how or whether to revise the benefit package
8 because that will perhaps -- it's entirely possible that
9 altering the benefit package could affect the degree to which
10 technological change affects spending.
11 Now for the session this afternoon Jill is going to
12 take you quickly through the logic of the material we present in
13 Chapter 1 and then we'll welcome any comments you have to make
14 about what we need to add or subtract, changes of tone and that
15 sort of thing.
16 DR. BERNSTEIN: The first chapter of the June report
17 incorporates a lot of material you've seen before in various
18 places and some new material addressing questions about
19 beneficiaries' access to care and financial protection, or
20 recast information.
21 Rather than spending time on the specifics I'd like to
22 go through the major themes presented in the report fairly

1 quickly so we can spend most of our time listening to you. In
2 particular we need comments on the presentation of the findings
3 about how Medicare's benefit design has or has not succeeded in
4 ensuring beneficiary access to care and financial protection.
5 We want to know what you think is unclear or incomplete or
6 extraneous in the chapter.

7 We also want to know whether the basic organization
8 and arguments are what you want to say and the way you want to
9 say it, and whether the chapter does what it needs to do to set
10 up the rest of the report.

11 The first chapter looks at how Medicare's benefit
12 design affects the programs' ability to address two basic goals:
13 ensuring beneficiaries' access to appropriate high quality
14 health care in the most appropriate setting, and ensuring
15 beneficiaries' financial protection. That is, ensuring that
16 financial considerations do not prevent access to care, and the
17 cost of health care do not result in the impoverishment of
18 beneficiaries or their families.

19 We have a bunch of charts and a bunch of tables in
20 there but I'm going to summarize it in about four sentences.
21 Basically what we want to do is to put those two questions,
22 whether Medicare has reached its goals, in the context of a

1 third implicit consideration which is whether changes in
2 Medicare's benefit package could be made to increase efficiency.
3 Recognizing that there are limitations available for
4 the program and like any other public program we need to also
5 figure out how we can sort out what the issues are with respect
6 to the benefits package versus issues that get into broader
7 questions of payment policy and budget constraints. This is
8 kind of a thought experiment. Benefits design is only part of
9 the equation about what determines whether Medicare is meeting
10 its goals. We recognize that. Which providers are paid by
11 Medicare, under what circumstances, how much it pays, they're
12 all important. Decisions about coverage and payment policy
13 involve considerations about other budget priorities. We
14 recognize that as well.
15 But what we want to do here is to focus in particular
16 on the characteristics of the benefits design itself and to
17 determine whether there are problems that, if corrected, could
18 foster more efficient care delivery and better protect
19 beneficiaries. So we know we've set ourselves up to do
20 something that's very difficult to do, but since we can't
21 reassess everything there is to do with the Medicare program we
22 are starting with the benefits package.

1 The next slide summarizes where we are with respect to
2 assessing financial protection and access to care. I want to do
3 that really quickly again, since we've gone over this in
4 previous sessions. Generally, we conclude after reviewing the
5 evidence on access and financial protection that the glass is
6 about four-fifths full. Medicare has made tremendous
7 differences in beneficiaries' lives, it's provided access to the
8 best in acute care services, it's lengthened the lives of
9 beneficiaries, it's increased the quality of life for many
10 people. Having Medicare is way better than not being insured,
11 and there are a lot of Americans who are really happy when they
12 turn 65.
13 Some beneficiaries, however, have problems gaining
14 access to and paying for the care they need. The vulnerable
15 populations include the people who are near-poor, older-old, and
16 those with serious chronic illnesses. In addition though, it's
17 important to note that full access and financial protection is,
18 for many beneficiaries, contingent on obtaining some form of
19 supplemental coverage in addition to Medicare. This is because
20 gaps in Medicare coverage leave beneficiaries exposed to some
21 very high costs potentially. These issues are going to be
22 discussed for the rest of this afternoon in the later chapters

1 and I'm not going to go into the data here unless you want to
2 talk about specifics.
3 Turning to the issue of efficiency, Medicare's benefit
4 design, the report I think demonstrates, reaps several forms of
5 inefficiency. Cost-sharing; that is, deductibles and insurance
6 are uneven and, in some cases, inconsistent from what would make
7 sense from an insurance perspective and may lead to some
8 undesirable incentives regarding the use of one sort of services
9 versus another, or one setting versus another.
10 Gaps in coverage for some services, notably
11 prescription drugs but also others, can create serious financial
12 problems for some beneficiaries and may deter people from
13 seeking care or conforming to treatment care that could prevent
14 or delay more serious health care problems down the road. Gaps
15 in coverage also lead beneficiaries to seek out supplemental
16 insurance. This can be confusing, it adds administrative costs,
17 and it encourage the overuse of some services if supplemental
18 coverage shields beneficiaries from costs associated with using
19 medical services that might be unnecessary or of limited value.
20 Later in the report, as you'll hear, we take a closer
21 look at supplementation and examine what emerging trends imply
22 for beneficiaries' ability to obtain coverage and financial

1 protection in the future. Finally, the report talks about
2 framing the options for addressing some of these problems.
3 What we want to talk about is how to limit the
4 discussion so that we can focus in particular on whether there
5 are changes in benefits that could lead to better access and
6 better financial protection for about the same amount of
7 resources that are currently being spent.
8 We do this in two different ways. One is looking at
9 whether there are improvements that can be made in Medicare's
10 benefit design that could be accomplished without increasing
11 Medicare spending. And secondly, as we discussed this morning,
12 we look at whether there are changes that could be made which
13 would improve the beneficiaries' access to care and financial
14 security without increasing total spending on health care for
15 these beneficiaries.
16 Actually, I want to stop there. We have overheads
17 that show all the charts and figures if there are specific
18 questions you have about them, but in general we just want to go
19 through the framework that we've set out and find out what you
20 think.
21 MS. ROSENBLATT: My comments span all of the chapters
22 on this issue of the Medicare benefit design and I've got a lot

1 of couple of concerns on the tone. I made a lot of comments
2 about the tone last time. The tone that Medicare supplement
3 plans are the work of the devil continues to come through in
4 this iteration. I think there are comments made that they lead
5 to increased cost for Medicare, that the administrative costs
6 are high, just what Jill just read, gaps create incentives to
7 seek supplementation, which often is complicated, inefficient,
8 or inadequate.
9 Throughout these chapters we're throwing out words
10 like Medicare supplement plans are complicated, the whole thing
11 is complicated. Well, all of health insurance is complicated.
12 Inefficient, I don't know that that's true. Then, will lead to
13 higher costs. In one of the chapters, I think in Section F,
14 there's comments that we can't really prove that. So I've just
15 got general tone issues.
16 Now I do have some questions on the charts that I do
17 want to get to in a minute, but I also, as I was reading through
18 this stuff, had an idea for an analysis. I don't know if
19 there's time to do it, but we keep looking at beneficiaries in
20 Medicare in different categories, whether they have supplemental
21 insurance or provided by the employer or that they bought.
22 What we're never looking at is what happens to the

1 person that's working, 64-years-old, what are they paying in
2 terms of their contribution? What are they paying in terms of
3 out-of-pocket costs? Then what happens when they pass that
4 magic age 65 barrier and how does it compare?
5 My guess is that we're going to see -- and I don't
6 know. I haven't done this analysis myself -- that if the costs
7 to that individual are lower because they end up switching from
8 64 to 65, then that says something about the need for increased
9 cost sharing. I don't think we need to have a decrease when
10 somebody turns 64 to 65.
11 So I know June is right around the corner and I'm
12 concerned. One of my concerns is I'd like to see us do that
13 analysis. That other overriding concern that I have is, there
14 is a sea change going on as we speak. I mentioned this last
15 week. Employers, we're seeing the third year of increased cost,
16 we're seeing no let up in sight, we're thinking about if the SGR
17 is not changed and physician fees are decreased by 5 percent
18 what is the cost sharing impact going to be on commercial
19 premiums?
20 All of that is going to lead to new and different
21 things and we're sort of looking backwards. We're saying, how
22 do we restructure the Medicare program -- it was designed back

1 in the '60s; what were insurance plans then? I think as we go
2 through the next few years of increased costs, increased cost
3 sharing to the employees, both their premium share is going to
4 be higher and the cost sharing is going to be higher, and plans
5 are going to be different.
6 We've got a fee-for-service program. I don't think
7 anywhere in here, unless I missed it, does it talk about maybe
8 we need to design programs that switch care towards more
9 efficient providers. That opens up a whole host of what is a
10 more efficient provider. But I've got a lot of unease about all
11 of this right now.
12 DR. ROSS: I just want to respond one technical
13 question because I think all the other issues you raised are
14 commissioner issues. You can get data for the 64 versus 65-
15 years-old. We don't easily have that and I'm not sure we could
16 get it usefully done in time for this report. But there are two
17 things that change, one of which is the source of insurance.
18 Presumably for the people who are retiring that year, although
19 most retire at 62, their incomes are also changing considerably.
20 So it's not enough just to look at the cost sharing changing,
21 you'd want to look at other pieces. That's a useful suggestion
22 but not in the next three weeks.

1 MS. ROSENBLATT: Murray, I would agree with your
2 modification. All I'm saying is we're just looking at the
3 Medicare population and we're not looking at what is insurance
4 as a percent of income when you're working versus when you're
5 not? Clearly, when you're working you've got expenses like
6 commuting costs, et cetera, that you don't have.
7 So the point I'm making is, I don't know that anyone
8 has ever done that and to me that would be an interesting thing
9 to do in connection with this.
10 DR. ROSS: Actually we have done some of that in past
11 MedPAC reports but we haven't got it to the close population. I
12 think we've done working versus Medicare. We haven't done -- am
13 I allowed to call them -- according to the USA Today, older
14 Americans 50 to 64 who are working versus Medicare. I'll see if
15 we have any of that.
16 MR. FEEZOR: Actually I had some comments that were,
17 with the exception of the Medicare supp market being the devil's
18 playground which I won't try to argue against, that mimics some
19 of Alice's concerns. First, we talked about earlier just
20 generally, I don't know that our presentation presents the
21 gravity of the dilemma that's facing us, nor the opportunities
22 that Medicare as this country's single largest fulcrum, if you

1 will, in health care and health care delivery represents. But
2 that may be something for a later report at a different time.
3 But that's sort of a lost opportunity.
4 Second, I think I share -- I looked at it a little
5 differently as I went through the materials, that Alice's
6 concerns about we keep looking back and maybe it doesn't give
7 sufficient weight to most recent trends. Maybe we should draw
8 from the actuarial sorority and fraternity and weight most
9 heavily our most recent experience. I think particularly when
10 we talking the materials in this first chapter, which by the way
11 did as good a job I think as anyone could in trying to frame the
12 issues. I should start with that.
13 But when we talk about, employer generosity is one of
14 the terms used here, without any doubt that's to be said. But
15 as Alice noted I think we're going to look at some, we are
16 looking at some rather fast-paced trends. That is mentioned
17 elsewhere in one of the chapters.
18 In addition, such things as employer choice of plans.
19 We say that employers do offer choice of plans, yes, but even
20 that -- and it's not just CalPERS. I would offer up a more
21 balanced such as Sears, which has dropped almost in half its
22 choice of plans. Then distinguishing whether that's a choice of

1 plans in terms of vendors or is that a choice of actual
2 benefits.
3 A couple of other things. I think on Alice's point,
4 and we're looking at Medicare in the absence -- actually I think
5 we're not consistent. I think there are areas there where we
6 talk about -- we do make it relative to the amount of -- I'm
7 trying to remember, somewhere in the chapter that the level of
8 Medicare coverage as a percent of population compared to that of
9 maybe younger people. Yet some other opportunities we do miss,
10 which is maybe, what are the medical expenses as a percent of
11 disposable income might be a helpful reference.
12 We talk about the percent of Medicare folks who have
13 trouble getting prescriptions or don't have prescription
14 coverage as being 8 percent or something like that. That's
15 relative to what? So I think just going back and reviewing, are
16 there some general public comparisons that I think I as a public
17 policy maker would want to think about and saying, okay, yes, by
18 itself this looks like we really have a lot of ways to go with
19 Medicare, but compared to what the general population that is
20 provided by employment-based, maybe I need to put that in
21 perspective. We're never going to hit Nirvana in this, so
22 that's the other thing.

1 Then finally, it might be helpful, just as a footnote,
2 we talk about the number of Medicare eligibles. We assume that
3 -- we probably want to break out a little bit as to why there
4 are some folks who are still not covered by Medicare B and what
5 can or cannot be done by that. There is a measurable
6 population. It is one that has a variety of reasons why, but
7 it's something that I think we probably ought to bring out in
8 perhaps this first chapter.
9 MS. NEWPORT: Considering the complexity of this I
10 thought you did a very good job in trying to capture everything.
11 I think your two framing options, I think the answer to both of
12 them is maybe. And I think a little bit to that point I would
13 just like to rearticulate, if I can, a frustration with not
14 having more recent data. That's not frustration with you folks
15 at all.
16 I think it's a problem here. Because I think that
17 although you were very consistent in using 1999 data, at least
18 in most of the discussion, because that's probably the complete
19 data, I think that there were some points where I think the text
20 has to inoculate against I think some significant changes that
21 have taken place in the marketplace since 1999. I think you
22 need to frame that in the text or whatever.

1 I think the other thing too, I think there are things
2 happening in the Med supp market. I'm not challenging Alice at
3 all on this, but I think that I see dynamics out there that -- I
4 think we should be neutral a little bit on that, or maybe a lot
5 on that. Just, here's the facts. This is what's happened in
6 the market. This is how this will -- again, frame the
7 discussion. I like your use of the word framing.
8 Part of it too goes to what's happened in the M+C
9 market. What I see as plans exit doesn't -- it may be anecdotal
10 more than factual or data driven, is that I don't see the types
11 of effects that you're articulating here. I think there are
12 greater impacts for those that are financially, in more
13 financial trouble than otherwise. So I think there's some
14 demographic data that I would hope that we could try to take a
15 look at too on the other side of this.
16 So I think that answering the options is harder than
17 setting out what the state of play is at this point, but I'm
18 very -- again, I wish you had more recent data on a lot of this,
19 and to the extent that you have and can get it from other
20 sources, I think it would be helpful for part of the discussion.
21 DR. REISCHAUER: I don't think we should go down the
22 road of explaining all the little peculiarities of Medicare like

1 why there are people who aren't in Part B; most of them are
2 actually working elderly. And why some aren't in Part A because
3 of federal service and things like that. You'll confuse the
4 story.

5 But I want to engage Alice on supplemental coverage
6 here. I understand why you don't like people to say it's
7 complex, it's inefficient, and it's inequitable but I thought
8 there was a convincing body of information here explaining why.
9 It's not that supplemental policies haven't performed an
10 extremely important function, but the fact of the matter is, we
11 could do it better under a different structure. Certainly you
12 feel that way at Wellpoint. You don't want, in a sense, all of
13 your covered lives to have two or three policies and have to do
14 coordination of benefits and things like this.

15 Maybe we can use different terms that are less
16 pejorative but I think the evidence is there and that we
17 shouldn't back away from this.

18 MS. ROSENBLATT: I am concerned about tone. The
19 direction may be appropriate, although I am very worried that
20 our direction is more the way the world has been as opposed to
21 the way the world will be. We're examining options that don't
22 deal with the efficient provider issue, or thinking about

1 Medicare in managed care. We get to it a little bit through the
2 coordination of care but there's a lot of other stuff going on
3 in the marketplace right now that is not touched upon at all.
4 So I'm concerned about that.
5 Now let me deal with the inefficient. Now there's a
6 comment in -- I'm getting into other chapters, not the one we're
7 one. But there's a comment in here I think about typical admin
8 cost is 20 percent. Admin cost probably ranges from 10 percent
9 to the 35 percent allowed by law. I don't know, with all the
10 functions that a Medicare carrier needs to do that one would say
11 that 10 percent is inefficient. It might look inefficient
12 compared to the admin charge of the Medicare program, but we all
13 know that there are different functions performed, (a). And (b)
14 I think most of us in this room would probably say that not
15 enough admin is being spent on the Medicare program.
16 But it really is tone. The other tone issue was -- I
17 actually highlighted this one. There was a sentence -- there's
18 a lot of comment about paying for supplemental coverage down to
19 the first dollar of coverage increases costs. As an actuary, I
20 believe that's true. But I don't know that there's definitive
21 proof. We make it sound like something -- let me just -- I'm on
22 page -- I'm sorry. It was the chapter that was in Section F.

1 It was the second stapled one, coverage beyond the fee-for-
2 service benefit package and total spending on care. It's page
3 12.
4 Bottom of the page it says, studies have not
5 successfully isolated the extent to which the differences in use
6 of care is due to those with supplemental coverage getting
7 unnecessary care versus those without supplemental coverage
8 going without needed care. That's a nice sentence but in other
9 places throughout these chapters there's this -- it's not said
10 as nicely as that sentence says it. There's this inference that
11 it leads to bad higher utilization.
12 DR. REISCHAUER: I think that that actually is a
13 function of the way we've set up supplemental insurance and
14 regulated it and it isn't the fault in any way of the entities
15 that provide this insurance, and the fact that people want that
16 and are willing to pay for it. Whether the increase in cost is
17 good or bad you're saying, Alice, is an open question.
18 MS. ROSENBLATT: All I'm saying is that the words -- I
19 tried to underline it and I will leave it with staff. There are
20 just areas in the report as it stands right now where the tone
21 is coming through differently than what I think we're saying or
22 trying to say.

1 DR. NEWHOUSE: I was going to say some of the same
2 things Bob did, but let me say specifically what I thought the
3 facts were that justified the somewhat negative tone. First was
4 the issue that Alice and Bob were just talking about on induced
5 spending. While it's right to say there's no conclusive
6 evidence good or bad and undoubtedly the true state of the world
7 is that it's some of both, the markets insofar as we have one in
8 managed care, for example, has gone away from no cost sharing
9 and care that's free at the point of use. It's even going
10 further away from it and there's, if anything, more control in
11 that setting than in the traditional Medicare world.
12 So I think Alice as I heard her just then doesn't
13 disagree that there's increased spending. The issue is whether
14 the increased spending is good or bad. And I say it was
15 probably right to take a view that, particularly for vulnerable
16 subgroups, some of the increases are good. But once we have set
17 -- first of all, part of that group is covered by Medicaid so
18 then cost sharing does not become an issue. Let me stop on
19 induced --
20 The other thing on the loadings, I think it probably
21 has to be right that individual marketing on the Medigap side
22 raises administrative costs above having it in the Medicare

1 program. If most people buy it or get it in some way, shape, or
2 form, as is the case with the back end coverage at least, then
3 it clearly seems better to bundle it with the underlying
4 Medicare program, which is basically how I read the chapter now.
5 So I was actually pleased with the generally negative tone about
6 Med supp.

7 DR. NELSON: Joe took it further than I would have. I
8 paid close attention to what Alice said at the last meeting so I
9 read this with an idea of trying to measure tone in my own view
10 and I thought it was quite neutral. I didn't think that it came
11 across particularly negative. As a matter of fact, if the tone
12 were altered in a way that it made it look like we were coming
13 out making a pitch for supplemental insurance I'd have a big
14 problem.

15 MR. SMITH: Alan, Joe, and Bob have said a lot of what
16 I wanted to say but I really did think that the tone here was
17 pretty flat. Let me just read two sentences from the pages that
18 Alice referenced. Multiple sources of coverage also increase
19 administrative expenses. It doesn't say it's wasteful. Doesn't
20 say they're thieves. It simply states a fact which we can find
21 easily in the literature. And on the page before it states that
22 Medicare beneficiaries with supplemental coverage cost the

1 Medicare program more than those without such coverage. There's
2 not a normative word in that sentence.
3 I want to be careful not to confuse tone with facts
4 that we don't like. I thought the chapter did quite a good job
5 of assessing and presenting what we know. The implications of
6 that may be troubling but I don't think the tone in which it's
7 presented is troubling.
8 The other point I wanted to make, just come back to
9 Bob's comments earlier today and Alan's, I think this is
10 terrific stuff and very well done, but it doesn't start on page
11 1. There needs to be a context setting chapter I think, Murray,
12 which establishes that we're looking down a set of boxes of the
13 health care system, the health care system as it applies to
14 Medicare beneficiaries, and at Medicare. And that the
15 interaction between Medicare and the balance of the system that
16 affects its beneficiaries and the other two-thirds of the health
17 care system, that those interactions are important. They're
18 important for policy reasons and they're important to Medicare
19 beneficiaries.
20 Part of what we're trying to do here is have the
21 Medicare conversation in that broader context. I think it's
22 very important to say that early before we get into the more

1 Medicare-specific stuff even in the introductory chapter.
2 MS. NEWPORT: I guess David hit it fairly accurately,
3 I think. My view of this is that as Medicare fee-for-service
4 coverage and technology and everything else that you've
5 articulated has changed, the markets have been created for extra
6 services, extra coverage, extra -- you know, covering
7 deductibles and copays as those have increased. This has driven
8 new entry and interest in new entry into -- TEFRA originally
9 with the old risk program and cost payments to M+C, the whole
10 plethora of things, options that are out there in terms of
11 filling the gaps that Medicare could not fill financially. So
12 it was a build upon, layered effect.
13 Now as costs have increased, those markets and
14 response in the markets have changed, as have employers ability
15 to respond to that, as have retirees demand to respond to that.
16 None of that which is intrinsically bad. It's just that as a
17 policy in this country do we want to cover all of that? Then of
18 course that puts pay to the whole description of, can we do this
19 without increasing total health care spending? No, we can't.
20 So I think that to the extent that technology has
21 moved us to consider broader coverage or different types of
22 coverage, it's still more costly. So how do you create an

1 environment where you have options for folks? But again, we may
2 never get to the point where we have to have a perfect or can
3 have a perfect world in terms of what is out there and is it
4 affordable for the greatest number of people. I guess without
5 cost sharing and having people, soon to be me, recognize that I
6 may have a bigger financial obligation than I thought when my
7 parents entered Medicare, we're just getting into areas that we
8 have to decide what the scope of this is going to be.
9 I just think we have to be, as you've attempted to do,
10 be prudent in recognizing the challenges out there in terms of
11 what this will cost. Yes, there may be inefficiencies in the
12 system. I don't care where they are. I'm not sure that we can
13 redirect this in a way that doesn't come up against what are we
14 going to be asking people to pay that we haven't asked them to
15 pay before?
16 So again, understanding what's happened in Medicare
17 and what it means for folks, and what is, from a public policy
18 decision, Congress or whoever needs to decide what to do. This
19 is kind of where we're going. I think we should try to be as
20 neutral as possible in all of this but I'm not sure that we can
21 really, in good faith, make any kind of recommendation that this
22 is not going to somehow increase total health care spending in

1 terms of out-of-pocket exposure that people are going to face in
2 the future.
3 MR. HACKBARTH: Can I just leap in for a second? I
4 keep pushing myself to the bottom of the queue and can't resist
5 jumping in.
6 Alice, I've thought a lot about the points that you
7 made at the last meeting and I'm attracted to them, in part just
8 because my personal philosophical orientation, all other things
9 being equal, I like private involvement, private solutions to
10 problems, if you will. But when I look at the supplemental
11 market I find it difficult to find a lot of the things that I
12 like about private involvement and I find some things that I
13 don't like.
14 What I often like about private solutions is
15 decentralized decisionmaking, not being involved in administered
16 pricing systems, such as we engage in here so often,
17 opportunities for innovation and clinical program design that we
18 might find in some of the best M+C plans and the like. Yet
19 that's not the sort of activity that supplemental plans are
20 involved in, by their very nature. They're not changing the
21 basic pricing mechanisms. They're not creating opportunities
22 for clinical innovation program development. I just don't see

1 it there.

2 I do see some confusion, complexity added to the
3 system which I don't think of as a plus.

4 One other potential advantage of private
5 supplementation as opposed to public expansion of benefits is
6 that it has a very different financing implication. Part of the
7 challenge that we have on the public side, if we have public
8 expansion, is the intergenerational transfer involved. Right
9 now we have a demographic situation where a smaller and smaller
10 number of workers are going to be financing care for a growing
11 number of retired people, and that's a very real problem.

12 To the extent that we have private supplementation as
13 opposed to taxpayer-financed supplementation we may reduce the
14 intergenerational transfer which, arguably, might be a good
15 thing. But even there you might say, let's have optional
16 supplementation with less intergenerational transfer but do it
17 through a mechanism that is cleaner, more efficient, than the
18 existing Medigap supplemental market. Now you could have
19 options under Medicare that people would pay for out of their
20 own pocket, no intergenerational transfer involved, that could
21 be much more efficient than the supplemental market that
22 currently exists.

1 If we're worried about the availability for low income
2 people and their ability to buy that supplemental you could have
3 income-related subsidies that would make it available to lower
4 income seniors. So you'd have reduced intergenerational
5 transfer, which is a plus of supplementation as opposed to
6 putting it into basic benefits, without a lot of the minuses.
7 I'll leave it at that.
8 MS. ROSENBLATT: May I respond?
9 MR. HACKBARTH: Sure.
10 MS. ROSENBLATT: I think you spoke much more
11 eloquently than I can and I agree with a lot of what you said.
12 I think you might be helping me articulate my problem by what
13 you just said. I too like a private solution. I don't
14 necessarily think that the existing Med supp market is a good
15 one. But I think one of the biggest problems with it is that
16 law set in 1992 what the benefits needed to be.
17 You mentioned the opportunity for innovation. When
18 you've got a set of 10 standard plans there's no opportunity for
19 innovation. I don't know of any benefit plan we have at
20 Wellpoint that hasn't changed ever in the last 10 years. That
21 would be unthinkable. We're changing our plans every year,
22 sometimes more often than once a year, as we're understanding

1 what's going on in the marketplace, what consumers want, what
2 employers want. So I think that we've created something that
3 can be undone.
4 The tone that I'm worried about is that we're taking
5 shots at what's there, maybe appropriately, without focusing on
6 there are ways to change it. We could change this private
7 market by allowing innovation, by allowing -- we've got a fee-
8 for-service program and maybe we could, through the supplement
9 market, allow some of the -- maybe the care coordination could
10 occur through the supplemental benefits. There's just a lot of
11 stuff like that that I think we've left out.
12 Now on the other side of all that is what led to the
13 legislation to start with. We talked about that last session
14 too. It will be very complex, but the financing issue cannot be
15 ignored.
16 DR. REISCHAUER: Just on this point, we do have
17 Medicare+Choice and it has a private fee-for-service option. It
18 has a PPO option. It has HMOs, coordinated care. It's the
19 whole enchilada as opposed to just a little filling on top of
20 Medicare fee-for-service. So the opportunity is there. We
21 might not pay it right but that's a whole different series of
22 questions.

1 MS. ROSENBLATT: That's exactly what I'm talking about
2 because I agree with you, but not paying it right is destroying
3 that as well as an option. You can't look at that and say,
4 where's the innovation when you've got a bigger problem with the
5 way it's being paid.
6 MR. FEEZOR: Three more pedestrian issues. One, in
7 this particular chapter and a couple that followed I felt that a
8 couple of the charts, while they were excellent, were almost too
9 laborious to -- you almost had to work at them to understand the
10 real meaning. If that's appropriate to Washington, fine.
11 Otherwise we might look at simplifying how those charts project.
12 I had to say, what does this really mean? So observation one
13 may speak more to my inabilities than it does anything else.
14 Second, I think we have to be very, very careful and I
15 found this in a lot of the employer surveys that I've looked at,
16 we've got to be very clear that when we talk about retiree
17 coverage we know whether it's pre or post-65. That's a big
18 issue and in some of the employment surveys that I've seen don't
19 make a good distinction of that. I may offer your early retiree
20 coverage up to 65. I may not offer anything after that.
21 Even more important, back to more current trends,
22 whether I may offer my existing workforce or my existing union-

1 negotiated contracts some retiree coverage, I may not be doing
2 it for any of my new hires. So I'd just make sure when we speak
3 to that that we make -- there may be some small distinctions.
4 Then the final thing, I can't remember whether it was
5 in this chapter or one of the subsequents when we talk about the
6 aggregate expenditures in the Medicare supp area as being $450-
7 some billion or whatever it was in Medicare and Medicare
8 supplemental. Just curious on that whether that was -- does
9 that include tax expenditures or was that simply cash outlays?
10 DR. ZABINSKI: Total spending outlays is everything
11 spent by all sources.
12 MR. PETTENGILL: By all sources.
13 MR. FEEZOR: Would not be tax treatments that were
14 given to premiums and so forth.
15 DR. ZABINSKI: No, it does not include tax treatment.
16 MR. PETTENGILL: No, it's actual spending.
17 MR. MULLER: I think these chapters have evolved quite
18 well over the course of the last few months. Maybe we're
19 beating ourselves up too much. I think especially a major
20 contribution that's been made as it evolves is this relationship
21 between the public spending and the total spending, and the
22 interplay between private and public. I think when one thinks

1 about -- I mentioned this to Glenn at lunch, when one thinks
2 about at least some of the conventional ways this issue is being
3 discussed just six, eight months ago, which drug benefit plan do
4 you prefer, and to try to put this now into the bigger context,
5 especially interplay.
6 For example, one of the more frightening statistics in
7 here in the sense of what one thinks about the consequence of
8 public spending is the dramatic decrease in retiree coverage.
9 Now playing that out, if that continues as it has over the last
10 few years, can have a very substantial impact on the Medicare
11 program costs independent of any judgment made by the people who
12 run it. So in some sense those private judgments being played
13 out, as they no longer cover the retirees in the same way, can
14 have a very big effect on the program costs, perhaps beyond some
15 other judgments that people think are in front of us right now.
16 So I think continuing especially in that -- whether it
17 was David or somebody else who asked for that kind of cover
18 chapter, I think trying to stress in that overview chapter, or
19 at least the overview paragraphs, the fact that we are paying a
20 lot of attention in these subsequent chapters to the interplay
21 between the private coverage of costs for the elderly, or the
22 over 65, versus total costs and the interrelationship between

1 the two. We mentioned last month the stresses that the states
2 are under now they may start changing some of their coverages as
3 well in terms of supplemental and so forth.
4 So I think understanding that interplay I think is a
5 major contribution. I think these chapters have done a very
6 good job of it, and I think pointing out the extent to which
7 these chapters deal with that issue is a very useful thing to
8 put right into the beginning.
9 DR. BRAUN: I think it's important to remember that
10 there are a tremendous number of changes that could be made to
11 Medicare to make it make it more sense, the cost sharing and so
12 forth, without adding any expense to the program. Certainly if
13 we add benefits, particularly the drug benefit, that's going to
14 require more money. But Medicare really could have a lot of
15 changes, and that would impact on the supplemental and the type
16 of supplemental coverage or whether or not anybody would carry
17 supplemental coverage.
18 But I think we should remember that we could change
19 the program tremendously without any extra cost, although we do
20 need drug coverage and we do need that extra cost.
21 DR. REISCHAUER: Could you just run down a list of
22 those things? Are you holding them in the secret vault at AARP?

1 [Laughter.]

2 DR. BRAUN: No, but I think the cost sharing could be
3 changed a good bit and the deductible situation could be changed
4 a good bit.

5 DR. REISCHAUER: You mean raise some and lower others?

6 DR. BRAUN: Yes, right.

7

8 DR. REISCHAUER: So you're compensating --

9 DR. BRAUN: -- and come out even in the end.
10 Catastrophic and drug costs I think we need to do something
11 about, and they may add extra money. But other things I think
12 could be shifted around without cost.

13 MS. RAPHAEL: I just had two things that I thought
14 needed to be amplified a bit. One of the principles that was
15 interesting was this notion that you should have higher cost
16 sharing when something is non-discretionary than when it is
17 discretionary. But one of the questions I had was whether or
18 not we know to what degree some of the services in fact are
19 discretionary.

20 For example, going into a nursing home, to what degree
21 is that something that's discretionary? We say that generally
22 you don't enter a hospital unless you have to. But I was very

1 interested in that whole area and what we know about patterns of
2 utilization.
3 Then the other thing I was struck by in reading this
4 that I don't think I had given enough thought to was that the
5 Medicare population really values predictability and they're
6 willing to pay a lot for predictability. As we think about
7 restructuring options I think we need to keep that value in
8 mind.
9 DR. BRAUN: I think that's really important because we
10 do have to remember that the older population can't go back to
11 work again and get back their assets or build up assets again if
12 they once lose them through programs. So that predictability is
13 explainable and I think is a very high value for older people.
14 MR. HACKBARTH: We've used our allotted time for this.
15 MR. PETTENGILL: But you didn't fix it.
16 [Laughter.]
17 MR. HACKBARTH: Is there anything specific that you
18 would have liked us to address that we didn't? Very specific.
19 MR. PETTENGILL: The way these things work is we
20 puzzle about what you said. Sometimes we aren't quite clear
21 what it meant, other times there's a conflict in what various
22 people said and we have to figure out which of them we should go

1 with. But primarily the way this works is we will take all of
2 what you said back with us and we will try to figure out how to
3 write some kind of an overview that sets the backdrop for the
4 report as a whole and says, we're really not ignorant of all
5 these other larger issues that are playing around in outer
6 space. We will send it to you, and you will read it, and then
7 you will get back to us and say, you either caught what we meant
8 or you didn't.

9 MR. HACKBARTH: On that note we will move on. Thank
10 you.

11 Next, issues affecting the Medicare benefit package.
12 Go ahead whenever you're ready.

13 DR. THAMER: As you've just heard, although Medicare
14 has been largely successful in meeting its goals of financial
15 protection and access to care for many beneficiaries, it's
16 important to consider whether there are trends in the
17 composition of the Medicare population and in the scope and
18 delivery of medical care that might make its future success less
19 certain. In this presentation we will briefly review the
20 contents of this chapter, Issues Facing the Medicare Benefit
21 Package, and we hope to get commissioners' guidance and
22 recommendations on possible revisions.

1 This chapter discusses four major demographic trends
2 that you've seen before. The first one, the older population in
3 the U.S. is growing rapidly as reflected by the fact that
4 currently Medicare serves 40 million, which is approximately
5 twice the number it did at the program's inception, and it's
6 going to double again by 2030 to exceed 70 million persons.
7 The second trend is that the fastest growing segment
8 of the older population is the 85-plus group which now numbers
9 4.2 million and is expected to reach nearly 9 million in 2030.
10 The third important trend is that the under-65
11 disabled population is increasing at a growth rate that's
12 significantly faster than that of the elderly population. Since
13 Medicare began providing health care services to disabled
14 individuals in 1973 enrollment has grown from 1.7 million to
15 more than 5.2 million persons.
16 Finally, the last trend that we think is very
17 important is that disability from chronic conditions among the
18 elderly has declined substantially over the last two decades.
19 This trend has led many experts to conclude that there may be a
20 compression of morbidity and mortality into the last few months
21 or year of life.
22 These demographic trends have particular significance

1 for Medicare beneficiaries and what they need since the
2 importance of various benefits changes based on one's health
3 status. One useful way to think about the beneficiary
4 population is to divide it into three segments according to
5 health status as follows. The first group is basically healthy
6 except for acute episodes. This group in particular may require
7 preventive services and access to routine care.
8 A second group are people with serious chronic
9 conditions who are at risk for further deterioration and who
10 represent significant current and future cost to the program.
11 This group needs ongoing coordinated care from multiple
12 providers and often from multiple institutions, and they require
13 protection from potential catastrophic costs.
14 The last group, the third group are people who are
15 terminally ill and nearing the end of life. Hospice and
16 palliative care are of particular importance to this group.
17 The importance of the perceived gaps in the Medicare
18 benefit package that are listed in this slide, they can differ
19 by what group a beneficiary is in. For example, while the lack
20 of a prescription drug benefit affects the entire Medicare
21 population, it may be of particular importance for those with
22 chronic conditions or those at the end of life who require pain

1 management.

2 Similarly, use of preventive services may be most
3 relevant to the generally healthy aged although it has a
4 potential to prevent further deterioration among those with
5 chronic conditions as well.

6 Finally, advances in mental health services most
7 directly affect those who have severe mental conditions, but
8 since mental conditions, particularly affective disorders, are a
9 common comorbid condition for people who have chronic
10 conditions, improvements in mental health services could also
11 affect this group.

12 For the remainder of this presentation we would really
13 just like to hear from the commissioners regarding whether this
14 chapter presents an adequate and comprehensive background as
15 well as provides compelling reasons for the options that are
16 later delineated in Chapter 3. Specifically, issues of tone,
17 missing topics, topics that are overlooked, or topics that may
18 not have been adequately covered we'd be interested in hearing
19 about.

20 MR. HACKBARTH: If we're focusing on the fact that the
21 population served is diverse, in this case in terms of health
22 status, and what is absolutely essential in terms of benefits

1 may be a function of what category they fall into, are there
2 other ways that we could think about varying -- other
3 classifications we could use? In the text you say, this health
4 status categorization is interesting conceptually but it would
5 not be practical in terms of administering the program because
6 of vague boundaries.
7 Should we be looking at other ways, age or --
8 recognizing that they're imperfect all of them. But I think
9 Floyd at the last meeting suggested maybe we ought to be
10 thinking about different benefits by age, recognizing that the
11 general tendency is for the oldest of the beneficiaries to have
12 the greatest needs and the greatest need for comprehensive
13 coverage. If we've got scarce resources maybe we ought to be
14 focusing benefits and the additional taxpayer contributions on
15 those in the greatest need.
16 DR. REISCHAUER: I think that's political
17 unsustainable and unwise, because it would be quite easy to show
18 somebody 67-years-old who was in much worse shape and denied a
19 set of benefits than somebody 84-years-old who was going to the
20 gym every day. If there were a pure correlation between
21 benefits needed and age, in effect you don't do much by
22 segregating the benefit package by age because nobody between 65

1 and 70 would need the benefit that you were providing to people
2 at an older age. So I don't think that's a way to go, for both
3 reasons.

4 MR. HACKBARTH: Your points are well taken, and we can
5 easily talk ourselves into gridlock and the status quo. It's
6 not perfect, therefore we'll hold out for the maximum for
7 everybody. That has happened through Republican and Democrat
8 administrations and various changes in congressional control.
9 So I'm just trying to think about the problem differently.

10 MR. SMITH: Just quickly, Glenn. I think the issue of
11 different packages for different cohorts, I agree with Bob I
12 think it's politically insustainable. But also it's not clear
13 that it's necessary. The appropriate delivery of services
14 doesn't mean that we inappropriately deliver services to
15 beneficiary A because beneficiary B needs them. I think that if
16 we start down the road of different benefit packages the
17 classification questions become enormously difficult, whereas
18 that ought to be a clinical decision.

19 We don't need to sort people into either these three
20 cohorts or anything else. I'd be very reluctant to spend much
21 time thinking about that, and I do think the politics of it are
22 just gruesome.

1 DR. BRAUN: The other problem that I see with that is
2 I think Medicare really needs to be thought of as an insurance
3 program rather than a means test or a cohort program or
4 whatever. I think it's an insurance program and the idea is
5 that you pay a little more when you're healthy and that will
6 take care of you maybe when you're sick. I think that's really
7 important.
8 I just wanted to say one other thing while I've got
9 the floor. I think it would be a good idea to check the text
10 and be sure that where we talk about elderly we also mention
11 disabled, because Medicare does cover disabled as well as
12 elderly and there are several spots where I think it needs to
13 get mentioned.
14 MS. NEWPORT: I agree with Bea on the disabled piece.
15 And the politics of trying to create different cohorts for the
16 eligible population, I think that just would be impossible to
17 administer or even think about in terms that are in alignment
18 with reality.
19 But I did want to probe a little bit on page 14, 15,
20 large share of the costs of Medicare managed care coverage has
21 probably been absorbed into Medigap. I think it's important
22 here to understand that the equivalency of the coverage will be

1 different in Medigap even though there is, as you disenroll
2 there's some protection in terms of allowing you, if you can
3 afford to, get into a Med supp package.
4 To me, I think we should guard against making this
5 sound like it's a perfect substitute. It is not, and I think to
6 some extent that --
7 DR. THAMER: Janet, I think you're talking about the
8 next chapter.
9 MS. NEWPORT: Am I?
10 DR. THAMER: Are you in Emerging Issues?
11 MS. NEWPORT: We're covering so many chapters. No,
12 Coverage Beyond Medicare Fee-For-Service.
13 DR. THAMER: That's the next one, so just hold that.
14 MS. NEWPORT: When we get to that, I will have to say
15 this, okay?
16 DR. THAMER: Hold that thought, right.
17 MS. NEWPORT: Okay, let me withhold. Or I can finish
18 it and I don't have to say this later.
19 MR. HACKBARTH: We'll put you on the top of the list.
20 MS. NEWPORT: Thank you very much.
21 MR. FEEZOR: At some risk I'm going to come back to
22 the chairman's efforts to try to think, because I had I think

1 suggested maybe a tiering of benefits based not necessarily on
2 age but on some other qualifications. It very well may be that
3 if we can't politically differentiate -- and I think the point
4 was made you can find the 67-year-old who in fact is every bit
5 as ill as your 85-plus. It very well may be though that in
6 terms of either the economic protections which Medicare tries to
7 provide, may be different at different times. It may be looking
8 at that construct that we may want to -- again, I'm raising a
9 question or a perspective, whether that yields any additional
10 thinking.
11 Secondly, there may be some other thresholds that may
12 differentiate benefits that might be more needed by some of
13 these cohorts or not. For instance, the issue of care
14 coordination seems to be particularly acute when we get into the
15 chronically ill, or in fact the terminally ill. It very well
16 may be that we begin to require some threshold of participation
17 -- not financial, but in terms of compliance and by which one
18 can in fact get greater coverage or greater protection.
19 One of the things that we've worked on with some of my
20 enrollees focus groups has been to say, given the fiscal
21 realities we have, the choice of perhaps less benefits for
22 everyone or some requirement that I participate, let's say in my

1 care management or my disease management protocols in order to
2 get additional protections, or to at least forgo maybe some
3 additional copay requirements. Even within my constituency,
4 which is I think very reluctant to give up on any benefits, they
5 find that to be perhaps a prudent benefit design that makes some
6 sense.
7 In other words, that if by in fact participating in
8 my, let's say disease management or my chronic care, that in
9 fact I either may get -- that may be a way I can channel into a
10 fuller level of benefits or I can avoid some of the copay
11 requirements that I might otherwise be visiting that could be
12 available for all. So there may be some ways of, for lack of a
13 better term, triaging into different layers of coverage that in
14 fact may be in fact not politically -- or may not be politically
15 objectionable and in fact may provide more effective care and
16 even more efficient benefit design package.
17 DR. REISCHAUER: The Clinton administration actually
18 suggested a number of initiatives just like that.
19 MR. SMITH: I think what you've suggested is
20 interesting and worth pursuing, but has nothing to do with
21 assigning beneficiaries to cohorts. It has to do with designing
22 access to a benefit which is maximally efficient and it's driven

1 by medical necessity.

2 DR. NELSON: My comments are not on tiering, so if you
3 want to complete that, if there are other comments on that?

4 I'm going to segue into a new part of this. There's
5 an area of overlap between benefit decisions and coverage
6 decisions and I think it deserves a paragraph or two,
7 particularly understanding the future implications of increasing
8 numbers of experimental procedures that either become a part of
9 the benefit package by legislative fiat, like osteoporosis
10 screening or PSA screening or whatever, when the technology
11 transfer doesn't keep pace with what public expectations and the
12 private sector have incorporated in their plans.

13 I guess I would like to see some reference to the
14 Medicare Coverage Advisory Commission, a reference to the way
15 currently new technology is incorporated within the existing
16 benefits with the implications for that being a much bigger
17 piece of -- getting more attention in the future as emerging
18 technologies are increasing in volume and the distinction
19 between whether it's a covered benefit under -- because it's no
20 longer experimental and the process by which that determination,
21 coverage determination versus benefit package determination is
22 made.

1 Am I clear?

2 MR. HACKBARTH: I think so.

3 DR. THAMER: You'd like more of a discussion on
4 currently how that's being done, how new technologies go from
5 being experimental to being covered and how that process -- we
6 should discuss that and what some of the caveats and limitations
7 are of the current process.

8 DR. NELSON: Yes, and how that relates to our overall
9 view of the benefit package and how we think that ought to roll
10 out in the future. You make one reference to the fact that
11 coverage decisions are often made at the carrier level. There
12 are additional processes by which that's impacted. From the
13 standpoint of the clinician that's every bit as important as
14 what's covered in the benefit package. It's what within the
15 current benefit package is covered and what isn't.

16 If concerns aren't satisfied in the traditional
17 fashion than the next recourse is to go to Congress and get it
18 changed.

19 MR. GLASS: Do you see some options coming out of
20 that, in terms of this paper?

21 DR. NELSON: No, but as I read the paper that seemed
22 an area where it was incomplete. One might think that the end

1 of the issue comes when you decide whether it's a covered
2 benefit. Actually there's a much -- it's much broader than that
3 because there are things that aren't covered benefits and should
4 be because they're still said to be experimental, by Medicare
5 anyway, so that needs standards.
6 MR. GLASS: Or they're only covered in some areas.
7 DR. NELSON: Right.
8 MS. ROSENBLATT: First of all, the tone of this
9 chapter was fine.
10 DR. REISCHAUER: It's not too late to revise it.
11 [Laughter.]
12 MS. ROSENBLATT: The whole subject of classifications
13 and categorizing people in Glenn's earlier question has me
14 thinking about the whole idea of need. It's really, when you're
15 saying different ages might have different needs, or the
16 classifications you used, the chronically ill, et cetera, there
17 are different needs. It raises the whole question of, if
18 beneficiaries have different needs than we need a different set
19 of benefits or whatever to satisfy those different needs. You
20 could do that through something -- what a great name,
21 Medicare+Choice. I mean, Choice meets different needs.
22 So I'm just thinking about some twist there. There

1 was a sentence in here, we believe it would be difficult to
2 develop criteria for assigning beneficiaries to different
3 categories. I wrote down when I read that, consumer could
4 choose. So I'm just wondering if we could take what Glenn said,
5 and this whole idea of choice, and getting into what Bob said
6 before about you could use a private program to fill in that
7 choice idea or introduce choice in the public program.

8 Now adverse selection jumps into my mind and I keep
9 saying, no, don't think about that. Let's be far-reaching. But
10 if you could get that idea out I think that would be nice.

11 MS. RAPHAEL: In terms of the benefit package there's
12 actually two groups. One group is benefits that currently exist
13 that we think might need to be enhanced, and then there's those
14 benefits that don't currently exist. The group that currently
15 exists, including preventive, mental health, I think it would be
16 useful to understand what the current expenditures are under the
17 Medicare program. We talk about the fact that CMS is beginning
18 to do some demos in care coordination, although I think it's
19 more disease management, not care coordination and I think
20 there's a difference. But even that, it would be interesting to
21 see how much are they putting into that attempt at some
22 innovation and what's the timetable.

1 I also was very interested in this chapter in the rate
2 of growth of the under-65 population because I hadn't realized
3 that the rate of growth there exceeded the rate of growth among
4 the elderly. I would be interested in hearing more in this
5 chapter about what is fueling it, because I expect there's some
6 correlation with mental health issues and the increase in this
7 population. But has there been some easing of restrictions for
8 becoming qualified as disabled under Medicare, or what has
9 transpired that has in fact led to that? I think it's important
10 to explore that.
11 Then you talk about the fact that this population
12 accounts for a disproportionate share of the mental health
13 spending and I'd like to understand per capita or some measure
14 of what is happening there.
15 DR. WAKEFIELD: I think I might have raised this at
16 the last meeting and that's why I'm going to raise it again
17 because I don't quite see it here. On pages 8 and 9, in
18 particular on the section, we're talking a lot about, I think,
19 quality of care issues. I think that's great. One thing you
20 might want to do is take a look at the IOM's report, Crossing
21 the Quality Chasm.
22 DR. THAMER: We did that. We just didn't cite it in

1 here. But I found it and I'm sorry we didn't put it in here.
2 You did mention it before.
3 DR. WAKEFIELD: Thank you. Because you've got some of
4 those concept here. The point here is to say, that might have
5 some ideas. Obviously it was developed to help people think
6 through how the broader health care delivery system could be
7 redesigned. We're talking about some redesign issues related to
8 the Medicare program and those two activities don't necessarily
9 have to travel parallel and non-diverging paths. I think some
10 of what's in that report may actually help inform our thinking
11 and should not be lost on the Medicare program.
12 A couple of them you've indirectly at least picked up
13 here, and some of that's related to care coordination, for
14 example, in your discussion there. Although one of the problems
15 you cite there is that, for example, medical training doesn't
16 adequately prepare physicians to assume the role of care
17 coordinator. I'd say in fact the issue there from my
18 perspective is is that all health care training doesn't
19 adequately prepare health care providers to work in teams and
20 that's the orientation. For example, in that report it isn't
21 who's doing the coordinating. It is very much how we maximize
22 the capacity we've got within the system and extract more from a

1 multidisciplinary team, as one example.

2 You pull in, for example, the discussion of other non-
3 visit specific interactions between provider and patient. I
4 think that's really good. Again, that's an IOM redesign issue
5 that's talked about there. I would say it's not just between
6 physicians and patients as it's described. It could be
7 psychologists and their patients, et cetera.

8 Also the Quality Chasm speaks a lot to chronic care
9 and you've got a lot of that in here too. So just wherever we
10 might be able to marry some of those ideas, each one might give
11 a little bit of lift to the other and I don't think that's all
12 bad. Thanks.

13 MR. HACKBARTH: I want to go back to the discussion we
14 were having a little while ago and react to David's point about
15 the ideal to be to have access to additional benefits based on
16 need, the clinical needs of the beneficiary. That would
17 certainly be my ideal as well. It also would be my ideal that
18 we expand the program in various ways because I think there are
19 important missing pieces in the Medicare program, obviously
20 including drugs but not limited to that.

21 But what I keep getting hung up on personally is our
22 ability to afford that. Or more specifically, the ability of my

1 children to afford that. That's what personally forces me to
2 come back to say, even if that is our ideal, are there other
3 ways that we can slice this? Are there other ways that we can
4 approach it that would better target whatever additional funding
5 is applied to the people who most need it? Age was one idea
6 that didn't go well. Income-related benefits is another that
7 publicly go over even less well.

8 But I worry if we keep saying, no, it's got to be
9 everybody gets everything that basically we talk ourselves right
10 into gridlock and nobody gets anything.

11 MS. RAPHAEL: Glenn, you could slice it by service
12 use. You could say that if you consume a certain amount of
13 service in some time period then you get into another tier of
14 benefits, on the assumption that no one would want to be in the
15 hospital five times in one year and have X episodes of SNF or
16 home health care. That's one way that you could do it, because
17 I think going to income or age is not workable.

18 DR. REISCHAUER: How does that save you any money
19 though?

20 MS. RAPHAEL: It doesn't.

21 DR. REISCHAUER: Because nobody in the other tiers
22 would have used it anyway.

1 MR. SMITH: No, but Carol states a way -- we could
2 change copays depending upon consumption. That would address at
3 least both pieces of the problem. But the notion that we're
4 going to put Bob in a tier and he will have access to a benefit
5 package that's different than mine based on income would be the
6 most disturbing flashpoint. But also on this --
7 DR. REISCHAUER: Just call it a catastrophic cap.
8 MR. SMITH: A catastrophic cap shouldn't be off the
9 table, some sort of consumption-driven changes in copays
10 shouldn't be off the table. But there's no reason why a
11 comprehensive benefit package means somehow we're all going to
12 promiscuously consume things that we don't need. That has much
13 more to do with the copayment design, Glenn, than with the
14 benefit package.
15 MR. HACKBARTH: Just for the record, you're
16 misunderstanding my point. It isn't about promiscuous,
17 inappropriate consumption. It's about a real legitimate need
18 but how do we pay for it, how do our kids pay for it?
19 One of the nice features of this report is that we
20 don't need to resolve this question. I'm not asking that we
21 resolve the question. I would like the text to address this as
22 an issue, an issue on which reasonable people can disagree. But

1 I think it is at the nub of why we've had so much difficulty,
2 over years of administrations of all varieties, in making
3 progress on this issue. I think to pretend it isn't the
4 question, it's just not appropriate.
5 DR. REISCHAUER: But we're paying for it already.
6 We're paying for it through supplementary premiums. We're
7 paying for it through out-of-pocket spending. It's just that
8 the distribution of how we would pay for it would change.
9 MR. HACKBARTH: But that's a critical difference.
10 DR. REISCHAUER: And that's the political issue.
11 MR. HACKBARTH: Right. But the distribution of the
12 burden, who's paying for it, is extremely important. In some
13 ways we say to our kids, you've got to pay it all. In other
14 ways, people are, participants in the system pay at least part
15 of it. Therein is a very big difference.
16 MR. SMITH: Glenn, I don't disagree. The questions of
17 how do we pay for it are important ones. But I think we are in
18 very dangerous territory if before we've thought about what is
19 in the appropriate benefit package and how do we allocate that
20 against medical necessity rather than some ability to pay-driven
21 metric, and start saying, no, we can't go there because it might
22 cost something, there's a critical question, you're right. How

1 do we pay for what we think is appropriate? But let's not
2 negotiate with ourselves about the second question before we
3 answer the first.
4 DR. ROSS: I'm sitting here trying to figure out how
5 on earth these guys are going to write this up.
6 MR. HACKBARTH: Carefully.
7 DR. ROSS: Carefully, yes, with no tone. But as I
8 listen to Carol talk about condition-driven benefits, and that
9 was kind of your point, David, that you have a uniform benefit
10 package but only certain people consume it. It's available to
11 all. I could think of that with things the way we do with care
12 in skilled nursing facilities, minimum three-day hospital stay.
13 If you're really sick and you've been in the hospital for 10
14 days, now we'll give you some care coordination or something
15 like that. You can at least think of some instances there.
16 Operationally though I have a harder time thinking
17 about how you'd take a small bite of the prescription drug apple
18 on anything but income grounds or something like that.
19 We could take a crack at this. I suspect in the time
20 available we would have a hard time framing all of this in a way
21 that satisfies all of you.
22 MR. GLASS: Murray, there is one example in the

1 Medicare package where we do something that which is hospice.
2 There you have to meet a certain diagnosis to be in it, and then
3 you have to give something up to get into it. You have to give
4 up curative.
5 MS. RAPHAEL: You have to give up traditional Medicare
6 fee-for-service.
7 MR. GLASS: Right, so conceivably you could say for
8 some benefits you have to give up some choice of provider or
9 something like and that would be possible.
10 DR. ROSS: We call that Medicare+Choice. To give up
11 your choice of provider you go into another program.
12 DR. THAMER: There are precedents in other health care
13 systems where you can, having a certain number or type or
14 severity of medical conditions, or a certain number of
15 functional limitations will get you into a different set of
16 packages. There are examples like that that are operational
17 today but they're difficult to do.
18 MR. HACKBARTH: We're going to have to bring this to a
19 conclusion.
20 DR. STOWERS: Mine is leaving this a little bit but it
21 kind of gets back to maybe what even ought to be in that
22 introductory chapter is some sense of order of how Congress or

1 we would approach this, is a matter of trying to figure out what
2 benefit package and all of that, but that's dependent upon what
3 we can afford or not afford, whether we're going to distribute
4 it or whatever. But we don't know unless we do the
5 reorganization first with the Medigap and all the other things
6 of what's going to be saved out of that. We don't know what
7 quantity one way or the other.

8 So I think we ought to approach Congress more from we
9 ought to be putting our efforts into creating these efficiencies
10 that we're talking about, and then from that know a little bit
11 more what this benefit package can be. But we seem to be just
12 charging into all of it at the same time and not really giving
13 direction as to how it ought to be approached. I think maybe we
14 could do that if we all agree that the reorganization and that
15 kind of savings should be up front to see what we're going to
16 have to spend afterwards.

17 DR. LOOP: I thought each of these chapters was
18 interesting and fairly well written, but together they're sort
19 of redundant. I think you could compress a lot of this. This
20 one was a little wandering, so let me wander around a little bit
21 more.

22 Somewhere in these chapters you have to say, and you

1 actually said this in the appendix of the first one, that
2 Medicare was designed as an acute care program and it has
3 evolved into, there's now more disability and now we have an
4 aging population. The discussion here has pointed out that
5 there's some politically undoable things like indexing to income
6 and perhaps indexing to age. You can't tier it based on age
7 even though the oldest-old are definitely going to consume more
8 resources.
9 I think maybe as long as we're talking about
10 politically undoable things we should look at maybe we should
11 expunge the word catastrophic care. We haven't quite gotten to
12 that yet. And look at instead, change the threshold for
13 expensive medical care, expensive medical necessities. Because
14 the only way that we can remodel Medicare -- because what we're
15 really talking about is expanding Medicare benefits. It's not
16 longer just acute care. We're going into pharmaceuticals, long
17 term care, and what we formerly called catastrophic care.
18 To do this, the only way we can do it and keep the
19 cost under control the government is cost sharing on the part of
20 the individual. I think it has to be stated up front that
21 that's what we're really talking about. If we're going to
22 expand Medicare benefits and we're not going to have the

1 government do it all, then it has to be on the back of the
2 beneficiary. Now I haven't said that very well but I think at
3 the beginning of these chapters, or in the middle someplace, you
4 have to say that, which I don't read it that way.
5 MR. HACKBARTH: This is thought provoking, which is
6 the whole reason for doing the report. There will be lots of
7 interesting issues raised. We look forward eagerly to the next
8 draft.
9 We need to move on though right now to our next
10 section, coverage beyond the fee-for-service benefit package.
11 Go ahead, Chantal, whenever you're ready.
12 DR. WORZALA: Good afternoon. Today I will focus
13 mostly on the results regarding the association between
14 supplemental coverage and access to care and use of necessary
15 services. Of course I do welcome your comments on the whole
16 chapter including the tone.
17 This slide, which you saw last month, summarizes the
18 eligibility restrictions, benefits, and enrollment for each
19 source of additional coverage. That is, employer-sponsored
20 insurance, Medigap, Medicare managed care, and Medicaid. Not on
21 this chart are other sources of coverage such as the VA,
22 military, and state programs. Those programs together cover

1 about 2 percent of beneficiaries and about 9 percent had no
2 additional coverage in 1999. Our best guess for 2002 is that
3 has increased to about 11 percent without some sort of
4 additional coverage.
5 I want to draw your attention to a couple of broad
6 points rather than going through each cell. First, the scope of
7 additional coverage does vary by the source. In general, full
8 Medicaid coverage is the most comprehensive at filling both
9 Medicare's cost sharing requirements and at covering non-
10 Medicare benefits like prescription drugs, preventive services,
11 and even long term care. Employer-sponsored insurance tends to
12 be the second most comprehensive.
13 Medigap, on the other hand, focuses primarily on cost
14 sharing with the exception of those plans that cover preventive
15 services or prescription drugs. Medicare managed care plans
16 were fairly comprehensive in the late 1990s and offered
17 additional benefits with low cost sharing. But as we have
18 discussed previously, they are becoming less generous over time.
19 The second major point is that access to these sources
20 of additional coverage is not universal. Each source has
21 eligibility restrictions as listed. This becomes important when
22 we look at the relationship between supplemental coverage and

1 access to care.

2 People without additional coverage report less access
3 to care. The chart you see here gives the results for three
4 self-reported measures that are included in the Medicare current
5 beneficiary survey access to care file. These are 1999 results.

6 As you can see, compared to those with employer-
7 sponsored insurance or Medigap, beneficiaries with only Medicare
8 fee-for-service benefits were nearly six times as likely to
9 report having delayed care due to cost, about four times as
10 likely to lack a usual source of care, and about four times more
11 likely to report having trouble getting care. While these
12 numbers do raise concerns about access to care for those without
13 an additional source of coverage it's important to recognize
14 that there may be other factors that are correlated with both
15 these access measures and insurance status and these things may
16 confound our results.

17 For example, you can see on this chart that
18 beneficiaries with the most generous form of additional
19 coverage, that is Medicaid, also report less access to care than
20 those with employer-sponsored insurance or Medigap. This
21 population is most similar to the Medicare-only population in
22 both health status and income. Other factors such as education

1 and culture, and knowledge of the health care system may impact
2 care-seeking behavior and other determinants of access to care.
3 I'm not trying to suggest that there's no effect from
4 having supplemental coverage. It seems clear that there is.
5 However, in future work I think multivariate analysis might help
6 us to better understand how much of these differences are due to
7 lack of additional coverage rather than other factors.
8 So assess the relationship between supplemental
9 insurance and use of necessary care we analyzed the access to
10 care for the elderly project indicators, or ACE-PRO indicators
11 by supplemental insurance status. These indicators were
12 developed by the RAND Corporation and funded at least partially
13 by PPRC. They were developed by clinicians and health services
14 researchers to be evidence-based and clinically valid. They
15 consider both preventive services and 14 medical or surgical
16 conditions that are common among the elderly, such as
17 hypertension, diabetes, hip fracture, and depression.
18 A total of 36 indicators were developed under the
19 project. We analyzed 22 of those indicators that were
20 applicable to at least 20 individuals with only Medicare fee-
21 for-service coverage in our data set. Chris Hogan, who is in
22 the audience back there, performed the analysis for us.

1 The indicators we looked at include three preventive
2 services, such as a yearly exam for all beneficiaries or a
3 mammogram every two years for female beneficiaries under the age
4 of 75. We also looked at 13 necessary services for specific
5 conditions and six avoidable outcomes. These indicators were
6 designed to measure necessary care which was defined as follows:
7 the benefits of the care outweigh the risks; the benefits to the
8 patient are likely and substantial; and physicians have judged
9 that not recommending this care would be improper. In that
10 respect then, these indicators represent a floor of clinically
11 appropriate care and they do not measure any sort of ideal care.
12 The data for this analysis came from the 1996 through
13 1999 MCBS cost and use files which include the claims. The
14 analysis was conducted only on those over age 64 and Medicare
15 managed care enrollees were unfortunately dropped out of the
16 analysis because their claims data were incomplete.
17 I should just note, for all of this chapter we define
18 supplemental insurance status as that in which -- what the
19 beneficiary had for at least six months out of the year. So
20 that's how we're defining, for example, employer-sponsored
21 insurance, they had it for at least six months, or for only
22 Medicare fee-for-service that was true for at least six months

1 in the year.

2 Overall we see that the analysis found that people
3 without supplemental insurance use less necessary care. Of the
4 20 indicators we looked at, 10 showed less use of necessary care
5 by those without supplemental insurance, including all of the
6 preventive services indicators. Only one showed greater use of
7 necessary care by those without supplemental insurance, and 11
8 showed no statistically significant difference. Of those 11,
9 six were avoidable adverse outcome indicators, and it's not too
10 surprising that these were statistically insignificant due to
11 the rarity of avoidable outcomes.

12 Getting into some of the specific indicators here are
13 the results for the three preventive services. You can see that
14 the differences between the two groups are large. All of these
15 differences are statistically significant. If we single out
16 mammography every two years for female beneficiaries under the
17 age of 75 we see that while 62 percent of those with
18 supplemental coverage do get these recommended routine
19 mammograms, only 27 percent of those with no supplemental
20 coverage do. That's a 35 percentage point difference, which is
21 clearly quite large.

22 Similarly, for a visit a year, the difference is 19

1 percentage points, and for assessment of visual impairment every
2 two years the difference is 25 percentage points.
3 On the next slide, to give you a flavor of the results
4 pertaining to use of necessary care for specific conditions,
5 here are the results for three of the indicators. The full
6 results are in your briefing papers. That's Table 2B-3. The
7 first indicator that I've highlighted for you here is a
8 preventive measure which is an eye exam every year for patients
9 with diabetes. Here we can see that those without supplemental
10 coverage are substantially less likely to have this exam done
11 than those who have it; it's a 17 percentage point difference.
12 The second here is a monitoring indicator and that's a
13 visit every six months for patients with congestive heart
14 failure. The gap between those with and without supplemental
15 coverage is smaller here but still seven percentage points. I
16 think the good news on this indicator is that clearly all of
17 these people are, for the most part, being monitored.
18 The third is a surgical procedure which is repair of a
19 hip fracture during hospitalization. Here too we see a gap of
20 10 percentage points between those with and without supplemental
21 coverage.
22 Clearly these results suggest that the cost sharing

1 and gaps in the fee-for-service benefit package may dissuade
2 some beneficiaries without supplemental coverage from getting
3 needed care.
4 Those were the results regarding the association
5 between supplemental insurance and access to care and use of
6 necessary services. They suggest that this kind of coverage
7 affords beneficiaries with a level of financial protection that
8 promotes access to care. However, that access to care does come
9 at a price and there are aspects of the patchwork of additional
10 coverage that make it less than optimal and suggest that there
11 might be more efficient ways to provide the same benefits and
12 access to care.
13 First, the system of multiple sources of additional
14 coverage confuses beneficiaries and providers. I want to be
15 clear that we're talking here about the system and the fact that
16 there are all these different sources: employer-sponsored,
17 Medicaid, Medigap. I'm not singling out any one of those
18 sources.
19 Second, having multiple sources -- and here again I'm
20 talking about all of them -- raises administrative costs. This
21 is especially true given that some beneficiaries, and that's
22 about 12 percent in 1998, hold more than one supplemental

1 product.

2 Third, a body of research has demonstrated that
3 generous coverage of cost sharing leads to increased use of
4 services, resulting in higher premiums for beneficiaries and
5 higher costs for the Medicare program. The size of this effect
6 varies across studies. Whether or not the increased usage is
7 completely unnecessary is not known, but I think the direction
8 of the effect is fairly clear.

9 Finally, a substantial sum of all resources spent on
10 beneficiary health care, excluding long term care, does flow
11 through private and governmental sources of additional coverage.
12 We estimate that to be about 20 and 25 percent of all resources.
13 As Anne and Ariel will discuss, those resources might be better
14 allocated to improve beneficiaries' financial protection and
15 their access to care.

16 I'll stop there.

17 MS. NEWPORT: I'll repeat, or try to, what I was
18 trying to say earlier. I was just trying to get this done.
19 Anyway, I appreciate your patience.

20 Again, I think that I was concerned that, as it
21 regards to managed care exits out of M+C, that going into Med
22 supp, and obviously there will be increasing participation in

1 those areas, but I don't think that we should leave people with
2 the potential impression that that's a perfect substitute
3 because the scope of the coverage may be very different even
4 though they have protection in terms of elimination of
5 preexisting conditions and getting into Medigap coverage in
6 those areas.
7 Then on your slide, I think that one of the things
8 about generous coverage of cost sharing leads to higher cost for
9 the Medicare program, I think that I would like to see that more
10 carefully constructed to say that the removal of financial
11 barriers to accessing care could improve quality, although it is
12 acknowledged that people are getting the necessary. I think
13 that I would hope that as you go forward and edit this that
14 that's clear.
15 These are economic barriers. If you don't have supp
16 coverage or the deductibles and copays are so high that it does
17 chill, in a very bad way, people's ability to go and seek care
18 when they need. Since your data shows that, let's change that
19 around.
20 MS. ROSENBLATT: In general the tone here was okay,
21 too. The issue I had on here was on the -- there's a whole page
22 on admin costs, particularly for the supplemental coverages. I

1 already made the comment that there's a reference in here on
2 page 13 to admin costs for Medigap plans average 20 percent.
3 There is a pretty wide range, so if you've got -- I don't know
4 what the DePaul study is but if it's got a range that would be
5 helpful.
6 Comparing that 20 percent to admin costs of 11 percent
7 for M+C is strange because it's 11 percent of a much bigger
8 number. The Medicare+Choice, I think you're getting the 11
9 percent of the total to cost as opposed to just the cost of the
10 supplement. Then I've already talked before about the 2 percent
11 for Medicare. So if you could just put some language in that
12 you're not really comparing apples to apples, because I think
13 the reader is left with 20, 11, two, without realizing that
14 you've got some apples and oranges there.
15 The other thing is, in terms of the difficulty of the
16 administrative stuff, I don't know what the generic term for
17 this is and maybe Glenn or Lu knows, but some of the Blue plans
18 do something called crossover. I know it as crossover, where
19 the Blue plan is both the intermediary and also has Med supp.
20 The individual is only submitting a claim once. There's no
21 language in here about that.
22 DR. REISCHAUER: Chantal, for these differences, I

1 presume that these are just raw differences between those with
2 some supp and those with none. I think we know that of
3 individuals with identical insurance policies, those with lower
4 educational levels, lower income, living in rural areas, non-
5 English speakers use fewer medical services than those in the
6 other category. We know that factors like that are positively
7 correlated with lack of supplemental insurance. So this is, in
8 a sense, an overestimate of the difference that is attributable
9 to lack of supplemental insurance and we should just make some
10 reference somewhere to that.
11 MR. HACKBARTH: Any others?
12 MR. FEEZOR: Just a question. When we refer to those
13 with supplemental coverage as using more services generally, is
14 that over their entire lifetime or is that simply measured as
15 year to year?
16 DR. WORZALA: Most of the studies are annual. I'm not
17 aware of any lifetime studies. That would be interesting.
18 MR. FEEZOR: It would be. Do you access the services
19 you need earlier and pay more so you may show up, and yet at the
20 end may -- just curious if there is such. Like to see that at
21 some point.
22 MR. HACKBARTH: Thank you. The last item for today is

1 options for modifying the Medicare benefit package.

2 MR. WINTER: Good afternoon. We will be reviewing the
3 final chapter in the report which presents an array of options
4 for addressing the limitations in the benefit package. Many of
5 these options have been discussed elsewhere in other contexts by
6 other organizations but we thought it would be useful to have
7 them all in one place with a discussion of their trade-offs
8 relative to a common set of criteria. We do not recommend any
9 specific proposals.

10 We will also be presenting some modeling we have done
11 of a comprehensive benefit package and its effects on total
12 spending and spending by different groups of beneficiaries.

13 We recognize that there are limited resources for
14 improving the benefit package so we ask if there are better ways
15 of allocating existing resources spent on beneficiaries' health
16 care. Some improvements, such as some cost sharing changes,
17 could be made without significant increases in Medicare
18 spending. Other changes, such as adding drug coverage would
19 require more Medicare spending but may decrease spending by
20 beneficiaries and supplemental insurers. Such reallocations
21 could improve financial protection and access to care for
22 beneficiaries and overall system efficiency, but they may or may

1 not increase current total health spending, as we will see
2 later.
3 We will discuss the key criteria for evaluating the
4 options to improve the benefit package. Then we will explore
5 three groups of options: changing Medicare's cost sharing rules,
6 expanding Medicare to cover additional benefits, and replacing
7 the current package with a more comprehensive benefit package,
8 which is where we'll talk about our modeling results.
9 Here are the key criteria we used to evaluate the
10 options. The first is financial protection. Does this option
11 improve protection for beneficiaries and their families from
12 financial difficulty due to high health care liabilities?
13 The second is access to quality care. Does this
14 option improve access to high quality health care, including
15 preventive, diagnostic, and treatment services in the most
16 appropriate settings?
17 The third is efficiency. Does the proposal promote
18 the purchase of appropriate care at the lowest cost, and does it
19 improve administrative efficiency for the system as a whole?
20 Feasibility. What are the challenges in implementing
21 the option? Would it cause major disruptions to beneficiaries,
22 providers, and payers, and how could we manage those

1 disruptions?

2 And the last one is cost implications. Would the
3 proposal require additional Medicare spending? If so, could it
4 be implemented without increasing total spending on
5 beneficiaries' health care?

6 Now we'll move on to evaluating the trade-offs of
7 specific proposals. First we discussed potential changes to
8 Medicare's cost sharing structure. As we discussed last time,
9 these options include reducing the inpatient deductible,
10 increasing the Part B deductible, combining the two deductibles,
11 and eliminating the deductible on blood.

12 One could also modify the coinsurance structure, for
13 example, by eliminating the inpatient hospital copayment, adding
14 copayments for home health and clinical lab services, and
15 reducing coinsurance on outpatient hospital and outpatient
16 mental health services.

17 One could consider adding a cap on beneficiary
18 liability for covered services. You discussed earlier the
19 possibility of tiering benefits. Capping liability for
20 beneficiaries with high medical costs is one way of doing that.

21 The fourth is modifying supplemental coverage so that
22 it exposes beneficiaries to modest cost sharing while still

1 protecting them from high out-of-pocket costs.

2 Last time we presented to you various combinations of
3 cost sharing changes that illustrate the trade-offs between
4 financial protection, access to care, efficiency and costs. We
5 showed that it is possible to make some changes that improve the
6 cost sharing structure without significantly increasing Medicare
7 spending.

8 The second section of the chapter examines proposals
9 to expand the benefit package to address concerns in six key
10 areas. This is the same list that you saw in the previous
11 presentation by Mae. The first is prescription drugs. We
12 explore ways to improve access to drugs by expanding Medicaid
13 and state-based programs, offering new Medigap options, reducing
14 drug prices, or covering drugs under Medicare.

15 Under care coordination we talk about covering case
16 and disease management services to improve care for fee-for-
17 service beneficiaries with chronic illnesses.

18 We also talk about expanded coverage of preventive
19 services, improved coverage of mental health care, improved
20 coverage of vision and hearing, and dental care. The last two
21 categories we haven't, at this point we don't have much
22 discussion of that in the chapter but we're going to be

1 expanding on that for the next draft.

2 Now long term care had been on that list and I wanted
3 to explain why it dropped off. We decided to drop it because
4 it's beyond the scope of the report and we didn't think we could
5 really give it the attention that it really requires in the time
6 and the space that we have, so that's why it fell off. We
7 didn't just forget about it. We do realize it's a very
8 important issue.

9 Now the third section of the chapter explores the
10 option of replacing the current benefit package with a more
11 comprehensive package that would include cost sharing changes
12 and drug coverage. Ideally, this approach would provide all
13 beneficiaries with a core fee-for-service package that better
14 meets their needs than the current package. This approach could
15 improve financial protection and access to care for
16 beneficiaries and make the current system more efficient by
17 reducing demand and need for supplemental coverage, which is
18 associated with higher administrative costs and it's first
19 dollar coverage, which leads to greater use of services.

20 Here we'll explore some of the key design issues and
21 we did this last time so I'll do this fairly quickly. The first
22 is the scope of the benefit package. Can we make the package

1 broad enough to include features that beneficiaries now obtain
2 through supplemental coverage, such as drug coverage and limits
3 on liabilities, without increasing total system costs?
4 The second is, should the package be offered as an
5 alternative to the existing benefit package or as a substitute?
6 The third is, should it be administered by CMS or by
7 private plans?
8 Finally, what proportion of higher Medicare costs
9 should be borne by beneficiaries versus taxpayers? This is
10 particularly important given limited federal and beneficiary
11 resources.
12 So we decided to model the impact of an illustrative
13 comprehensive benefit package on current spending on
14 beneficiaries' health care as well as its effects on different
15 groups of beneficiaries. So this slide shows the features of
16 the package we modeled comparing each feature to current law.
17 These elements should seem familiar to you from the cost sharing
18 illustrations we presented last month.
19 These features include a combined Part A and B
20 deductible of $400, and out-of-pocket cap on covered services of
21 $3,000, no inpatient hospital copays or limits on days of a
22 stay, a home health copayment, a modified skilled nursing

1 facility copayment of $55 per day, no cost sharing on preventive
2 services, reduced coinsurance on outpatient mental health and
3 outpatient hospital services, and prescription drug coverage,
4 which includes a $500 deductible, 50 percent cost sharing up to
5 $6,000 in total spending after the deductible, 25 percent cost
6 sharing between $6,000 and $10,000 in total spending after the
7 deductible, and no cost sharing after $10,000 in total spending
8 after the deductible.

9 For the purpose of this model we assumed there would
10 be mandatory enrollment in the new package. That is, there
11 would not be a choice of a high option versus a standard option
12 or the current option. And we did not specify whether the
13 package is administered by CMS or by private plans. We
14 essentially assumed that spending would be the same under either
15 approach. That's for the convenience for the modeling, not
16 because we assumed that would necessarily be the case.

17 MR. FEEZOR: On the drug component, primarily retail
18 as opposed to any sort of mail order?

19 MR. WINTER: We assumed that there's 10 percent cost
20 savings from a more tightly managed benefit than the way
21 beneficiaries currently obtain their drugs. So there would be
22 some formularies or bulk discounts and those kinds of things.

1 One of the model's most important assumptions is the
2 extent to which beneficiaries continue to purchase or be
3 provided supplemental coverage. In large measure, this
4 assumption drives whether total spending on health care goes up
5 or down, because supplemental coverage has higher administrative
6 cost than Medicare and often covers Medicare's deductibles and
7 coinsurance, which increases use of services. If beneficiaries
8 reduce demand for supplemental coverage in response to a
9 comprehensive package there could be lower administrative costs
10 and lower use of service, which could help offset additional
11 Medicare spending. Because of uncertainty about this assumption
12 we decided to vary it to illustrate a range of possible
13 responses.

14 In the first scenario we modeled we assumed that all
15 beneficiaries who currently have supplemental coverage would
16 keep it, and supplemental insurers would cover the same percent
17 of beneficiaries' cost sharing as they currently do. Because
18 such cost sharing would decline under this new package, because
19 Medicare is covering more, supplemental insurers would spend
20 less money.

21 In the second scenario we assumed that only 25 percent
22 of beneficiaries with employer-sponsored coverage and Medigap

1 would keep it and that all beneficiaries with other types of
2 supplemental coverage, such as Medicaid, would keep what they
3 have. We decided to only vary the share that participates in
4 Medigap and ESI because people with Medigap may decide they no
5 longer want to buy supplemental coverage for the more limited
6 liability they would have under the comprehensive package, and
7 because employers may decide to reduce coverage and subsidize
8 the higher Medicare premium that beneficiaries would be likely
9 to pay. We thought that Medicaid would be likely to continue
10 coverage for all beneficiary cost sharing as it currently does.
11 Before we get into the modeling results I want to
12 caveat our findings. In addition to the supplementation
13 assumption we've made many assumptions that drive the results,
14 such as the current distribution of supplemental spending,
15 administrative costs, and induction effects. Thus, there's a
16 high degree of uncertainty around the results, so please keep
17 that in mind.
18 This slide highlights the main effects of scenario
19 one, which is the continued participation in supplemental
20 coverage, compared to current law. To reiterate the point of
21 the exercise, all beneficiaries would have access to a better
22 fee-for-service core package. There would be significant shifts

1 in spending. Because Medicare would cover more and
2 beneficiaries would continue to retain their supplemental
3 coverage, beneficiary cost sharing would decline relative to
4 current law. Spending by supplemental insurers would go down,
5 probably causing supplemental premiums to go down. Medicare
6 spending would increase because it's covering more benefits.
7 And Medicare premiums would increase.
8 Now if all of the higher Medicare spending were
9 financed entirely by beneficiary premiums then the increase
10 would be about $125 per month. This would more than triple the
11 current Medicare Part B premium. Assuming that supplemental
12 premiums would decline, these savings could be used to help pay
13 this additional Medicare premium. Because beneficiaries would
14 maintain their supplemental coverage in their scenario there
15 would be minimal administrative savings. There would also be
16 increased used of services due to broader Medicare coverage and
17 continued supplemental coverage. These two factors would cause
18 an increase in total system costs, which we'll see on the next
19 slide in our approximate terms.
20 This table illustrates the spending shifts I was just
21 describing. Please keep in mind, as I said before, these
22 numbers are rough estimates. This table compares approximate

1 2002 spending on beneficiaries' health care under current law
2 and scenario one. It divides spending into health care outlays,
3 which are direct spending on goods and services and
4 administrative costs incurred by Medicare and supplemental
5 payers. Thus it doesn't separately show financing sources such
6 as premiums or taxes.
7 If you're interested, the supplemental premiums would
8 be reflected in the supplemental coverage payments and
9 administrative costs, and the Medicare premiums paid by
10 beneficiaries would be reflected in Medicare payments and
11 administrative costs and similarly, taxpayer contributions to
12 Medicare.
13 As we noted earlier, beneficiary cost sharing and
14 supplemental coverage payments would decline while Medicare
15 spending would go up. Most of the additional Medicare spending,
16 about $50 billion, is attributable to the drug coverage.
17 Administrative costs would decline slightly because supplemental
18 spending declines, and the total spending would increase by
19 about 4 percent in this illustration.
20 Now the impact of this new package on individual
21 beneficiaries would vary by their current supplemental coverage
22 and use of services. We'll highlight some of the impacts of

1 scenario one on different groups of beneficiaries. Those
2 without any supplemental coverage would obtain better coverage
3 at a higher Medicare premium. Beneficiaries with Medigap and
4 employer-sponsored insurance would have higher Medicare
5 premiums, probably lower supplemental premiums, and lower cost
6 sharing.

7 Employers could decide to subsidize the higher
8 Medicare premium for their retirees, using money they save on
9 the supplemental coverage. Similarly, states could use the
10 money they save on Medicaid to subsidize the higher Medicare
11 premium for dual eligibles.

12 Now we'll move on to the results of scenario two in
13 which 25 percent of beneficiaries with Medigap and ESI keep
14 their coverage. The direction of the shifts in spending are
15 similar to scenario one, with the exception that beneficiary
16 cost sharing stays about the same as it is currently. This is
17 because many beneficiaries who had supplemental coverage no
18 longer have it, and are exposed to greater cost sharing.

19 Spending by supplemental insurers would go down, even
20 more than under scenario one, probably causing a larger decline
21 in supplemental premiums. Medicare spending would go up, but
22 it's a smaller increase than in scenario one. This is because

1 beneficiaries are exposed to more cost sharing which causes them
2 to use fewer services.
3 While Medicare premiums would increase, it would be a
4 slightly smaller increase than in scenario one, about $100 per
5 month, which still would triple their current Part B premiums.
6 DR. BRAUN: Could I ask a question? Is this by $100
7 or to $100?
8 MR. WINTER: By $100, to $154 per month.
9 Because many beneficiaries would reduce their
10 supplemental coverage in this scenario there would be some
11 administrative savings and reduced use of currently covered
12 services although use of prescription drugs would increase.
13 This would result in slightly lower total system costs than
14 under current law.
15 This is a similar table to what we showed for scenario
16 one. It illustrates the shift in spending I've just described.
17 As you can see, beneficiary cost sharing would stay about the
18 same, supplemental coverage payments would decline, Medicare
19 spending would go up but it's a smaller increase than in
20 scenario one, administrative costs would decline, and total
21 spending would decrease slightly by about 1 percent.
22 This slide looks familiar because the impacts of

1 scenario two on different groups of beneficiaries are similar to
2 the effects of scenario one. The only difference is with
3 regards to beneficiaries with Medigap and ESI. In particular,
4 these beneficiaries would have higher cost sharing than under
5 current law, whereas in scenario one they have lower cost
6 sharing. This is due to the reduction in supplemental coverage
7 for this group of beneficiaries. These beneficiaries would have
8 higher Medicare premiums, but not as high as in scenario one.
9 And they would probably have lower supplemental premiums than
10 under current law, and lower than in scenario one.
11 Now for the bottom line to all this modeling. What we
12 think this shows is that it's possible to introduce a more
13 comprehensive Medicare benefit package without increasing
14 current total spending, but it depends on whether beneficiaries
15 and employers reduce supplemental coverage. Moreover, the
16 impact on beneficiaries would vary according to their use of
17 services, their current type of supplemental coverage, and how
18 much of the additional Medicare spending they would be required
19 to finance.
20 It's also important to note that because this proposal
21 would substantially redistribute spending there's significant
22 feasibility issues, such as how to manage the disruptions to

1 providers, payers, and beneficiaries.

2 So that concludes my portion of the presentation.
3 We'd like to get your feedback on the tone and content and
4 organization of the chapter.

5 MS. ROSENBLATT: Tone could use a little work. It
6 wasn't bad but there were some instances where it could be
7 improved.

8 Was any sensitivity -- these assumptions that you've
9 made can really swing things. Would it be difficult to run some
10 sensitivity analyses just to see what kind of changes some of
11 your assumptions make?

12 MR. WINTER: In terms of beyond the supplementation
13 assumption that we modified?

14 MS. ROSENBLATT: Yes.

15 MR. WINTER: We could do that. Do you have
16 suggestions?

17 MS. ROSENBLATT: I'd need to give it some thought.

18 MR. WINTER: Sure, we could look into that.

19 DR. BRAUN: I just wondered, all the options are sort
20 of a snapshot at a one-year interval. I'm presuming here you're
21 talking, also as you did in the others, with indexing to
22 Medicare spending. I wonder whether it would be helpful to have

1 at least some projection out ahead, because Medicare spending
2 probably will be increasing faster than people's income, than
3 the per capita income increase. So I think that's --
4 MR. WINTER: We considered originally doing a five-
5 year estimate. We ran into problems about predicting such
6 things as trends in supplemental coverage when there's evidence
7 that that is declining, at least the generosity of benefits are
8 declining. It just quickly got very complicated, so it was
9 beyond the time we had available for this kind of illustration.
10 But in the text, describing it we can talk about how future
11 trends would affect these approximate costs for 2002.
12 DR. BRAUN: Good. That might be enough to make people
13 aware of that differential that will occur.
14 MR. SMITH: Ariel, Anne, I found this very helpful.
15 Let me make sure I understood it and then I have a few --
16 You've assumed that 100 percent of the reduction in
17 employer-paid insurance and Medigap paid premiums would end up
18 being paid, or the offset would end up being paid out-of-pocket
19 by beneficiaries. I'm reading that correctly?
20 MR. WINTER: That's right.
21 MR. SMITH: It seems to me then that there is an
22 important missing piece of analysis here which is the

1 distributional consequences of that across beneficiaries, income
2 groups, and probably age as well would be important to look at.
3 That will be very unevenly distributed when measured against the
4 ability to fill in the gap between the current Medicare premium
5 and the implied new premium.

6 Just back 30 seconds to long term care. Let's at
7 least say we realize it's important and we didn't talk about it,
8 rather than simply let it evaporate.

9 I want to come back to a point that Carol made
10 earlier. The discussion of the insurance model or the
11 inappropriateness of the first dollar model on page 6, it's
12 troublingly phrased. I think it's descriptively right. But
13 we're not simply concerned here with an insurance model, we're
14 concerned that the structure of the system encourage people to
15 get medically necessary coverage.

16 To the extent that copays, higher copays for what you
17 describe as discretionary services, because they aren't randomly
18 distributed, I think misses the point here. The need for those
19 services is not randomly distributed; it's universal. We don't
20 want the payment system to treat those as if they were botox
21 injections for 50-year-olds. This discussion suggests that
22 everything that's not randomly distributed catastrophic is

1 discretionary, and therefore, easy to forgo. I know that's not
2 what you mean but it's the way that that paragraph reads.
3 Lastly, I'd like us to at least think about -- and
4 we've talked about this in an awkward way a little bit, but the
5 notion that we would take a look at the current net pot of money
6 on the table. Then we'd say we're going to hold it constant,
7 but we're going to shift responsibilities from employers to
8 beneficiaries in that case, and from relatively well-off
9 beneficiaries who can afford Medigap to relatively poor
10 beneficiaries who can't. It's a troubling construct and I think
11 if we're going to use these scenarios, as the text gets
12 rewritten I think we need to acknowledge some concern with both
13 those aspects of the way we've distributed costs looking at the
14 alternatives.
15 MR. HACKBARTH: Could I just pick up on David's point.
16 I agree with the basic point that the distributive implications
17 of this are maybe one of the most important questions here and
18 they need to be dealt with a little bit more fully and clearly
19 in the text.
20 DR. ROSS: Two quick things. One is just I'll pass
21 along a suggestion from Professor Newhouse who actually wanted
22 some frequency distributions to show some of these

1 distributional swings between current law. I think that's
2 something we could probably do in the time available.
3 The other piece, David, responding to your point, is
4 that again there's not a policy direction intended in these.
5 I'll take your point that we just need to be careful with the
6 language. But this was much more illustrative of, given the
7 funds that are now in the pool, how else might they be spent to
8 generate a benefit package? It wasn't in any way intended to
9 suggest a redistribution from shareholders to --
10 MR. SMITH: I understand, but it will inevitably -- it
11 has that potential effect. We want to make sure we acknowledge
12 the ways in which this is discussed.
13 MR. HACKBARTH: You run the risk, if you don't discuss
14 explicitly the distributive issues that -- it's a little too
15 glib to say, there's just this pool of dollars out there and
16 we'll take it and use it more rationally. It misses a great big
17 point if that's all the further your discussion goes.
18 DR. LOOP: Ariel, you may not be able to answer this
19 but these options have some effect on the dual eligibles and
20 there would be some cost shifting, I assume.
21 The other question that I had is, in just the
22 presentation of the chapter each option, you're supposed to

1 discuss the criteria that you pointed out on page 4, financial
2 protection, access, and so forth. I didn't think that was done
3 consistently with each option. As you present the option you
4 might think about putting it in an inset, in a box in the
5 chapter as you go along and then also summarizing it at the end
6 as you've done.

7 DR. BRAUN: Floyd hit on one of the things because I
8 was wondering about the impact on Medicaid of this situation
9 because of the shift. But also I was wondering, in line with
10 that, whether this would require a higher subsidization, whether
11 the level for subsidizing deductibles, for instance, would have
12 to rise a little bit with that deductible going up and so forth.

13 MR. FEEZOR: Just to underscore I think David's point
14 about reflecting on the distributional not only within income
15 groups within retirees, but as you said, between employee and
16 employers because that will be, inevitably, any push on the
17 debate.

18 Second is, I guess as I looked at those criteria, and
19 this gets back to Medicare, a theme that you've heard me say
20 probably ad nauseam, Medicare is the single biggest determinant
21 in terms of how health care is delivered in this country. We
22 really do an excellent job of saying, okay, this is basically

1 reallocating dollars and protections, or current dollars against
2 perceived needs. We say, what are their potential inflationary
3 cost impact within the use of that? But there is not a
4 criteria, do any of these models have any significant, or that
5 we might conjecture, have a different impact on how health care
6 is actually delivered itself?

7 I don't know whether that may be beyond the scope, but
8 ultimately I think that's a public policy question that I hope
9 Congress would at least think through or pay some homage to.

10 MS. RAPHAEL: I just wanted to also underscore the
11 point that Floyd made. When I read this, at the end of the day
12 I had a hard time understanding what it all meant. Since change
13 is always alarming I think that we need to somehow tie it
14 together, whether we go back to the criteria and analyze the
15 options. But from the stakeholders point of view, for most
16 beneficiaries if you do scenario one, what do they gain, what do
17 they lose? From the point of view of the public taxpayer, what
18 do they gain, what do they lose?

19 I somehow felt that that was hard to discern, because
20 you talk about it more at the end from an insurance model rather
21 than from the point of view of the stakeholders and their
22 interest in increased financial security, increased access,

1 whatever.

2 MS. ROSENBLATT: I brought up twice today an issue
3 that nobody else has jumped on, so let me bring it up for the
4 third time because it probably belongs in this chapter. The
5 name of the chapter is, Options for Changing the Medicare
6 Benefit Package. We're focusing on vision, dental, coordination
7 of care, but we're not focusing at all on moving the basic fee-
8 for-service program to a managed care program. There's nothing
9 that I found in the chapter at all on that.

10 I don't know if any other commissioner feels that it
11 would be nice to have that in there. I personally think it
12 would be an interesting -- at least a paragraph on that.
13 There's another set of ways to change the program that involve
14 what I would call managed care concepts, choice of provider,
15 things like that. So that's comment one.

16 Comment two, much more particularly, in this chapter
17 there was a discussion of what current employers provide. I
18 think that's where I had the most objection to the looking
19 backwards at what has been provided as opposed to the looking
20 forward as to what's going to happen with greater cost sharing.
21 The other point I want to make there is, there's a big
22 difference between what large employers provide and what small

1 employers provide. If you were to look at that, you'd see that
2 someone that works for a small employer is probably paying a lot
3 more in the way of cost sharing. So always doing a comparison
4 against the large employers that have tended to provide to rich
5 benefits may not be the appropriate balancing factor.
6 MR. FEEZOR: And who are increasing less a part of the
7 labor market.
8 MR. SMITH: And large and small, generally the largest
9 employer in the country provides virtually no health care. The
10 old notion of the big industrial firms and the small service
11 sector no longer describes the economy. But you are right, the
12 distribution of what employers provide varies widely.
13 MS. MUTTI: On Alice's first point talking about
14 managed care and introducing some of those topics, I think
15 something that we struggled in in writing this too is where we
16 can just focus on benefits and when we start bumping into
17 payment and other incentives. We've tried to draw a line
18 sometimes, but I don't know that we've captured it just right,
19 but that was one thing that was factored into our --
20 MR. HACKBARTH: In other contexts, not with regard to
21 this report but in other contexts completely separate I think
22 we've alluded to the difficulty that the government has in

1 selecting among providers for a variety of legal and political
2 reasons. At least implicitly, if not explicitly, said that
3 that's what the M+C program is about. If in fact there are
4 beneficiaries who are willing to give up their free choice of
5 provider in exchange for gains in efficiency passed on to them
6 via increased benefits or lower out-of-pocket costs, whatever,
7 that's the way to do the managed care piece as opposed to in the
8 traditional program.
9 Not that that's the only way to think about it, but
10 that's certainly the way I've thought about it.
11 MS. ROSENBLATT: I guess I'm thinking you could have a
12 fee-for-service plan where any doctor willing to accept the fees
13 is in it, or maybe you've got two fee schedules -- maybe you've
14 got a tiering of doctors in here. There are two fee schedules,
15 and that would affect benefits. If there are two fee schedules
16 and the benefit, there's a lower copay for the doctors that are
17 paid the lower fee schedule, it's still a fee-for-service plan,
18 I think, and it's also affecting benefits.
19 I guess I'm just thinking about stuff like that.
20 DR. BRAUN: I think I was trying to differentiate
21 between the comprehensive benefit package and the method of
22 delivery, which is sort of where you were coming from. But I

1 realize that this comprehensive benefit, in order to get to some
2 figures they've got the copays outlined and so forth. Whereas
3 you could visualize the benefits would all have to be but the
4 payment could be different.
5 DR. REISCHAUER: My guess is that as the value of
6 supplemental insurance declines and the fixed cost of marketing,
7 et cetera, stay high you would get a tremendous fall-off in a
8 scenario like this in the insurance. Even your scenario two
9 probably has too much supplemental insurance in it. That would
10 be point one.
11 Point two is, is the Medicaid number, I mean the
12 people who are in Medicaid number a net one that counts for the
13 federal government saving in Medicaid payments? Because you
14 could probably lop a couple billion dollars more off of the net
15 federal cost.
16 MR. WINTER: We haven't estimated that because --
17 going back to the table, it's basically a matrix of outlays that
18 is the source of payment for those services, like a flow of
19 funds kind of thing. So the monies flowing through Medicaid we
20 don't show savings for any of the groups financing --
21 DR. REISCHAUER: There would be VA savings, or there
22 would be Medicaid savings --

1 MR. WINTER: Yes, there would be.
2 DR. REISCHAUER: So what I'm just thinking, I thought
3 this was very well done and I congratulate both of you on it. I
4 just thought that the numbers would be lower if one was looking
5 at the federal liability. Now maybe Murray from his days as a
6 cost estimator will disagree.
7 DR. ROSS: I guess I'm not quite clear on what federal
8 savings. When the feds expand the benefit package that drives
9 down the states spending, and the feds go from 57 percent to 100
10 percent. We go from 57 percent of that to 100 percent of it.
11 DR. REISCHAUER: But if we're counting 100 percent in
12 this table here, I'm just asking --
13 DR. ROSS: Is that a net.
14 MR. HACKBARTH: The first point that Bob made about
15 the likely impact on the supplemental market is an interesting
16 one. Those marketing costs, those fixed costs, if you will,
17 will become larger, a significantly larger share of what the
18 people are buying. How did you arrive at the assumption in
19 scenario two?
20 MR. WINTER: We picked the extreme optimistic end of
21 what the response in supplemental demand would be.
22 MR. HACKBARTH: Optimistic being?

1 MR. WINTER: Optimistic being there would be maximal
2 decline in participation because the comprehensive benefit
3 package would fill people's basic needs and they wouldn't have
4 the need any more to go out and purchase a supplemental product
5 or have one provided to them. So we thought that was the
6 extreme of what would be feasible. But now I'm hearing Bob say,
7 maybe we haven't gone far enough; we could go farther. It
8 wasn't a scientific estimate. It was just one we thought would
9 be one end of the range, but we could reconsider that.
10 MR. HACKBARTH: Of course another way, not necessarily
11 an mutually exclusive way is to say, in order to make it a wash
12 you have to assume this much change in supplemental. Then an
13 optimistic scenario would be something larger than what's in
14 scenario two.
15 DR. ROSS: In deference to Alice we won't call it
16 optimistic.
17 MS. MUTTI: In effect that's what ended up happening,
18 too. We pulled the number out of the air a little bit but it
19 did come very close to saying, at a minimum you have to have
20 that kind of behavior.
21 DR. REISCHAUER: What's going to be left is largely
22 cost sharing for prescription drugs for those who don't have

1 catastrophic prescription drug expenditures. That's going to be
2 a lot of people with chronic conditions which are rather
3 predictable. So this is really going to be prepayment with a
4 service charge on top of it. There's nothing wrong with that.
5 As Bea pointed out, it's like laying away for a Christmas club
6 plan or something and some people like to do that.
7 MR. WINTER: Also the Part B coinsurance would be left
8 too under this comprehensive package.
9 MR. MULLER: Just in thinking about this presentation
10 broadly compared to what one might have done seven, 10 years
11 ago, the fact that we're focusing so much on what beneficiaries,
12 consumers pay, what the share is between what the government
13 pays versus private markets, compared to let's say 10 years ago
14 where we looked more at price control on providers, on managed
15 care systems, and efforts to use both professional scrutiny and
16 administrative scrutiny as a way of controlling utilization
17 service. I'm not saying it's relevant to this chapter but just
18 kind of looking at -- sometimes we have the danger of saying at
19 the current point that we're at is what's going to be the line
20 for the next four, five years.
21 I think in the same way that maybe in '95 when a lot
22 of people thought that capitation would sweep the American

1 universe without realizing what the reaction to capitation then
2 was, and it came apart pretty quickly, whether by '98 or 2000 or
3 whatever. I think in the same sense, to assume that putting a
4 lot of cost sharing on beneficiaries or on employees is going to
5 be incredibly popular is not something that I expect to happen.
6 So I know what Wellpoint is trying to do and where
7 they've been a leader, and the article in Health Affairs just
8 recently by Jamie Robinson pointing out all the various efforts
9 to shift these costs to employees. But my sense is that there's
10 the same unwillingness to take on those costs as there was
11 unwillingness to take on the constraints of gatekeeping and
12 managed care and so forth.
13 So I think this is a very fruitful exercise and I
14 think you've done an excellent job of going forth on this, but I
15 would not be surprised if two years from now these scenarios of
16 how much we're going to shift costs to beneficiaries or
17 employees are dramatically thrown out and a rebellion against
18 that as well.
19 DR. REISCHAUER: And the alternative?
20 MR. MULLER: I think we're all struggling with that.
21 As I saying to some of you at lunch having -- maybe I've spent
22 too much time in England this year, but the interesting debate

1 over there between what share of this is done in the public
2 sector versus the private sector, at least in the case of the
3 Blair government recently making the decision they're going to
4 put it all in the public arena versus, as in the U.S., France,
5 and Germany having significant set of sharing between the
6 private and the public.

7 My sense is that the efforts to -- you definitely know
8 that where people have a lot of ability to vote and a lot of
9 ability to -- in fact the employers, as they do in our system,
10 they're going to rebel against any efforts to put a big burden
11 on them as individuals. So my sense is the burdens are going to
12 go back to institutional sectors, whether it's doctors as groups
13 or insurers as groups or government as groups. But I think
14 we're going to move back towards institutional controls versus
15 trying to put it on individuals, but that's worth the price of a
16 cup of coffee.

17 DR. REISCHAUER: What amazed me about this actually
18 was that under scenario two, for less than the cost of the
19 average Medigap policy now you get an unbelievably richer
20 package and much greater protection. It struck me, if you're
21 willing to pay $111 or whatever it is now for something that
22 doesn't cover drugs, why not $100 for something that does?

1 MR. SMITH: Again, I thought this was terrific and
2 very helpful. I think we need to be careful to write it in such
3 a way that the discussion that we engender doesn't become, gee,
4 is a $10 home health copay the right number, or is this the
5 right drug design?
6 I think you said, Ariel, that all of this was
7 somewhere in the public domain. It might be useful to cite each
8 of it, just to distance -- so we don't own this package piece by
9 piece. The import of it is much greater if we can think about
10 it as a package rather than we recommend. It will inevitably,
11 if we're not enormously -- maybe inevitably even if we are
12 enormously careful, but we should be real careful.
13 MR. WINTER: Yes, we've tried to emphasize throughout
14 that these are illustrations and you could select different
15 levels of copayments. We can go back and look at that again.
16 For prescription drugs, the plan we've modeled is
17 similar to one of the Democratic proposals in Congress. But we
18 chose not to make it identical because we didn't want to get
19 into competition with CBO about scoring an actual piece of
20 legislation. So we varied it a little bit, but we can make
21 reference to its similarities.
22 DR. NELSON: This intersection between a benefit

1 decision and a coverage decision that I referred to before is
2 relevant in discussions about the prescription drug benefit. If
3 we decide there will be a prescription drug benefit then the
4 next question is what prescription drugs will be covered, how
5 will they be selected? There's enormous elasticity in the cost
6 depending on whether it's bare bones or whether we decide to
7 cover Claritin for everybody or botox.

8 MS. RAPHAEL: I think David's point is very important.
9 Somehow we just have to try to avoid the SNF industry being
10 concerned because you're raising the amount there, the home
11 health care industry, the Medigap sector, et cetera. Somehow,
12 if we go to what Bob said at the bottom line, which is you take
13 the total pot, you're shifting how some of those dollars are
14 spent, you can really gain so much more That needs to be the
15 message.

16 MR. HACKBARTH: Okay, good job. We are well ahead of
17 schedule and we'll entertain public comments for 15 minutes.

18 Okay, hearing none --

19 MR. FEEZOR: Glenn, are we going to spend a little
20 more time on some of the topics for the -- I was going to say
21 off-site -- for the July retreat and discussion beyond what has
22 already been discussed?

1 MR. HACKBARTH: What I'd suggest is maybe if you would
2 share ideas -- what Allen has raised, for those of you who
3 haven't heard, is topics for the retreat in July. If you have
4 ideas about that, why don't you send them in? You can either
5 send them just to me and Murray and Lu, or you can share them
6 with everybody and maybe generate some thought on the part of
7 other commissioners. So far as I know, not a whole lot of
8 thought has been given at this point to the agenda, so we've got
9 a clean slate on which you can write.
10 Okay, we reconvene tomorrow morning at 9:00.
11 [Whereupon, at 4:05 p.m., the meeting was recessed, to
12 reconvene at 9:00 a.m., Friday, April 26, 2002.]
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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, April 26, 2002
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA PAGE

CMS's proposed prospective payment system for long-term care hospitals -- Sally Kaplan 205

Using information on quality in Medicare -- Karen Milgate, Nancy Ray 233

CMS's proposed risk-adjustment system for Medicare+Choice -- Scott Harrison 266

State-level variations in Medicare spending: preliminary observations -- David Glass, Dan Zabinski 295

Public comment 307

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

2 MR. HACKBARTH: We're going to go ahead and get
3 started. Welcome to our guests in the audience. We have
4 several items on the agenda for today beginning with the
5 prospective payment system for long term care hospitals and the
6 review of the regulation that was just issued, followed up by
7 using information on quality in the Medicare program and the
8 proposed risk adjustment system for Medicare+Choice. Then
9 finally we're going to have a preliminary conversation about
10 state-level variations in Medicare spending and some
11 congressional requests we've had to provide some analysis on
12 that issue.

13 MR. SMITH: After yesterday's meeting Mary and Craig
14 and I talked a little bit about the wording of the section which
15 deals with the 85 percent payment for non-incident-to services.
16 I'd like to spend a couple minutes at some point just making
17 sure we're all on the same page about the way that language is
18 framed in the text. The language in the text I don't think
19 reflects yesterday's discussion and Craig would like a little
20 more guidance and we ought to make sure we know what we're

1 saying.

2 MR. HACKBARTH: Why don't we do that right at the

3 front end? Can we just defer you for one moment, Sally? So we

4 need Craig up here.

5 MR. SMITH: The text in question is the first full

6 paragraph on page 4 of Tab C. When we talked yesterday, and

7 Glenn, you and I had a little conversation where we both agreed

8 it seemed to me, and it seemed to me the Commission agreed, that

9 there was no justification for a differential in payment for the

10 same service. It wasn't clear whether the appropriate step was

11 to level up or level down. We clearly didn't reach that

12 decision.

13 But it did seem to me that what we ought to say here

14 is rather than, there's a justification for the 85 percent,

15 we're not sure that 85 percent for the same service provided by

16 a non-physician practitioner is the right answer. We are clear

17 that there's no justification to pay nurse midwives less, and

18 they ought to get the 85 percent, and the subject of 100 or 85

19 deserves further consideration.

20 The text at the moment is conclusive on that. I don't

1 think we are.

2 MR. HACKBARTH: My own perspective on that, David, was

3 that we were conclusive on there being a difference. The point

4 that I made was that there were several different arguments,

5 potential justifications presented for why 85 versus 100. And

6 the point I made was that in keeping with the overall logic of

7 the RBRVS system, the only really consistent justification would

8 be the product is different.

9 DR. NELSON: Right, it might be 75 percent.

10 MR. HACKBARTH: Can we specify, quantify exactly what

11 that difference is? No. We have not reviewed the evidence on

12 that and we haven't delved into it in that detail. But my own

13 view was that, yes, it is a different product.

14 MR. SMITH: It may be a different product, but our

15 conversation yesterday continued the March meeting where we

16 expressed some confusion about whether or not it was a different

17 product. At the moment we're defining the product as the same,

18 and in keeping with our policy and good practice it would seem

19 to me to that extent we ought to be paying the same fee.

20 But we're clearly not ready, I don't think, to reach

1 the question of whether or not the product is different because
2 it's provided by a different clinician. So rather than be
3 conclusive in this paragraph it seems to me we ought to be
4 neutral or open. It doesn't change the recommendation. It
5 doesn't commit us to new policy. But it also doesn't conclude
6 that in a case where we're defining the service as the same, the
7 differential is justified, which is the way the current language
8 reads.
9 DR. ROSS: Can we just add language to the effect, at
10 issue is whether in fact the service or the product is the same,
11 and just lay out the possibilities for the difference?
12 MR. SMITH: I would think we could do something -- I
13 think we ought to reiterate our belief that the same service
14 ought to be similarly compensated and that there is a question
15 of whether or not this is the same service and that deserves
16 further examination.
17 Mary, would that --
18 DR. WAKEFIELD: Yes. I think the issue is, at least
19 from my perspective, we don't have -- in responding to Congress
20 we ought to making some comment, I would think, about the

1 payment rates, because that seems to me what we're being asked
2 to respond to. Yet we didn't come to a consensus about that 85
3 percent payment rate. There were different perspectives about
4 it.
5 So it seems to me we ought to at least be neutral on
6 that at this point and open up the possibility, or allow the
7 possibility that it ought to be informed by further study or
8 further analysis or whatever, which doesn't change any of our
9 recommendations. It's just how are we, what are we saying about
10 that 85 percent? Right now I think what we're saying in text
11 there's not general agreement about.
12 So that being the case, could there be a caveat
13 inserted there that is somehow neutral on that part of the
14 issue? Unless you don't feel compelled to be responsive to
15 Congress on that piece, but it seems to me that's what they're
16 asking for. So I don't know how you dodge that bullet, frankly.
17 So it's not changing recommendations or conclusions.
18 It's the approach to that discussion that I think we're talking
19 about.
20 DR. STOWERS: I'm okay with reframing that as long as

1 we open or leave open the debate of whether the service is the
2 same or not. I don't think we should make that decision at this
3 point either.
4 MR. SMITH: Right. I think that reflects our
5 ambivalence and uncertainty about whether or not the service is
6 the same. It would be inappropriate to conclude that it is the
7 same at the moment, given the concerns Alan and Ray raised
8 yesterday. So we ought to be open rather than close it. The
9 current language says, we concluded. I think that is
10 inappropriate.
11 MR. HACKBARTH: Does it seem like there's agreement?
12 Okay, we'll modify the language in the text.
13 Thank you, Craig. You did a great job there.
14 [Laughter.]
15 MR. HACKBARTH: Okay, Sally.
16 DR. KAPLAN: CMS published its proposed rule for the
17 new PPS for long term care hospitals on March 21st. They use
18 the acronym LTCH for long term care hospitals so I'll use it
19 too, particularly on the slides.
20 The Congress has required MedPAC to analyze and report

1 on the proposed PPS for exempt hospitals, of which long term
2 care hospitals are one category. As part of our general
3 responsibilities we're required to analyze payment rules. We
4 can formally comment on the proposed PPS if we determine that
5 there are potential problems with the payment system. Comments
6 are due by May 21, 2002.

7 During the first part of my presentation I'll focus on
8 what these hospitals are and do, and the general features of the
9 proposed PPS. During the rest I'll focus on four issues that
10 raise concerns. At the end of my presentation you'll have the
11 opportunity to discuss these potentially problematic issues and
12 raise others. We plan to use a formal comment letter to HHS on
13 the proposed PPS as part of our response to the congressional
14 mandate.

15 Long term care hospitals are defined by an average
16 length of stay greater than 25 days. These hospitals furnish
17 acute care to patients who have multiple comorbidities. A
18 number of these patients are ventilator dependent.

19 Thirty-eight percent of these facilities are in
20 Massachusetts, Texas, and Louisiana, although only 10 percent of

1 Medicare beneficiaries leave in those three states. There were
2 270 long term care hospitals in 2001. In general, these
3 hospitals are very dependent on Medicare patients. For
4 hospitals established after 1983 Medicare represents, on
5 average, 74 to 80 percent of their discharges. Growth in the
6 number of hospitals and spending has been rapid in the 1990s.
7 The number of hospitals has more than doubled and spending
8 almost quadrupled. About one-third of long term care hospitals
9 are co-located in the same building or on the same campus as
10 acute care hospitals.
11 The proposed PPS will change the definitions of long
12 term care hospitals so that the average length of stay will be
13 calculated for Medicare patients only. This provision helps to
14 ensure that these hospitals treat beneficiaries that need acute
15 long term care and cannot be treated in acute care hospitals.
16 Almost 40 long term care hospitals have a Medicare average
17 length of stay of less than 25 days.
18 The Congress mandated that the unit of payment be a
19 discharge. CMS created boundaries so that it does not pay
20 hospitals full DRG payments for less than a full course of

1 treatment, and pays more for extraordinarily costly patients.
2 The acute care hospital DRGs are used to classify patients who
3 stay more than seven days. The hospital-specific relative value
4 method uses charges which are normalized within each hospital
5 and then made comparable across hospitals. This method has the
6 advantages of simplicity and removes the bias introduced by
7 hospitals using different levels of markups on charges.
8 The PPS will not adjust payments for either local
9 input prices or for a disproportionate share of low income
10 patients. Finally, the PPS will be phased in over five years.
11 For long term care hospitals case-mix adjusted per-
12 discharge payments will range from $14,500 to almost $89,000 per
13 case. CMS found that about half of patients stay less than two-
14 thirds of a 25-day length of stay. Twenty percent of patients
15 stay seven or fewer days.
16 If hospitals were paid a full discharge payment for
17 short stays they would be paid well above their costs. As a
18 result, CMS established two short stay policies which are shown
19 in that chart on the screen. One for very short stays is for
20 patients that stay one to seven days. These cases will be put

1 into one of two special groups, one for psychiatric cases and
2 one for non-psychiatric cases. Hospitals will be paid a special
3 per diem rate for each day that these cases stay. The purpose
4 of the very short stay policy is to discourage long term care
5 hospitals from treating Medicare patient that do not require
6 more costly resources and who reasonably can be treated in acute
7 care hospitals.
8 The other short stay policy is for patients that stay
9 eight days to two-thirds of the average length of stay for the
10 DRG. These cases are classified into the DRGs and hospitals are
11 paid the least of three rates, 150 percent of the DRG per-diem
12 rate times the number of days, 150 percent of the per-diem cost
13 times the number of days, or the DRG per-discharge payment. For
14 patients who stay more than two-thirds of the average length of
15 stay for the DRG long term care hospitals will be paid the full
16 DRG per-discharge payment.
17 Now we're going to talk about our concerns. The first
18 concern is about very short stays. We actually have two
19 concerns about the very short stay policy. First, patients who
20 die within seven days of admission to a long term care hospital

1 are included in the short stay but they cost more than twice as
2 much as those who don't die and have the same length of stay.
3 Second, the cliff between payments when a patient
4 stays for seven days or eight days is huge. I've chosen two
5 DRGs to illustrate the cliff on the screen and in your handouts.
6 The DRG with the lowest weight, number 430 for psychoses, and
7 the DRG with the highest weight, 483 for tracheotomy except for
8 face, mouth, and neck principal diagnoses. For DRG 430 the
9 difference between payment for a seven-day stay is almost $5,000
10 less than for eight days. For DRG 483 the difference is almost
11 $16,000. These large differences create financial incentives
12 for long term care hospitals to keep patients until the eighth
13 day.
14 Our next concern is about the fact that there is no
15 adjustment for local input prices. As you all know, PPS rates
16 are generally adjusted by a wage index to account for
17 differences in local input prices. Everything we know says
18 costs vary with wage index. In this case, however, CMS found
19 that those differences weren't detected in the data.
20 We investigated two reasons why differences might not

1 be significant. First, we investigated whether hospitals with
2 high case-mix indexes have high wage indexes, which would mean
3 that these indexes would be highly correlated. We found that
4 the correlation coefficient is low: less than .12.
5 We also investigated whether the wage index varies by
6 long term care hospital location. The X axis on this figure is
7 the location of each long term care hospital that existed in the
8 year 2000. As you can see on this slide, cost of living does
9 vary in those places where long term care hospitals are located.
10 If CMS doesn't adjust rates for local input prices hospitals
11 with low wages may be overpaid, and those with high wages may be
12 underpaid. If CMS does adjust by wage index exactly the
13 opposite error may result. Because there is a concern about the
14 quality of data it may be more prudent to use a wage index.
15 Our next concern is about the fact that there is no
16 DSH adjustment. There are two rationales for DSH. One is to
17 improve payment accuracy because low income patients are more
18 costly. The other is to offset hospital's revenue losses due to
19 uncompensated care. CMS only believes in the first reason.
20 They found that DSH does not improve payment accuracy for this

1 PPS. We, however, have concerns about beneficiaries' access to
2 care. Without a DSH adjustment, low income patients may have
3 difficulty accessing care in long term care hospitals.
4 This is another concern. Seventy percent of long term
5 care hospital patients are transferred from acute care
6 hospitals. These are not the transfers affected by these
7 policies. Almost one-third of long term care hospitals are co-
8 located in acute care hospitals, even in the same building or on
9 the same campus. We can think about onsite transfers as round-
10 trips from the onsite long term care hospital to the onsite
11 acute care hospital and back again, or from the long term care
12 hospital to an onsite SNF, rehab, or psych unit and back again.
13 CMS has concerns about extra payments that onsite long
14 term care hospitals can generate by round-trips and proposes
15 limits on the proportion of round-trips onsite long term care
16 hospitals can have without changes in payment. This policy,
17 however, is not clinically based. It's based on the facility
18 with no distinction in length of stay. In addition, the policy
19 is based on a ratio of round-trips to discharges in real time,
20 although the numerator and denominator can change daily. A

1 better policy might be to have the QIOs monitor round-trips to
2 determine if they are clinically appropriate.
3 This slide summarizes the crux of what the comment
4 letter will say, we think. We don't have a lot of information
5 so we've decided to raise issues about our concerns. We will
6 distribute the letter to you by e-mail.
7 So the letter would express concerns about the very
8 short stay policy, both the deaths and the cliff. It would
9 express concern about the no wage index, and would express
10 concerns about no DSH. We would state that instead of an onsite
11 transfer policy CMS should use the QIOs, which were formerly the
12 PROs, to monitor appropriateness of patients for long term care
13 hospitals in general and onsite readmissions in particular, or
14 onsite round-trips in particular. And because many design
15 decisions are based on poor data that they should revisit the
16 PPS design in two years.
17 MR. HACKBARTH: Questions?
18 DR. LOOP: I agree with your concerns. The question
19 is, if a patient exhausts their Part A benefits and reverts to
20 Medicaid, is that not considered part of the length of stay then

1 if they change their status?

2 DR. KAPLAN: My reading of the rule is that when

3 considering the length of stay they're considering the entire

4 Medicare, or the length of stay. They aren't just concerned

5 about covered days. What you're talking about is when covered

6 days expire. But from what I'm able to read in the rule, and

7 it's something that CMS needs to clarify, is that it would be

8 based on the average length of stay, not the covered days.

9 DR. NELSON: Sally, is the proportion of the total

10 hospital census that is Medicare comparable to acute care

11 hospitals or are they skewed either toward greater percentage

12 Medicare or a lesser percentage Medicare?

13 DR. KAPLAN: I believe, and I think Jesse or Jack can

14 -- it's much higher, but I think the acute care hospital is

15 about 40 percent Medicare. The hospitals that were established

16 prior to 1983 have about 55 percent Medicare patients, but those

17 established after 1983 average 75 to 80 percent.

18 DR. NELSON: The second question is -- this relates to

19 the DSH thing -- do most of them have access to capital when

20 they need it, or is there a problem within that industry with

1 access to capital?

2 DR. KAPLAN: I'm really not aware of what their

3 ability to access capital is. There's some big chains that are

4 on the New York Stock Exchange and my understanding is they've

5 done very well so I would assume that they have access to

6 capital. The non-profits generally were established prior to

7 1983. I don't know what their situation is. And then some of

8 them are not chains as well.

9 DR. NELSON: Thank you.

10 DR. REISCHAUER: I find this whole segment of the

11 health care industry a little unsettling. You were saying that

12 the judgment of whether the new system is okay is payment

13 accuracy. I'm wondering how that's measured. It's cost versus

14 payments under the new system, but costs presumably include a

15 lot of costs that may be there because these are entities or

16 some of these are entities which were stimulated by a desire to

17 get around the PPS system, especially during the last decade.

18 So they might have a lot of costs imbedded in them that really

19 should be spread more evenly across the larger economic

20 enterprise which we're talking about.

1 By building a system that makes everybody more or less
2 whole what we're doing is, in a sense, confirming what was an
3 attempt to circumvent the old system. So should we have this
4 worry about payment accuracy?
5 DR. KAPLAN: I think that CMS primarily most of their
6 decisions that they made, design decisions on this PPS were made
7 on the basis of accuracy. How they defined accuracy was the
8 amount of variance explained in the cost by the various
9 variables.
10 DR. REISCHAUER: But it's the old costs.
11 DR. KAPLAN: Right, the old costs. And of course, did
12 not take into consideration that some of these hospitals are
13 very old and came in under TEFRA under very different cost
14 levels than the newer hospitals.
15 As far as hospitals, particularly hospitals within
16 hospitals who benefit from being co-located in an acute care
17 hospital and may have been established to get around the acute
18 care PPS, we're hoping to be able to look at this issue next
19 year to be able to determine whether those people really do have
20 different costs, and whether the hospitals that they're co-

1 located in have different costs.

2 DR. REISCHAUER: Given the very strange distribution

3 of these entities it's clear that a lot of Medicare patients who

4 need long term care are served in acute care hospitals and

5 they've become the outlier probably in that system. One wonders

6 what, under the acute care system, the outlier payment is

7 relative to what you would get for the same kind of activity in

8 a long term care hospital under their new payment policy. You

9 want some kind of evenness to this system.

10 MS. RAPHAEL: The other question I had, Sally, was

11 trying to place long term care hospitals in the constellation of

12 post-acute, in terms of thinking about DSH and access problems.

13 I don't have a good sense of what kind of patients are

14 appropriate or tend to land in long term care hospitals versus

15 rehab facilities versus SNFs or home health care. Do we have

16 any sense of that?

17 DR. KAPLAN: The Urban Institute did a really good

18 study on the difference between long term care hospitals -- not

19 home health, because it's unlikely that these people could be

20 cared for at home. Theoretically they have to need hospital

1 care to be in a long term care hospital, theoretically.
2 Although I'm not sure that the PROs are really monitoring them,
3 but theoretically they do. They're much sicker than patients
4 who would be in SNFs, and rehab particularly.
5 The Urban Institute generally found that a lot of
6 these cases are rehab cases. In fact some of these hospitals,
7 as I told you in the mailing material, do specialize in rehab.
8 But that these are not the same types of patients that one would
9 find in a rehab hospital. They couldn't -- they're too sick to
10 be able to sustain the three hours of therapy per day and don't
11 have -- they improve but they don't -- have the capacity to
12 benefit from the rehab but certainly not to the extent that they
13 would in the rehab hospitals.
14 So I really envision these people when I think about
15 post-acute care as really being the sickest people with probably
16 the worst prognosis of the people in post-acute care. They're
17 more acutely ill than the people who would be in a SNF, even
18 those that are in hospital-based SNFs. And have a pretty high
19 death rate also. I can get you all that information but not --
20 unfortunately we're not meeting again until the retreat.

1 I guess my question would be, what do we say about the
2 payment system in the comment letter?
3 MR. HACKBARTH: Can we go back to Bob's comment? What
4 you say makes sense to me. This is an unusual institution in
5 that it's so clustered geographically. But if you're CMS you're
6 in a bit of a box. The statute does provide for this different
7 class and legitimizes it in that sense. If you're CMS and
8 writing a reg and you make all the points that you just made,
9 Bob, and say, we're going to take money out of the system
10 through the reg-writing process, that may cause some problems to
11 say the least.
12 So if in fact what we're going to do is say, no, this
13 isn't an appropriate expenditure of Medicare funds, this sort of
14 class just doesn't fit right and we need to go back and revisit
15 that, I'm not sure that that's a regulatory sort of activity.
16 So what I'm trying to get a feel for, Bob, is if we adopt your
17 point of view, how do we couch it in a letter commenting on this
18 regulation? What exactly should we say? What is the policy
19 direction that we're articulating?
20 DR. REISCHAUER: I think this is a much bigger issue

1 and certainly one that we don't have the information to resolve
2 whether my concerns are legitimate or not. So what this would
3 suggest is that, at the most we just say that we would like the
4 payment policy to be one in which there weren't huge
5 discrepancies between the treatment of these individuals in
6 acute care facility versus this long term care facility unless
7 there are clear justifications. Just to give a little
8 flexibility, but I wouldn't do anything more than that. We're
9 being asked to actually answer a relatively narrow kind of
10 question that assumes away all of my concerns.
11 MS. BURKE: But if I might, it's suggested in the
12 comment we suggest or review within a certain time frame, within
13 two years. I absolutely agree with Bob. I think there are a
14 series of underlying questions about -- there is this odd
15 geographic location issue and presumably the rest of the country
16 somehow manages to struggle along. So one might want, going
17 forward, to have a better understanding of what issues there are
18 in terms of the equity of the treatment of patients and the
19 costs that people are incurring. I mean, they can't all live in
20 Texas. There has to be people in California with a similar

1 problem.

2 But it would seem to me in the context of looking at
3 this, knowing that they have the short term problem, that the
4 longer term is to look at these underlying questions and be
5 prepared to come back within a time frame, perhaps in a year,
6 which would allow you then to make an adjustment in anticipation
7 of the following year; some time frame where you could adjust,
8 but get them through this period. But it seems to me those
9 questions are questions that ought to be addressed over the long
10 term.

11 I think what Sally suggested, and I think the points
12 you've raised, Sally, in terms of the other issues are perfectly
13 legitimate and absolutely comfortable raising each of those as
14 questions about this absolute structure. But I think the
15 underlying questions are ones that bear some study and I think
16 it's not inappropriate for us to say that in the context of
17 going forward.

18 DR. KAPLAN: And you want us to say that CMS should do
19 this study.

20 MR. MULLER: This is built on Bob and Sheila's

1 comments. I think the geographic incidence obviously has caused
2 everybody to say there's something going on here that's
3 independent of the patient's condition. So this is more a
4 function -- now I'm just guessing, whether there are state or
5 county institutions that they converted towards this in those
6 states. I know from my own experience that these kind of
7 patients are now in acute hospitals as well, and in fact 483 is
8 probably the biggest outlier that most hospitals have in terms
9 of -- I mean the DRG that kicks into outlier status.
10 So I think looking at information on the patients in
11 the acute setting vis-a-vis the setting is something we should
12 suggest they look at very carefully, because my guess too is
13 that the incidence of these facilities is more a function of
14 institutional characteristics of the state rather than
15 characteristics of the patients. So therefore, exactly -- and
16 whether one wants to get it therefore into -- I mean, even the
17 issues that you appropriately suggest on disproportionate share,
18 for example, and so forth, may not come out as smoothly given
19 that it's so concentrated in three states, as it would be if it
20 was across the 50 states.

1 MR. HACKBARTH: I think that's true. The
2 disproportionate share adjustment in our view of the world is a
3 broad public policy to provide some support for indigent care.
4 Given that this is clustered in three or four states it does
5 look odd.
6 DR. LOOP: I think that geographic dispersion is
7 biasing our feelings here. I believe that the long term care
8 facility does really add a lot of value to the health system, if
9 it's done right. I'm familiar with the one that we're
10 affiliated with and I don't know -- there's no profit related to
11 that. It really takes the chronically ill people out of the
12 hospital. More than 30 percent of them have long term
13 respiratory needs.
14 I think this is sort of a cookie-cutter approach to
15 these patients who are just deadly ill. They have a huge number
16 of comorbidities. There's even some pediatric and psychiatry
17 patients mixed in with all of that.
18 So I think there's some perverse incentives in here
19 too, many of which Sally mentioned. But if you are in a long
20 term care facility and have to be transferred to an acute care

1 hospital, and then after treatment are transferred back to the
2 long term care facility, the long term care hospital only gets
3 reimbursed for the second admission, which is kind of strange.
4 It would be a perverse incentive not to send people to the acute
5 care hospital when they're sick, just like the cliff between
6 seven and eight days is a perverse incentive.
7 So I think those things have to be cleaned up and her
8 letter will say that. But I'd like to go on the record as
9 saying that the long term care hospital in my experience adds a
10 lot of value to a health system.
11 MR. HACKBARTH: From my perspective, the point is not
12 to denigrate what they're doing and say that it's not valuable.
13 But having said that, one of our cardinal payment policy
14 principles is that you need to look at payment across different
15 types of settings, so that if similar patients are handled in
16 different ways in different states, different communities, you
17 don't have gross disparities in the payment across communities,
18 or for that matter within one community. So I think Bob's point
19 about looking at reference points other than the historic cost
20 of these institutions is a legitimate thing to do, without

1 denigrating the work that's being done.

2 DR. NELSON: Not to denigrate, but they've quadrupled
3 in spending. What percentage are investor-owned, Sally,
4 roughly? The majority?

5 DR. KAPLAN: I can't remember offhand, to tell you the
6 truth, but there are two big chains involved. Vencor, or what
7 used to be Vencor, which is now Kindred, which is primarily
8 ventilator dependent hospitals, and another chain.

9 DR. NELSON: I think the important contribution is to
10 refine the PPS as accurately as possible. Remove -- if it's a
11 really sweet deal, make it a deal that's no sweeter than the
12 rest of the hospitals.

13 DR. REISCHAUER: Sally, besides expressing our concern
14 about the seven to eight-day cliff are we going to suggest
15 alternatives? Because just looking at this it strikes me that
16 it's strange to have a seven-day limit for everything. That it
17 should be half of the average length of stay for that DRG or
18 something like that, which would then, in a way, reflected the
19 distribution of lengths of stay for each DRG and would reduce
20 this kind of problem. Because when you look at that number for

1 tracheotomies you go, good Lord, of course you keep the person
2 the eighth day. But it might turn out that 99.9 percent of
3 tracheotomy patients are in the hospital 23 days or more, so
4 this isn't something that we should spend sleepless nights
5 worrying about.
6 Are we just going to express concern, or are we going
7 to suggest some alternatives was my question?
8 DR. KAPLAN: I think that our alternative was to
9 smooth -- to get rid of the huge cliff.
10 DR. REISCHAUER: How?
11 DR. KAPLAN: I don't know.
12 DR. REISCHAUER: I was suggesting a way to do that.
13 There must be hundreds of --
14 DR. KAPLAN: Right, which would be over half the
15 average length of stay.
16 DR. ROSS: One of the ways to do it is to go to a per-
17 diem instead of a per-discharge, but I don't think we're ready
18 to make any recommendation along those lines. We don't know
19 enough about it at this point.
20 MS. BURKE: You could do it by proportion, scale it

1 up. The farther out they go, the closer you get to full weight.
2 MR. MULLER: Sally, what do we know about the cost in
3 these facilities vis-a-vis the comparable cost in acute
4 facilities? I mean in those other 47 states.
5 DR. KAPLAN: First of all, they aren't quite that
6 concentrated. Unfortunately, I didn't bring the map that David
7 very nicely made for me which showed where they're located. But
8 there is a concentration in those three states, but they are a
9 little more dispersed than that.
10 MR. MULLER: I understand.
11 DR. KAPLAN: We haven't done a comparison of what it
12 costs in an acute care hospital. There's been a comparison done
13 as to how many of these folks are outliers before they go into
14 the long term care hospital. I was kind of surprised that they
15 actually weren't as heavily tilted towards the outliers in the
16 acute care hospitals. It sounds like the acute care hospitals
17 pretty much shift them before they become outliers.
18 I think this is all work that if you're interested in
19 we could do next year, or we could ask CMS to do this type of
20 work. I think it would give a lot more information. I don't

1 think this work can be done before the PPS goes -- before we
2 have to comment and certainly not before the payment system is
3 implemented in October.
4 MR. MULLER: If you go with Floyd's and Bob's
5 comments, I think the rational place these facilities have is in
6 fact taking care of these patients and then having acute
7 hospitals -- you don't want these staffed up to acute hospital
8 staffing standards. So the opportunity to have an acute
9 hospital, as Floyd suggests, where they go back when they need
10 acute care in a seamless way is a very efficient way of doing
11 that.
12 I know my own experience, such as Floyd's as well is
13 that you can staff these at a much lower level than an acute
14 setting. When you have a patient that you know is going to be
15 in for many, many days or often months on end it becomes a very
16 cost effective way of treating these patients, as long as you
17 have the acute backup. Therefore, being able to go back and
18 forth between the acute and the long term care setting without
19 having steps or cliffs and so forth is a very appropriate way of
20 trying to match the payment policy with the clinical policy.

1 So I think having some sense therefore of what the
2 costs are, my guess is that in a lot of these settings that the
3 institutions haven't been created. I'm familiar with one of
4 these states and having run these programs in one of these
5 states, these are basically the old TB places that you converted
6 into these long term care hospitals. So if you have some extra
7 TB facilities in your state that are being shut down you convert
8 them into this. So this happened just in one of these states.
9 MR. HACKBARTH: So what we're talking about here is
10 basically a two-part letter I think. One part addresses the
11 specific issues raised by the proposed regulation within its
12 frame of reference. Then the second is actually probably more
13 addressed to the Congress than it is to CMS raising some more
14 basic questions about how these institutions and the associated
15 payment policies fit with the larger scheme of things. There is
16 work to be done, analysis to be done to answer those questions.
17
18 DR. STOWERS: I just want to make a comment. I agree
19 with everything about the cliff and all of that kind of thing.
20 But as we talk about the distribution, I know we have one in

1 Oklahoma which is related to a hospital that closed. It serves
2 a good purpose there.
3 We have some past work on uneven distribution with
4 Medicare+Choice, which is concentrated in a few states but yet
5 is scattered out across the country. I'm wondering if it
6 wouldn't be a good idea, like we looked at the market and what
7 supported that in certain parts of the country and other -- that
8 before we move too quickly on this distribution thing, if we
9 don't approach is somewhat from the same angle of looking at
10 market and why it is happening in those states before we would
11 proceed too far.
12 So I know that some hospitals in some areas are closed
13 hospitals and other reasons -- and those that I've seen I agree
14 with that entirely. That may be occurring more in certain
15 states and parts of the country because of other market factors.
16 So I just think we need to look into that a little deeper.
17 MR. HACKBARTH: So if we couch this not as answers but
18 questions that occur to us as we look at this particular type of
19 institution. No conclusions at this point.
20 DR. STOWERS: Yes, I think we'd be helping all parties

1 concerned to approach it from that angle on this distribution
2 thing and look into it a little deeper if we're going to go
3 ahead and proceed with this.
4 MS. BURKE: Glenn, just one side note. Frankly, Ray,
5 I care less about where they are than the equity issues that Bob
6 raises. I don't care if they're all in one state. The question
7 is, how are we treating similarly disposed patients in different
8 settings? So I don't argue with your point, there are clearly
9 market reasons they have occurred, in part the pre-'83s my guess
10 are some of these guys that were the old TB hospitals. But I'm
11 less concerned about that, differently than I would be in terms
12 of Medicare+Choice, than I am about what is the underlying
13 question of similar disposed patients.
14 DR. STOWERS: I was just using Medicare+Choice as an
15 example that we do treat patients differently in some
16 metropolitan areas than in other areas because of a market
17 difference. But I agree that in the end the payment ought to be
18 somewhat equitable for what we're doing.
19 DR. REISCHAUER: We do, but people are complaining
20 about it.

1 DR. STOWERS: I agree.
2 DR. LOOP: There are also some recent trends in
3 hospitals that weigh into this. Volume of admissions are way
4 up. There's a big problem with capacity management. Hospitals
5 are really not designed either in structure or the labor issues
6 today for long term care. A good long term care hospital adds a
7 lot, which I said earlier. But if we were talking 10 years ago,
8 there was not the same capacity issues in hospitals than there
9 is today.
10 MR. HACKBARTH: Others?
11 DR. NELSON: In going through the numbers of cases
12 that have been submitted on claims, the diagnoses, acute
13 psychiatric diagnoses, the top half-dozen are respiratory
14 failure requiring a ventilator, rehab, skin ulcers, stroke,
15 congestive heart failure, renal failure, septicemia. So it
16 doesn't read unlike the kinds of diagnoses that would be within
17 the outlier population in a general hospital.
18 MR. HACKBARTH: Sally, do you have what you need?
19 DR. KAPLAN: I think so. Thank you.
20 MR. HACKBARTH: Next up is using information on

1 quality.

2 MS. MILGATE: So now we're going back up to the

3 20,000-foot level, I believe, so adjust your minds. In this

4 session what we're going to be discussing is a proposed workplan

5 for the upcoming year on the subject of using information on

6 quality in the Medicare program. What we'd like from you today

7 is feedback on the general direction and specific goals that you

8 found in the outline we provided for you as background material,

9 but wanted to suggest that this is an introduction really to a

10 more detailed discussion at the summer retreat. So you'll have

11 a second stab at this and presumably we'll be able to provide

12 you with even more detailed materials before the summer retreat

13 to discuss.

14 Medicare is responsible for ensuring access to high

15 quality care, yet we know little about the product that Medicare

16 purchases for so many beneficiaries. We know what services are

17 bought, where they are delivered, how we pay for them, and how

18 much the program spends. However, we know little about how safe

19 they are, how effective the care delivered is, how timely they

20 are, or much about what beneficiaries or their families think

1 about the manner in which the services are delivered.

2 So why does Medicare need information on quality? How

3 would they in fact meet that goal of ensuring access to high

4 quality care? First, Medicare needs information on quality

5 because it's their responsibility to assess the value of the

6 care that's purchased. In this aspect of measuring quality it

7 really helps the program identify problem areas and helps them

8 identify ways to seek ways to actually improve care overall.

9 We do have some information in the aggregate that's

10 already used for this. For example, the QIO program indicators

11 that look at hospital care and some indicators of ambulatory

12 care. They have aggregate data, for example, on how many

13 Medicare beneficiaries across the country actually get beta

14 blockers after AMI in the hospital. Then there's 26 other

15 indicators in fact which we have information on what

16 beneficiaries are and aren't getting which is appropriate care.

17 Another way to actually use information to assess

18 value would be, for example, to identify diabetics that are in

19 the program and then look at the types of services they get to

20 see if in fact they're getting the right services at the right

1 time.

2 As I said before, we're beginning to have some
3 information in some settings to assess value. However, we don't
4 have that information in all settings and it's unclear whether
5 the information we have is in fact what we really want for this
6 purpose.

7 The second purpose for Medicare needing information on
8 quality is to evaluate payment adequacy, which is clearly a goal
9 that's near and dear to the hearts of the folks on this
10 commission. We do use some information to evaluate payment
11 adequacy. One indirect measure is the financial health of an
12 institution, for example. Whether in fact the institution has
13 the ability to delivery quality care is in some ways related to
14 whether they are financially healthy or not.

15 Another measure that we use, in particular in the
16 dialysis world, is whether quality is improving over time. So
17 we do have some information on that. However, we need this type
18 of information in more settings. We don't have whether quality
19 is improving over time in all settings. In fact one could
20 suggest that we might want to use additional measures to

1 evaluate payment adequacy. For example, the occurrence of
2 adverse events over time might be one to look at, or in post-
3 acute settings there have been some research to show that there
4 may be case mix changes over time depending upon payment levels.
5 The third reason Medicare needs information on quality
6 is to distinguish among providers. In fact there are several
7 purposes for distinguishing among providers. The four that
8 we've identified are, one, to inform consumer choice. Two, to
9 stimulate provider improvement. Three, to focus surveyor
10 efforts. And four, to reward high quality. Whether we think
11 the information that was provided in the full-page ads yesterday
12 in fact was the most useful information, the goal of this
13 information I would say would be all four of those in many ways.
14 So it's an example of CMS trying to actually find a way to
15 distinguish among providers.
16 However, once again we don't have this information in
17 all settings. We have the ability to distinguish on some
18 measures between dialysis facilities, some measures for nursing
19 homes, but there are many other settings in fact where CMS
20 doesn't have this information. Then there's also questions

1 about whether the information that the Medicare program does
2 have is the most useful information in fact for distinguishing
3 among providers.
4 One of the most important things to look at in this
5 area is how valid or reliable the information is that's able to
6 be collected and used in various settings of care.
7 The goals of the proposed analysis are three. First,
8 to evaluate Medicare's strategies for measuring and using
9 information on quality. Then falling out of that evaluation, to
10 potential recommend ways to improve the collection and uses of
11 information on quality. We also believe the analysis could help
12 lay groundwork for future work on the interaction between
13 quality and payment.
14 The last slide here just describes a proposed
15 workplan. We think there's basically three steps involved.
16 Each step is designed to answer a different question and they're
17 sequential steps. The first question would be, what do we know
18 about quality and quality measures? So in this step what we
19 would need to do is get a sense of what we already have. What
20 do we know about quality? What types of measures are out there?

1 We would presume to do this analysis based on various
2 settings, and we would include the providers in the Medicare
3 fee-for-service program and also the M+C plans, which of course
4 in the report we just issued we had a lot of analysis there on
5 what's already collected on Medicare+Choice plans.
6 Then from that step, when we get a sense of what
7 information we do have, try to identify gaps in what we may in
8 fact want to know beyond the information we have. Find out if
9 the information is sufficient in fact to assess value, to ensure
10 payment adequacy, or to distinguish between providers. Then if
11 not, and we do identify gaps, would we in fact be able to get
12 that information from better analysis of data we already have?
13 For example, what's the capacity of administrative
14 data? Have we reached that capacity in terms of what we might
15 be able to glean from that on quality? Or are there other types
16 of information that we may need to collect from providers or
17 plans? If so, are there other ways to get it? For example,
18 could we get some information from private accreditors rather
19 than requiring direct collection from providers or plans?
20 So that concludes the formal presentation. I hope

1 it's given you a sense of what we're talking about. We'll be
2 glad to hear comments and, of course, any questions you might
3 have.
4 MR. HACKBARTH: Based on things that we've said
5 previously it seems to me that there's no disagreement about the
6 premise of the absence of quality information. We've said in
7 various places it's a major problem, not just for the Medicare
8 program but for the health care system in general. So from my
9 perspective the questions here are, what can we contribute
10 within the available resources we've got to move the ball
11 forward? Are there efforts of other groups that we need to know
12 about or maybe piggyback on that would give our efforts here
13 some more impact?
14 DR. BRAUN: Apropos of what Glenn just said, I noticed
15 that the National Quality Forum was not mentioned and that
16 certainly is one group that's working on quality and I would
17 think that would be helpful in this situation.
18 The other thing that comes to my mind is, we need a
19 lot more emphasis on information technology. We think about all
20 the things that can be done to move toward quality, but until we

1 really put enough investment in information technology we really
2 can't do it.
3 MS. MILGATE: Could I say something to your point,
4 Glenn and Bea's?
5 MR. HACKBARTH: Sure.
6 MS. MILGATE: What we would assume and the first step
7 I suggested in the workplan is in fact that we would go beyond
8 what CMS has and look at what's out there at accreditors, at the
9 state level, employers, in a similar way that we did with the
10 quality improvement report where we looked at the standards that
11 a lot of different entities use. We would then turn our
12 attention more to the information they gather on actual quality
13 measures. So we wouldn't assume to develop all of this at all
14 ourselves, but more to look at what's out there and then take a
15 look at what we have and whether we might want to use some of
16 that information.
17 MR. HACKBARTH: Maybe I can articulate my concern a
18 little more clearly. I view this as an investment decision.
19 We've got limited resources and we need to use them in a way
20 that we get the maximum return possible. This is certainly a

1 critical issue.

2 It's not clear to me what we're talking about right
3 now in terms of investment, and I suspect it's not clear to you
4 either. Are we talking about this is the focus of the next June
5 report or are we talking something substantially smaller than
6 that? I don't mean for this to sound as criticism, it's just a
7 question I have about how far we go down this track and whether
8 we're going to get a return on our investment. I'm very open to
9 it. In fact I'm delighted that you're bringing it here, but I
10 think we need to get a handle on how much we're going to invest
11 in it.

12 MR. FEEZOR: I think it's a worthy topic. I guess,
13 Glenn, I'm sharing a little bit of your concern about trying to
14 pare it down or at least put it in a couple different buckets
15 that may help it solidify, if there an ROI, if you will. The
16 one that I get, we tend to -- and I notice we use the
17 terminology throughout several of our reports where we talk
18 about the Medicare program buying. I would argue that the
19 Medicare program pays for. That the purchasing and the buying
20 is done largely by the beneficiary.

1 It's in that construct or that division that it may be
2 helpful to think about quality measure. One would be quality
3 measures that in fact help enable the purchasing decision, which
4 is largely that of the individual. That may be the quality of
5 the provider, or the value of one Medicare+Choice versus
6 another.
7 The second is in fact those quality measures that
8 really verify the value of the payment. That in fact we are
9 getting what we paid for. That perhaps is more what the
10 Medicare program is interested in. It may be that looking at it
11 in those two ways may help us say, first off whether we'd like
12 to contribute, and probably more narrowly constructed it's in
13 that latter category that we'd have program, I guess,
14 responsibilities. So that's some thoughts.
15 DR. WAKEFIELD: Actually I'm taking a little bit of a
16 broader view, maybe the 25,000-foot view instead of the 20,000
17 we kicked off with here. My sense is what we're all -- what
18 we're doing right now is just putting some ideas on the table
19 that will be fleshed out in much greater detail and with more
20 precision and focus at the retreat. So mine are a broad picture

1 perspective.

2 One, I think one might think about starting off this
3 discussion and grounding it a little bit, I'm always an advocate
4 for the Quality Chasm report so I'm putting it out there again.
5 But to the extent that in that report some of the discussion is
6 about aims for improvement I don't think that's a bad place to
7 start frankly.

8 One of the recommendations was suggesting that public
9 purchasers, for example, ought to think about the application of
10 those aims. They are the care for, in this context, Medicare
11 beneficiaries would be safe, that it's effective. That is, that
12 it's based on the best scientific knowledge so we're not driving
13 overuse and underuse. That the care is patient centered so it's
14 responsive to Medicare beneficiaries' preferences and values.
15 When it can be, that it's timely. That it's efficient. That
16 we're not wasting resources, money, technology, et cetera. And
17 that it's equitable. That the quality doesn't vary because of
18 where somebody is getting it, or by gender, or by a Medicare
19 beneficiary's socioeconomic status, or whatever.

20 So stepping back, big picture, I don't think that it

1 would be a bad idea to think about whether or not, at least as a
2 backdrop to this discussion one might think about starting
3 there.

4 I think from my perspective a fundamental question for
5 us is, can we get better quality? Can we work toward improving
6 the quality of care that Medicare beneficiaries get? That's
7 quality improvement, that is a little bit separate from quality
8 assurance. We've talked about both of those historically. I
9 thought this discussion was a little bit more slanted toward QA,
10 but you do have improvement there. So I'd want to make sure
11 that we're covering both of those bases in a document.

12 I also think that a lot of attention on the extent to
13 which one could align financial methods to decrease care
14 fragmentation would be a good thing to think about. So really
15 looking at the issues that you've raised a little bit thus far,
16 looking at quality related to payment policy. And can our
17 payment methods, can we look at them to ensure at least that
18 they're not putting barriers up, where that can be identified,
19 to providers attempting to provide good quality care.

20 For example, even the discussion we had a couple of

1 minutes ago, Ralph's comments, and I'm going to take them -- if
2 you suggest I'm taking them out of context you can comment,
3 certainly make that comment. But Ralph's comments earlier about
4 long term care facilities and acute care facilities and patient
5 transfers between those two entities and that if we had seamless
6 -- if we had payment policies that were structured to facilitate
7 seamless continuity of care, for example.

8 So could we be looking at the extent to which some of
9 our payment policies may or may not be facilitating quality
10 improvement, actually might be serving as barriers to high
11 quality care, at least with that notion in mind.

12 Also, I'd keep an eye on coordination of care. We
13 talked a little bit about that yesterday in different context
14 but I went back this morning and pulled one page from one of the
15 documents that we're looking at that mentioned that, for
16 example, the average beneficiary with one or more chronic
17 conditions was seen by eight different physicians during 1999
18 according to one study, and had 17 to 24 prescriptions filled in
19 1998. My God, if those stats don't beg for coordination of care
20 across eight different providers, it certainly asks the

1 question, I think, are patients -- is that care being
2 coordinated in a way that it should be, et cetera?
3 So some of the discussions that we had about care
4 management and disease management yesterday, and how can we,
5 with financial incentives, et cetera, or demonstration programs,
6 or strengthening the demos that CMS currently has underway, just
7 to try and think about that, given the nature of the beneficiary
8 population that we're dealing with. So I think quality is just
9 a terrifically important focus.
10 Last point. With regard to looking at -- or two last
11 points. One, to the extent we can think about engaging Medicare
12 beneficiaries themselves and their response in terms of the
13 usefulness of information, other vehicles for disseminating
14 information, is a finer point that we can put on some of these
15 embryonic efforts to push information out to the Medicare
16 population like the newspaper ads that we're seeing so far? Is
17 there a way that we can engage beneficiaries themselves a little
18 bit more fully?
19 And in terms of drawing on other resources, just a
20 comment that early next year AHRQ, as you know, has been asked

1 to produce for Congress and the Administration its first report
2 on quality, a national perspective on quality of health care in
3 America. There might be, as they're developing that there may
4 well be some things that we could draw on here that could inform
5 our thinking as they're doing their work.
6 I would suggest they've put tremendous amount of
7 resources already in the last six months into the development of
8 their data collection structure, and how they're thinking about
9 capturing that information. Why reinvent the wheel? I think
10 some conversations with those folks about how they're moving and
11 what we might be able to capture from that would be appropriate.
12 MS. MILGATE: Mary, all the discussion of the ideas
13 you have about what to look at in my mind would fit in the
14 second step of, first we'd see what we know and then say, okay,
15 do we have enough, for example, to look at care across settings?
16 So your discussion is exciting to me because that's exactly the
17 more detailed discussion that I'd like us to have in the second
18 step of the process.
19 Just on the IOM comment in terms of starting there,
20 one other thought we've had is to start with the IOM components

1 of quality as one way of analyzing also what information we
2 have. What information do we have on effectiveness? What
3 information do we have on safety? Is it enough? Do we want
4 more?

5 DR. WAKEFIELD: That's really Bea's comment about
6 information technology.

7 MS. MILGATE: Yes.

8 MS. RAPHAEL: I guess my view is, I don't think we
9 need to produce another report on quality. I think we really
10 need to clarify our focus and what we're going to contribute. I
11 think there are two areas where we could contribute, and some of
12 this is building on what has been said already.

13 I think the first issue for me is the relationship
14 between quality and payment policy because ultimately quality is
15 determined by what happens at the practitioner encounter level,
16 whatever that encounter is. I can tell you that my greatest
17 challenge is taking evidence-based knowledge and having that
18 translated to what happens every day out in the field. That is
19 the challenge.

20 I don't want any more evidence-based knowledge right

1 now actually. I have more than enough. I have to really focus
2 on the application and the translation. If there were some way
3 that payment policy could help in stimulating that, I think that
4 would be significant. Also, if there are techniques or
5 demonstrations of how other systems have done this I could
6 really benefit from that knowledge base.
7 The other thing, I do agree with Mary that wherever
8 payments can facilitate the transitions, not just looking at
9 quality in one setting but really the trajectory of care across
10 settings, I think that also would be a contribution.
11 Secondly, I'm going to take a very minority position
12 here, but I would like to better understand the relationship
13 between information and quality. There is an assumption that if
14 you have more information you have more quality. I really
15 believe you need just-in-time information. Someone recently
16 told me he sat -- he worked with the National Quality Forum and
17 he said, I've done all this work for two years with the National
18 Quality Forum. I had a serious illness. He said, did I look at
19 any of the information that I gathered? No. I called up a
20 friend and I said, what should I do and where should I go?

1 I think to me that is something that we need to tackle
2 because just to create more and more information to me is not
3 going to really move that ball down the field of quality. So if
4 we could really tackle that whole issue on how to get people
5 useful, just-in-time information, or really work through the way
6 people make decisions, that would be useful.
7 Lastly, I think when we have this view of quality as
8 totally focused on patient safety and errors, I think that's too
9 narrow, because I think part of the issue on quality that I
10 grapple with has to do with not intervening in time, not
11 identifying a problem and not moving to deal with the problem.
12 In some cases you could say it's neglecting the situation.
13 But I think a very key component of quality has to do
14 with that sort of problem identification rescue and moving to
15 deal with it. It's beyond just making an error. It's a system
16 of care, a process of care. I think that to me, particularly in
17 the post-acute setting, perhaps as well in acute, and even with
18 physicians, it's something that has to be part of how we're
19 looking at the quality equation.
20 MR. MULLER: Like Carol, I feel we don't need to do

1 one more macro quality study, but I would suggest at least three
2 areas where we could be helpful. One is to get a sense of where
3 we spend the money, Medicare spends money on quality efforts
4 right now.

5 I know for many of us who come from institutional
6 settings, if I had to think about where the most considerable
7 expenditure of resources are towards quality, both assurance and
8 improvement, they are in fact in traditional functions of
9 complying with state regulatory codes, Joint Commission,
10 liability reduction efforts and so forth. So there's money, and
11 I wouldn't say it's 5 percent of the total resources but it's
12 more than a trivial amount of resources that gets spent in those
13 ways, probably far more than trying to do the things that the
14 Quality Forum and so forth are suggesting.

15 So there's a considerable -- so I think whether one
16 does it through cost reports or surveys and so forth, getting
17 some sense -- and maybe this is by Mary's definition old-
18 fashioned quality efforts, but I think if you look at where the
19 resources are being spent on quality enhancement efforts right
20 now it would be good sense, and maybe those become targets for

1 redirection in ways people would want us to redirect. So one is
2 just get a sense of what we're spending on quality broadly
3 defined right now.
4 Secondly, to build on Carol's point is the question --
5 in many ways I think the quality of the Medicare program is
6 driven by payment policy. Now we had a lot of discussions both
7 this year and in many years prior to that as to how payment
8 policy affects quality. I think we probably more than other
9 players inside the system are equipped to talk to the issue of
10 how payment policy affects quality because I think that's our
11 natural bent. And I think there's a lot of effects on quality
12 as to how -- just going back to the discussion we just had on
13 long term care hospitals.
14 So I think the interrelationship between payment
15 policy and quality I think is where we have a natural advantage
16 in contributing to this conversation.
17 The third point I would make is thinking about the
18 role of the national system versus a more decentralized and
19 local system. Again going back to my first point, a lot of
20 efforts at quality control are localized; the state health

1 departments regulate almost all the providers inside the system
2 that we're talking about.
3 Again going back to my recent examples, having seen a
4 government over in England try to do this now from the point of
5 view a national setting in terms of quality control and have
6 very tight control from the center of quality measurement versus
7 the more decentralized model we have here, I think at least to
8 me it's informed my thinking about that.
9 I don't think, despite what ads CMS is putting in the
10 Washington Post and Denver Post that we're likely to go through
11 a national quality measurement system any time soon. Yet many
12 people talk as if we're going to move towards that kind of a
13 system.
14 So a third thing I would look at is the question of
15 how much of this can in fact be done centrally as a kind of
16 national level quality measurement effort versus building on all
17 the other parts we have inside the system right now.
18 I would argue that, going back to my first point,
19 there's a lot of expenditure of resources being spent on quality
20 measurement around the country right now. Perhaps not as well

1 as many people would like to have done, but there is the most
2 significant effort right now in terms of expenditure of
3 resources is on a very decentralized basis. So I think it makes
4 sense to take that into account and try to measure that, and
5 then perhaps speak a little bit then to what that balance might
6 be.

7 If I could just, if I made up a number and said, if
8 80, 90 percent of the expenditure of resources were really
9 decentralized -- and I don't know if that's the number. I'm
10 just using that for the purpose of argument. That would tell
11 you something about how much you would move towards a national
12 quality control measurement system if in fact 80, 90 percent was
13 being spent in a very decentralized basis right now.

14 So I think, again, very much tied, to summarize, tied
15 to where is the quality, where is the expenditure of resources
16 right now? And very specifically I would like, since I feel
17 strongly that what Medicare most does to affect quality is its
18 payment policy I think that's a natural place for us to speak
19 somewhat knowingly about it.

20 MR. SMITH: I'm always happy to follow Carol in the

1 queue because she helps me clarify what's on my mind. I would
2 really focus I think, Karen, on the second point that Carol
3 made. There's an enormous amount of quality information out
4 there. There are certainly holes in it and step two is
5 important to try to identify those. But my guess is that it
6 would be very important to focus on how effectively the
7 providers, payers, and purchasers consume that information. Do
8 they have access to it in an effective way? Do they consume it
9 in an intelligent way?
10 The existence of the information doesn't mean that
11 it's well utilized by any of those three players. I suspect
12 Carol's example of her friend is more typical of all of us in
13 our purchaser role and not surprisingly it probably affects
14 Medicare in its payer role.
15 So I'd like us to take a look at the consumption and
16 the barriers to effective consumption of the information that we
17 already have as well as thinking about where there may be holes
18 in the data itself. But Carol's second point it seems to me is
19 central to making sense out of this.
20 DR. LOOP: Let me give you some points that you might

1 want to discuss on the retreat. One, if you take too broad a
2 view you're liable to come up with nothing. So in terms of
3 hospital quality you might consider starting with the top 10 to
4 20 DRGs, since that's the highest volume.
5 The second point, in clinical medicine surgery is a
6 lot easier to measure than medical outcomes.
7 A third point is that the real outcomes are often far
8 removed from the site of diagnosis and treatment, and that
9 requires follow-up, and that requires a lot of money.
10 I think you're wise to start somewhere, and I think
11 the IOM report is a good one. You have to decide whether you're
12 going to push evidence-based medicine as a part of the quality
13 outline.
14 The other point that I have is that if we could figure
15 out how to decrease the regulatory burden we might actually
16 improve quality.
17 Last, I believe that quality begins with assessment by
18 the individual provider, and that hospitals in particular should
19 be encouraged to assess and ensure quality as their top
20 priority.

1 MR. DeBUSK: I want to make a comment about the second
2 bullet point there and David referred to. The second part of
3 that is, is the information used by Medicare adequate? It's
4 certainly not JIT. If anything it's historical and probably
5 should be archived. But the absence of proper information as it
6 relates to quality is certainly missing.
7 Now how can we get, how can we look forward and access
8 that information, regardless of where it comes from and be more
9 JIT in the way we function and we make decisions? That affects
10 everything.
11 And our data, we talked about it many, many times, is
12 inadequate. I was glad to see it come up in bullet point two.
13 I think this is something, if we want to improve quality and
14 whatever aspect we're talking about, we're going to have to get
15 better data. We always talk around this. Now I know it's
16 complex and I certainly don't have the answer but out there
17 somewhere is the answer to us getting better data. That's where
18 we should be spending our money. If you were in business in the
19 private sector you'd sure go broke fast if you didn't have that.
20 MS. BURKE: Having listened to everyone's list of what

1 we might do and why we might do it, I am struggling to
2 understand, given your opening comment about limited assets and
3 limited resources, how many of these things are in fact within
4 our purview, how many of them we can actually have value added
5 in terms of content, and the order in which those things make
6 sense. I'm not disputing the value of any of the things that
7 people have discussed, but I am questioning our capacity to do
8 them all.
9 The goals of the analysis as articulated in the
10 document that look at the effectiveness of the current
11 strategies and try and understand ways to improve how we collect
12 and use information, and then further how we use that in terms
13 of the linkage to payment I think can either be expanded to
14 cover the universe or can be narrowed to something that is
15 doable. I guess my only cautionary note is, and perhaps this is
16 best done at the retreat, is that before we start down a road
17 that would have us literally consumed over the next 10 years in
18 looking at every single issue related to quality, that we look
19 at where we can add value, and what it is that is doable in a
20 reasonable time frame.

1 I think the issues around what it is Medicare is doing
2 currently and how it is spending its money with respect to
3 quality is quite an important one. I think questions ultimately
4 about how we link specific expectations of behavior or output in
5 order to link it to payment, it's critically important for our
6 purposes in terms of how we structure payment systems. The use
7 of information is obviously important. How consumers use it is
8 obviously important.

9 It's not clear to me that is where we can do the most
10 work in terms of value added; not questioning the value of that
11 work. It's not clear to me that for our purposes that's what we
12 might best do.

13 So I would just ask that we try and narrow down to
14 something that is doable and reasonable. Some of it is looking
15 at work that has already been done by others, which I think
16 makes a lot of sense, and obviously you are tuned in to already
17 begin to do. But I think there are a whole series of questions
18 out there that everybody is struggling with.

19 I think Carol is right on, that there are practical
20 questions that must be dealt with. It's not clear to me we are

1 capable, nor should we do all of them. But there are some that
2 are specific to Medicare, just getting a handle on what it is
3 they're doing today and how much money is being spent.
4 The whole issue of regulatory burden is quite an
5 appropriate one. The claim and cry that you hear from many
6 providers and organizations is that the magnitude of the demands
7 on data from a variety of sources that require them to
8 constantly duplicate efforts, or produce information in a
9 different way for different purposes to be used for presumably
10 the same reason, there are a lot of issues like that that are
11 quite legitimate.
12 Again it's not clear to me we can answer all those
13 questions. So I guess I would simply hope, I think everyone is
14 committed to quality. I think going forward with some attempt
15 to try and understand what it is that we can be doing and what
16 Medicare is doing is appropriate. But I would hope we refine
17 that a little bit rather than add to the list of things that
18 need to be done. Perhaps that's best done in the retreat, but I
19 think I'd just -- I'm having trouble getting my arms around what
20 literally you're being tasked to do other than the universe of

1 quality.

2 MS. MILGATE: The logic in my head at least, and this
3 really is just my head I guess at this point. Let me just throw
4 that out there -- is that this would be a first step to some of
5 the other things that people were saying was important in how
6 you would use information. We didn't have enough of a sense in
7 our heads about what we actually knew in various settings to
8 even know what we might want to know.

9 But I guess what I'm hearing back from some Commission
10 members is a sense that we may want to go more directly to the
11 question of the relationship between using the information
12 rather than just more of a passive look at what's out there.
13 Let me just throw that out.

14 MS. BURKE: I'm not sure that, at least from my
15 perspective I'm not sure that's what I meant; that is to go
16 directly to the what. I think it's really to try and
17 understand, what do we need to know, to what end? That will
18 hopefully guide us in where you can best target your efforts.

19 Obviously, linkages to financing is a critical issue
20 for us because of the way we create expectations in payment

1 policy. Equity between sites of care, what are our
2 expectations? The publication of the list yesterday raises the
3 point, all right, are there similar expectations with individual
4 providers? Are there expectations with large institutional
5 acute care facilities? Getting some sense of what those
6 linkages are.
7 But again, I'm just struggling to understand how best
8 to task you so that it's targeted to the things that we need to
9 do.
10 MS. MILGATE: In terms of resources, just to be clear,
11 we weren't anticipating this be a stand-alone big report like
12 the quality improvement report. We would hope to have some
13 information that's already out there gathered by CMS to include
14 an aggregate summary perhaps as part of the description of how
15 settings are doing in the March report. But then also possibly
16 in a June report as a chapter, identify information needs for
17 quality. There's been some discussion of perhaps doing a report
18 next year on information needs of the program and that this
19 would just be one segment of that. Just it wouldn't be
20 anticipated that

1 -- because obviously could be huge.

2 MR. HACKBARTH: This probably seems a bit of a downer
3 to you, the response that you're getting. But I'd emphasize the
4 positive here. I think there is unanimous agreement that the
5 broad issue area is important, but also a fair degree of
6 unanimity that it's so broad that we could easily get lost in
7 it.

8 One of the things that I've been learning this past
9 year as chairman is that, and I get most concerned when we take
10 on these really broad topics because we've got not only finite
11 staff resources but we've just got a limited amount of time
12 together. We can only process so much as a commission as a
13 group. When we tackle the very big topics, regulatory burden or
14 the benefits project, those are the times that I worry, are we
15 making a contribution or not?

16 So I'd like for us to have, before we take things on
17 and make that big investment, pretty clear ideas of where we can
18 offer something unique. So that's the question. What I'd ask
19 is that you and Nancy come back at the retreat, having heard
20 some ideas about what the handles might be, and see if you can

1 help focus us in some compelling areas.

2 DR. NELSON: I raised my hand also to make an appeal
3 to not try and redo the Chasm report, to be more narrow. I
4 think that the question we ought to address is what
5 expectations, what reasonable expectations should Medicare have
6 as a purchaser for quality demonstration. GTE has certain
7 expectations, the Leapfrog group has expectations.

8 If computerized order entry is the key to error
9 reduction, should the Medicare program, should we recommend that
10 the Medicare program by some point certain in the future insist
11 on computerized order entry as part of conditions of
12 participation? Right now the main quality expectations are
13 centered around the conditions of participation. That clearly
14 isn't going to be -- that plus the requirements for
15 Medicare+Choice. That clearly shouldn't be the way this program
16 goes.

17 Business is way ahead of us in demanding certain
18 deliverables with respect to quality. I think that we should
19 focus on what those kind of deliverables for Medicare might
20 reasonably be, taking into account the need to balance with the

1 administrative burden. You can't require performance
2 measurement on all of these office-based practitioners who are
3 keeping a paper record; you know, how many of your diabetics had
4 their feet examined, because you can't retrieve those data
5 without just an enormous burden. But there are things that can
6 be done.

7 DR. STOWERS: To me, I think we need to narrow it down
8 to a couple questions: how is current payment policy affecting
9 quality? Then how could it be changed to improve quality? To
10 me this is like looking at ethics in a medical school
11 curriculum; do you teach it in an isolated class or do you
12 integrate it through the whole curriculum? I think it would be
13 good here maybe to do an overview report or an idea of where
14 we're headed on this.

15 But I think something that would be very valuable to
16 everybody would be, whether we talk long term care facilities or
17 home health care or physician payments, that in every one of
18 those chapters from here on out we ask ourselves those two
19 questions and start integrating it into each report on an
20 ongoing basis; hospital updates, whatever. And not just look at

1 a single report but start integrating it more into all of our
2 reports and working it in that way.
3 I think in the long run we're going to be more
4 valuable that way than trying to come up with one more giant
5 report on quality. But every time we deal with those updates we
6 bring that into the discussion.
7 MR. HACKBARTH: Any final questions?
8 MS. MILGATE: No. I think that's useful feedback.
9 MR. HACKBARTH: Next on the list is risk adjustment in
10 Medicare+Choice.
11 DR. HARRISON: Good morning. I'm here to fill you in
12 on CMS's recent announcement on the development of a risk-
13 adjustment system in the Medicare+Choice program. We are not
14 required to make any formal comments but we might want to do
15 some work over the next year on this issue.
16 First a brief recap. The idea behind health status
17 risk adjustment is for Medicare to pay plans based on the health
18 risk of the particular beneficiaries they enroll. Doing so
19 provides incentives for plans to compete based on efficiency and
20 quality rather than on the ability to attract a relatively

1 healthy group of enrollees. Also risk adjustment rewards plans
2 for efficiently treating beneficiaries in relatively poor
3 health.
4 Further, successfully adjusting for health risk is
5 vital for pursuing the Commission's recommendations that the
6 payment system be financially neutral between enrollees in the
7 Medicare+Choice and beneficiaries in traditional fee-for-service
8 Medicare.
9 Since January of 2000, Medicare+Choice payments have
10 been risk adjusted using a blend of 90 percent of a demographic
11 model and 10 percent of a health status model called the PIP-DCG
12 model which is based on diagnoses collected only from hospital
13 stays. Dissatisfaction with the PIP-DCGs because of the model's
14 low predictive power and uneven treatment of beneficiary health
15 status based on whether or not beneficiaries were treated in the
16 hospital led to a statutory mandate in the Benefits Improvement
17 Protection Act of 2000, BIPA, to include diagnoses from
18 ambulatory data in the risk-adjustment system.
19 The Medicare program began collecting data on every
20 physician and hospital outpatient encounter of each

1 Medicare+Choice enrollee in order to simulate the effects of the
2 different multisite diagnostic models that were being developed.
3 Last May, Secretary Thompson suspended the collection of
4 ambulatory site data in response to insurer complaints about the
5 burden of the data collection, that it was just too
6 overwhelming. Last month, CMS released its plan for the
7 resumption of data collection and some details on the new risk-
8 adjustment model that it intends to implement in 2004.
9 In examining different potential risk-adjustment
10 models, CMS was looking to meet several objectives. First it
11 wanted to find a model that would have better predictive power
12 than the PIP-DCG model. Also it was essential for a new model
13 to be implemented in a way that would lower the administrative
14 burden on the plans relative to the full encounter models
15 proposed. In addition, CMS felt that the risk factors should be
16 clinically meaningful so they could be explainable to
17 beneficiaries, providers, plans, and the policy community.
18 CMS wanted a model that incorporated a wide range of
19 diseases treated by a range of physician specialties so that it
20 would create incentives for plans to contract with a broad

1 spectrum of providers and all the specialties could feel that
2 they contributed revenue to the plan through the needed services
3 that they provide.

4 On March 29th, CMS announced the parameters of the new
5 risk-adjustment system. It will be based on the hierarchical
6 condition category, or HCC model, which clinically maps ICD-9
7 diagnosis codes into disease groups. The full model which CMS
8 was considering using as its full encounter model has 86 disease
9 groups with payment differentials. For its new model, CMS
10 scaled it back a bit and chose a 61-group model, although the
11 exact number and definitions are still being ironed out.

12 The most common disease group is COPD which contains
13 13 percent of beneficiaries, and the most costly group is
14 dialysis status which would pay plans an extra $14,000 in 1997
15 dollars. I should not here that this dialysis group would be
16 for beneficiaries who had acute renal failure requiring dialysis
17 during the base year. It would not include ESRD beneficiaries
18 because they are excluding from the model, and CMS continues to
19 try to find an appropriate risk-adjustment system for them.

20 As I just implied, the model is prospective in that

1 diagnoses in a base year determine payments in the following
2 year. The model is site neutral: where the diagnosis comes from
3 does not affect the value of the risk adjuster. Some models
4 would have paid more diagnoses that were made in a hospital.
5 It's an additive model which pays an additional amount
6 for each disease group in which a beneficiary is placed. And
7 there are additional interactive payments for beneficiaries who
8 have selected multiple conditions. I'll show you what I mean in
9 this following example.
10 In this example we see how the total annual payment
11 would be determined for a 67-year-old man who has uncomplicated
12 diabetes and congestive heart failure. Remember that these
13 numbers are very rough and they're in 1997 dollars.
14 For being a man between the ages of 65 and 69 the base
15 payment would be $1,700 per year. If the man had no other
16 conditions that would be the total payment, by the way. But for
17 this man there would be an additional payment of $1,200 because
18 he had diabetes, and another $2,300 for having congestive heart
19 failure. The combination of diabetes and congestive heart
20 failure is one of the interactive groups and it would trigger an

1 additional payment of $1,300. So the total for this beneficiary
2 would be $6,500 for a year.
3 Taking a quick look at the performance of the 61-group
4 model, it seemed to do pretty well in simulations. The model
5 explained 11 percent of the variance in Medicare spending while
6 the PIP-DCGs explained about 6 percent. The model was also much
7 more accurate in predicting the Medicare costs for groups of
8 beneficiaries such as groups by quintile of spending in the base
9 year, and those were some common conditions.
10 Further, this model performed almost as well as the
11 full HCC model. The difference in the percentage of variance
12 explained is less than half a percent, and the only subgroup
13 where the full model performs noticeably better is for those
14 beneficiaries who spent the least in the base year. So this
15 would still pay a little bit more for the default groups than
16 the full HCC model would.
17 CMS really seems to have simplified the data
18 submissions as much as possible while still being able to
19 actually operate the model. Plans will be required to submit
20 data only for those diagnoses that trigger additional payment.

1 Plans only need to submit five data fields for each diagnosis.
2 I think that's down from about 50 under the
3 full encounter model. The type of provider and the beginning
4 and ending dates that are three of the variables are really used
5 for audit purposes, although you do need to make sure that the
6 diagnosis was made during the proper base year.
7 The plan would be responsible for retaining enough
8 data to be able to prove that a diagnosis was actually made
9 during an encounter. Plans would only need to submit data once
10 a quarter and only for enrollees that had a reportable diagnosis
11 that didn't already occur earlier in the year. If it's more
12 convenient for plans CMS will also accept the full encounter
13 data.
14 When deciding on the number of diagnoses to use in the
15 model there is a trade-off between increasing the accuracy of
16 the model and increasing the burden of data collection. CMS
17 picked a model that had almost as much explanatory power as the
18 full model and reduced the number of disease groups by about 30
19 percent. I should note here that the model of 61 groups does
20 use over 3,000 different ICD-9 diagnoses codes that get mapped

1 into this groups, so plans still do have to collect a
2 considerable amount of data and some have still expressed some
3 concern about that.
4 Representatives of plans that specialize in enrolling
5 the frail elderly, such as the social HMOs and PACE plans, have
6 been concerned that this model might result in lower payments to
7 them. They base these concerns on simulations of the impact of
8 the full HCC model that they had done. I think that their test
9 did not include some of these interactive terms which perhaps
10 might produce higher payments for the frail. CMS was aware of
11 these concerns and made an effort to include disease groups that
12 were likely to occur in the frail. The new model really
13 wouldn't apply to these specialty plans however until CMS makes
14 an explicit decision to do so. We may want to monitor this in
15 the future.
16 We really don't know anything yet about the financial
17 implications of the model. For example, we don't know how much
18 or even whether this model would decrease or increase total
19 Medicare payments to plans. We would monitor this situation as
20 well and look at how much money would move between plans and try

1 to describe the types of plans that would receive higher
2 payments and those that might receive lower payments under the
3 use of this model.

4 Finally, we have the issue of how CMS will handle the
5 time lag between when diagnostic data is available for enrollees
6 and when payment is to be made based on those diagnoses. At the
7 beginning of 2004 CMS will pay based on diagnoses made between
8 July 2002 and June 2003. The current plan is to move the
9 diagnostic period up to the calendar year and adjust
10 retroactively when the data does not arrive by the beginning of
11 the payment year.

12 CMS feels that since they're already doing a
13 retroactive adjustment for some of the working aged categories
14 and for institutionalization they don't think that this would be
15 much of a problem. I know Alice in the past has been worried
16 about being able to predict ahead of time what the payments
17 would be.

18 To sum up, this model development appears to keep CMS
19 on track to begin adjusting payments with a health status model
20 that will include data from ambulatory sources by the

1 statutorily mandated January 2004. It will, however, no longer
2 have the comfort of a trial period. Data will be collected for
3 enrollees beginning this July and that data will actually be
4 used in setting the 2004 payments. The full model, however,
5 won't be fully phased in until 2007. It will be phased in
6 gradually.

7 Simulations suggest that the new model is greatly
8 improved over the current PIP-DCG model in terms of predictive
9 power in fairness to those beneficiaries who are treated in
10 ambulatory settings. And the plans' burden in submitting data
11 seems to have been reduced relative to the full encounter models
12 that were previously contemplated, but only full implementation
13 will be able to decide whether their burden was lifted.

14 Questions, comments?

15 MR. HACKBARTH: So the answers to the questions about
16 the financial implications, whether total payments will go up or
17 down and how they might be redistributed, we won't be able to
18 analyze those questions until we've actually done the data
19 collection, and the schedule now in place really doesn't provide
20 for any analytic phase it's just straight into payment.

1 DR. HARRISON: That's right.

2 MR. HACKBARTH: So the plan will proceed without
3 having answered those questions.

4 DR. HARRISON: Correct.

5 MR. HACKBARTH: Before I forget, Joe Newhouse had one
6 issue that he wanted to raise. Did he talk to you directly
7 about it? His issue was that with regard to physician payments,
8 the physician side of this, he think there's going to be
9 significantly undercoding of the diagnosis information. So if
10 you leap into this there will be a big opportunity to upcode
11 which could result in much higher than anticipated expenditures.
12 So he would slow down the phase-in. Give people enough of an
13 incentive to do the proper coding at the first step but not make
14 too much of the payment based on the new system until you've
15 actually got better coding information.

16 Does that make sense to you? Did it come out clearly
17 at least?

18 DR. HARRISON: Yes, certainly we could be worried
19 about that since we'll have no information ahead of time really.

20 MR. HACKBARTH: So he would like any comment we make

1 to suggest slower phase-in of this while we figure out what the
2 system means.
3 MS. BURKE: Just a side note, not that I think there's
4 anything we can do about it. But having gone through this on a
5 couple of occasions I think the chances of there not being a
6 fair amount of hue and cry once the distributional analysis is
7 done and we begin to see a reallocation of assets based on risk
8 adjustment, the likelihood that Congress will not intervene if
9 there are huge shifts is around zero I should think.
10 So as we begin to anticipate, I just can't imagine if
11 in fact it shows any real shifts in terms of payment rates in
12 some of those areas you've got to believe that they're not going
13 to sit by and let that happen, whether they do a zero sum game
14 or something. I don't know how we anticipate that but I think
15 we have to anticipate that that, unless something changes, is
16 likely to occur.
17 MS. ROSENBLATT: I'm just wondering if there's a way
18 we can do some analysis. Would it be possible to approach some
19 plans and get some data for -- instead of waiting for the 2002
20 to 2003 data that's going to be used, can we go backwards and

1 get some 2001 data and project what would have happened in 2002?
2 DR. HARRISON: We've tried to do that in the past and
3 every time we do the plan then figures out that they really
4 don't have the right data. We can try and if any plans have
5 data we'd be happy to --
6 MS. ROSENBLATT: Unfortunately, Wellpoint's population
7 is not a very large population and Janet is not here, but maybe
8 between PacifiCare and Aetna, if they were willing to give some
9 information -- I mean, it seems to me that's the key question in
10 everything you raised here, the financial modeling.
11 I think we've all moved past the model. I'm willing
12 to take, based on what you're saying, that this model is better
13 than the existing PIP-DCG. I don't think that the value we
14 bring is in saying, maybe there's a better model out there.
15 Let's just accept that this is an okay model and is a nice
16 compromise in terms of the data. But then the issue is, we've
17 got a system that is very broken; is this going to break it even
18 more?
19 DR. HARRISON: I've heard some comments from plans
20 that suggest they don't care because it's not going to apply to

1 them because they won't be here, which actually is a problem for
2 data collection too because if a plan announces they pull out
3 July 1st are they going to bother collecting the data that will
4 be needed to code their beneficiaries in the next year?
5 DR. LOOP: I don't think this is going to work because
6 when the statisticians get to this the change in r-square from
7 0.06 to 0.11 may be twice as good as it was but it's still
8 pretty bad. You want to comment on that?
9 DR. HARRISON: I know Joe always says that you
10 probably couldn't explain more than 20, 25 percent anyway; the
11 rest of it really is random. So I don't know whether he would
12 think 11 is good, but it seems a lot better. It could be that
13 they're explaining half of what's potentially explainable.
14 DR. LOOP: The other point I wanted to make is that
15 those who will have concern about payment for the frail elderly,
16 I think their concern is validated in Table 2 because the
17 predictive power really declines as you get into higher and
18 higher cost quintiles.
19 MR. HACKBARTH: Scott, those organizations are now
20 paid based on a negotiated rate?

1 DR. HARRISON: Social HMOs, I believe, are paid still
2 based on the old AAPCC with their own little system, and I think
3 PACE plans are as well; gets the frailty adjustment.
4 MR. HACKBARTH: Their concern is that they not be
5 moved automatically into this new system but considered
6 separately?
7 DR. HARRISON: Correct, and we as a commission have
8 also said that in the past, that we should make sure that it
9 would work before we move them.
10 DR. REISCHAUER: I'd just like to reemphasize Joe's
11 point but from a different perspective. He was worried about
12 the uncertainty with respect to total federal spending, and I'm
13 worried much more about the business side of this, that this
14 introduces an element of tremendous uncertainty. If I were
15 running a business, not knowing how this was going to come out,
16 if I were thinking of withdrawing before I would be totally
17 convinced that that was the right move now.
18 If we have a desire to keep this endangered species
19 alive in the hopes that out of it might come some future
20 Medicare reform I think it would be wise to suggest that, given

1 that administrative action was taken to delay this whole thing,
2 that Congress consider pushing off the implementation for a year
3 just so people can know what kind of world they're going to be
4 moving into.

5 MR. HACKBARTH: The likelihood, as Sheila points out,
6 that it's going to happen is high to begin with. You could end
7 up with the worst of both worlds, where it is in fact delayed
8 but only after damage is done and people have done anticipatory
9 pull-outs.

10 DR. REISCHAUER: But we have a chance to start a
11 debate that could occur in sort of a crisis atmosphere and after
12 any good that might come from the result has been blown away.

13 MR. HACKBARTH: So we've not been asked to
14 specifically comment on this by the Congress; is that right?

15 DR. HARRISON: No, this announcement was actually in
16 the form of a letter from a CMS official to the plans. So
17 they're really plan instructions. What the announcement does is
18 it limits what -- it tells the plans, you're going to have to
19 collect these codes. You won't ever have to collect other
20 codes, at least for the initial phase. So it lets the plans

1 plan how to collect the data. There is no other force of law.
2 They can end up dropping codes. They can fiddle around a little
3 bit --

4 MR. HACKBARTH: So CMS is in a position where they're
5 trying mightily to meet the statutory deadlines that are already
6 established and have been in place for years now, and our
7 concern is that given where we are at this point in time and the
8 amount of work that remains to be done that that may not be a
9 reasonable thing to do, but it's Congress that has to change the
10 schedule. So what we would be doing is offering our unsolicited
11 opinion to the Congress that maybe they ought to give CMS some
12 more space to do the analysis on this?

13 DR. HARRISON: Right.

14 MS. BURKE: Can we just look at the schedule that you
15 included in our books for just a second so we understand? One
16 of the things you could imagine happening
17 -- this is as I recall and I was checking, is phased in on
18 fractions over time. So you might imagine a scenario that has
19 them hold it at 30/70 for three -- I mean, you could imagine the
20 Congress trying to intervene in a variety of ways.

1 When do you anticipate the plans will actually begin
2 to collect the data that is now going to be required on the 61
3 diagnoses? And at what point, to Alice's point, at what point
4 could you imagine our saying, all right, let's do a data run and
5 figure out what in fact this will look like? We've done that
6 before. We did that when we transitioned in the past. So the
7 question is, at what point will the plans have done this that we
8 could actually run a model?
9 DR. HARRISON: They are supposed to submit data by
10 October retroactively to July. So in other words, things that
11 happened to patients from July on are supposed to be reported.
12 MS. BURKE: This coming July?
13 DR. HARRISON: Yes.
14 MS. BURKE: Who's bright light was it that did it
15 prospectively instead of retrospectively so that behavior can
16 already begin to shift? You could imagine all sorts of crazy
17 things occurring. You've identified the 61 and now you're
18 telling them four months out that that's what you're going to
19 look at?
20 DR. HARRISON: Right. Now they were actually

1 collecting data before it was suspended.

2 MS. BURKE: But they're not going to go back.

3 DR. HARRISON: No, because they suspended it between

4 May of last year and July of this year.

5 MS. BURKE: One of the first questions I'd want to

6 look at is whether you see a change in pattern at all. They

7 ought to back up at least six months, if they can, if they've

8 begun to collect it. At what point could they in fact run the

9 model?

10 DR. HARRISON: It is possible -- I had heard that

11 plans were continuing to submit data and I don't know whether

12 CMS accepted it throughout this whole period. We could go back

13 and see if they actually did get a substantial amount.

14 MS. BURKE: That's a good question to ask.

15 MR. HACKBARTH: But Joe's point, as I understand it,

16 is that the reporting may change but it actually may be moved

17 towards more accurate reporting. So if you look back, you're

18 not necessarily getting the pure right answer by looking back.

19 You may be getting just an even more inaccurate answer.

20 MS. BURKE: No question, but we don't know that. It

1 could err on either side.

2 MR. HACKBARTH: We don't. It's a hypothesis.

3 MS. BURKE: I think Joe may well be right. But it
4 would seem to me, getting a sense of how quickly one could have
5 enough data to actually run at least the model is the question
6 we're asking, so that you can begin to see what kind of shifts
7 there would be.

8 DR. HARRISON: I would think it wouldn't be till the
9 end of the year.

10 MS. ROSENBLATT: Because you're assuming that you
11 can't -- I would think, Sheila, that plans who aren't -- some
12 plans probably have the capability to run models now.

13 MS. BURKE: Right.

14 MS. ROSENBLATT: It depends on how the plans are
15 reimbursing the providers and what data they're collecting on
16 their system.

17 DR. HARRISON: I have heard that some plans have done
18 internal analyses and are actually quite happy.

19 MR. HACKBARTH: So where do we stand? Should we, or
20 do we ever write unsolicited letters to Congress or the

1 committees making suggestions about this sort of stuff, changing
2 the schedule?
3 DR. ROSS: You're certainly free to do it. The
4 question is the strength of feeling the Commission has and the
5 knowledge base on which to put that strength of feeling. A
6 vague letter of, oh, there's new information and we don't know
7 what to make of it wouldn't be particularly helpful. I think if
8 we could start to get something, either preliminary runs --
9 MS. BURKE: Do we know enough, Glenn, today to ask for
10 a delay, or are we asking in fact what's out there that we could
11 use to look at in anticipation of this? Because it doesn't
12 occur to '04. They have a phase-in starting in '04 and the
13 question is, do you want to delay '04 based on what we think may
14 be a problem or do we want to ask -- can we do some initial
15 analysis now before deciding whether or not a delay is
16 appropriate?
17 DR. ROSS: And recall that you're on record in a
18 number of reports as expressing implementation of risk
19 adjustment as quickly as possible.
20 DR. HARRISON: One possibility could be we're

1 currently paying 10 percent of a risk adjuster. Switching this
2 one for the hospital one in '04 and maybe suggesting that we not
3 go to 30 but go to 10 might perhaps slow things down enough to
4 see what's happening.
5 MS. BURKE: Again I don't think we know. We're
6 guessing it's going to have a disproportionate effect but we
7 don't know the answer to that.
8 DR. REISCHAUER: But the problem is we won't know
9 until after the fact and there's an uncertainty issue here. It
10 strikes me that couldn't we sniff around and see if Congress
11 would find it beneficial if we expressed this discussion.
12 MR. HACKBARTH: In a somewhat analogous situation
13 where -- my old group was completely prepaid, so there was no
14 incentive to code information correctly, no apparatus to do it.
15 Then we had to start doing it because of self-insured employers
16 demanding claims data and it began to affect payments, revenues
17 to the organization. The impact is huge. People had no reason
18 to pay attention to that. Now they do. I think that's the
19 problem that Joe is identifying and the consequences could be
20 very large for total program spending and for the distribution

1 of the dollars.

2 I think it's more than just a vague concern out there.

3 I think in some similar situations you've seen the sort of

4 problem that could arise, so I feel some anxiety about this.

5 Now whether now is the time to write the letter or it's six

6 months from now, I don't know. I don't know what better

7 information we're going to have and exactly when we're going to

8 have it. Maybe that's the question you can help clarify for us,

9 Scott.

10 DR. HARRISON: It's hard to think that we would have

11 any meaningful data before the end of the year, and even that

12 could be sketchy. Unless CMS has been collecting data all

13 along, perhaps some plans may be in a position to give us data,

14 or CMS might be able to give us the data on some plans but it

15 certainly wouldn't be the whole universe.

16 DR. REISCHAUER: But what is some data going to tell

17 us? Some plans are going to be positively affected and some are

18 going to be negatively affected. Us coming forward with the

19 three plans that are positively affected isn't going to reduce

20 the anxiety of some plan that doesn't have the data and is

1 unsure.

2 MR. HACKBARTH: Going back to Murray's earlier point
3 about our being on record as saying as quickly as possible, what
4 we're doing is defining as quickly as possible. I don't think
5 it is as quickly as possible to just close your eyes and say
6 we're going to leap into the darkness. We could do that right
7 as we speak. You know, let's just make up a system. That's not
8 prudent policy.

9 DR. ROSS: Let me offer a suggestion because I think
10 what you need then next is at the retreat to be able to have at
11 least an analytic discussion and whatever additional information
12 we have on timelines, whatever we've gleaned, whatever
13 indications we're getting from the plans, and then to have a
14 discussion of this and presumably the larger issue of again
15 whither Medicare+Choice or what you think you want to be saying
16 over the coming year. Whether it will be just a continuing
17 reiteration of the so-called payment neutrality, expressions of
18 potential concern about risk adjustment.

19 My gut instinct is along with Joe's, that most of the
20 uncertainty about this in the short run is pretty one-sided.

1 Yes, it adds uncertainty to some business decisions, but given
2 the coding issues most of that is going to be pumping more money
3 into the system, not less.
4 We won't be able to bring you a whole lot more data
5 between now and the retreat but what we can do perhaps is set
6 something up to help guide your thinking on it.
7 MR. HACKBARTH: But a better understanding of the
8 timeline would help me. I may be slow on the uptake, but I
9 still don't have a handle on exactly what we're going to have.
10 DR. HARRISON: In July --
11 MR. HACKBARTH: I don't think we need to do it right
12 now. As a matter of fact, maybe you and I can talk separately
13 and I can get smarter about it. The real issue on the table is
14 if we want to send a letter to Congress, when do we send it? Is
15 it something we send now or should we wait for some additional
16 opportunity to look at analysis or data to help us think about
17 that.
18 MS. ROSENBLATT: Glenn, I'm just wondering, is there a
19 way to simulate the analysis, not worry about collecting the
20 data but just make some assumptions about -- getting to Joe's

1 point, if getting the data resulted in X, and we're phasing in
2 30 percent, what would that do to total Medicare spending in
3 2004. That type of analysis, it's back of the envelope kind of
4 analysis, but it at least puts some parameters on it and might
5 get the juices flowing, so to speak, of what might occur.
6 DR. REISCHAUER: Is it possible to -- we've brought a
7 lot out on the table here. We'll know a little bit more. We
8 can sniff around a bit and have a short discussion at the
9 retreat on this.
10 MR. HACKBARTH: Yes.
11 DR. REISCHAUER: Because I don't think now versus the
12 retreat is critical.
13 DR. NELSON: If Congress wants to try and resuscitate
14 Medicare+Choice, there are two ways to do it. One is an
15 arbitrary across the board, pump more money in in a way that has
16 no rational basis for it.
17 The other is to do it in a way based on severity of
18 illness and at least have some logic.
19 So I guess the point that I'm making is that we ought
20 not to necessarily fear increasing spending for this particular

1 part of the program, because if plans keep dropping out of
2 Medicare, Congress is going to have to do something one way or
3 another if it wants to retain Medicare+Choice.

4 MR. HACKBARTH: I can't remember which meeting it was,
5 maybe it was January, when we last discussed Medicare+Choice and
6 our view of it. The consensus, what came out in our report, was
7 that we think we should pay the same amount whether the
8 beneficiary chooses traditional fee-for-service or a private
9 plan. We shouldn't pay more to private plans just to bail out
10 the Medicare+Choice program so that it stays around. We need
11 to, as quickly as possible, improve the risk adjustment in
12 Medicare+Choice.

13 I don't want to go back and review still again, for
14 the fourth or fifth time, our basic principles about
15 Medicare+Choice. This is a narrow question now about is this an
16 improved risk adjustment and when it should be implemented, how
17 it should be implemented.

18 And so that's the conversation that I think we need to
19 have in July, and there's no rush to have it before July, with a
20 little better understanding of what the timetables are. At that

1 point we can then make a judgment about what, if anything, to
2 say to Congress about the schedule.
3 DR. NELSON: I'm not arguing that point at all. I'm
4 certainly not arguing for us to abandon our previous principles.
5 The context for my comments were in concerns I heard about well,
6 maybe this will lead to increased spending because we will be
7 making severity adjusted payments without sufficient experience
8 on what the cost impact is going to be.
9 As a matter of fact, if we were to do so and it was
10 consistent with our original principle, which is if there's an
11 increased severity of illness that needs to be acknowledged and
12 paid for, let's do it. That's still with a neutral public
13 policy.
14 MR. SMITH: Alan, I don't think the concern is whether
15 there would be more spending or less spending or whether or not
16 the proposed system is a better risk adjustment system than the
17 current one. I think the question is distribution, as I heard
18 Bob raising it, is whether or not the consequences of a better
19 system that more appropriately pays on a risk adjusted basis
20 further adds to the difficulty of the program.

1 Now whether or not that's a good basis for us to make
2 a judgment or not, I think is a different question. I don't
3 think the concern here is that spending might go up. That would
4 be a consequence of what we think is a better way of determining
5 spending. The question is whether spending would be
6 redistributed either in anticipation of redistribution or
7 because of redistribution more plans would leave.
8 DR. NELSON: I misunderstood what Joe was trying to
9 say through Glenn, because I thought the concern was that
10 spending would go up.
11 MR. SMITH: That is Joe's concern, I think.
12 DR. ROSS: The point I was trying to make is that
13 concern offsets or mitigates somewhat the other concerns about
14 uncertainty about changing systems. To the extent it does
15 induce additional spending, it also greases the wheels a little
16 bit on the redistribution.
17 DR. REISCHAUER: But the problem is, as Alice pointed
18 out, is two things are happening. You're introducing a better
19 risk adjuster and you're going to 30 percent, and they work in
20 opposite directions probably, maybe.

1 DR. BRAUN: I guess if we're concerned about
2 redistribution problems, shouldn't it be redistributed according
3 to the illness of the patients? It will encourage the plans.
4 MR. HACKBARTH: Yes, and that's the whole reason you
5 do the risk adjustment is to achieve appropriate redistribution.
6 So that's not a bad thing in and of itself. Again, I think the
7 issue here is a narrow one. Do we understand what we're doing
8 before we do it? Do we create such anxiety by truncated time
9 schedules that people just drop out? I don't want to hang
10 around and find out. This is the last straw for me, thank you,
11 I'm out of here. That wouldn't be constructive.
12 I think we've exhausted it for now but we can take it
13 up again, the timing issue, in July. Thanks.
14 Okay, we are down to our last item on state-level
15 variations in Medicare spending.
16 MR. GLASS: This is a look at some preliminary
17 analysis that we've done. It's kind of a heads up for everybody
18 on what we've been talking to Congress about.
19 First of all, why is geographic variation of interest?
20 Well, it's politically important because it's a question of

1 equity in the eyes of those in Congress. They look at it and if
2 their state is way at the bottom, they say why is that? That's
3 what we're going to talk about first in this.
4 It also, of course, determines M+C payments under our
5 Commission recommendation. And it may help us understand
6 appropriate resource use and maybe even how quality affects
7 resource use.
8 I realize no one can read this from the slide, but I
9 hope you all have it in front of you. The point of it is
10 there's a somewhat peculiar measure that's commonly used when
11 talking about spending per state. These numbers that you see
12 here appear in something called the Green Book that the Ways and
13 Means Committee publishes, and CMS publishes them. The Kaiser
14 Family Foundation actually put these out.
15 The reason people are concerned about it, of course,
16 is that if you happen to live in Iowa and you realize that
17 you're under 60 percent of the national average, and you look at
18 people in D.C. and they seem to be over 180 percent of the
19 national average, you say this isn't fair.
20 So these numbers raise a tremendous amount of concern

1 in Congress. We think, though, that it's a very peculiar
2 measure and one that probably shouldn't be used because it's
3 misleading.
4 Basically, the reason it's misleading is what these
5 numbers are is they're taking the total amount of Medicare
6 dollars spent in the state that providers receive in payments in
7 a state, and dividing it by the number of beneficiaries in a
8 state. What that doesn't account for is beneficiaries who go
9 outside of the state to use health care services.
10 So in Iowa, if a lot of people in Northern Iowa go up
11 to the Mayo Clinic in Minnesota, just across the border, that
12 depresses this number for Iowa. In the District of Columbia,
13 where we are now, lots of people from Maryland come in and use
14 doctors and hospitals in D.C. So you get a tremendously large
15 number showing up in D.C.
16 But the point is it really doesn't have anything to do
17 with the number of beneficiaries in D.C. It's the number of
18 beneficiaries using health services in D.C. So this is not a
19 very helpful number to use, and it's fairly easy to correct, and
20 the next one shows that.

1 In this chart, we've corrected for this migration
2 question. This is what we call a better measure. This is
3 spending on behalf of fee-for-service beneficiaries, not just
4 spending in a state. So this actually traces the spending back
5 to the beneficiary and his state of residence.
6 Now we see that Iowa is suddenly not under 60 percent,
7 but up closer to 80 percent. And D.C. has dropped down to a
8 little under 140 percent. So there's still some variation but
9 you can see that it's much more compressed than it was in the
10 previous example. This would just be a better measure to use.
11 This is looking at spending numbers so it includes all
12 the GME and the DSH payments to hospitals and it includes the
13 cost-of-living differences between states and all that sort of
14 thing. And of course, it doesn't adjust for health status, that
15 maybe you have healthier beneficiaries in some states and sicker
16 beneficiaries in another.
17 So in the next slide, we've done all that. And we've
18 come up with a measure that we call service use per beneficiary.
19 Here you can see the variation has been compressed even more.
20 Iowa is now just a little bit under average, as it turns out as

1 the District of Columbia. So we've now managed to crunch those
2 down very much and there are a couple of oddities here. Hawaii
3 is way under and we see a couple of states, like Louisiana and
4 Mississippi, are pretty far over.
5 So this is a measure of service use, we've adjusted
6 for health status using, in fact, the HCC risk adjuster that
7 we've just talked about. We used the full model, the whole HCC.
8 So this is taken account of health status and we've taken out
9 all of the geographic costs of living and that sort of thing,
10 the adjusters.
11 Now another view of this same data is shown on the
12 next slide, where light is less, dark is more. Hawaii is not on
13 here, but it was light. You can see that curiously, the dark
14 states all seem to be down around the Gulf of Mexico and
15 stretching up through Appalachia. One could conclude, I guess,
16 various things from here. One is that our risk adjuster doesn't
17 account for some demographic things that are also affecting
18 service use. Maybe some places have lower health care quality
19 and therefore have more use because they don't get well the
20 first time they go in. Or maybe service use is a good thing. I

1 don't know.

2 But this raises many questions. But the point is that
3 it's a very different picture from the first one we started
4 with, which got people very excited about inequity in the
5 system.

6 So depending on how you look at equity in the system,
7 you get very different answers.

8 So let us quickly move beyond this to the last slide
9 and talk about some possible next steps. This is kind of an
10 issue probably for the retreat, do we want to pursue this kind
11 of questioning and analysis? We can certainly refine the
12 current analysis. We can look at some of the distribution,
13 rather than just the average. Because an interesting question,
14 whether -- the average is about 20 percent of people go to the
15 hospital. They use a lot of spending.

16 Is it that in some states that number is 25 percent
17 and in some states it's 15 percent? Or is it that in some
18 states the entire distribution has moved up and everyone in that
19 state just uses more services than a similarly situated person
20 in another state. So we'd kind of like to do some of that

1 distributional analysis to understand what this looks like.

2 We also want to consider what geographic area is most
3 relevant. We've been looking at a state level variation. Some
4 people would say well, that's ridiculous even to look at because
5 it's too big an area and it's not very meaningful. But Congress
6 thinks it's very meaningful.

7 County is used on the M+C world and we don't
8 particularly like counties. I'm not sure anyone does, but
9 that's another possibility. Metropolitan statistical area is
10 another one. Hospital markets are a very interesting one and
11 Wennberg and the Dartmouth Atlas people have defined several of
12 those. We used a definition of those in our last June report.

13 The curious thing about that is the Wennberg analysis
14 shows that you get really high use where there are a lot of
15 specialists. But if you look at the state level, I mean it's
16 not obvious to me there are a lot more specialists in Louisiana
17 than New York, but I don't know.

18 Anyway, what level we look at is interesting and it
19 might just depend on what question we're trying to answer. And
20 we might want to look at all of these areas and all of these

1 levels and compare. But the question is do we want to pursue
2 this line of analysis? And we can bring it up at the retreat.
3 DR. ROSS: I just want to reiterate what David started
4 out with, the motivation for bringing this to you, is that first
5 measure that we've called a peculiar measure has been generating
6 a lot of -- I don't know if it's heat or light or something up
7 on the Hill. And since it's sort of fundamentally an odd thing
8 to look at, we thought at a minimum we wanted to get some
9 information to you to look at this a little bit differently.
10 But honestly, it's not clear where you go next on this and
11 that's where we'd like whatever feedback you can offer.
12 MR. HACKBARTH: The graph, a measure of service use
13 per beneficiary, that's the analysis that we did for the rural
14 report basically?
15 MR. GLASS: Right, that's the June report added up by
16 state instead of county.
17 MR. HACKBARTH: So there are two distinct questions
18 here. One is is my state or my Congressional district getting
19 its fair share of the dollars? A second question, and the one
20 we were trying to address in the rural report, is are people

1 getting access to care?

2 This one, a measure of service use, is not about

3 dollars but about service use. So to the extent that people are

4 concerned about the wage index adjustments and the teaching

5 payments, et cetera, that doesn't show up here but rather on the

6 preceding graph that has the dollars allocated appropriately to

7 jurisdictions. So there really are two distinct questions.

8 MR. GLASS: That's correct.

9 DR. WAKEFIELD: I just wanted to affirm that.

10 Actually, I was asking Alan before the very same question,

11 Glenn. What's reflected in the service use graphs, separate

12 from the actual costs or the price of providing services in

13 those different states. So what does the payment side of this

14 look like? Because I think if you just show them service use,

15 that's a part of the answer to the question but it's only a part

16 of it, it seems to me.

17 MR. HACKBARTH: The payments are totally captured in

18 the preceding graph that has the dollars per beneficiary

19 properly allocated to the states.

20 MR. GLASS: Right, and we presented both because it's

1 a question of what do you look upon as equity.

2 DR. REISCHAUER: I would say that we've gone about as
3 far as we should go into this area because this is a slippery
4 slope that gets you quickly into some real political
5 difficulties, where we really can't shed a lot of light on the
6 underlying relationships and where there will be superficial
7 claims of inequity.

8 We don't have the relative age distribution or the
9 health status adjustment here, do we?

10 DR. WAKEFIELD: Yes, you do.

11 MR. GLASS: The service use actually does that.

12 DR. REISCHAUER: But my guess is that's a tough one to
13 do. There's the issue of taste for medical care and there is a
14 distinction between the Norwegian bachelor farmer in Minnesota
15 and the hypochondriacs in New York. Carol's gone? Good.

16 MS. RAPHAEL: I heard that.

17 DR. REISCHAUER: It's like a bad opera, from the wings
18 a voice comes.

19 [Laughter.]

20 MR. GLASS: Though interestingly enough, if you look

1 at service use, New York is actually less than Minnesota.

2 DR. REISCHAUER: Upstate. They don't have access.

3 But then let's say there is a perceived inequity on one side of

4 the balance sheet here, which I'm not sure we could ever show or

5 would want to show. There's a whole other side to this

6 equation, which is who's footing the bill, which another group

7 will come up with.

8 I just think this is interesting. We've enlightened

9 or cleared away some misunderstanding. Stop.

10 DR. NELSON: Bob, do you recommend that as far as

11 we've gone that we share in a report?

12 DR. REISCHAUER: We've already shared it, in one

13 sense.

14 DR. ROSS: It's being shared.

15 MR. FEEZOR: My one suggestion, if you're going to use

16 the map, we probably ought to include all 50 states.

17 DR. REISCHAUER: Judging from this, Hawaii is probably

18 under the water.

19 MR. HACKBARTH: Can I just ask one question? We have

20 the letter from Senator Harkin. How are we responding to the

1 specific requests here? I think we've answered them all.

2 DR. ROSS: We'll respond to that at the staff level,
3 but that's a follow-up to a request in an appropriations bill a
4 year ago for information on this, which we've mostly been
5 handling at a staff level because this is just technical
6 information. There's no policy recommendations that drop out of
7 it immediately.

8 MS. ROSENBLATT: I probably agree with Bob but I want
9 to offer a contrarian view anyway, because looking at the risk
10 adjusted graph and seeing the numbers, my intellectual curiosity
11 is still aroused as to why are we getting those differences. If
12 we wanted to go down that path, what I would want to do is I
13 would want to look at it by hospital area. What did you call
14 it, hospital market area.

15 And I would want to look at it totally desegregated.
16 I'd want to look at what's inpatient use versus cost. So I
17 think the actuary in me is seeing all these things and saying
18 this is pretty interesting, but I don't know that it would lead
19 to any conclusions that would be beneficial. So that's where I
20 agree with Bob.

1 MR. SMITH: I think we should restrain our
2 intellectual curiosity. I had some of the same reactions, but I
3 think Bob's call for --
4 MR. HACKBARTH: And there are other institutions that
5 can do the intellectual analysis. We don't need to put
6 ourselves in the middle of that.
7 I think we've covered this topic for now.
8 Interesting. So we're now to the public comment period. Any
9 public comments?
10 MR. KALMAN: My name is Ed Kalman. I'm counsel to the
11 National Association of Long-term Hospitals. We have the same
12 concerns that were addressed by Dr. Kaplan to you earlier.
13 There was one matter which I briefly would like to
14 discuss a little bit more, and that's the matter of crossover
15 cases, and how they're affected by the proposed payment system.
16 CMS has clarified to us recently, about 15 minutes ago
17 at this meeting, that in their policies they count crossover
18 cases as discharges, even though they do not leave the
19 hospitals. 9.6 percent of all discharges in long-term hospitals
20 in the year 2000 were crossover cases. 25.5 percent of all

1 days, that's combined Part A days and crossover days, 25 of them
2 were crossover cases.
3 Of the 39 hospitals that are disqualified from
4 certification by the proposed changed definition, that is using
5 Medicare only days, 39 of them are disqualified because the
6 crossover cases are counted as discharges, even though they do
7 not leave the hospital.
8 The incentive of that policy is do not admit crossover
9 cases.
10 The very short stay policy has an overall cost-to-
11 payment ratio of 58 percent. For crossover cases, it is 27
12 percent. For crossover cases who die, it is 22 percent. That
13 is another incentive not to admit crossover cases.
14 There is no disproportionate share in the proposed
15 rule so there is no ability under the payment system to show the
16 financial requirements related to these cases. And since
17 payment for the financial requirements for the medically
18 indigent is not in Medicare cost reports, there's nothing in the
19 system.
20 I would say worse than all I have said is there is a

1 federal statute that allows states to pay Medicaid providers
2 Medicare rates. I'm fearful that states will look to the very
3 low payment of very short stay policy to pay these providers for
4 crossover cases. Because Medicaid cases in long-term hospitals
5 are usually all crossover cases.
6 Finally, Medigap policy is, under a PPS system, is
7 that Medigap insurers pay what and when Medicare would pay if
8 they were going to make another payment, usually an outlier
9 payment. In this case where I think 48 percent of the cases are
10 paid on the per diem and the per diem is deep discounted for
11 crossover cases, I am fearful that Medigap will pay much less
12 than cost. Which means that the payment system as a whole,
13 Medicare and Medicaid and Medigap, will not be budget neutral.
14 I think that these are serious considerations and I
15 certainly hope that the Commission will consider them in making
16 comments to CMS.
17 Finally, with regard to the wage index, I would
18 request that some consideration be given to a rural adjustment
19 if there's going to be a wage adjustment. In rehab PPS there's
20 a rule adjustment of 19 percent. There were very long-term

1 hospitals in rural areas. They perform a unique function.
2 There is at least one or two cases I know where there are rehab
3 units in competitive hospitals in those areas, when the absence
4 of a rule adjustment the long-term hospitals will be in a
5 disadvantaged position, in terms of competing for labor.
6 Thank you very much.
7 MR. HACKBARTH: Okay, thank you very much. We're
8 adjourned.
9 [Whereupon, at 11:29 a.m., the meeting was adjourned.]
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