MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
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COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

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AGENDA PAGE

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P R O C E E D I N G S

MR. HACKBARTH: Good morning, everybody. Welcome to our guests. Beside me is MedPAC's new executive director, Mark Miller, who is joining us for the first time today.

This morning's session, we have three presentations that are basically informational for the Commission, the first of which pertains to Medicare spending compared to spending trends in the private sector; then, second, we will get an update on recent developments in Medicare+Choice; and then, finally, right before lunch, we will have a discussion of county-level variation in Medicare per capita spending.

Before lunch, as always, we will have a brief public comment period, and with that, I will turn it over to Anne.

MS. MUTTI: This topic today is a second installment in a series of presentations that are intended to give you a broader sense of Medicare spending patterns. Last month, as you might recall, we talked about fee-for-service spending, both historical and projections, and how that spending was divided by service sector.

Today, we will be talking about comparing Medicare spending trends, compared to other health spending indicators, and we hope this information will be useful in thinking through the appropriateness of spending trends, the adequacy of Medicare's payment and coverage policies, and Medicare's effectiveness at controlling costs.

In today's presentation, it will be sort of a three-parter. We will start with how Medicare compares to other payers in dollars spent, both how much and on what, and then we'll talk about growth rates, how Medicare and other payers compare in their growth rates. And, lastly, we will look at the different factors driving those growth rates, but first a few words to caution us in this endeavor.

With respect to the Medicare projections, first, throughout this presentation, we will be using the Medicare trustees' intermediate assumptions as the basis for the data that we present before you. You must bear in mind that these projections assume current law. So that even though certain provisions are set to expire that will lower spending, we assume that that lower spending will be achieved, even if that is maybe unlikely, given Congress's inclination to change it.

Then, it also points to the greater issue of the uncertainty around these projections. The trustees do high, medium and low estimates. Here, we are using their intermediate, their medium estimates, but there is certainly some variation or a difference of opinion as to what really will happen.

On the next point, we also point out that the projection data that we are using, especially when we are looking at national health expenditure data, ends at 2011. This is just prior to the retirement of the baby boom generation. So just bear in mind that probably beyond that point or, definitely, we are going to see spending increase.

When looking at some of the private sector numbers that we are going to show you, we just also want to alert you to the fact that premium growth may be somewhat sort of depressed or suppressed because we are seeing a trend of insurers moving more of the total cost of their benefit package to beneficiaries, in terms of cost sharing. So their premiums may not be increasing as much as really the total cost of the benefits are increasing.

Lastly, we just want to point out the somewhat obvious point that Medicare beneficiaries are older and

sicker than other insured populations, and this will certainly affect the level of spending and also may affect growth rates a little bit.

So, first, we wanted to refresh you on the size of Medicare and how it compares with other payers of health care services. In 2000, Medicare comprised 19 percent of all personal health care spending. Personal health care spending refers to the spending directly on services. It excludes research, construction, public health spending, administrative costs, things like that.

Medicare spent about $224 billion or about $5,600 per beneficiary in 2000. When you are looking at this chart, it might help you to bear in mind that out of pocket includes co-insurance, deductibles, co-pays. It does not include premiums. The premiums are implicit in the private health insurance section of the pie, as well as the Medicare section of the pie. Overall, 43 percent of personal health care spending was from public sources, while 57 percent was from private funds.

On the next chart, you can see this is our attempt to compare Medicare spending and how it is spent over service sectors compared to that of other payers. We have

highlighted the Medicare and Medicaid and then lumped everybody else together, just so you can really focus on the Medicare numbers.

As we just mentioned, Medicare comprises 19 percent of personal health care spending overall, but when you look here at the hospital line, it paid for about 30 percent of all hospital services. Its spending was about 28 percent of all spending for home health services and about 25 percent for DME.

In contrast, Medicare paid for about 2 percent of Medicare spending, comprised about 2 percent of prescription drug spending, virtually no portion of dental spending and a very small or relatively small portion of nursing home care.

MS. MARSHALL: We had a data correction on the actual chart. So the figures that she just cited are correct, and the chart that is displayed is correct. The one that was handed out to you previously, like that has 20-percent for hospital, is not. So we apologize for that. It was corrected late yesterday.

MS. MUTTI: So next we turn to sort of the second part of this, which is examining growth rates and making a comparison.

First, we are looking here at personal health care spending as a percent of GDP, and then on the next chart we compare that with Medicare as a percent of GDP. We are doing it on two different charts because the scale is so different, and we have different windows of projections here for you.

We chose to make this comparison, in terms of percent of GDP, to give you a sense of how fast health care is growing in relation to the economy.

As you can see here, after a relatively stable period through much of the 1990s, personal health care spending is projected to increase from about 11 percent to over 14 percent of GDP by 2010.

On the next chart, we see much of the same upward trend line with Medicare as a percent of GDP. You can see sort of the spike and dip that's concurrent to the enactment, just prior to enactment of BBA and afterward, the decline there. This chart also shows that after 2011, the effect of the baby boomer generation increases spending in relation to GDP, so that by 2030 Medicare is expected to be about 4.5 percent of GDP, nearly double what it is now.

Next, we compare per capita growth of Medicare

spending to per capita growth of private insurance spending.

As you can see, while there are different divergences, growth in the two have been roughly comparable since 1980. Looking at current growth estimates, we see that private insurance is expected to outpace Medicare in the short run, and even employee benefits consulting firms have suggested that there will be even higher premium increases. They show in the range of 12 to 16 percent in this year and next year, so these estimates may even be on the low side.

By about 2005, private insurance -- this is just a projection -- is predicted to grow just slightly faster than Medicare. The divergences between the growth rates are attributable to a health insurance underwriting cycle and other trends in the private market that occur at different times than the major legislative changes that are affecting Medicare.

So you can see, for example, Medicare spending growth rates were high prior to the BBA and then dramatically dipped, so much so that we even saw a decrease in 1998. And in contrast, during this same period, private insurance annual spending growth rates were relatively

steady around the 5-percent mark.

As I mentioned earlier, you might want to bear in mind that many private insurers are increasing their cost-sharing requirements so that their premium growth may not be, in a way, is somewhat depressed. We also want you to bear in mind that Medicare spending reflects current law, as we mentioned before.

DR. ROWE: Could you explain that? Why is it that if cost sharing is increased -- which I think, actually, it's not the private insurers that are increasing cost sharing so much as the employers, so I see that differently than you -- then why would that reduce the private insurers' premiums?

MS. MUTTI: Because it's my understanding you would not need to increase your premiums at such a fast rate if you were able to sort of deflect some of your increased total costs by raising cost sharing. So you would have to build it into your premium.

MS. ROSENBLATT: Jack, suppose you get a 15-percent increase on a plan, a PPO plan with a $500 deductible, and the employer changes the deductible from $500 to $1,000, the 15-percent increase might then become 12

percent.

DR. ROWE: I understand completely. I just think it matters whether, by increasing cost sharing, you mean the same premium, but the employee is paying a greater proportion of it or whether you mean --

MS. MUTTI: No, cost sharing, I meant in terms of deductibles, and cost --

DR. ROWE: -- benefit, high-end changes, and that was what I was referring to.

MS. MUTTI: Thank you for the clarification.

On the next chart, we have compared Medicare per capita growth to that of other large public purchasers, CalPERS, FEHBP and Medicaid, for the last 5, 10 and 15 years. At this point, I'd like to just caution you that I think these are somewhat preliminary. We are going to come back and revisit just to make sure that we are really comparing them as accurately as we can. So these are somewhat preliminary numbers.

As you can see, the last five years of Medicare spending is so low, due to the BBA, that Medicare is considerably lower than CalPERS and FEHBP. However, when you look over the 10-year window, Medicare's growth is much

more in line with CalPERS and FEHBP. The 15-year window catches some of the high private-sector growth of the late '80s/early '90s, making their growth rates higher over that time period.

Medicaid is also here on the slide, and we just would note that their growth rates tend to be influenced by factors that are sometimes unique to Medicaid in terms of the disproportionate-share payment policies and the upper-payment limit policies. So it may reduce somewhat the usefulness of that comparison, but we still provide it here for you.

MS. DePARLE: Anne, are prescription drugs in FEHBP, and CalPERS and Medicaid?

MS. MUTTI: Yes.

MS. DePARLE: So do you have any idea what it would look like if you backed that out of it?

MS. MUTTI: Sometimes I think I have heard people say that a certain percentage is associated with that, but I don't have that. I can find that out for you.

DR. REISCHAUER: Marilyn Moon tried to do this in one of her papers and make some impact, but not an immense.

MS. MUTTI: Then here's the third part. We're

examining the factors here that are driving growth and spending, on personal health care spending. We start at the bottom of this chart. You see the population growth is one factor, and it's remaining relatively steady.

Next up is economy-wide inflation, which was a big driver in the 1980s and then has settled into the 2- to 4-percent range more recently.

Medical inflation, which is inflation above general inflation, fluctuates some and is a relatively small factor in the mid-'90s. As you can see, at times, volume and intensity rivals inflation as the prime driver of growth, and this was particularly the case in the late 1980s, before managed care expanded and curtailed some of that growth. We are working on actually getting a companion chart to this which would just give the factors for Medicare, but we don't have that at this point.

The next slide compares growth by service sector between Medicare and private health insurance between 1995 and 2000. As you can see, Medicare growth during this time is really largely due to growth in hospital and physician spending, in contrast, and as Nancy-Ann pointed out, we see the role of prescription drugs driving the increase on the

private side, as well as hospital and physician spending.

Just a note on the Medicare side, the negative portion in the Medicare bar reflects a decrease in home health spending over that period and explains why the bar tops out of over 100 percent there.

A similar analysis of the contributing factors to private insurance growth was recently published by Strunk and Ginsberg. They found a higher percentage of change due to hospital spending increases. I'm not exactly sure. We used national health expenditure data, had a few methodological differences, but I'm not exactly sure what explains why we came up with such differences on that. They used a different data set than we did, though.

So we look forward to your feedback on the substance of this presentation. Certainly, in the next few months, we are going to be working at making sure that we've got all of our numbers right, bringing in some other sources, so that we are not relying exclusively on national health expenditure data to give you a sense of what the projections look like, and so we just look forward to your feedback.

I just also want to give you an idea of where we

are going to go next on this. This is sort of a series of information that gives you the broader sense of Medicare spending. Next, we hope to talk to you about how Medicare spending fits in with the overall budget, and deficit, and surplus projections, and then also look at how Medicare spending trends affect beneficiary cost sharing and what the trends are in that too.

DR. REISCHAUER: I thought there was a lot of interesting stuff in here, but I wasn't exactly sure what question we're trying to answer. Not knowing that, I felt there was some confusion here, and let me give you just a couple reactions I had.

Throughout the paper there is a lot of discussion or reference to the 1997 through '99 period and the slowdown in Medicare spending that attributes everything to the Balanced Budget Act, when in fact there was a lot else going on, not the least of which was the crackdown on inappropriate payments by the Justice Department, the IG and others. So I would dampen that down.

With respect to the discussion about spending as a percent of GDP, I think you want to point out that at least or a very large component of that was because the economy

grew like gangbusters, as opposed to the reduction in the growth rate of spending. I mean, both things were going on, but the denominator was going berserk in that period. So let's not treat it sort of is this is a story about health care as much as it is about health care and the economy.

There is a certain amount of contamination that is going on here. If the question is sort of how is this insurance program for the elderly/disabled doing versus the insurance program that covers other kinds of Americans, and that is because Medicaid is, a significant fraction of that spending is for Medicare-eligible people -- I mean, over half. The private numbers, I think, include supplemental policies for Medicare-eligible people and employer-sponsored wraparounds, which are a component. If we are trying to look at these as separate, there maybe is some way we can ferret them out.

The final point or concern that I have has to do with us going along blindly with this notion that medical inflation is somehow over and above economy-wide inflation. And, Joe, in his paper, has a really nice three pages basically explaining why you shouldn't believe that at all. It's mismeasurement more than anything else. And I wouldn't

want us to be contributing to the "common belief" that we know for a fact that the health care inflation is above economy-wide inflation because I suspect appropriately adjusting it for quality and reweighting it, in fact, the opposite is the case.

MS. ROSENBLATT: I too found this to be excellent. I'm not sure where it's going but I think we might know as we get additional analyses.

I do have a couple of comments on dives that I would like to take, if the data is available.

The most interesting chart to me, and I don't have page numbers on this, but it's the one per capita spending growth in Medicare and private insurance, going from 1980 through 2010, where you have got it Medicare versus private health insurance. Yes, that is the one.

A couple of comments on that. I would love to see this broken down by service category. So, if you could do that, and my guess is you can't, but if you could look at hospital growth in the private commercial sector versus hospital growth in the Medicare sector, and physicians, et cetera. Again, I don't know if there is a way to do that.

The other thing is I've got a comment similar to

what Bob just said, that if we could dive down into separate the commercial premium out from the commercial population under 65 versus Med supp, and if we can't do that for the retirees connected with employers, if we could at least do that for the retirees that buy it as individuals. And then if we could separate the M+C out of the Medicare, that might all might be interesting as well.

The paper did a good job of describing some of the influences on the premiums, like the cost shifting that we were talking about with Jack before. One of the things that is also influencing, particularly over this long time frame, is shifting between types of plans, like from HMO into PPO or indemnity into HMO. So I think you might want to mention that shift as well.

We talked earlier today about the concern of projections. I am concerned about using the intermediate growth assumptions from the trustees' report, and I'm very concerned about using those projections out to 2030.

I think that is it. Thank you.

DR. NEWHOUSE: I'm assuming this is a stage-setting and descriptive chapter, and so the comments on it

are not the most important comments we'll have over the course of the session, but let me throw in some anyway.

There's a few of my pet peeves have arisen here. One is trying to project spending, especially many years out. I don't think we have been very good at that, historically. The trustees have to do it by statute, we don't, and my preference would be just that we don't present somebody else's projections or, if we do, we present several other people's projections. I think it has a large element of crystal ball gazing in it.

Second, on the slide that is up there and elsewhere in the chapter, I don't think it makes sense to compare spending across time in nominal dollars. If you, for example, look at those, the peak of this curve in 1980 there, on the far left, that is an era of very high general inflation rates, and I think that should be taken out if we're going to try to compare 1980 with 1990 or any other year. In other words, the fluctuation in general inflation may be obscuring some things that one would want to see.

Third, I have never liked the CMS classification that's on the Slide 2 charts, hence about volume service use, medical inflation economy-wide and population, for a

couple of reasons, one of which Bob said. I don't think we measure medical inflation at all well, especially historically. But another reason is that this seems to underplay, in its language, really, it's really a semantic issue, the role of new products, technological change, old procedures in new populations, which the text lays some emphasis on, but this discussion makes it sound as though it's population grew, providers raised their prices, and they just gave more services to the same folk or the same old services to those folk.

I think I would just not use this. I don't see any reason why we need to use that. I think you can have a discussion of how new products and kind of existing procedures in new populations, especially the very old, have tended to raise spending. That, by the way, also obviously complicates the measure of medical inflation because inflation really has to be defined for a specific product. The price of that product over time. If the product is changing, then there is a major conceptual problem trying to say what inflation is.

Finally, the discussion that compared the private side with Medicare, I didn't see why we were comparing

private premiums with Medicare spending. I thought we should be comparing private spending with Medicare spending or Medicare and Medicaid spending. The CMS numbers have private spending, and I don't know why we just didn't use those instead of premiums.

MS. MUTTI: We went back and forth on that and we can easily add that.

MS. ROSENBLATT: Joe, when you're saying spending, are you saying take the sum of the premium -- the amount spent on claims in the premium with the amount that the employee spends for co-pays?

DR. NEWHOUSE: Yes, I'm talking about basically spending per capita on the privately insured or the non-public, if we want to include the uninsured.

DR. ROWE: Are you including the SG&A expenses or are you just including the claims payments?

DR. NEWHOUSE: It's not going to make a great deal of difference, but you can throw in the SG&A on the privately -- it's not going to make a great deal of difference the total spent per person, but you can throw that in if you --

DR. ROWE: No, I just wanted to know what --

DR. NEWHOUSE: I thought about that. Yes, in principle, that should be included.

MS. ROSENBLATT: I'm not familiar with the various data sources that the staff would use, but the employee is only picking up 20 percent. So, when you say per capita spending, is it --

DR. NEWHOUSE: Well, there's also non-covered items. If you look in the national health accounts, there's a total for public sources, and there is a total for private sources that is broken down between out-of-pocket payments and third-party payments. Indeed, it's implicit in that pie that's up there for everybody. There is a similar breakdown for private -- and that's what I had in mind comparing. It seems to me that's a much more apples-to-apples number than private premiums against total public spending.

MS. ROSENBLATT: Okay, that's similar. That other chart, when I said I wanted to see it split out by hospital versus physician, I guess I'm asking for the same thing.

MR. FEEZOR: Being a subject of some of the scrutiny here in a couple of comments, first off, I think Anne and her colleagues did a good job in trying to put together otherwise rather disparate comparisons.

A couple of words of caution. One, I don't know too many people that would consider CalPERS or the FEHBP program to be typical of private payers. So we should not refer to it as private, but rather other public employment-based coverages.

I think it is critical that we probably give a little bit more analysis to the types of coverages that are employed, and particularly what that may do in terms of the burden to the individual. As an example, we have 80 percent/78 percent of our folks in insured HMOs, and that is to say we use a flat co-pay and have had the same flat co-pay for 10 years, until last year. Whereas, other forms may, in fact, be co-insurance, which may rise more traditionally with the rise in cost.

Also, I think when we start talking about employers shifting costs to employees, this can be borne out, but my sense is that that really has only become a significant factor probably in the last two to three years, from about 2001 on; that, in fact, in most areas I think a relatively tight labor market and relatively modest increase in insurance premiums have caused most employers to maintain their coverages, at least until through about 2000 would be

my guess.

We may want to see if there is some way of indicating if that has increased. I think it is increasing now certainly in terms of the products being sold.

DR. ROWE: Allen, let me comment on that, if I can. I think, actually, if you look at the period of time that is covered by that slide that began 1980, during that period of time the overwhelming trend, particularly in the early part, is for the employee to pay less.

MR. FEEZOR: Yes, in fact ours dropped rather noticeably, and that is what --

DR. NEWHOUSE: Actually, it's been constant in that period. Hospital costs actually goes up in that period; physician comes down and drug.

DR. ROWE: I thought that in terms of, well --

MR. FEEZOR: In terms of burden of total expenditures borne by the individual versus their plan, at least our experience has been there ha been a significant shift away from the individual and to the plan, and then it depends upon your employer/employee contributions towards premium, in terms of what the total impact of that is.

DR. ROWE: I agree.

MS. ROSENBLATT: I'm sorry, could I interrupt? This discussion would say that another good historical chart would be to show that percent of cost sharing, which I think we may have looked at in the past, for Medicare versus the commercial population.

MS. MUTTI: Absolutely, and that was sort of our inclination, when we were first looking at it, at least, and I will go back and probe this a little further, but the way the NHE reported it, it was all out of pocket, it was lumped together, and I couldn't separate Medicare from other private, which thwarted us on that, but I will keep looking.

MR. FEEZOR: Then the final thing. I think the paper tries to touch on it, and I don't know, it would be an interesting question, whether the change in the benefit package itself, whether the Medicare benefit package is likely to change and enrich faster than say that of insured coverages. Again, because we use, at least up until this year, use 80 percent of basically traditional HMO products, which are subject to state regulation, that the issue of mandated benefits has been considerable on that.

And so I can say we had a 3 or 4 percent bump about three years ago, two years ago, for instance for

nervous and mental parity and other issues. So I think we probably need to at least try to give some account to that.

And then I guess the final issue, and I'd have to go back to some folks, maybe Alice can help me or Jack. Are the plans within the FEHBP program able to modify their own benefits from time to time each year? I was thinking that's the way it used to be.

DR. REISCHAUER: They get approval from the negotiations with OPM.

MR. FEEZOR: Having said that, and we've got a couple of other things, we do have about 30,000 people that are outside of California.

The paper does bring up that particularly when you're looking at CalPERS figures, the geographic concentration of our enrollees in California, which may be a little bit of a different market, is important to keep in mind, as well.

MR. MULLER: If I can go back to the 30-year slide again on Medicare and private, and I think this just makes the point that Joe was making earlier about the difficulty of projections. Because if you look at the first decade, you have quite a few spikes up and down but basically in the

cycle, in the '80s. Then in the '90s, you have countercyclical, and we've commented on that in the past, with private and Medicare moving in different directions.

And now our projection basically shows no spikes and moving together, which not what happened in either one of those decades.

I understand why people regress towards the mean, but it may be useful if we're going to get in the project game based on the conversations we've had, is to also show this with spikes both cycling together and spikes cycling countercylically. Because obviously, if one thinks, as a matter of policy, that the trend of the last 10 years of the private and public sector moving to balance each other somewhat is going to occur again, then one has much different budgetary implications than if one thinks you're going to go together.

The likelihood of them going together, I understand why one does that for projection, but it's probably the least likely one to come out. The fact that we're going back to the '80s -- and I know you're reflecting someone else's estimates here -- but I would like to at least, in the spirit of showing a range of estimates, to

show both the countercyclical estimates and the ones with the spikes.

Thank you.

MS. ROSENBLATT: If I could just tack on to what Ralph just said. I think that first dip for the private health insurance is 2003, if I'm looking at the graph right. And I don't believe that for a minute.

MR. DURENBERGER: This question, Mr. Chairman, is out of ignorance but it goes back to, I think, a question that Bob Reischauer raised and it's all excellent data, but it's to what end? And if I go back to the issue involved here, the reason we're doing this it says is to help policymakers assess the factors driving Medicare spending trends. And that's a little bit where I'm not focused.

I'm trying to figure out what information about the cost drivers or the trend drivers comes out of this and what is coming out of other things that we're doing. This is just a context for other things that we're doing. It seems to me the most important part is what are the cost drivers, either historically or currently or projected or something like that? And how do you express those against the dollars that you see here?

And I'm not quite getting, out of this information -- the medical inflation one is a good example, but I'm sure there are breakdowns within that context that I don't see here. I just have difficulty putting this in appropriate context.

MS. RAPHAEL: I guess in line with that, trying to understand what we can glean from all of this, besides the difficulty of making projects, from what we see here the ability to sort of suppress costs in the Medicare program have been attributable to legislative action and investigations of provider behavior. Those are the two things that led to cost drops.

From what I can see in the private health insurance market, the main cost drops have been due to shifts of costs to employees.

MS. MUTTI: And also managed care.

MS. RAPHAEL: And discounted payments, right. I mean, I'm trying to sort of figure out what we can draw from all of this. Are there any other preliminary conclusions that you can draw at this point, when you put this all together?

MS. MUTTI: We were trying to avoid actually

coming to conclusions. This was supposed to be everybody put this in your head so when you're making your recommendations you just bear in mind. I think it's for others to put a finer point on this, but from my perspective I think it's helpful to know how fast, just in general, Medicare is growing and how fast it's going to grow and comparing that to the private sector, just as a check to see how are we doing? Are we in line with other people? There are certainly differences accounting for different growth rates.

But it just seems to be a useful check, if we saw really dramatically different trends. And this might come out more in some sector-specific analysis that we did, rather than this aggregate number. But if you saw that Medicare was going up really high for one sector over another, compared to private insurance, that might tell you something.

At this point, we're not trying to tell you what to glean from it. We're trying to collect that data. You could use this, it could inform you on a lot of different levels. It just seems like a good thing to have in the back of your head.

But as I say, I think we'll probably put a finer point on --

MS. RAPHAEL: I don't know if I understood this. It seems that hospital and physician costs are a greater factor in Medicare growth than in the private insurance market.

DR. ROWE: Because there's no pharmaceuticals.

MS. RAPHAEL: Do you think that that can be the conclusion we draw?

MS. MUTTI: Right, there's no drugs. I did do the quick math on them. They represent a faster portion of the growth than they represent in spending.

DR. ROWE: It's 13 percent of spending but it's 44 percent of the growth.

MR. MULLER: So the indication is that if you have drugs you have more ups and downs?

MR. HACKBARTH: We need to keep moving ahead here. I think Dave has asked a very important question, and I have a reaction to that. But Alan, why don't you go first?

DR. NELSON: I was going to try to answer Dave's question. As I remember, we asked for this. As I remember, we were talking about projected Medicare spending and we

decided that we couldn't deal with that in a coherent fashion without some understanding of both the previous trends and what was expected in the private sector. So we asked that to put together some material that would allow us to make some comparisons.

Joe, you said something that interests me, and I wonder if there's any further clarification on it, that previous projections hadn't proven to be terribly accurate. Can you give me some brackets around how inaccurate they were? I mean, what's the confidence level on these projections based on earlier experience?

In 1980, you looked at the projections that were made in 1980 for spending in 1990, or '85 and '95. What was the experience?

DR. NEWHOUSE: I can't give you numbers but I was thinking of something that Louise Russell did several years ago where she did go back and look at the trustees' projections and then map them against what happened. And my recollection is the actuaries didn't look too good. And for sure people missed the '97 to '99 drop or plateau. I mean, nobody was predicting that. I mean, thank of all the rhetoric about the BBA "overshot."

I mean, one can argue with that assertion, but at bottom it was that people weren't expecting what happened.

DR. REISCHAUER: With all of these projections you can't go back and blame the projectors because policy changes --

[Laughter.]

DR. REISCHAUER: I'm innocent.

DR. NELSON: It's not a matter of blame, Bob, it's a matter of reality. I mean, you just made my point. It's not a matter of blaming them for lousy projections. It's that it's impossible to anticipate all the variables that are going to come in the future. And that gets back to Joe's point, don't get into that business.

DR. REISCHAUER: But both things are going on.

MR. HACKBARTH: We need to move on in just a minute, but to me the most interesting thing about data like these is trying to answer the question what, over the long term, drives the increase in health care costs in general and for Medicare in particular? What are the forces that policymakers need to wrestle with?

It's not the individual, year to year variation, or certainly not the long-term projection. But what are the

underlying forces? And Joe's made a couple of interesting observations in that regard about what we label volume and intensity and medical inflation.

I think sometimes, maybe hopefully, we say well, it's driven by factors like ease. And we can get a grip on medical inflation and unwarranted volume and intensity. But in fact, I think a big part of that is the unrelenting increase in technology and new ways to do things for more people. And that means getting a grip on this poses very difficult choices about what, as a society, we're willing to pay for.

I would like to try to draw some of those fundamental questions out of the data, as opposed to just report lots of data.

MR. MULLER: I think one could also argue, looking at this slide, that both private parties and government took steps in the last 10 or 12 years to change the reality that the projections indicated. So you could, in a sense, interpret the '80s as kind of saying expenditures are flowing due to those kind of underlying charts, medical inflation, population, et cetera, and so forth. But the '90s was an effort, you could in part argue, whether it was

the BBA efforts or the fraud efforts or the managed care efforts, to make some change in the projections.

So in a sense, as one makes projections, one can therefore also assume that somewhere between government and private -- and they're not just two entities -- that some change will occur.

My concern is just that middle line, the kind of driving down the middle of the road, it's just not going to happen. That's why I'm a little concerned about putting that kind of forecast out there. But I would assume with numbers this big that interested parties will take policy actions to change what the projections would otherwise imply.

MR. DURENBERGER: Can I just add to what you said? My only concern is to educate policymakers and I don't think these numbers do. Probably a lot of the rest of our work will, or getting behind the consistent cost driver, getting past aging and technology misused and defensive medicine and the consumers not paying with their own money, getting to some of the real factors in addition to that that drive costs consistently, like all the transaction costs in health care generally, the way we practice, and those kinds of

things.

That's what I see, I guess, as the desperate need by policymakers, because they're plain old citizens like us, that's the part they need to understand. This sort of thing, in some context, is part of their job. But what causes these things consistently to happen? And why is it that when you do '97 to '99 it's going to be followed by a '99 to 2002? And it will continue to happen because that is the behavior that we've seen consistently in the current health system.

So when we get to other things that are on this agenda, I think we're probably getting at some of those kinds of issues. I hope I'm not way off the wall, but I'm just really trying to get at what are these cost drivers that are not dealt with simply by increasing or decreasing the chase for fraud and abuse or the physician payment reimbursement or some of those kinds of issues.

MR. HACKBARTH: This was thought-provoking, Anne, and we'll have more on it later. Thank you very much, both Anns.

Next we have our update on Medicare+Choice. Proceed whenever you're ready, Scott.

DR. HARRISON: It just wouldn't be fall if I wasn't telling you about all the Medicare+Choice plans pulling out of the program, would it?

Currently, there are 155 Medicare+Choice coordinated care plans, or CCPs, and two private fee-for-service plans. For 2003, nine contracts are ending and another 24 are pulling out of some of the areas that they currently serve.

Because of these withdrawals, about 200,000 Medicare+Choice enrollees will not be able to stay in their current Medicare+Choice plans past the end of the year. Of those enrollees, about 36,000 live in counties where there is no other CCP available.

These numbers may be actually overstated for a couple of reasons. First, in the Kansas City area, one plan with 23,000 members is ending its contract because it's being bought by another M+C in the area. And second, about 50,000 of the enrollees losing their Medicare+Choice plans and about 11,000 of those with no other CCP available are accounted for by Kaiser members in the metropolitan Cleveland and Washington, D.C. areas.

In those areas, Kaiser is ending their

Medicare+Choice contract but is switching the members into cost contracts that they currently hold. Therefore, those members will be able to stay with Kaiser. Bear with me in a few minutes and I'll remind you exactly what cost contracts are.

DR. REISCHAUER: [Off microphone.] So what you're saying is the second column should be 2,000? The 36,000?

DR. HARRISON: The 200,000 should be more like 125,000. But of the ones that don't have anything else available, that probably should be more like 25,000.

DR. REISCHAUER: [Off microphone.]

DR. ROWE: [Off microphone.]

MS. BURKE: [Off microphone.]

DR. HARRISON: Yes, and the fact that there are --

DR. ROWE: [Off microphone]. There's the one in St. Louis that's being bought by another one [inaudible].

DR. HARRISON: Right, so the contract is technically ending but those members, because they're being bought by another existing area plan can actually --

MS. BURKE: [Off microphone] but they're not in [inaudible].

DR. HARRISON: No, they're not in the 36,000.

MR. HACKBARTH: Could I ask people to take care to use your mikes? It really makes things easier later on for people who need to work with the transcript.

DR. HARRISON: Let's put this level of withdrawals in historical perspective for a minute. In simple terms, the level of pullouts is the least severe in the Medicare+Choice program's history.

As a general characterization, withdrawals in 1999 and 2000 were mostly smaller plans, plans that didn't have large market share, and plans that were trimming back their service areas after rethinking recent expansion.

In 2001 and 2002, major national plans made large or even total withdrawals. For 2003 we seem to returning to a general pattern of some withdrawals by smaller plans and the trimming of service areas by larger plans.

The pullouts this year did not seem to be concentrated in any particular types of geographic areas, urban, rural or floor or non-floor. They were pretty well disbursed. There were some local areas that were hit hard. Delaware, Indiana and South Dakota all lost their only plans. However, none of those plans had as much as 3 percent market share in the areas they pulled out of.

Sterling, which is the only multi-state private fee-for-service plan, continued its pattern of pulling out of some urban areas. It pulled out of Columbus, Ohio; Nashville; and San Antonio. Nationally, Sterling's withdrawals will affect about 8 percent of its enrollees.

We can look at how the pullouts affect Medicare+Choice availability to beneficiaries. I should note here that while we generally learn about the pullouts all at once, plans can enter the program and expand their service area throughout the year. For example, Marshfield Clinic has recently begun offering a plan to a large portion of Wisconsin. And a plan in Puerto Rico has expanded to cover much of the island. There have also been a couple of other, smaller expansions.

But as a result of the pullouts and the entries that we know of as of now, Medicare+Choice plans will be available to about the same percentage of beneficiaries next year as this year. More specifically, in January 2002, about 61 percent of beneficiaries had an M+C CCP available to them, and the same will be true in January 2003. About 34 percent of beneficiaries will have a private fee-for-service plan available, down from 36 percent.

In 2003, 78 percent of beneficiaries will have at least one of the two M+C choices.

Beneficiaries in urban areas are still about four times more likely to have a CCP available than rural beneficiaries, although that gap has narrowed from 2003, primarily due to the entrance of a couple of large rural plans.

About 84 percent of urban beneficiaries will have some type of alternative available, while about 62 percent of rural beneficiaries will have an M+C plan available. The urban choices are most likely to be coordinated care plans while the rural choice is most likely to be private fee-for-service.

What we don't know yet is how premiums in the benefit packages will change. That information should be available, I believe it will come out in early November.

CMS has had concerns about the Medicare+Choice program. CMS believes that more plans are needed in the program in some geographic areas in order to foster competition that would lead to efficiencies and health care delivery that would lower the growth and expenditures over time.

In its current form, the Medicare+Choice program does not provide beneficiaries with the range of choices that they had when they were in the working population where PPOs, not HMOs, are now the dominant delivery model. PPOs are popular with both employers and employees. For the most part, PPOs have not entered the Medicare+Choice program, leaving HMOs as virtually the only choice for beneficiaries.

CMS found there were several barriers to PPO participation in the Medicare+Choice program. One, Medicare+Choice rates were too low in some areas. Two, the Medicare+Choice limit on cost sharing hinders benefit design in some areas. The actuarial value of all cost sharing, including premiums and copayments related to basic Medicare services, cannot exceed the national average cost sharing amount for the traditional fee-for-service Medicare program, which is about $102 per month in 2003.

This cap had been troubling for insurers in high payment areas and would be even more of a problem for PPOs which often include substantial out-of-network cost sharing.

Another barrier has been that PPOs have been wary of entering a fully capitated program. In the commercial world, PPOs usually share the risk on medical costs with the

employers that offer the PPOs to their employees. In many cases, the PPOs carry no medical risk and offer administrative services only contracts to self-insured employers.

So to encourage plan entry, CMS has initiated a demonstration program for PPOs. It will start in January and is scheduled to run for three years. CMS has approved demonstration waivers for 33 plans in 23 different states and they ill be available to 11 million Medicare beneficiaries. At this point, we don't know what the premiums and benefits will look like, however.

Why might a plan be attracted to offering a PPO product under the demonstration rather than under the regular Medicare+Choice program? In some areas, the demonstration will pay more than Medicare+Choice rates. The demonstration will pay the maximum of the current Medicare+Choice rates or 99 percent of the average per capita Medicare fee-for-service spending.

About a quarter of beneficiaries who will have one of these demo plans available to them will live in counties where the demonstration rate is higher than the Medicare+Choice rate.

The demonstration will waive the cost sharing limit that I mentioned a few minutes ago. Benefit consultants have stated that lifting the cap will allow plans to compete more effectively with Medigap for those beneficiaries who are willing to buy a higher priced product. This waiver may be particularly helpful in attracting PPOs to high cost areas where the cap is more likely to be constraining.

Perhaps the waiver has been an effective measure because most plans are going into relatively high cost area, including three in New York City alone.

The demonstration also allows for negotiated risk sharing between the plans and Medicare. Details of the risk sharing arrangements have not been released but apparently most of the demo plans are availing themselves of this option.

While the PPO demos may provide an additional option, they are not likely to expand choice to beneficiaries who don't already have choice. Of the more than 11 million beneficiaries who will have a PPO available, only about a half million do not already have a CCP available.

Although a couple of the PPO demos are targeted to rural areas, generally they're going into the rural areas. About 600,000 rural beneficiaries will have access to PPOs, but even those are already pretty well represented with CCPs. Only 150,000 don't already have a CCP available.

Generally, it appears that the PPOs are going into areas where there are already Medicare managed care options. It remains to be seen whether those who enroll in PPOs are coming from the coordinated care plans or from fee-for-service or Medigap options.

I'm going to skip and tell you about the cost contracts now. Some beneficiaries across the country have another alternative to the fee-for-service Medicare program available to them, and those are the cost HMOs.

Cost HMOs were the original HMOs in the Medicare program. They were designed to allow beneficiaries who had been in HMOs before they became eligible for Medicare to stay in those HMOs. Medicare pays cost HMOs their cost, as determined by a cost report, for providing basic Medicare benefits for their members, less the actuarial value of traditional Medicare cost sharing.

The beneficiaries generally cover this cost

sharing through their monthly premiums. In addition, members are free to seek Medicare covered services outside of the HMO's network. If a beneficiary goes to a non-network provider, Medicare pays the provider its share of the Medicare-covered charge and the beneficiary is responsible for the usual Medicare copays.

While cost plans have been an attractive benefit package for some beneficiaries, past studies have shown that this option costs the Medicare program significantly more than serving beneficiaries in the traditional fee-for-service program.

Currently, there are 30 cost plans in operation and they have a total of 290,000 members. We would expect that to go up with Kaiser's switch. Under current law, new cost plans cannot be formed and existing plans must cease operation at the end of 2004. So cost plans are scheduled to go away. There are proposals on the Hill to extend them.

DR. ROWE: Can I ask just quickly on that, how much more was it costing Medicare, what percent?

DR. HARRISON: The studies are old, and I'd be reluctant to give you a particular number, but it was definitely double digit.

So, when you combine the availability of Medicare+Choice plans, PPO demo plans and cost plans, about 80 percent of beneficiaries live in counties where they will be able to enroll in an alternative to the traditional Medicare fee-for-service program, 85 percent of urban beneficiaries will have such a choice, while 62 percent of rural beneficiaries will. Urban beneficiaries may have a range of plans to choose from, while usually the only choice for rural beneficiaries is the private fee-for-service option.

As for county payment rates, 90 percent of beneficiaries who live in counties with payment rates above the floors have a plan available, while only 72 percent of beneficiaries in four counties have a plan available.

In summing all of this up, we might optimistically view the Medicare+Choice as stable and evaluate it by plan availability and the relatively small numbers related to plan withdrawals this year. However, we do not yet know what benefit and premium changes are in store for enrollees. Those changes could force many enrollees out of plans and back into the fee-for-service Medicare program. We will need to reserve our judgment until we see the benefits and

the resulting enrollment in 2003.

The staff plans to continue doing a few things. We will examine the benefit packages, both for the Medicare+Choice and the PPO plans to compare them with each other and see what they look like with regard to Medigap plans.

The staff will request timely enrollment data from CMS to monitor the enrollment in the PPO demo to see if enrollees are coming from fee-for-service or existing Medicare+Choice options. We will also investigate cost plans to see whether maybe they could be viable options, particularly for areas without Medicare+Choice plans.

We will look at how beneficiaries are affected when Medicare+Choice options change, and we will follow legislative action on payments and report back to you.

MS. DePARLE: You may have already said this, Scott, but I lost track here. What is the total number now of beneficiaries who have lost an M+C -- this is not lost an M+C plan, but it's more the category of no M+C plan available, because some of these people were affected multiple times, right?

DR. HARRISON: Right. I think, before this round,

I think I've seen the figure a little over 2 million.

MS. DePARLE: Yes, that sounds right.

I think you may have answered this question, too. I thought that the cost contracting was phased out in the BBA, and is that the track we are on, that this is not by --

DR. HARRISON: They were originally scheduled to be phased out. I know they were extended at least once. I know at one point the deadline was 2002. It may have even been extended twice, but now it is 2004.

MR. FEEZOR: Scott, the ones that dropped out this year tended to be smaller areas or smaller volumes, I mean, South Dakota, Indiana -- all right, you're confirming that.

I wonder, we keep looking at the drying up of the M+C program and sort of as a default of something that's unique about this market. I wonder if there have been any comparisons in terms of how maybe that has compared to the drying up of, say, managed care and the traditional commercial market. I think that might be an interesting example.

We have had a withdrawal of about 17 counties in five years, and I'm talking about in our under-65 population. So I think it might be helpful to sort of put

that in perspective, that it may not be something that is necessarily a part of the Medicare, even though it's affecting it, it may be, in fact, that some of the entities which are willing to take on such arrangements, are, in fact, significantly rechanneling from their overall market strategy.

DR. HARRISON: Right. We are going to try to look at that a little bit. Next month you may very well see a presentation that looks at payment areas. And to do the work on that, we have purchased some data on commercial market share, and we will try to trace what service areas look like in commercial plans --

MR. FEEZOR: Particularly, and even within that is they shift even in the commercial market, shifting from say a capitated risk over to more of a PPO arrangement. So I think that would be helpful.

A final thing that I would like to see, if there are beginning to emerge any qualitative or outcome differentials in these products compared to the, and I think that would always, we need to keep an eye on that if any of that is beginning to emerge.

MS. ROSENBLATT: I thought your concluding

statements in the summary paragraph in the written material were very good, and I just want to make sure I have a sense of the timing. Because I think one of the things you said is it looks like it's going to be stable, but we really won't know until we see how enrollees move.

My expectation is you're going to see a lot of premium increases and a lot of reduced benefits and that that is going to cause a great degree of beneficiary shifting. So my question is will we have that information before we have to do any sort of written report?

DR. HARRISON: We won't have enrollment information before -- I wouldn't trust any -- if CMS did things really quickly, about mid-February is about as quickly as we could really expect to have solid data on enrollment.

MS. ROSENBLATT: So I think we're going to have to be real careful about any statements. I mean, you will have a better sense what you see what the premiums and benefits are, but I think you're going to have to be real careful about making any statements about stability without that kind of number.

I never knew a lot about cost plans, and I have

forgotten what little I knew, but I remember that the little I knew said to me that these plans only worked for staff model HMOs, that it was very difficult to do it if you weren't a staff model, and I don't know that you hit on that.

DR. HARRISON: Well, I think these were the first-generation HMOs, I thin, yes.

MS. ROSENBLATT: Maybe if you could explain that, as part of your discussion of the cost plan, that would be helpful.

DR. WAKEFIELD: Scott, a question on the private fee-for-service. In the text, you mentioned that Sterling is multi-state, and that there is a second private fee-for-service plan. I am not familiar with that second one. I assume it is not --

DR. HARRISON: It's DuPage County, Illinois, and it's at Humana.

DR. WAKEFIELD: Is that like one county?

DR. HARRISON: Yes.

DR. WAKEFIELD: Early on with Sterling we had a sense or at least you heard that that was clearly a plan that was in an expansion mode. Do you have any sense at all

about this other private fee-for-service plan about whether it is going to stay local or it's positioning itself to go multi-state?

DR. HARRISON: It's a demo, and I'm not sure, I think it was positioned just to deal with a particular local problem.

DR. WAKEFIELD: And they're dropping it, you think? So, anyway, local at best is what you're saying.

DR. HARRISON: I believe there are a couple of applications for private fee-for-service pending in CMS, but I don't know the nature of those.

DR. NEWHOUSE: Scott, did I hear you say that at the end one of your next steps was investigating the viability of cost HMOs for rural areas?

DR. HARRISON: Well, there has been some congressional interest from time to time about these plans; you know, does it make sense for us to force them away when we have beneficiaries in these areas who are happy.

DR. NEWHOUSE: Well, I mean, it's not surprising that the beneficiaries are happy that do have them. But to me it's an anomaly in at least two ways: One is that the general thrust of policy over the last several years has

been to get rid of cost-based reimbursement as much as possible. That is clearly not what is going on here; and the second is an equity consideration. I mean, to have the cost-based HMOs available in some areas and not in other areas seems to me to be not good policy.

I agree with everything that has been said about they only work for staff HMOs, but in part we got them because we weren't willing to do risk contracting with especially Kaiser in the '70s or when Medicare started in the '60s. We said we invented this, but it seems to me policy, for good reasons, has gone away from it in other areas. We should learn something from that.

So, if anything, I thought, given the tone of what I was reading in the document, we were going to come to some kind of negative comment about cost-based HMOs, but then at the end, that we're considering them for -- I mean, it just doesn't make a lot of sense to me, both for policy reasons and for the analysis, that staff-model HMOs are not exactly what one sees in rural areas.

DR. HARRISON: One thing is that the cost HMOs haven't been evaluated vis-a-vis what the Medicare+Choice payment rates are. There could be some interest on the Hill

in seeing if these things are any more costly than regular Medicare+Choice plans in some areas.

DR. NEWHOUSE: But Medicare+Choice rates are, if anything, less than traditional Medicare rates, right? I mean, so if cost base is losing traditional Medicare --

MR. HACKBARTH: Not in the floor areas.

DR. NEWHOUSE: Not in the floor areas.

DR. MILLER: But Scott, it's correct that any analysis we do on this is going to contemplate the questions that Joe is talking about.

DR. HARRISON: Absolutely.

DR. MILLER: Right. I think that is the point.

MR. DURENBERGER: Let me use Marshfield as an illustration, and I'm not speaking for them.

If you compare, on the equity issues, I am sure they have made a choice of not a cost-base, but whatever we call them, the CCB or something like that, made it on a very divided boat, and what I understand one of the issues was how do you make money, any money, when you're operating with half the amount of money to do the same thing as they get in Miami or some other part of the country. That is an equity

issue I want to continue to raise as we get into some of these other areas.

But I can't leave what you said about inequities on cost base alone because I think there are a lot of experiences that I have had with cost-based contracts where Medicare is paying a lot less to get the same result as they are in some other parts of the country. So just on the issue of equity, which we can come back and visit, I need to get on the record with that.

DR. ROWE: First of all, Scott, I continue to find you to be a source of insight into this. You've been following this for a long time and seem to really understand it very well. I don't think we should be too encouraged by the fact that the percent of all enrollees who dropped out or who were affected this year is significantly lower than the last couple of years.

I think that what plans have done over the last couple years is evaluated their participation in a heterogeneous market across the United States, which different plans have different levels of efficacy in different markets based on their non-Medicare enrollments, and then that works in other things.

And they have evaluated where they can, in an economic way, participate in this program and where they can't, they have dropped out or they have changed the co-payments, et cetera, and then the next year they come back and take another look to those in the gray area, and they drop out of some more, and they kind of clean it up, and then they are done with that process.

So what happens after that is you pretty much don't, you get a drop-off in the proportion of individuals who are affected, and it doesn't mean things are better. In fact, things are probably very much exactly the same, and it doesn't mean that you can now expect to see growth either. I mean, it's just that's the way it is, unless there is some change in the program that is fundamental, that changes the equation for the plans as they evaluate it in a market-by-market basis. It's not bad or good, but I just don't think we should -- it's not a headline here that it's only 4 percent that are affected this year, as opposed to 10 last year or 15 the year before or at least that is my view. I don't know if Alice would agree how her firm approaches this.

MS. ROSENBLATT: Jack, that was my point. That I

think a lot of the plans, the action they took, rather than withdrawing, was to increase premiums and cost sharing, and that therefore -- that's why I was pushing to get the enrollment numbers.

DR. ROWE: So you agree.

MS. ROSENBLATT: Right.

DR. REISCHAUER: Scott, could you or somebody else on the staff remind me what the rules are about access to Medigap, if you leave a plan that you have been in for three or four years that remains in business, but it has raised its premiums or cut its benefit. Is the Medigap policy underwritten at that point or do you have -- I mean, I thought if the plan didn't disappear, you could only get a policy, well, if the insurer wanted, as underwritten.

DR. HARRISON: I think if you had been in for more than a year, and you didn't join up when you were 65, I think that is correct. You are underwritten, but let me see --

DR. REISCHAUER: If that is the case, then some of the reaction that Alice anticipates may be quite muted because these people are really captured, in a sense, which then creates all sorts of other problems.

DR. HARRISON: Last year there was a special enrollment period decreed by CMS which allowed basically everybody to go back -- anybody that who was in a plan to go back in. I don't know whether that is likely to be an annual event or what their thinking is on that.

MS. ROSENBLATT: Bob, I agree with you, that's a great question for us to get the answer to because it will affect what's going to happen.

MR. HACKBARTH: Scott, I have a couple questions about the PPO demonstration. You said that it is common in the private sector for PPOs to share financial risk, and I wanted to ask Alice and Jack whether, in fact, that is the case. Four or five years ago, when I was involved in this stuff, in fact, PPOs were not risk-bearing organizations. It was strictly discounted fees. Has that changed?

MS. ROSENBLATT: I'm not aware of any capitated PPOs, if that's what your question is.

MR. HACKBARTH: I'm not sure exactly what the risk-sharing entails here because they haven't publicized what the arrangements are, but I assume it involves sharing some risk for utilization patterns.

MR. FEEZOR: Glenn, if I could go back to my days

as a regulator, that where, first off, it may vary by state, depending upon the structure of the regulator, whether anything that is risk bearing, in fact, then drops off insurance, but in some of the self-funded contracts, we are able to do something what I call up-side incentive, but not necessarily capitated, but Jack probably has some more recent data on that.

MS. ROSENBLATT: To the extent that the insurance company in an insured program, not an ASO program, has a set premium, that the insurance company for that year, until it can increase the premium, is fully on the risk. As I said, I don't know of any PPO arrangement where the providers are in a capitated arrangement. So the insurer is bearing the full risk for that year until it can increase the premium.

MR. HACKBARTH: You do see insured PPO arrangements, as opposed to only on the ASO side?

MS. ROSENBLATT: Oh, absolutely.

DR. REISCHAUER: What I think Scott is referring to is that the government makes you a payment that is equal to the M+C payment or 99 percent of fee-for-service, and you could sign an agreement that if that proves to be inadequate, the government will pay part of your losses, and

it will capture part of your profits, right?

DR. HARRISON: I think the structure is likely to look like you're going to negotiate with Medicare as to, say, an administrative percentage, and that stays fixed, and then there's a medical loss ratio implied with the rest, and I think that there are bands around the medical loss ratio.

DR. ROWE: I think there may be -- for instance, we don't currently participate in this program, so I am not certain, but I think the TriCare program, which is Department of Defense, used to be CHAMPUS, has like a corridor of a defined risk, and if you're within that, fine, and if you go beyond that, then there is some sharing of the risk from the part of the Department of Defense. Those kinds of arrangements are out there, but otherwise I agree with what Alice said.

MR. HACKBARTH: Let me cut to the chase. The problem, I thought, is that private plans are having difficulty, basically, competing with traditional Medicare. They are finding the rates that Medicare is willing to pay too low relative to their costs, and the plans currently participating in M+C are all the more restrictive than PPOs, in terms of their ability to control the utilization of

services because they are closed networks, to varying degrees.

So, if the existing plans that are more closed are having difficulty competing with Medicare, and doing it at Medicare's costs, now we're talking about a more flexible arrangement with still fewer controls on the costs, it is unclear to me what the likelihood is that these organizations are going to be able to provide the Medicare benefit package at a cost lower than Medicare or are we just saying that we are going to risk share and agree this is an avenue for Medicare to systematically pay more than we would have paid in fee-for-service?

DR. ROWE: Is that a question?

MR. HACKBARTH: Sort of.

DR. REISCHAUER: Isn't the issue here that they don't have to provide the actuarial equivalent of Medicare's cost sharing when they set up the PPO structure?

DR. MILLER: Right. I think it's two pieces, in response to that comment. That is the first one. In the PPO, if you can draw more revenue in through a differential cost-sharing structure, that is one of the flexibilities of the demonstration, but I think the other issue kind of

imbedded in your comment is how the plans can compete to provide, in the traditional structure, to provide the standard benefit is one question, but the way they have been competing is just to provide additional benefits, and that is what is getting driven out in the current system and then people are not taking them up relative to fee-for-service.

I think if somebody is entering with a PPO option and saying I can provide -- I mean, if this is the argument they are going to make -- I can provide the traditional Medicare benefit within this range, take some risk, have the beneficiaries cost structure be different and compete against fee-for-service in that arrangement, but not necessarily provide the additional benefits that an M+C would be providing or in the past had provided.

Scott, I don't know if you --

DR. HARRISON: I think that the intention, probably on most of the PPOs is to provide a richer package than the M+C plans so that they will have a bigger total set of revenue, and I think the idea is to compete more with fee-for-service plus Medigap.

Alice, if you --

MS. ROSENBLATT: I don't know. Our various plans

looked at the PPO, and we are not -- any of it was not in the demo.

DR. ROWE: We are. We are in the demo in several areas, and all the details aren't worked out, as Scott pointed out, but we see it as a way to try to continue to serve this population within a program that has somewhat more flexibility because of the waiver on the cost sharing. Whether that will wind up, how much of that waiver will be utilized and what the benefit package will wind up looking like, compared to the other, is I think yet somewhat uncertain. But I think that our decision to participate was based on the fact that we thought it could be no worse, and maybe better, because of the flexibility, and we want to participate in the population.

But the comparison for us always is I think the correct comparison has to be whatever program you are in versus traditional Medicare plus Medigap. This concept that we have here of comparing this program to traditional Medicare is half a loaf because the beneficiary out there, I think 83 percent of them or something like that in traditional Medicare, have Medicare supplemental insurance. And so when we're asking, we're going to increase the out-

of-pocket payments for people beyond the cost-sharing arrangement, they still may not be even approaching what they are paying with respect to some of this other stuff.

So that is really the -- and this includes pharmaceuticals, et cetera -- so that is really the combination, and I think here one of the things that we do because of our data set structure maybe is we are always comparing these programs to traditional Medicare, and I think that that is less informative than a different comparison.

MR. HACKBARTH: What you say makes great sense. If we're trying to find ways to make this more flexible and make it more palatable to both plans and beneficiaries alike and allowing more flexibility on the cost sharing is a critical factor, it seems to me we ought to allow traditional M+C plans with closed networks do a demo with some flexibility on cost sharing and see if that sells in the market for, against the market for Medicare plus supplemental.

DR. ROWE: So the question is, is this a PPO demonstration or is this a pathway to increased cost sharing?

MR. HACKBARTH: Right. Yes. We're going to have to bring this one to a conclusion.

Thank you, Scott. We'll talk more about it later as well.

Next on the agenda is variation in Medicare per capita spending.

DR. ZABINSKI: As the title suggests, this is primarily a presentation on the variation in per capita spending and local Medicare spending, but this analysis of the variation is actually part of a larger study we intend to do on improving the payment system in Medicare+Choice. So before we specifically get into the variation analysis, I will briefly review our workplan on that larger study.

The starting point for this larger study is the Commission's recommendation in the March 2001 report that payments in the Medicare+Choice and the fee-for-service Medicare programs should be financially neutral within local markets. This runs counter to the Balanced Budget Act of 1997, which reduced the link between M+C payments and fee-for-service spending in order to reduce the geographic differences in M+C payments.

The Commission, however, said that the geographic

differences in M+C payments should be addressed through the variation in local fee-for-service spending and recommended that the Secretary analyze that variation.

In addition, the Commission recognized that Medicare's current policy of using counties as the payment area can result in unreliable estimates of local fee-for-service spending. In response, the Commission also recommended that the Secretary consider the definition of local payment areas and explore alternative payment areas that have enough beneficiaries to produce reliable estimates of spending.

More recently, the Commission has expressed interest in having MedPAC's staff investigate the issues of variation in per capita local spending and payment areas in Medicare+Choice, and we intend to include analysis of those issues in a chapter for the March report.

Also, the financial neutrality between the Medicare+Choice and fee-for-service sectors requires an effective risk-adjustment system. CMS has proposed a system that is intended for use beginning in 2004, and we plan to include an assessment of that system in our study for the March report.

Now, to get the ball rolling on this larger study, we started by analyzing the variation in per capita local fee-for-service spending, and that work is the focus of the rest of this presentation.

We started by looking at factors that affect variation in fee-for-service spending, and the first of these is input prices. MedPAC work has shown a strong geographic relationship between the way that we measure input prices and the wages in other occupations. Also, geographic differences in the way we measure input prices are strongly associated with geographic differences in the cost of living.

Other factors that affect variation in per capita spending include IME, GME and DSH payments, beneficiaries' health status, beneficiaries' service use, which can include the effects of providers' practice patterns and beneficiaries' propensity to consume care, and the final factor that affects variation that we identified is differences in use in Medicare covered services provided in VA and DoD facilities.

Now we wanted to estimate the variation in per capita spending that is attributable to each of those

factors. Our database for obtaining those estimates is a spreadsheet of county data on fee-for-service Medicare spending, input prices, health status and IME, GME and DSH payments. This database allows us to obtain reliable estimates of the variation in per capita county spending that is attributable to input prices and IME, GME and DSH payments, but we also have a couple of issues that I think I should point out regarding the database.

The first issue is that our measure health status is county risk scores from the principal inpatient diagnostic cost group or PIP-DCG risk-adjustment system that CMS currently uses in Medicare+Choice. Now we realize that there is no health status measure that fully accounts for the differences between beneficiaries, but there are measures that actually do a better job than a PIP-DCG, such as the hierarchical condition category or HCC risk adjustment system.

But we chose to use the PIP-DCG, rather than something like the HCC, because we have PIP-DCG risk scores for the entire fee-for-service Medicare population, but the HCC risk scores that we have are based on a 5-percent random sample, and we estimate that that 5-percent sample is

probably too small to give us reliable estimates in about 25 percent of the counties.

A second issue regarding the database is IME, GME, and DSH spending cannot directly estimate the variation attributable to differences in service use and to differences in use of VA and DoD facilities because we don't have data on those variables.

Now these next two slides display the results of our analysis. On this first diagram, we show the distribution of per capita county spending before and after we remove factors that affect variation. Along the horizontal axis of this diagram, we show the levels of county per capita spending. The green bars on the diagram show the percentage of counties that have per capita spending at each level. The black bars indicate the percentage of counties at each level, after we adjust for differences in input prices, health status, and IME, GME and DSH spending.

What the diagram reveals is that removing these factors from per capita spending reduces the number of counties that are towards the tail of the distribution and increases the number of counties around the central

tendency. An important note, though, is that we weighted the distribution by the number of beneficiaries in each county. What that means, for example, is that a county with 10,000 beneficiaries will count twice as much in the distribution as a county with 5,000 or half as many beneficiaries.

Now, in this second diagram, we show the relative importance of the factors that affect variation in per capita spending. Specifically, what we did is we first calculated a beneficiary-weighted variance in per capita county spending without any adjustments. Then we first of all removed the effects of differences in input prices and calculated the percentage change in the variance. Then we did essentially the same thing with health status and DSH, IME and GME payments.

We found that removing input prices has, by far, the largest effect on reducing the variance, decreasing it by 33 percent. Removing health status has the second-largest effect, followed by DSH, IME and GME payments. Now, due to data limitations, we cannot estimate the effects of removing service use differences or use of VA and DoD care, but we do conjecture that serious use has a larger effect on

the variation than does use of VA and DoD facilities.

Finally, I would also like to point out that when we simultaneously removed the effects of input prices, health status and IME, GME and DSH payments, the variance declines by about 62 percent.

Now, in closing, I'd like to say that we really view this variation analysis as a starting point, and as we turn things over to the Commission, we are looking for your thoughts on the direction you would like us to take this analysis. One possibility that I see is that we could take a relatively broad perspective and consider appropriate policies for addressing variation in local fee-for-service spending, which would in turn have an indirect effect of addressing variation in M+C payments and would be consistent with the Commission's view that differences in M+C payments should be addressed through variation in fee-for-service spending.

But I think another possibility is to take a little bit more narrow perspective and consider which of the factors that affect variation in fee-for-service spending should be reflected in M+C payments. For example, a fair amount of the variation is, in fee-for-service spending, is

within the direct control of policy levers, and we can consider whether any of these policies should be modified so that the appropriate costs are then reflected in the M+C payments.

MR. HACKBARTH: Dan, the latter approach would be a departure, wouldn't it, from what we've had as our guiding principle in M+C, which is we ought to be offering beneficiaries a choice: pay, as best we can, the same amount to private plans as we would pay on their behalf if they stayed in Medicare, and we have laid out a bunch of reasons why a gap between what we pay private plans and what we pay under traditional fee-for-service causes problems.

So I'm not clear why we would want to consider the second option.

DR. ZABINSKI: I guess I picture it as, we have considered things like, for example, ProPAC, in the past, considered the appropriateness of including DSH payments in M+C or, at that time, risk-plan payments, and due to the nature of what DSH payments are for, you know, supporting hospitals that provide a lot of indigent care, you know, perhaps a more appropriate policy might be or at least they recommended excluding DSH payments from the risk plan base

rates, and then paid the hospitals directly for each risk plan enrollee that goes to the indigent care hospital, something like that. I don't know, it's something that the Commission might want to consider.

DR. MILLER: You also recall, I tried to talk about this a little bit up front. I think there's, among the staff, and we're looking at the question that you've asked, and we're not precisely clear what direction it came in. it sort of came out of an M+C conversation to look at geographic variation in fee-for-service.

One could look at it purely on that side and ask about policy implications there. That would be one approach, which is what I think Dan is saying, or, alternatively, on the M+C side, and we're looking for a little direction, given this request, what you had in mind for this. I think that's part of what we're trying to pose here.

MS. BURKE: Going to the example that Dan used, the other obvious one that has been the subject of a fair amount of discussion for some years has been the treatment of GME and IME for very similar reasons, which is to what extent it should be in a base rate and to what extent it

should, in fact, be a direct payment to an institution for a specific activity.

I think there is, in fact, and there should well be, a conversation about that as the structure of the base rates because it is a fundamental question as to whether or not we should replicate solely on the basis of one-to-one or should it, in fact, reflect what it is we expect we are paying for. And so that, to me, would seem to be a series of issues that ought to, in fact, be engaged, as we look at it, but it is a question really on the fee-for-service base, which is what ought to be in the base as an expectation, and then should we duplicate that as some percentage in calculating M+C.

So I think Dan's example is exactly right, and I think it could be expanded to do the other things that are policy choices that are part of the payment rate that are distinct. I mean, the input prices are what they are, and they are reflected across the board, but the other issues, those remaining three, DSH, IME and GME, are obvious policy presumptions in the way we have calculated the rates and may well want to be revisited, whether you use that in a base or not.

Health status, similarly, I think like input, is what it is. Can we do a good job of it? But I think the other three warrant some question in calculating M+C.

DR. WAKEFIELD: Three sort of unrelated topics.

From the text that you provided us with prior to the meeting, I appreciated the comment about beneficiary populations in small counties and the difficulty of estimating per capita spending. Those erratic changes from year-to-year I think are absolutely worth noting, and I appreciated seeing that point reflected in the text.

Now two questions. One, you also said in text for 2004 that CMS has a system that is combining both demographic data and in-patient data, but you didn't mention outpatient, and I thought outpatient was also a category that was going to be factored in. Am I wrong about that?

DR. ZABINSKI: Not at all. I'll have to look at what I wrote there, but if I said that, that was completely off-base. It is a broader context of inpatient, outpatient and physician office visits.

DR. WAKEFIELD: Okay. Then the third point that I wanted to ask about, I understand the difficulty of being able to quantify the DoD and VA impact, that, whatever those

differences are, they would really resonate at the county level, right? So, for example, Montgomery County, probably a big impact for DoD and another county perhaps not much impact at all.

So, when you are commenting on beneficiary use of VA and DoD facilities driving down per capita spending in traditional Medicare, it is really at the county level that you are talking primarily, not so much in the aggregate nationally, although you have impact there, too. If I am wrong about that, please let me know.

The second point I was kind of wondering, along that same line, is there any interplay between, again, it would be in very sort of localized ways, but is there any interplay between IHS and Medicare II or is that just completely separate, different from the DoD/VA populations? If you think about Nevada, or Arizona, or Oklahoma, for example, would there be some county impact there, as you would see with DoD or is that just completely separate?

DR. ZABINSKI: I don't know about the IHS. Maybe somebody else does. But I think you are right about the county-level variation in the VA/DoD. I mean, even from a 1996 ProPAC report, there is even a fair amount of state

variation, not huge, but some, at the VA/DoD measure. So I would think the variation is even greater at the county level.

MS. ROSENBLATT: Dan, I thought this was a great analysis, but it raised quite a few questions in my mind on the calculations.

This chart showing the effect of variation, this is the variation in per capita fee-for-service spending?

DR. ZABINSKI: Right. Yes.

MS. ROSENBLATT: So a couple of months ago the commissioners were shown an exhibit where the issue was that we had the numerator and denominator reflected the fact that we had snowbirds, so that there were services performed in another county, and wouldn't that be one of the factors we need to account for here, particularly if we're going to use these conclusions for the M+C program, where everyone would have their services in the service are of the M+C program?

DR. ZABINSKI: If I follow your thinking, and I think I do, I believe the data account for that. In this database, say you have a beneficiary who lives in County A, but they go get care in County B, that care that they got in County B actually gets included in the per capita rate for

County A.

MS. ROSENBLATT: But then it's distorting the price, if you will, of County A. So if there is any way to segment that --

DR. ZABINSKI: I have thought about that, Alice, and so far I haven't come up with anything. I don't want to like stab it in the heart right now, but I am not hopeful for finding a good way. But there's two things: I mean, I'd really like to get VA/DoD data and this particular point you're raising.

MS. ROSENBLATT: Then I have another question. When you're pulling out health status, is that based on the PIP-DCG for M+C or is that based on the PIP-DCG for the whole fee-for-service population?

DR. ZABINSKI: It's for the fee-for-service population.

MS. ROSENBLATT: It is?

DR. ZABINSKI: Yes.

MS. ROSENBLATT: My last question is, when you talked about being unable to look at service use, I read the statement that you couldn't differentiate between practice

patterns versus propensity to seek care. If we were to say that's real hard, forget about that, but can we at least look at the impact of service use by county in total, whatever the cause of the service use difference, can we do that?

DR. ZABINSKI: Ultimately, if I can get VA/DoD amounts then you would think that then I would have measures on all of the factors that affect variation then except service use, and so any remainder I think would then be service use. I think that is right. I'm not 100-percent certain, but I think that is the right way to look at it.

MS. ROSENBLATT: I'm uncomfortable with anything that uses a remainder approach. So if there is any way of looking directly at service use from whatever cause, then I would be real interested in looking at that.

DR. ZABINSKI: Okay.

DR. NEWHOUSE: I have a narrow technical comment and then a broader comment. The technical comment is, I think you threw out the HCC measure prematurely. I mean, granted that you can't use it for 25 percent of the counties, you could still use 75 percent of the counties to get an estimate of how much the variation is reduced.

DR. ZABINSKI: That's something we're definitely considering.

DR. REISCHAUER: It is 75 percent of the counties and probably 95 percent of the population.

DR. ZABINSKI: You're probably right about that.

DR. NEWHOUSE: I'd much rather see your health status number based on 75 percent of the counties for the PIP-HCC than what you have got up there.

DR. ZABINSKI: I did run the numbers with the HCC.

DR. NEWHOUSE: What happened?

DR. ZABINSKI: You got a lot more variation accounted for by the health status.

DR. NEWHOUSE: Right.

DR. ZABINSKI: Maybe even, and I don't remember exactly, but maybe 50-percent more than what we are showing here.

DR. NEWHOUSE: Was that on 100 percent of the counties or 75 percent of the counties?

DR. ZABINSKI: That was on 100 percent of the counties.

DR. NEWHOUSE: Well, why don't you run it on 75 percent of the counties and see what you get.

DR. ZABINSKI: I agree with that.

MR. SMITH: Joe, can I just say for a second -- that data, I assume that the 17 increases, but the residual decreases. It doesn't come from input prices or --

DR. ZABINSKI: Right.

DR. NEWHOUSE: I want to go to the issue of what the context is for this endeavor. One context, which is a narrow context and which I think I come out at for the moment is just essentially an educational mission on what accounts for the variation, where the bottom line is kind of don't get too carried away with the raw variation because we can, in fact, account for it. Sheila's point on the policy measures I agree with. That is one context.

The broader question it seems to me that this raises, but I don't know what to do with it, is what should the policy be toward variation in traditional Medicare? And it seems to me that if you start approaching that question, the only thing I can think about is kind of spending caps or floors maybe, and I can't imagine caps working, I mean, particularly at the county level or even at the state level, for that matter.

I am comfortable in just not going there and

leaving this in the context of the variation is kind of not as great as it seems. There is also, by the way, particularly at the county level, in effect, according to what Mary said in a different context, I mean, there is some variation that at the annual level is just random. I mean, it kind of dies down when you weight the variation, but the unweighted variation at the county or even at the state level, there will be some noise just from random events in a year.

DR. ZABINSKI: Joe, do you think it would be helpful, thinking of that the variation from year-to-year, to use two years' of data together?

DR. NEWHOUSE: Yes.

DR. ZABINSKI: Because we do have that, and I actually looked at it, and it reduces the overall variation, by my recollection, by about 15 percent.

DR. NEWHOUSE: Yes, and maybe more. I mean, maybe more years, rather.

DR. ZABINSKI: I've only got two years, so I think that we're stuck at --

DR. NEWHOUSE: Well, one thing you could do is you could show how much reduction it makes going from one to

two, and you could potentially get an estimate from that of what it would do to go to more years.

MR. DURENBERGER: I think the questions I was going to raise have been touched on, to some degree, by this series of questions and responses. As long as I have known Joe, I have heard him say variation is not as great as it seems. That always sort of like gets my hackles up, and I don't know why because I don't have his talent, but I cannot accept -- just experience does not allow me to accept that.

I mean, I can't go back, for example, to Billings or Grand Forks or Minneapolis-St. Paul and say that something like over a third or a third of this is input price variation just for starters. You say that it is, but it's kind of like hard to do. It's one of the reasons why congressmen and governors in Iowa get all upset during elections and talk about what are you doing.

But that leads me to the second point --

MR. HACKBARTH: Could I just ask for a clarification, Dave? Are you saying that it doesn't right to you? You don't believe that one-third is input prices or you think the input price adjustments are inaccurate?

MR. DURENBERGER: No, the large percentage of the

variation that is attributable to input prices -- it's, what, 34 or 35 percent, something like that?

MR. MULLER: The factors vary two to one.

MR. DURENBERGER: Pardon?

MR. MULLER: The wage factors vary two to one so that is quite possible.

MR. DURENBERGER: I'm just telling you, from a political standpoint, a lot of people don't believe that. There is a big debate over the wage index going on now and a lot of things like that, and I'm not, please, on this one, I'm not arguing. It's the second one, the next one that I would like to go to, which is the provider practice patterns and the issues of the beneficiary propensity to use care.

I think I have already suggested either Wennberg or Skinner or somebody call you and talk to you about --

DR. ZABINSKI: Skinner called me already. I have known John for 15 years.

MR. DURENBERGER: I thought you had. Yes, I was hoping he had, because these kinds of issues in variation in practice across the country, and even within our own states, and communities and so forth, are hard to come to grips with. I mean, it's hard to come to grips with them in

statistical terms. And those of us who would argue on behalf of the Marshfield Clinic or whoever it may be are sometimes hard-pressed to lay a solid foundation under that, premised on the kind of work that is done by some of our colleagues here and by Jack Wennberg and others.

I just hope that we find a way over time to go into that issue and to talk about it in ways that folks on the hill can begin to understand, and doctors, and hospitals back home can understand.

And then the last one, of course, the one that goes with propensity on behalf of beneficiaries and practice patterns, is the issue of effectiveness, and I know that's really hard to get into, but I just want to lay it on the table because I think it's important for us, at some point, to get into it. Particularly, if we started in the context of Medicare+Choice, the issue is under Medicare+Choice, we're going to reward beneficiaries with more benefits, and we're going to reward doctors and hospitals with more money.

It's legitimate to ask the question, for what? What is the value? What is the benefit in 500,000 knee surgeries that prove, in effect, or whatever, you know, I don't want to get into all of the details of this, but that

particular issue of what are we buying with this, again, becomes important to those of us who have gone through the experiences, at least in our part of the country, say, 25/20 years ago with the first-ever risk contracts and so forth and seeing behavior change and then not get rewarded.

The issue is how do you explain to people where the incentives are to improve and enhance the practice of medicine and then get rewarded financially or penalized financially for doing that.

MR. HACKBARTH: The variation, based on differences in practice patterns and propensity to use services, is large and well-documented. We can add our voice to the chorus of people that have called attention to that. I think the question that it begs is, okay, what could, what should Medicare do about it? And I think that is the difficult part. It would involve a Medicare program with a whole different premise than the original Medicare program, which quite explicitly was we're not going to shape medical practice, we're going to pay bills.

Here, the Federal Government would be saying this is the appropriate standard of medical practice, and we are going to force people towards the explicit federal standard.

I think that is the debate that you would have to have.

MR. DURENBERGER: May I respond? I'm glad you laid it out that way because I didn't come on this Commission to stay with the old system, to get very blunt about it.

So the answer to your question, and I think Joe raised the same issue, comes tomorrow sometime when we start listening to some of the folks talk about quality, but expressed in, say, CMS terms, it is pay for performance, and it is a drastic, it is clearly a drastic change. But if it doesn't come from us, from whom is it going to come? I guess that is the bottom line of the question.

MR. MULLER: I think that discussion indicates why it is important to continue the very fine work you have done here to try to explain the variance. I think all of us have read the Wennberg literature over the years, and to get 62 percent I think is a good step forward in terms of understanding the variation. I think Joe's suggestion -- I don't know what his estimate is as to by looking at health status through those codes might drive that number up more. So I think, in part, if the residual -- as I said 62 -- if the residual is 20 percent, and as Al said one can

contribute all kinds of things to residuals, that is a different debate than if the residual is 80 percent.

I think sometimes we discuss the variation around the country as if it wasn't due to GME, IME, DSH, health status and input prices. So, in fact, I think one of the ways we can help this debate quite a bit is to drive this number as close to 100 as we can, understanding that these are policy variables that are in this chart right here that -- some of these are policy variables -- that are reasonably well established.

Some of them obviously, like input prices, reflect realities -- one may like them or not like them, but they reflect significant realities around the country. So to continue this work to try to clarify as much of the variations as we can explain by these variables, I think it may perhaps help this debate quite a bit because I think there is a tendency, an increased tendency to think about the variation in the country as just due to practice style, and I think we can help clarify exactly how much that is practice style and how much that, in fact, is due to the factors here.

So I would urge us to get this number up as high

as we can get it, in terms of legitimate explanation.

MR. SMITH: Dan, I found this very helpful, and for reasons that Ralph just expressed, it seems to me this is stuff we ought to press ahead.

One observation and one question. I found the compression around the central tendency equally powerful as the 62 percent. There is less here than sometimes the political discussion, which we need to be mindful of, but there is less unexplained difference across a smaller range going on than the political discourse sometimes suggests, and I think we ought to bear that in mind, as well as 62 percent is explaining a lot.

My question is I found myself wondering several times as I read this, whether or not there is a useful connection to explore between input prices and propensity to seek care or practice patterns. Last year, when we spent a lot of time looking at rural issues, we looked at a fair amount of data which suggested that the relative lack of availability of Medigap and relatively lower incomes depressed the choice to utilize services by rural residents.

I am wondering whether or not there is a cost link to either the practice patterns by the industry or the

propensity to seek care by beneficiaries? Is it linked perhaps to higher rates of lack of secondary coverage, lower income, higher prices? I don't know. But there were two or three times, as I read the mail material, where I wondered whether or not the part of propensity to seek care and practice pattern that seems to be imbedded or account for a lot of that 38 percent, whether or not there is not a relationship between that and the 34 percent that we start with on the price side.

MS. BURKE: Can I just follow up to add to David's list of questions? To what extent are there also variances, and health status may pick this up, but in terms of the DI population? I mean, is that the entirety of where we represent that in terms of health status?

DR. ZABINSKI: I'm not sure, with the DI population?

MS. BURKE: The disabled.

DR. ZABINSKI: I was just thinking too hard what DI meant, so can you say that again?

MS. BURKE: My question is, is health status essentially a proxy for the difference that the disability

population, those who are qualified for Medicare and participate in the program, is that the proxy for their utilization patterns and their propensity for services, which will be radically different than the basic Medicare population?

DR. ZABINSKI: Well, to the extent they're there, they're going to affect that measure because they're in the measure.

DR. NEWHOUSE: Another way to put that would be how much of the variation is accounted for by different proportions of the DI population across counties.

MS. BURKE: Yes, because it has to have a dramatic impact on that question.

MR. SMITH: But shouldn't that be picked up, Joe, in county variations and health status?

DR. NEWHOUSE: Imperfectly. So it'll be what, given this multivariate approach, it'll be you could pick up some more of it that way I think, maybe not a lot, probably not a lot.

MS. ROSENBLATT: Particularly using the PIP-DCG, I don't think it would pick it up.

DR. ZABINSKI: But David's question on, just

paraphrasing, I think he was saying is there some sort of correlation between the input prices and say the propensity to use care or --

MR. SMITH: To seek care.

DR. ZABINSKI: I would think there is. Joe might be able to answer that better than I can, but I would think there is.

DR. NEWHOUSE: My first reaction was that cost is low in the rural areas so that would promote utilization, but in fact we know utilization is lower there. Probably, you point to several reasons, Medigap being one, but also just distance. We know distance to provider affects use, even in urban areas, and there may well be health status differences there as well.

Can I continue or do you have somebody ahead of me on the list? I wanted to come back to Dave on the variation, and it kind of echoes Glenn, and it goes back to your earlier conversation about has M+C really hit bottom in the disenrollment.

The position of the Commission historically has been neutrality between M+C and traditional Medicare as the kind of desired principle, as Glenn said. So the issue that

is joined then is, well, if we are going to try to do something about forcing or reducing variation in M+C rates and bringing St. Paul closer to Miami or however, we are going to unbalance local markets. In particular, that means if we give Miami 2 percent and the traditional program has markedly greater rate of cost increase, we are going to drive people back, in Miami, back toward the traditional program and out of M+C.

So, while I share your concerns about inappropriate use in the fee-for-service program and that probably varying across areas, it seems to me the effect of the policy of only working on variation in M+C is to, if anything, increase that.

MR. HACKBARTH: In fact, let me go back to your initial question about whether this belongs as an M+C issue or fee-for-service.

For the reason that Joe just articulated, I think we said several reports ago that this really needs to be a fee-for-service issue. If we're concerned about variation, it needs to be done with the dog and not the little tail that we call M+C.

I think it's timely because there is a lot of

debate about the variation within the fee-for-service program, and at a minimum we could, as Joe said earlier, do some education about why the variation exists and perhaps even go so far as defraying the issues that would need to be addressed in trying to reduce that variation within the fee-for-service program.

Needless to say, it is a very difficult topic and a quite sensitive topic right now, but I think to put all of this in a M+C chapter is to put it in the wrong place.

DR. REISCHAUER: I agree with that completely.

Dan, I think this is terrific piece of work, even though it takes the thunder out of one section of speeches that I give.

[Laughter.]

MR. MULLER: You could use old data, Bob.

DR. REISCHAUER: Yes, I'll have to use old data and old analyses.

I just would be interested, not something that we'd ever publish, but to have this analysis done on an unweighted basis because that is where the political discussion is. People act as if Slope County, North Dakota, which is the lowest county in America, has as many people as

Los Angeles County in it when they make these arguments and just to see how much of the variation is reduced. Now maybe you have done it.

DR. ZABINSKI: I've done that, and the difference --

DR. REISCHAUER: I'm setting you up.

DR. ZABINSKI: The difference, to me, is astounding. When you don't weight it, the effect of input prices is practically zero.

DR. REISCHAUER: It would be nice to have that table. You don't have to give it to everybody, just to me.

[Laughter.]

DR. ZABINSKI: Just a few thoughts on it.

DR. REISCHAUER: Mary was there, but too shy to speak, as always.

The other thing, and I'm not sure that this is appropriate for MedPAC, but it would be an interesting analysis, which is to take the residual variation that you have and run a regression to try and ferret out what it's related to, such as the fraction of the population with supplemental insurance, the availability of providers, hospital beds per capita or docs per capita, density or some

other environmental factors, and of course the most important one, which would be health outcomes, you know, age-adjusted morality rate or something like that, and hope that that has a zero coefficient.

DR. ZABINSKI: One other thought on the input prices, just the underlying reason what's going on there, if you don't weight by the number of beneficiaries in the county, what happens is that most counties, nearly 90 percent of the counties in the United States have an input price that is below one. It is an index, so what you are doing essentially is spreading the distribution.

It sort of bothers me to do it that way, though, because the average of the input price should be one --

DR. REISCHAUER: The only reason you would want to do it is because it would allow you to understand how the political debate unfolds.

DR. ZABINSKI: Right.

DR. REISCHAUER: It shouldn't affect sort of the analysis.

DR. MILLER: I think this can be very short because I think I'm only going to say what I think I have heard here. I think when we started out, the question was

which direction we're going. So we're clearly on the fee-for-service side, and I feel like there is a couple of contributions that can be made here, and I think this drives off of comments mostly off of this end of the table. The notion of sort of clarifying -- and some down there, I guess -- clarifying the impact of the policy variable.

Some of how the policy variables play into the discussion, clarifying precisely when people are talking about input prices, trying to get the point across that input prices reflect general economy-wide prices and then to try and engage the discussion, and that people can end up in very different places just because of mixes of providers. If you have IME, GME, and DSH, and you don't have any teaching hospitals, that is going to affect where you end up. Try and illustrate that part of the debate more clearly.

And then the other side of the debate, which I think Glenn was speaking to, which is the extent it is not that, how do you deal with this complicated issue? And I don't think it's completely an issue of throwing up your hands and saying the program ends up setting standards, which I'm not sure what Glenn's point was anyway, but do you

pay differentially either -- sorry.

MR. HACKBARTH: You could have asked me.

[Laughter.]

DR. MILLER: I know. I mean, can you pay differentially, I think we got the point over here, differentially as the program or differentially as the beneficiary for different kinds of services?

So I think, if I am trying to follow what the Commission is saying here and where we're going to go with our work, that's how I'm sort of organizing my thoughts for how we proceed from this point to try and drive at the analysis. Is that fair? I wanted to at least get that out.

MR. HACKBARTH: Okay. Thank you.

We will have our public comment period, brief, as always.

Seeing none, we will adjourn for lunch and reconvene at 1:15.

[Whereupon, at 12:27 p.m., the meeting was recessed, to reconvene at 1:15 p.m., this same day.]

AFTERNOON SESSION [1:24 p.m.]

MR. HACKBARTH: Our first topic for this afternoon is coverage and payment for new technologies, and we have got a couple pieces. My understanding, Chantal, is you are going first.

DR. WORZALA: Good afternoon. During this session, I want to give you a quick summary of the chapter outline that is in your briefing book at Tab E on paying for new technologies in prospective payment systems.

We would greatly appreciate your feedback on the outline. Are there topics we have missed, is there a particular aspect of paying for new technology that should be addressed in more detail, and how should the chapter be focused? Those are the kinds of questions I would like answers to.

The chapter will draw, in part, on work that Penny Mohr of Project HOPE has done for us. You will recall that in September she presented the findings of a structured interview survey of large purchasers to find out their approaches to paying for new technology, and we are fortunate to have her back this month to present the findings of the second stage of her work, which was an

expert panel on options Medicare might consider.

First, I want to review some of the more conceptual elements of the chapter. This first slide provides a general review of how the incentives built into a prospective payment system operate when it comes to new technologies. A PPS generally allows decisions about technology adoption to happen at a local level. By setting a fixed payment for a bundled service, the system gives providers freedom to determine the mix of inputs they need to provide the service.

So this flexibility in determining inputs, allows many technologies to be adopted without any formal decision making. In addition, the use of local coverage decisions allows many more to enter with limited scrutiny.

Bundled payment, as you have in a prospective payment system, also provides users of new technologies, the providers, with an incentive to evaluate the value of a new technology and to negotiate with suppliers to obtain the best-possible price. The incentive structure does favor technologies that decrease costs, but might slow adoption of costly new technologies.

It is also important to note that prospective

payment systems are built on averages. Therefore, it is not likely that the payment for any specific service will be exactly right. However, I think everyone would agree that payments should, in fact, approximate the costs of providing the service.

Three limitations of prospective payment do bear mentioning. First, the system works especially well with large bundles, such as you have on the inpatient PPS, but less so with narrow bundles, where technology can represent a very large share of the total costs. For example, a new scalpel might not represent a large share of the costs for a surgical stay on the inpatient side, but the costs of a new cancer drug could dominate costs for outpatient chemotherapy administration.

Second, the system has little ability to distinguish and reward quality. I think we will talk about that some more tomorrow.

And, third, the system relies on coding and cost reporting data systems that take time to provide reliable information for setting rates. Therefore, the payment systems can be slow to incorporate the costs of new technology, potentially providing a disincentive to adopt.

CMS has taken some steps to accelerate these processes in the past year or two. Some manufacturers and providers, however, would argue that they are still too slow.

It is, however, difficult to find reliable and credible alternative sources of cost information to set payments in the short run, and in support of these time lags, some would say that these processes do allow more time to evaluate a technology and to establish a payment rate that better reflects market prices and potentially efficiency of gains over time. So that is the broad structure of PPS.

Now I want to think about types of new technology and how prospective payment systems might capture the costs. There are many different kinds of advances in medical sciences. Some are new drugs, others are new surgical treatments or techniques, and some might be imaging devices. Still, others aren't specific to the treatment of a condition, but improve the management of a hospital or the quality of all services, such as physician order entry systems for pharmaceuticals.

This very simplified chart is an attempt to look at the payment process at a conceptual level and show how

prospective payment systems incorporate the costs of three kinds of new technologies. This classification is really germane to the payment system, rather than any clinical characteristic.

The first category here encompasses new services or procedures, such as laser, angioplasty or new transplantation techniques. The category also describes some services related to new capital equipment, such as digital mammography or proton beam therapy.

New services need to be placed in the payment system. This may occur with a lag during the annual review of payment classifications. Payments may start sooner, however, through special payment provisions like the new technology APCs in the outpatient PPS.

The second category includes new inputs to an existing service, such as a new chemotherapy drug or a new device like the dual-chamber implantable cardiac defibrillators that replace the single-chamber ICDs. These technologies raise the costs of delivering the service without changing its payment classification. The increased costs will eventually be reflected through the annual recalibration process. They may, however, be captured

sooner through special payment mechanisms linked to the technology itself, such as the outpatient pass-through payments.

The third category describes overhead costs, which increase the overall costs of delivering care, rather than the costs of providing a particular service. The update process is really the forum where we look at whether or not there are sufficient funds in the system globally.

So that is a rather simplified schematic, but I hope it helps to clarify thinking about these issues.

Prospective payment systems tend to put a brake on adoption of new technology, as the coding, reclassification and recalibration processes all take time to capture the costs of expensive new technologies. Consequently, there has been debate over whether or not to allow carve-outs or other mechanisms to accelerate the recognition of those costs since the inpatient PPS was first implemented. This has really been a discussion. We have, in the last two years or so, seen the introduction of specialized payment mechanisms in both the inpatient and outpatient PPS's.

These design questions that I put up right now are really asking you to take a step back and consider not the

specifics of what is currently in place or their very tortured implementation, but really what are the elements of a special payment mechanism? These questions are really meant to guide evaluation of the current mechanisms and perhaps decision-making about new technology payments in other settings. For example, we expect a new payment system for ambulatory surgical centers in the relatively near term, so that might be another area where this question arises.

The first question up here is really the most basic. Should there be a mechanism to provide accelerated payment for new technology? In some settings, the question has been answered already, but some would argue that the pressures to slow adoption that are inherent in prospective payment are really countered by clinical and competitive forces that compel adoption. I think this is a conversation that we have had in the past.

The rest of the questions up here address really the design of a special payment provision.

First, which technologies will qualify? I think there is consensus, and Penny will talk about this, that special payments should be limited, and that makes determining the criteria to judge which technologies should

qualify essential.

Should cost be the only criterion? Do we want a mix of cost and clinical improvement? There is really an inherent tension between loose and stringent criteria, and policy designers need to consider as well the ease of administration and the ability to provide adequate guidance about the level of evidence that is required.

The next question will be how will the payments be financed and will they be budget neutral or not? If payments are budget neutral, this, of course, makes it easier to control total spending. However, as we saw in the implementation of the outpatient PPS, budget-neutral payments can have distributional impacts.

Third question, what is the proper unit of payment? Should a price be established for a given product or should payment be tied to increasing costs for delivering the whole service? I think there is a very key distinction there.

Then, what is the proper level of payment? Are we looking to pay the entire costs of a new technology or is the system maintaining some of the incentives for judicious use of new technology that is inherent in prospective

payment?

And the last question is what information should be used to set payment rates? When a technology is new, as we know, it is difficult to obtain reliable cost information. Are there other sources, and what are the implications of using them?

So I think we have had discussions about some of these things in the past. What we have tried to do here is take a more conceptual approach and lay out all of the questions, rather than thinking about a single one in a single context.

So I am going to stop here. I am happy to answer questions about this presentation and also some of the nitty-gritty details that are in the outline about the specific mechanisms in the outpatient and inpatient PPS.

I don't know if you want to do that now or if you want Penny to go on first.

MR. HACKBARTH: What do you think? Would it make sense to do the expert panel and get that out on the table?

DR. WORZALA: I think probably, yes.

MR. HACKBARTH: Why don't we do that?

Pete, you will be first on the list when we get to

the questions.

DR. WORZALA: Let me just take a quick minute to introduce Penny, since I didn't get the pleasure last time around.

We really are fortunate to have Penny with us here today. She is a senior research director at Project HOPE, Center for Health Affairs. She has many years of experience looking at issues surrounding new technologies. She has looked at payment policy, cost-effectiveness analysis, coverage policy, technology diffusion and the cost implications of technological change.

With that, I will turn it over to Penny. We are also going to switch seats, so she can do her overheads.

MS. MOHR: Good afternoon. As Chantal mentioned, I will be presenting the summary of an expert panel meeting that was convened at the MedPAC offices last month.

The purpose of this panel was to identify mechanisms Medicare might use to pay for new medical technology and to discuss the relative merits of each option. When I use the term new medical technology, I mean products that have been on the market one to two years that have not had time to work their way into existing

prospective payment mechanisms.

Also, I must emphasize to the listening public that the points I will be making represent those raised by panel members. They do not necessarily reflect my own opinion, nor do they necessarily reflect the views of the Commission.

To assist with this goal, Project HOPE convened a 14-member panel comprised of representatives from large insurers, multi hospital system, pharmaceutical benefit management organizations, device and pharmaceutical manufacturers, academia and the centers for Medicare and Medicaid services.

It is important to point out that the goal was to obtain various perspectives on these issues and not to achieve consensus. Because this was the format for the panel, there were a diversity of opinions expressed. I am afraid I will be presenting this discussion in very general terms due to the time constraints. However, there was a rich discussion, with multiple layers, that the panel raised, and I welcome your questions at the end to clarify any points.

The discussion focused around answering three

questions with respect to how Medicare might pay for new technology: What principles should Medicare follow? What constraints does Medicare face? And what options might Medicare consider?

The panel members identified several characteristics of a good payment system. I need to emphasize here that it was recognized that some of these characteristics may be in conflict, and not all panelists agreed with how they should be defined or their relative importance. For example, there is an inherent tension between a stable system and one that builds on timely data.

Some of the characteristics mentioned were that the system should be simple, transparent and stable. By this, the system is easy for providers and beneficiaries to understand and navigate. It also needs to be administratively feasible. There should be an ease for CMS and its contractors and also for health care providers to administer the system.

A good payment system would be adequately funded. A point that was emphasized throughout the day was that a good payment system would avoid the starvation of basic services to make room for high-cost new medical technology

and it should be flexible. There was widespread agreement that a prospective payment system probably needs some mechanism similar to a pass-through mechanism to accommodate breakthrough technologies that have a substantial clinical impact, but may cost more.

Panel members also suggested that it should encourage value-based decisions. This was somewhat remarkable, in my opinion, that there was widespread agreement on this point; that Medicare needs to be a prudent purchaser and should consider both the impact of a technology on quality of life and cost in setting payment rates. No one was willing to say systematically use cost-effectiveness analysis, but the term value-based purchasing was used.

While some panel members emphasized that Medicare's payment system should be built on timely data, there was a large contingent that underscored these data should also be credible and unbiased.

Some panel members also raised an issue that has concerned the Commission for some time now, and that is that a payment system should provide consistent incentives across providers for the appropriate use of new technology.

A final characteristic that was mentioned was the need for continuous evaluation. In order to build a good system, Medicare needs to have the resources to monitor and evaluate the effect of payment systems on access and outcomes.

Panelists raised several constraints Medicare faces in paying for new medical technology. Some of these are not unique to the Medicare program. For example, there is an inherent tension between the rapid pace of innovation and the timeliness of available data. One panel member stated that data, by their nature, are retrospective, and payment decisions based on data available from two years ago offer different incentives for using medical technology than those that might be set on real-time information.

Equally, all payers, including Medicare, face budget constraints. However, panelists noted that the effectiveness research is expensive, and others, including public payers like the VA, arguably invest more than Medicare in understanding which technologies to purchase and the effect of their decisions on patient outcomes.

Many constraints, however, are somewhat unique to the Medicare program. For example, some panel members noted

that Medicare must be responsible to diverse constituents, taxpayers, health care providers, manufacturers and its beneficiaries. As a result, it must work through a political process in setting coverage and payment policies. This has constrained its ability to use value-based purchasing tools we make in coverage decisions.

Several panel members also noted that the Federal Advisory Commission Act was a considerable constraint faced by Medicare. This regulation establishes rules about public notice for meetings and required that Medicare welcome all comers. In this sense, some panel members felt that enforced transparency is limiting the flexibility of the program.

As we noted in Project HOPE's survey of large purchasers of health care, most other large purchasers have close ties between their coverage and payment policies. In contrast, Medicare's Coverage and Payment Policy Divisions were formally separated in 1995. While some panel members felt that this was a constraint, other panel members commented that informal communication mechanisms between these two divisions have been growing in recent years.

Some panel members remarked that budget neutrality

has led in the past to situations where payments for basic services were being reduced to pay for high-cost new technology.

While the sheer size of the Medicare program offers some opportunities, for example, it has been able to implement an administered pricing system, some panelists remarked it also imposes some constraints for Medicare. For example, several panel members noted if the Medicare program were to limit access to a few suppliers through a competitive bidding process, it, in essence, will be picking winners and losers in the medical technology marketplace.

Also, panelists remarked, when Medicare sets its prices, it can have a huge effect on the health care market. This effect is enhanced by the fact that many private payers adopt Medicare's prices as benchmarks for their system. By setting prices too low, it can effectively eliminate the market for a particular new technology. By setting prices too high, it can encourage inappropriate use of new technologies.

Also, one panel member noted judgments about which technologies are appropriate may best be done at a local level, where you can get physician buy-in. It is difficult

to get physician buy-in at a national level.

Finally, the fact that Medicare has 15 different payment systems, each of which operates on their own rules, that is, one for hospitals, one for ambulatory surgery centers, one for physicians and so on, limits the ability to adopt a system that provides consistent incentives across settings and among providers for appropriate use of new technology.

Throughout the afternoon of our meeting, panel members discussed various mechanisms that Medicare might use to establish better prices. I must emphasize, at this juncture, that even though all of the mechanisms that I list on these slides were discussed by panel members, some of these options were rejected by many panel members.

By listing them, I do not mean to imply panel members felt they were viable mechanisms or the best option. They just were raised, and panel members pointed out some of the issues the Commission may need to consider as they move forward with their recommendations.

However, as we found in the survey of large purchasers of health care, presented last month, there was widespread agreement among panel members that Medicare does

not obtain the best prices for brand new technology.

Panel members discussed several options, including surveying hospitals and insurers in order to find out what they're paying for new medical technology, requiring that manufacturers submit average manufacturer's price in order to be paid under a pass-through mechanism, peg payment for new technologies to acquisition cost or invoices, and use prices set by the Veterans Health Administration.

This last point generated a lot of discussion and most people felt this was not a viable option for Medicare. The VA achieves good prices because it is able to trade guarantees of volume for discounts by restricting use to a few products on its formulary, something Medicare currently cannot do. If Medicare were to set prices as the same rate established by the VA, panelists cautioned prices to the VA would go up dramatically.

Also, panel members were not optimistic about an option that has received a fair amount of attention by the commission, setting prices for new technology based on fair return on equity, as is done by the U.K. One panel member adamantly explained, this is not on the table. Concerns were raised that the federal government would drive out

innovation through this approach.

Among the questions panel members raised about this approach were should Medicare pay for innovation throughout the world? What is the right level of innovation? How would failed products enter into calculations? And if they did, what incentives would this offer to produce successful products?

Some panelists also felt, as Medicare is currently constructed, it would be difficult to accommodate the use of competitive bidding. First, some panel members noted truly new technologies that might be listed on a pass-through mechanism often do not have competitors and there's little room for negotiation.

Second, even for those products that may have competitors, some panel members said that competitive bidding is resource intensive and requires a different infrastructure than Medicare currently has.

Finally, several panel members noted that Medicare cannot trade guarantees of volume for price. Unlike the VA, it is not a closed system and it is not in the business of directly purchasing from manufacturers and distributing to providers.

While the use of private organizations to do competitive bidding for Medicare might be an option, some panel members caution this approach is probably not warranted for the few new technologies that will be put on the pass-through list in future years.

Panel members also discussed mechanisms to improve value-based decisions at several levels. One panel member suggested providers could be given stronger incentives to make value-based treatment decisions of Medicare were to broaden its payment bundles, as Chantal had mentioned earlier, to focus on treatment of conditions or diseases, as was currently being done in the demonstration project on payment for case management of chronic conditions.

Another option panel members mentioned was the value choice might be given back to the beneficiary by implementing a system of sliding copayments. This mechanism can be explained in this way. Consider two competing technologies for treating the same disease. One is a conventional therapy and the other is a new treatment with the possibilities for improved quality of life or outcomes but at substantially higher cost. However, the data are still not strong enough to definitely state outcomes will be

improved through the use of the new technology.

Medicare could set payment rates the same for both treatments, but have higher copayments for the new technology until there is better evidence about the clinical superiority of the new technology.

I believe there was widespread agreement that Medicare needs to use, at some level, the concepts of value-based purchasing such as cost-effectiveness analysis. However, there were differences among panel members in how this might be defined or ultimately implemented.

I mentioned I was surprised at this discussion earlier. It is notable that one representative from a manufacturer said we are used to having to justify our prices based on cost per quality adjusted life year in Europe. And many private purchasers in the United States use this also in their procurement decisions. Medicare lags far behind the rest of the world in the use of cost-effectiveness information.

With respect to ways to improve the adequacy of Medicare's payment for both new and other technologies, there was lively discussion. Several panel members were proponents of a more general mechanism that has been used in

the inpatient setting. That is, allowing the conversion factor to rise to accommodate the costs of these new technologies rather than providing specific monies through a pass-through payment.

Other panelists felt Medicare should allow for pass-through payments within a budget neutral constraint but limit its decision about pass-through items to a very few technologies so that the relative values of the prospective payment system are not widely distorted.

Still other panelists felt that if you were deciding to make exceptions for new technologies, the budget neutrality constraint should be lifted to pay for these exceptions.

As I have said on several occasions during this presentation, most panelists felt Medicare's payment system must be flexible and many felt a pass-through mechanism was a good way to do this. But its use must be limited only to those few products each year that offered clear clinical advances.

CMS has introduced language to quality for pass-through payment that a technology must offer substantial clinical improvement over existing therapies. However,

staff at CMS feel that defining substantial clinical improvement is not any easier than defining reasonable and necessary, as is used currently for determining coverage.

Another mechanism mentioned by one panelist to allow new money into the system would be to take stock of the trust cost of Medicare inpatient care or rebase the payment system, something that has not been done since 1983. In this manner, the cost of non-clinical quality enhancing technologies, such as computerized physician order entry systems would be better reflected in Medicare's payment rates.

Finally, some panel members underscored that CMS currently does not have adequate resources to evaluate the effects of its current payment and coverage policies on beneficiary use and outcomes. And that it cannot substantially improve upon its payment policies unless it is given adequate resources to do so.

In closing, I would once again like to state the views I have presented are those of the expert panel and not of my own or the commission's. What we obtained during this one-day meeting truly was a free-wheeling discussion reflecting a variety of perspectives. Nevertheless, there

was widespread agreement on at least two areas.

First, panel members strongly supported the use of value-based purchasing concepts. Panel members also agreed that Medicare could do a better job at establishing prices for brand new technologies in the pass-through mechanisms. However, there was not agreement about how best to do either of these two things, and we did not have time to explore solutions in depth in this format.

Thank you.

MR. DeBUSK: First of all, I want to go back to the basis and understand how we sort of started this thing with these pass-through codes. I'll probably have to ask Joe and Carol, this is before my time. But initially, with the outpatient prospective payments piece, where the C codes and the L codes were being defined, we took a whole bunch of procedures, took the products out of those procedures and dumped them all in that first year.

Why did we take a lot of procedures that existed that were already using devices and call it new technology and dump it into that initial payment system? Do you know?

DR. NEWHOUSE: We dumped stuff in, as I recall, that was post-1996 because there was no data post-1996 for

those products and that's why there's been a marked reduction this year in the number. That's as much light as I can shed on it, anyway.

MR. DeBUSK: Somehow it got there. In trying to understand this, because I don't think this thing is quite as cost prohibitive as we might think. But trying to understand the system, we come along and we supposedly exceeded the 2.5 percent cap. But come to find out, that was a projection. That wasn't reality because the coding was quite complex and difficult and the hospitals rarely got it right, so they never got paid for it. So it actually never cost the government all that money.

But in going forward, new technology, and that 2.5 percent cap, and the actual dollars that's going to be involved here with restrictions on what actually new technology should be, in going forward -- the system, I think we've had about four different items that come up. Some of them are not even approved yet by the Food and Drug Administration, like the drug-treated stent.

The way we arrived at that, like the cardiovascular procedure -- and I'm just making these numbers up, so please don't -- if the APC code, or whatever

it may be on an outpatient basis, and let me use that for an example because that's where your C codes are involved, was $10,000. And under the present system the device was $1,000 of the $10,000, like the new stent was going to be $3,500, we would take and reduce the stent by $1,000 and then divide the remaining amount by 50 percent and add it to the initial code; right?

You know, that sounds pretty feasible to me. I'm not so sure this thing is broke. And all these dollars we anticipate, I don't believe they really exist. I think if you go forward with that system and ultimately, after two years, after you've looked at this new procedure using this new device, by that time the medical profession is going to know whether it's feasible or not.

Then roll that back in to the APC code and perhaps group other things in it as well for the total treatment, as you do with DRGs. It looks to me like that would be a pretty simple solution to this. Not simple, but it would be a solution and probably this thing is not nearly as broke as we think it is.

DR. WORZALA: I think there is a fair amount of sentiment out there that we -- it's an old analogy that Dan

started last year. I don't know if I should say it, but the snake swallowing the rat. Now that the rat has been digested, perhaps it's time to wait and see how the snake does.

There is some thought to that effect out there, and perhaps that is the right answer. I think that's one of the reasons I wanted to raise it to a more conceptual level and look at our thinking, rather than maybe sort of getting into the nitty-gritty of the existing payment systems.

But there is still a lot of uncertainty, I would say, about spending, particularly on the outpatient side. My analysis of the 2001 claims data indicate that the pass-through items, which should have been limited to 2.5 percent of payment, actually consumed 8 percent of payment. Now again, that was the rat, so...

MR. DeBUSK: That was projection, not reality.

DR. WORZALA: No, that was reality. In the 2001 claims that were processed, the final action claims that came out and were released this summer, the actual payments that were made represented 8 percent of total payments for pass-through items, not the 2.5 percent.

Now this was without any pro rata reduction

because we're talking about 2001. And it was really when the bulk of technologies, when a very large number of technologies were flowing through the pass-through mechanism.

Now in terms of projections for the future, people have looked at those 2001 claims. And depending on how much cleaning you do, I tried to do as much cleaning as I could to capture as many pass-through items as I could. I ended up with something like 1.2 billion, which is obviously much less than the $2-plus billion that they were using to estimate the pro rata reduction for 2002.

But what they spent in 2001, when coding really was an issue, is not necessarily equivalent to what would be spent in 2002 when presumably coding processes are more refined.

MR. DeBUSK: When this rolls back in December of this year, though, it's going to be a whole new ballgame; right?

DR. WORZALA: That's correct. And looking forward, I think one of the reasons we do need to, and again if the commission wants to not continue these discussions, that's fine. But there will continue, with these systems,

to be lots of discussion about things like the criteria. That argument is still, that discussion is still ongoing. What are the criteria? And what should the payment be? There is active legislative proposals to change those things.

So these parameters are still very important and maybe that first design question I had of should we have one of these things, maybe that's answered. But I don't think that some of these other parameters are sort of nailed.

MS. MOHR: Could I also say that during the panel several people did say that they felt that the system is really not broke, what are we doing discussing these issues? So they did ask that question during the panel, as well.

I can say that at least one person there was saying, okay, we've set new stringent criteria, we don't know what it's effect is going to be. Let's watch to see what its effect is before we move too dramatically at this point.

MR. DeBUSK: I was noticing something else in the text. It's stated there is no cap or budget neutrality provision with the outpatient piece. There is.

DR. WORZALA: That's on the new technology APCs,

which are a different mechanism than the pass-through. Perhaps I didn't make that clear enough. There are two different mechanisms on the outpatient side, the new technology APCs that are for a whole service, and then the pass-through payments. Pass-through payments obviously are limited with a budget cap. But the APCs are not, the new technology APCs are not.

DR. MILLER: I just want to make sure I get one clarification, and this is as much for myself as anything else. Because we've been hearing this, as you've said, from many sources. The wave is over. But your point, when you said there are people actively considering different ideas, and you talked about the notion of a criteria.

This is what I need clarification on. Does that point refer to the fact that you can redefine new categories for pass-through? Is that what you're referring to?

DR. WORZALA: Right. Really, what are the criteria for eligibility for special payment, moving forward.

DR. MILLER: So that's the first point. The way it's passed but if you redefine the categories, it remains to be seen.

And then your second point was people directed towards ideas of holding steady or how they set the price for when you move it into the APC. Is that what your second point was referring to? You had made two points, that people were still thinking about criteria and then prices, I can't remember exactly...

DR. WORZALA: No, really the other piece is, what will the payment be? And this refers more to the inpatient PPS, where it's a marginal payment. It's only 50 percent of the increased cost. And people would argue that you need to cover a greater share of the cost of the new technology.

On the outpatient side, it's 100 percent of costs, and we think that's probably an overpayment.

MR. DeBUSK: I thought it was qualification criteria as well.

DR. REISCHAUER: Educate me for a minute. We're talking about the wave having passed. I thought the wave consisted of a lot of stuff that we really didn't think was new technology, that just got washed in here. And so we really don't know how much new technology has been coming in the last few years, compared to how much will come in the next few years under the criteria that they're going to lay

out. And once they do set this criteria and try to hold to it, what is going to be the reaction of the political system and the producers of this stuff?

My guess is the same as it was a few years ago, which is to redefine what we mean by new technology to be more lenient. And therefore, the question is is there some more objective criterion which we might use to qualify new technologies, such as value-based or cost-benefit or something like that, right?

MR. HACKBARTH: We probably ought to avoid the colorful language that this is broken, and simply say that going forward, as with all of our other payment systems, we're going to have to answer policy questions like what are the clinical and cost standards to be eligible for pass-through? How much do we pay for those items? How do we avoid adverse effects on basic services? And all the money being shifted towards the new technology.

Those are ongoing issues and I think we can walk away from those.

MR. DeBUSK: I retract my statement.

DR. REISCHAUER: There's a question that I had reading all of this, which is sort of how important is

Medicare as a payer for new technologies? If Medicare got the payment exactly right, would that really do much to the introduction of new technologies overall? If it screwed it up tremendously, would it show things down very significantly?

For certain kinds of things that particularly affect the elderly, I can see it being very important. For other things, it might be 15, 20 percent of the total market forces out there and what Medicare does doesn't make a whole heck of a lot more difference than what Jack does.

DR. ROWE: I want to make two points. One small one, and that is that you did comment that Medicare couldn't guarantee a certain volume like the VA could because it wasn't a closed system and there was choice on the part of providers, of course. And I think that, of course, Medicare can guarantee a certain volume. It can estimate the prevalence of different conditions that might be susceptible to technologies and make some estimates of the use of the technologies and guarantee a certain volume. And maybe if it's not reached, they could pay anyway or something, but use that possibility guarantee to get price.

Or do a sliding scale, which would be very

interesting figuring out how to do it, because then the hospital that bought the first stent would be paying more in January than they might be paying in December.

In other words, if you did a sliding scale and the price fell with utilization, you'd have to consider that. But I think that for Medicare to walk away from its volume leverage because it's an open system is not playing a card that it should play in this system, and I think this should be a way to get around that.

The second thing is I was interested in the quickness with which you moved past base prices on a fair return on equity. I wasn't there, but it sounds like you suggested well, why don't we pay you a fair return and people said no, that's off the table, and you went on to the next suggestion.

And I think that maybe that I would return to that suggestion. Just because they weren't attracted to it wouldn't mean that we should not consider it the proper use of the taxpayer's dollars, and that if their concern is that the fair return number is being arbitrarily decided by Medicare and it's really what we think we want to pay you, as opposed to a fair return, there might also be mechanisms

that could be established whereby one could figure out what a fair return might be, with an independent group of experts or something like that. So it wouldn't have to be Medicare's presumption of a fair return.

I think that might be worth pursuing a little further, also. Those would be the two thoughts, and I'd be interested in your reaction.

MS. MOHR: I just have two points. One is in terms of the guarantee in volume. I think you raise some very interesting issues there. However, I think the issue is in terms of do you use this particular stent versus that particular stent? It's very difficult for Medicare to guarantee a volume of product selection at that level. So that was what was --

DR. ROWE: But if Medicare -- the way the hospitals generally do it, is if this is an artificial hip or a clamp, every neurosurgeon has got his own clamp that he wants to use to clamp a subarachnoid bleed. And what hospitals generally have learned to do is to somehow get clinicians to work together to try to narrow the choices and go with one or two and get some volume there and get a better price.

Medicare can do the same thing. And if Medicare is buying 10,000 of these clamps and is getting a better price, and if the hospital then sees that it's going to be cheaper for them to use the one that Medicare is buying in bulk than another one, that that would influence which one got used in the hospital.

So there is some way to influence things, is what my point is. It's not all entirely random.

MR. DeBUSK: How do you do that with new technology, Jack? Then there's only one.

DR. ROWE: I don't know that there's only one.

DR. REISCHAUER: If there's only one then you can make the volume guarantee, is the problem.

DR. ROWE: That's right. That's right.

And if there's more than one you can have a price effect.

DR. REISCHAUER: If there's more than one, then I think you're into the practice of medicine and it becomes illegal for Medicare to specify A versus B when they're therapeutic equivalents.

MS. MOHR: I think the issue is as Medicare is currently constructed, and I think a lot of serious concerns

were raised about distribution of product. So okay, let's say Medicare does get into the bulk purchasing. Then how does it get it out to all these providers? There were a lot of questions along those lines.

DR. ROWE: I guess my point would be that the assignment might be something along the lines of given these restrictions and constraints, how can Medicare utilize either its volume that's inherent in this system or the concept of a fair return to influence its purchasing of new technologies? There's got to be some way to do it, rather than just walk away from those two elements.

MS. MOHR: The other thing that I would say that -- again, we discussed so many different topics. It was really just sliding past this, as you say.

But I think that the main point raised with the fair return on equity was that there are so many methodological considerations that you really have to think about it. And I don't know how much we know the effect has been in the U.K., either. I'm not sure if there's good evaluations of that, yet.

DR. NEWHOUSE: Chantal, I hope your comment that if the Commission doesn't want to discuss this, we can go on

doesn't mean you want to be let off the case. Because I think this is a problem that, in a sense, has been with us forever and will continue to be with us forever. And then the issue is really there is no good way to deal with it. So what's the least bad way to deal with it?

Having said that, I want to say I think you set out, at the beginning of the conceptual discussion, a criterion of cost or paying cost. And I think it's actually more complicated than that for a few reasons.

One is that doesn't distinguish the difference between average cost and marginal cost which for things like drugs and devices is frequently large.

It's marginal cost that's going to drive decisions at the provider level. So that has a couple of implications. One is you tend to minimize the issue of items such as management systems that affect the entire organization. And you say it's relevant to the total funds in the system but not to the relative payment.

Well, that's technically correct, but that could still drive a greater difference between average and marginal costs. So it could still have real behavioral effects if you pump more money into the system for these

"overhead" items.

The second point is that costs, whether they're average or marginal, for truly new technology are very likely to change fairly rapidly. And that aspect doesn't really come up very prominently but taking account of how the costs will change or are changing, seems to me, to be an almost impossible problem, which is why I say this is always likely to be with us.

Oh, and a third point along these lines is that you raise the issue of partial payment and you said, at one point, 100 percent of cost would be overpayment. I'm not sure what you meant by that, but I would have said partial payment raises the issue of underuse. I think we have to be symmetric in our treatment of what we're paying here.

Then, to come to the discussion of the mechanisms to establish better prices, Bob's point about the Medicare share is very important. I think if we are using other prices and the Medicare share is small, and especially if there's competition or substitutes, then that's probably a viable policy. But as the Medicare share grows and as the degree of lack of substitutes grows, that becomes increasingly problematic because if we use, for example, the

price to the hospital we don't really go to the incentives that Medicare is giving the manufacturer to mark up the price to the hospital.

We talked about this in the discussion of pass-through, but it seems to me surveying both hospitals and insurers doesn't really reach to that point. In fact, I think when the Medicare share is above a fairly modest level and there's not much competition, the use of other prices is probably not a viable strategy. Or it's viable in the sense of feasible, but it's probably not a very desirable one.

That leads me back to the fair return on equity, which I had raised. I'm not particularly happy with that solution but I still think it's probably, like Winston Churchill said about democracy, the least bad answer.

The sense I have, from talking to my colleagues in the drug area, is that the U.K. system is generally thought to have worked fairly well. Now the U.K. is a small actor in the context of the world drug market. Medicare would be a bigger actor.

Nonetheless, I am reluctant, like Jack, because the panel swept it off the table, to have us take it off the table. As I say, the other options here don't seem, to me,

to work very well either in the cases where you have a reasonable Medicare share for the product and you don't have good substitutes because that, to me, rules out using other prices and using competitive bidding.

And for the technology that's truly new, there may well be no good substitute.

And then using PBMs, for the reason that both of you said, the ability to channel within traditional Medicare is pretty much not there. I don't see that that can be used, unless Medicare is willing to do that. Of course they have a mechanism to do that, and that would be M+C if they wanted to use it. But we're not going to get to a huge share in M+C, I think, any time soon. We're certainly not going to get there on the read of this is how to handle new technology.

So with that, I hope you stay on this and maybe make the discussion a bit richer, but I don't think it's going to get any easier.

MR. HACKBARTH: I think you made it less attractive to stay on the case, it became more complicated.

Joe, a couple of times now, has made the point that we need to take into account how important Medicare is

as a purchaser of this particular product and whether there are other substitutes or near substitutes for it.

I envision that as we work through these issues we need to have sort of a grid, a table, and we might have different strategies based on different combinations of those variables.

DR. REISCHAUER: It would also be nice to have some examples from the past in that grid.

MR. DURENBERGER: Mr. Chairman, on the point you were just on, I'll characterize it as the grid, I do endorse that and I want to get to that, though, after I pay a compliment to Chantal and to Penny.

I think at the last meeting I pointed out that I had been president of not a think-tank but a talk-tank called the Medical Technology Leadership Forum for six years. And a lot of people, from patients to others who are involved in particular Class III device technology.

I think what you have pulled out of not only the day-long conversation but the background that went into it that you presented last time, is a much more thorough and potentially very effective piece of work in identifying what the problem is than anything I've experienced.

If I look at it simply as where are the problems and where are the potential and things like that, i can't compliment you enough on the effectiveness of that part of the presentation. The principles, the value-based decisions, timely data, consistent incentives, the continuous evaluation. These are critically important. They're different priorities to different people, but they're all terribly important.

Getting to value-based decisions will probably depend on which of the technologies you're talking about. That's why I think this grid has value. The timeliness of that and the accuracy clearly distinguishes technology, particularly the drug people have had

pharmacoeconomics going for them for a long time. So they can give you all kinds of data before they get anywhere near presenting the product for general use.

Whereas, particularly with the implantable device field, it's very, very difficult to come by the kind of data that you would normally want to present. So as an example, I think, of why the concept of the grid, if I understand it, is a good one. But let me just finish the argument.

Particularly for the devices and now the

biologicals and the recombinant products that are in between that. I think at the end we have an example of the beginning of tissue engineering and so forth. And it really comes home as you begin to work into that area, that there are distinctions between the ability of the creator or the inventor to get to market with a device or these recombinant products and so forth, and say drugs or information technology, the amount of public investment that goes into one versus the other.

I think something like 3 percent of the NIH investment currently is going into bioengineered products. I mean, compared to 97 percent going into everything else. The challenges in clinical trials and the challenges of small producers, small investors in the device field, as opposed to large companies and drugs.

So there are a lot of reasons why, as we head in the direction of what I think has been laid out here as an excellent way to approach solving the problem, there is an importance in looking somewhat differently in the implementation process at each of these technologies somewhat differently.

MR. SMITH: I find this both very useful and I

think like a lot of my other colleagues, I'm not at all sure where to go with it. Joe's least bad answer search may be the right way.

But two observations and two thoughts. You did slide over the sliding scale proposition. I just want to underscore the importance of sliding over that, for a whole variety of distributional and equity reasons. It seems crazy to decide something is important enough to pay for it but that we will ration its use based on whatever the beneficiary's characteristics are. So I would hope we wouldn't spent a lot more time thinking about that.

Bob, it seems to me, was on to something when he suggested that this is probably a two-track problem. That we have a very different problem where Medicare is a market driver than we do where it isn't. I'm not sure who's price, but it doesn't seem to me either a policy dilemma or an administrative dilemma where Medicare is not a market driver, to use somebody else's price.

I'd like to see if we couldn't spend some more time thinking about who's price and what do we know about the differences in who's price that would allow us to follow it rather than try to figure out how to try to create a

Medicare price in a marketplace where Medicare is not going to be able to be a price setter.

In the other situation, where Medicare is a market driving purchaser, it seems to me that's where the most complex questions come. And where I'd like to see us think some more about how to use value-based or cost-benefit analysis, as contrary as that is to some of our instincts. It seems to me in searching, wrestling with those is likely to lie the answer to Joe's question.

But if we could try to begin by dividing the world into place where it really matters what Medicare does and where Medicare ought to be a price taker because somebody else is shaking that market, I think that at least would reduce the scope of the problem we face and maybe allow us to concentrate on what do we know about either the cost-benefit schemes or our ability to use value-based analysis on those relatively few areas where Medicare is going to set the price.

DR. WORZALA: Can I just clarify, when we're talking about this, would that then fall into sort of my schema, something that would fall under the eligibility criteria? That when you want to apply for a special payment

you have to give data that say what share of the product is Medicare? I'm just thinking about operationalizing this and where it fits into my schema.

DR. NEWHOUSE: That's what I certainly had in mind, but I think the grid idea of Glenn's is a good idea, but we should still be aware that the effect of the Medicare's share on a price, if you use the other person's price, is going to be continuous. That is there is no bright line here. It's going to have a bigger effect with a 20 percent share than a 10 percent share, and so on and so forth.

The manufacturer, or the profit-maximizing manufacturer will raise the price to everybody to greater the Medicare share.

MS. BURKE: Glenn, could I just ask a follow up question? When would we not be a price setter of something that was of interest to us? Pull out pediatrics, pull out OB-GYN, pull out the things where we would not, in the normal course of our patient population, where would we not, in fact, be the driver? Who else buys more of anything than we do?

MR. DeBUSK: Nobody.

MS. BURKE: So if we were to take a price, if we become a price taker --

DR. REISCHAUER: No. What, 20-something percent of hospital expenditures.

MS. BURKE: But in terms of a single purchaser. I mean, I know if you --

DR. NEWHOUSE: It's the market share. It's going to vary by the disease. Any particular supply, drug, device?

MS. BURKE: Just on the face -- I mean, I understand on any individual case there might be some variance, but I can't imagine many circumstances where if it were a technology that we would, in fact, envision being utilized by our population, that we wouldn't in almost all cases be the single largest purchaser.

MR. HACKBARTH: As I understand it, it's not just a question of who's the largest purchaser but whether Medicare is basically the only purchaser. Again, a continuous variable, but Medicare represents a very large portion of the business. So this is a product that basically older people use and almost all of the business is coming through Medicare. Then Medicare's pricing decision

has huge consequences for innovation.

DR. NEWHOUSE: But I think it has very serious consequences a lot short of that, for the market. I mean, it's the same problem as saying the price of drugs that Medicaid pays is going to be the same as the VA, and watching the prices to the VA go up because we're no longer going to grant the discounts, we can't afford to grant the discounts, if Medicaid is going to have to get those discounts.

DR. REISCHAUER: David said he thought it was appropriate that you slide over this system of sliding copayments. I would suggest you stop long enough to drive a stake through its heart, because presumably what this is is we have a new device, procedure, whatever, that costs a lot more and we're unsure whether it represents an improvement. And if you say well, you can use this and the way you will get your extra resources to pay for it is to charge the patient more, that provides an incentive for the hospital or the physician or whatever to do this to get more money. I think it's pernicious. I don't think we should suggest that there's a good way to go.

MS. RAPHAEL: Chantal, I just wanted to be sure in

the report we paid a little more attention to what the current infrastructure and capacity is not of CMS to evaluate new technology. I was struck that the budget for research is $50 million, almost none of which is devoted to this. And VHA has a budget of $350 million.

I just think that we have to do some capacity building here, no matter what the process is t hat we go through, whether we focus on starting off four to five promising technologies. But I would like to see a recommendation in that regard ultimately.

MR. DeBUSK: Remembering the back of this is the thing called competition. Just to give you an example, like with stents, there's numerous other companies right now on the verge of having new coated stents out. So what's going to happen?

I can assure you this $3,500 charge for a stent, cost for a stent, is going to take a nosedive in short order because of the free market. That takes care of a lot of it itself.

DR. NELSON: I think it's important, in whatever report comes out of this, to remember that for many of these products now we have a global market. And Medicare may be

the big hitter in our country, but I always worry a little bit about our program subsidizing the rest of the world in these products that indeed are global in scope rather than just our country.

MR. HACKBARTH: Can I ask a question about budget neutrality to make sure that I've got this straight in my head? If we establish ground rules that we bring these new things in, needs to be on a budget neutral basis, however, and you just stop there, then that's where you have the risk that if there's too much of the new technology, if the volume is large, that it can start to cannibalize the resources available for other services, staff salaries, nurse salaries, whatever.

But then in each of our analyses of the different payment policies, we have a step where we look at the overall update factor and can adjust that upward to accommodate new technology. So if we have the budget neutral step but then we look at the update and say well, we want to add an increment for new technology, I guess paradoxically that added increment almost becomes the resource that's available to protect the basic services.

It's labeled a new technology factor in the

update, but it's what assures that there's money in the pot that protects the basic services.

DR. NEWHOUSE: But the issue is whether that goes to the new technology or whether relative prices are constant, so then it just washes over the whole thing and changes the incentives to provide the basic services.

MS. BURKE: So you have no idea whether it actually ends up in the pocket of the individual hospital or particular service that is actually increasing the cost.

MR. HACKBARTH: Right. To me that's an important part of this puzzle. I don't understand it as well as I need to, but I do worry about this bent that we have to make room for the technology, but then what happens to the other stuff? We're not going to resolve that right now.

MS. MOHR: But of course, you're aware that the new technology consideration is only done for the inpatient conversion factor. It's not done for the other settings. So for the scientific and technological adjustment, that's just for the inpatient setting.

MR. HACKBARTH: Maybe a discussion worth having is whether we need an analog for the outpatient payment system.

DR. WORZALA: Our own update framework does

consider that issue.

MR. HACKBARTH: Okay. Lots more to do on this. Thank you for your good work in laying out the issues. We do need to move ahead.

Now to discuss the first step in an analysis of hospital financial performance and trying to compare the financial performance of hospitals based on their characteristics. And I do underline that what we're going to hear today is the first step in that analysis and we need to avoid premature conclusions on this subject. Jack, whenever you're ready.

MR. ASHBY: As Glenn says, this session is to go over the results of the first phase of the initiative we've undertaken to learn more about why some hospitals seem to fare extremely well under Medicare inpatient PPS and some do quite poorly.

By way of some background, this first chart replicates data that we presented in our March report focusing for the moment on the solid line which is our full inpatient margin and excludes critical access hospitals, by the way. We can see that there is quite wide variation in financial performance in this PPS. We have a 10th

percentile of minus 14 percent and a 90th percentile of 27 percent.

When we first presented these data last winter, you basically asked us to attempt to determine why we see a distribution that is this wide. And as we say, this is our first go at attempting to answer that question.

MR. HACKBARTH: Jack, can I ask a question before you go further. I know all of this analysis is done using the inpatient margin. My recollection is that we see the same sort of distribution if we use overall Medicare margin; is that right?

MR. ASHBY: Yes, we would see basically the same picture. The whole scale would be moved downward a bit, but you'd see the same basic pattern on the overall Medicare margin.

DR. ROWE: And the overall margin as well or just Medicare?

MR. ASHBY: The overall margin, there's a wide variation there, too. But the dynamics are considerably different and we may get to looking at that down the line, too.

MR. HACKBARTH: I was referring to the Medicare

margin including outpatient services.

DR. REISCHAUER: Jack, are these weighted by hospital bed size?

MR. ASHBY: No, reflecting your earlier comment this morning, these are not weighted. Each observation is treated as a hospital in this analysis. Every hospital counts in this look at the picture.

But we have known for a long time that hospitals receiving disproportionate share and indirect medical education payments is indeed a predictor of good financial performance. Because there is little relationship between the DSH payments and cost, and because a substantial portion of the IME payments as well, over half of the payments, are beyond the documented impact of teaching costs, we would expect, all else being equal, that hospitals receiving these payments would have higher margins.

And as we see in this next chart, that is indeed the case.

MR. MULLER: You mean higher Medicare margins.

MR. ASHBY: Yes. These again are Medicare inpatient margins.

We see that major teaching hospitals here have

margins that are twice those of the other teaching hospitals. And in turn, those are almost twice the margins of non-teaching. We see the same pattern with the disproportionate share payments. And as you can see at the bottom, there appears to be some interaction between these two payment adjustments as well.

As you can see, hospitals that are major teaching and also receive DSH payments have the highest Medicare margins of any of the standard groups, the 40-odd standard groups that we look at.

MS. BURKE: Jack, I want to make sure I understand. This excludes those costs or includes? The previous chart excludes, as I understand, DSH and IME. This includes DSH and IME.

MR. ASHBY: Right, although if we can go back to the previous chart.

MS. BURKE: The previous one does not. It excludes.

MR. ASHBY: The solid line here includes, that's our starting point, the solid line here. This includes all and this is the distribution you look at.

Then continuing with the includes DSH and IME, you

can see that we get this sort of disparity.

DR. ROWE: Can I ask one question since we've got you taking your breath for a second?

The fact that the distribution in the first graph would be roughly the same if you included outpatient as well as inpatient should not be, I believe, construed to be carried through the rest of these data. And that if you included outpatient as well as inpatient margins in this slide, these numbers would be quite different then, wouldn't they?

MR. ASHBY: The outpatient margins differ very little among these groups, so the effect that you see here would be diluted by essentially adding in a constant for the outpatient sector. But the variation you see here would still very much be there, it would just be --

DR. ROWE: Is that right? Because I was under the impression that many of the major teaching hospitals had negative -- had a much less salubrious experience in the outpatient than --

MR. MULLER: Because the weights of in to out are much different in some of these. Right, Jack? You wouldn't say that the in and out weight is the same across all

hospitals?

MR. ASHBY: No, it's not. But nonetheless, we can produce that graph.

DR. ROWE: That would be great.

MR. ASHBY: If we did this on the combined inpatient and outpatient, you would still see these very substantial differences that you see here. They would just be somewhat reduced.

DR. ROWE: That might be a more -- with respect to the role of Medicare, I just never have accepted the view of just looking at the inpatient margin. I think we're talking about the hospital, not the inpatient facility, particularly these days since more is done in the outpatient. To see the whole institution data, I think would be very helpful.

MR. HACKBARTH: Jack, why in the first instance did you use the inpatient? Why did you start with the inpatient?

MR. ASHBY: It was kind of a segue to the next point I was going to make, and that is going back to this graph. When you pull out the DSH and the subsidy portion of the IME, one of the things that you see is that there remains a great deal of variation. The variation is every

bit as large. And that speaks to why we wanted to look at this.

I mean, inpatient payments, obviously, in dollars are the lion's share of the system. But what brought us to this study in the first place is the fact that we see such extreme variation here. And while, as you see on that chart we just looked at, IME and DSH obviously explain a great deal of that variation, you take them out of the picture and lo and behold you still have tremendous variation.

That's what we wanted to learn more about. Showing that IME and DSH make a great deal of difference is kind of shooting fish in a barrel basically. We know that. What we don't know, or anywhere near as well, is why when you take away the big guns do we still see tremendous variation? I think it suggests that there are other factors at play or we wouldn't have this same degree of variation on the dotted line.

And of course, it also suggests that the hospitals receiving DSH payments and IME payments themselves vary. You can just deduce that from the fact that you take away from the solid line all the way across distribution. So explaining that remaining variation is what we're about

here. Okay?

Now our approach, in doing so, then began as we say by calculating a Medicare inpatient margin that excludes DSH payments and the portion of the IME payments that exceed the teaching cost relationship. Then we divided the hospitals into quintiles, that is five evenly sized groups, defined by this margin. So we now have hospitals that array on margins.

And then we compared those quintiles on various characteristics. And just to finish off this methodological thing, this is what we're looking at with our five groups of hospitals. They range from the lowest, which averages almost minus 19 percent, to the highest, which averages up to 20. And again, back to Bob's points, these are non-weighted averages of margins.

DR. REISCHAUER: Any idea of what fraction of beds were in the lowest and in the highest?

MR. ASHBY: I don't know that right off but you can be sure that the upper range has more beds in it than the bottom range. And we'll see that as we go along.

DR. ROWE: It's interesting that you have such deeply negative numbers in the first quintile, but that none

of the categories that you had on one of your preceding slides had negative margins. They all had positives. They had from 23 to some number less than that, but still north of zero.

MR. ASHBY: Right.

DR. ROWE: Which suggests that there's not one subset, at least the way you broke it down, that is hyperconcentrated down in --

MR. ASHBY: Precisely. That's exactly the point we want to get across. There is variation within every one of these groups of hospitals. And that begins right off the bat to tell you something about the nature of the dynamics here.

We addressed three types of characteristics in this study. First is features of the payment system like the wage index level, for example. If we find differences between high and low margin hospitals on this kind of variable, it might indicate the need for further study to determine whether we ought to change the payment system.

And secondly, we looked at the facility/environmental characteristics that we generally consider beyond management control, at least in the short

run. The best example would be urban/rural location. If we see differences in this type of variable it might suggest that such variable might need to be taken into account in designing our payment system.

Then finally we looked at characteristics that are generally within management control, such as cost growth, the rate of cost growth, for example. In this case, of course, we would not want to take this kind of factor into account in designing the payment system, even if it is associated with major differences in performance. This is the kind of thing that hospitals ought to be on their own to influence.

DR. ROWE: So you think that the annual growth in health care cost is within the control of the management of the hospital?

MR. ASHBY: Let me make the --

DR. ROWE: Certainly not any hospital I ever managed, but that was well documented.

[Laughter.]

MR. ASHBY: Let me make the very next sentence. My very next sentence was going to be that among these facility characteristics virtually none of them are entirely

exogenous or entirely endogenous. There are always factors that are on both sides. So we sort of put them in camps by what we thought was a predominant influence.

DR. ROWE: You might say management influence, rather than management control.

DR. REISCHAUER: Or effective management, Jack.

DR. NEWHOUSE: It's the other managers that weren't controlling them.

[Laughter.]

MR. ASHBY: I kind of had in my notes predominant influence.

DR. ROWE: Once in a while I wonder why I'm here, and then I find out. I'm glad I'm amusing you guys.

MR. ASHBY: But indeed, that is a mixed bag situation. I guess we're hypothesizing that there's more room for influence on something like your cost growth than there is on something like the location or the size of your hospital and what have you.

Limitations of the study. The most important one perhaps is that the relationship of one variable we might be looking at to margins will indeed reflect the effects of other variables. And consequently, this type of bivariate

analysis can only be seen as the first step in analysis and the results need to be interpreted rather cautiously.

We have already begun two different multivariate modeling efforts that will extend what we're seeing today and we thought we might also consider doing case studies down the line as a way to possibly get at the effects of some of the more management oriented factors that are not easily measured with secondary data sources.

Then a second limitation that's forever in our studies is that the relationships may indeed have changed since 1999. Although, as we go along I think you might really postulate that some of these are patterns that have been there forever and may very well not have changed that much.

Unless there are any other questions on methodology, we're ready to summarize our findings.

MR. MULLER: Glenn, is now the time or later to suggest some other variables? Should we do it later, after the presentation is over.

MR. HACKBARTH: If you're willing, Ralph, what I'd like to do is let Jack get all of his presentation out. I set a bad example by leaping in right at the beginning.

Let's let him get his stuff out and then we'll have questions.

MR. ASHBY: In this next chart we have the list of variables that we considered, more or less, generally beyond management control, although the flip side of Jack's point, none of these save possibly your base location is completely outside of management decisions in the longer term.

The first one of these is urban/rural location. We found that hospitals in large urban areas performed better than average and those in rural areas worse. This is a finding, of course, that we remember from our rural report a year-and-a-half ago.

But by the way, by perform better, I mean in this context that they are both more likely to be in the group with the highest margins and less likely to be in the group with the lowest margins.

This finding at least partially reflects the fact that hospitals in large urban areas have access to the higher base rate, and you'll recall that we recommended a year ago that we phase out that differential in base rates. I can add that both the Senate and House bills that are on Capitol Hill right now do include that provision, to

implement MedPAC's recommendation, if you will.

Next we looked at hospitals in particularly isolated rural areas, the least populated areas, and found that they actually performed much better than other rural hospitals. It might seem counterintuitive at first blush, but we believe that this is due primarily to the fact that many of these isolated hospitals are helped, in fact, by the existing special payment provisions that are oriented towards rural hospitals. That includes the critical access hospital program which basically just pulls out the hospitals with negative margins from the PPS and therefore pulls them out from the data that we are looking at.

How well these special payments are targeted at the individual level is indeed a subject of debate, but we can at least say that broadly across this group of the most rural hospitals, the payment system is indeed helping them.

Next we looked at some volume-related factors. First, our finding is that there is no relationship between margins and Medicare dependency, that is Medicare patients as a percentage of total. The average Medicare penetration, which is right around 50 percent, is about the same for all five of our quintiles by margins.

This, indeed, squares with our earlier findings, that actually go back several years, but our earlier findings of a multivariate analysis that found no relationship between Medicare dependency and cost per case.

But of course, we have an adjustment in our payment system that is based on Medicare dependency. And while many of the qualifying hospitals probably do indeed need assistance, all evidence points to the fact that Medicare dependency is not the best means for targeting that assistance.

Then we next looked at low volume hospitals. Here we're looking at low volume across all payers. This is a production function kind of question. The finding here was that hospitals with low volume are much more likely to have low margins. That squares again with our multivariate analysis done for the rural report that found a very high correlation between low volume and cost.

That led us to recommend that Medicare implement a low volume adjustment, and that recommendation was seriously considered in the Senate Finance Committee but it ultimately was not included in the bill that was just introduced a few days ago.

We also, though, found that a goodly number of these low volume hospitals are in the highest margin group, which seems again a bit contradictory. But that is due to the fact that some of the low volume hospitals are helped by existing programs. Existing programs don't target to low volume so some get help and some don't. But those that do receive the assistance are vaulted up into sort of the winning category here. We'll have more on those provisions in a moment.

Next, type of control. We found a clear relationship here. The investor-owned hospitals performed considerably better than voluntary hospitals. Again, this is both at the low and the high end of the spectrum. That's due in part to the fact that investor-owned hospitals have indeed had lower cost growth during the '90s. So we have to assume that there is some link to management of these facilities.

But of course, to sort of amplify on Jack's point again, management actions can mean a lot of different things. They can indeed include real efficiency improvements. They might also involve cutting services in a way that affects access. They might involve cutting staff

in a way that affects quality. We have no information here on how this was accomplished, other than through lower cost growth by one means or another.

Then we also note that the government hospitals performed worse than the voluntary. It's really hard to know what combination of management/circumstance/mission types of factors are in play here.

MR. MULLER: That's independent of Medicaid mix? This answer is independent of Medicaid mix, or not?

MR. ASHBY: No, I mean if you mean controlling for Medicaid mix, no, it does not.

MR. MULLER: That's the usual explanation, is they do Medicaid and uninsured.

MR. ASHBY: Right. But it leaves open the question that we're only looking at Medicare payment relative to Medicare costs here. But there are possibilities for carryover, indeed, and we know that, too.

Now we're moving to features of the payment system.

DR. ROWE: I'd like to ask a technical question here. When you are including for-profit, is the margin post-tax?

MR. ASHBY: Yes, I believe the margin would be post-tax because tax is an expense on the cost report like any other expense.

First, we wanted to look here to hospitals receiving IME payments. We did indeed find that hospitals receiving IME payments performed better than average. We have to remember here that this is performing better, higher and higher margins, more likely to be on the high end, less likely to be on the low end, before we even add in the IME payments or the portion of it that is above the cost relationship. They still fare better.

That reflects partially the benefit of this higher base rate we were talking about a more ago. Most major teaching hospitals are located in those areas. And it also reflects the fact that teaching hospitals, again, have had lower cost growth during the '90s.

Now on disproportionate share, we did not find any relationship at all. When you think about it, that's really what we would expect, given that there is very little evidence of any relationship between DSH payments and cost. These deal with revenue issues. DSH is intended to deal primarily with revenue issues. On the cost side here

there's no relationship and therefore we see no relationship in the margins, either.

Then we wanted to look at the two primary rural payments, and that is sole community hospital program and small rural Medicare-dependent programs. I wanted to clarify here that we're talking about hospitals that actually receive extra payments from these programs. A far greater number of them qualify for the programs, but they have the choice of the existing PPS rates or the special rate, whichever benefits them the most.

What we found here was the hospitals receiving extra payments were more likely to have the highest margins and were not less likely to have low margins. No difference on the low end, but they were much more likely to end up on the high end. That suggests the possibility of some overcompensation from these programs. And there's at least a couple of reasons to think that that might very well be the case.

One is that both of these programs base the payment on these hospital's own cost in a base year, and the hospitals may very well have had an unusually high cost year that they get to lock in as their base rate.

And then secondly, the point I made a moment ago, that MDH, the Medicare-dependent program, has these hospitals qualifying on a factor that has essentially nothing to do with cost. So indeed, we can simply have some high cost hospitals that happen to have a lot of Medicare patients, and they get the benefit of these higher rates.

Okay, then we looked at issues related to wage index. First, we found that hospitals that are geographically reclassified perform worse than other hospitals, again at both the high and the low end of the distribution. This is despite a design here that again suggests some possibility of overcompensation. Those in the outlying area, away from large cities, benefit from an average that is pulled up by the large hospitals in the core city that might be 70 or 100 miles away from them.

But we have to remember that most of these are rural hospitals and they probably have other disadvantages that we see in some of these other variables. And also, that this reclassification category includes not only reclassification by wage index, but reclassification for the large urban-based rate. And the rather strange feature of that provision is that the main thing a hospital has to do

to qualify for that extra payment is to have high costs. That's what they have to do to show that they're a high cost hospital.

So we should not be surprised to see that high cost hospitals end up in this group and therefore have lower margins. That's exactly what we see.

Then on the wage index itself, prior to reclassification there's very little relationship between margins and wage index value. And after we account for the movement due to reclassification, there's virtually no relationship at all between wage index level and financial performance.

And that despite a wage index system that ranges from .7 all the way up to 1.5. We found all five of our groups within a couple of percentage points of each other. There's virtually no relationship. And that supports the conclusion that we made in our June report, that there really is no need for a wage index floor that would indeed give very large payment increases to those hospitals in the low market areas.

Lastly, we're going to move to factors that, at least to some extent, appear to be within management

control. This is the list. We'll start out with service mix.

The theory behind why we would think that hospitals offering post-acute services themselves would have something to do with financial performance on the inpatient side is that first it allows the hospitals potentially to discharge their patients earlier simply because it's a little easier to arrange it down the hall than it is to arrange a transfer to the next county or something.

But also because it gives them the opportunity to allocate costs out to these post-acute services, therefore reducing the costs that are carried over on the inpatient side.

But our finding, in fact, was that there's very little evidence of relationship here. The hospitals offering SNF or home health were only slightly less likely to have low margins and virtually no difference on the high side. As far as offering inpatient psych or rehab, there's a little bit more of a difference on the low end, but still nonetheless the general picture is not much action on these variables.

For outpatient services, we did find that the

hospitals with the lowest margins do indeed have much more outpatient care, a larger proportion of their resources devoted to outpatient care. But we really doubt that there's a cause and effect here.

Many of the small rural hospitals do proportionately have very large outpatient operations but I would tend to suspect that the problem really is the very small scale of their inpatient operation that is causing them the financial trouble for inpatient payments.

Lastly, we have the three variables that at least have the potential for significant management influence. I think the word influence does look better up there than control, but at least some potential for management influence.

First, we found a strong relationship to occupancy rate. Lower margin hospitals do indeed have low occupancy and vice versa. Same situation with the decline in length of stay. Now just to sort of set the landscape here, all hospitals had very large declines in length of stay during the '90s, but the low margin hospitals were able to reduce their length of stay to a much lesser degree than were the higher margin hospitals.

But then the strongest bivariate relationship of any of the variables that we looked at was between margins and the 10-year change in Medicare cost per case, which is to say quite simply that those that controlled their costs are the ones that are doing well today. Those that did not control their costs are doing poorly today. It's pretty much as simple as that.

Of course, one of the ways that you control your costs is through reducing your length of stay. But since the effects of differences in the cost growth were much greater than the effects of differences in length of stay, we have to surmise that there is something going on here beyond manipulating length of stay. We don't really know why there is such a huge range in cost growth. This really is a very large difference between the high margin hospitals and the low margin hospitals here. But the finding does indeed suggest that there is plenty of room for influence for the hospital's own management decisions.

Because we really know why there is this huge difference in cost growth performance, which leads to financial performance differences, the next step that we intend to take in this analysis will be a multivariate

analysis in an attempt to identify the factors that are correlated with these differences in cost growth. Craig Lisk will be reporting on that analysis at an upcoming meeting.

MR. HACKBARTH: Until we do that we really do need to regard these results as quite --

MR. ASHBY: Fairly preliminary, right. We're kind of at the hypothesis-forming stage, as it were.

MR. MULLER: The inpatient margins, as I've said for quite a while now, always attract a lot of attention. I notice it already hit the trade press yesterday around the country. So it gets out there pretty fast, despite that they might be hypotheses.

Jack, if I could make a suggestion on the management influence ones. In the same way that maintaining cost control maybe, as you say, is a good indicator of where the margins may be, some form of revenue control I would hypothesize would come from perhaps looking at the proportion of DRGs and the higher weights for some kind of case mix index, probably even more than case mix index, which is more of a continuous function, perhaps looking at the proportion that are more than a certain weight.

Certainly, we're seeing the kind of specialty hospitals going up, I think, in the DRGs that have higher weights and so forth.

So one of the things, if it's not too hard, you may want to look at is the extent to which hospitals concentrate their services in the kind of higher weight DRGs and see what that's a measure of. I would hypothesize that's a measure of revenue opportunity and growth and therefore would lead to margins.

So either looking at the case mix index or looking at some proportion by high DRGs might be a good thing to look at.

The second thing is, it just goes back to the comments, to always look at the inpatient and outpatient in some kind of concert, I think is an appropriate thing for us to keep looking at. I understand your point about the inpatient margins being worth analyzing in and of themselves, by and large, since as we discussed last year, there's such a depressing effect from the outpatient margins on the inpatient margins. These numbers of 20-plus get a lot of attention. So I think having them in some kind of concert usually makes a lot of sense.

Thank you.

MR. ASHBY: It's kind of a frustrating situation because pointing out how high some of these hospital's margins was not the purpose of today's session. We're trying to get at why there are such differences across the distribution. But nonetheless, that's what some folks notice.

DR. NEWHOUSE: I'm going to wind up suggesting a more radical hypothesis but let me start with a question. Have you, Jack, computed these margins for a multi-year basis? That is say over a three or five year period?

MR. ASHBY: Let me first of all say that I missed a point that I intended to stress, and that is that these margins are already two year margins and we used the two-year margin rather than the one-year margin under the theory that it would help us a little bit in avoiding the effects of perhaps data anomalies, but also just one-time factors that might affect it.

We really wanted to go farther than even a two-year and look at a longer period, but our fear in doing that is that with us constrained with only having '99 data in the first place, you go back very much further than that and you

get into a time when the world was really different. '97 and before we had, first of all, much higher margins. A whole lot of cuts had not gone into effect yet. And we thought that that would contaminate things to go back that far.

DR. NEWHOUSE: Let me put forth my hypothesis and then say that computing margins over several years would be a weak test of it. One of the implications is besides multi-year, would be to also look at most of Medicare.

The hypothesis I want to put forward is that some amount of this variation is basically attributable to a variation in accounting policies. And that this discussion has tended to treat it as real and it may not be real.

One example to keep in mind that's too extreme for this probably is the variation in the direct medical education payments, which is basically all attributable to variation in accounting policies in 1984. That's an extreme amount of variation.

MR. ASHBY: That would be on the GME payments.

DR. NEWHOUSE: Direct medical education payments.

MR. ASHBY: Yes, the direct medical education.

DR. NEWHOUSE: But beyond things like revenue

recognition, treatment of depreciation and so forth, how hospitals allocate overhead to the inpatient unit versus to the other units could well vary. That could be stable. The reason I wanted you to go to multi-year was that if this variation persists on a multi-year basis, it suggests that it's -- first of all, it suggests that it may not be real, because how are these hospitals with big negative margins managing to survive. And second of all, it is consistent with a variation that's stable over time in accounting policies.

Beyond how you allocate your overhead to the inpatient unit versus the other units in the hospital, which could vary, I think Ralph let you get away too easily with the answer on Medicaid and uninsured, that if this was only the Medicare margin --

MR. ASHBY: It gets back to the allocation question.

DR. NEWHOUSE: Absolutely. I mean, the rest of the patients, we know that, for example, nursing time just gets allocated on a per diem basis, but the true costs could well vary and presumably do vary. That's again basically an artifact of these numbers then, in terms of the variation.

The final point I wanted to make was on the control issue. There are different incentives in accounting in the for-profits. It even goes to your point about the control of costs. Because the accounting, you were treating that as real. The hospitals that were controlling their costs better were showing better margins. But if the control of cost is something of an artifact of accounting policy, then it's going to turn into an artifact in the margin.

Now I don't know that it is an artifact and I'm not implying that most all of this is an artifact. It may not be. But I think we have to entertain the hypothesis that some amount of this, and it may well be a non-trivial amount, is just an artifact of how the hospital does its accounting.

As I say, I think you can minimize some of that by going to most of Medicare and away from inpatient. And I think that if you see much of this variation persisting over time, and particularly if you see the hospitals with negative margins persisting over time, then it suggests that it's probably not real.

MR. ASHBY: Right. The one thing that I can say

about over time is that we were kind of interested in the question of whether the variation has increased over time. But in fact, it has not. The standard deviation of these margins in 1991 is almost exactly the same as the standard deviation in 1999.

DR. NEWHOUSE: No, that's not what I mean by over time. By over time, taking the margin over a 10-year period, not how it changed between '91 and 10 years later. But if I took a much longer period than two years, how much variation would I see across hospitals?

MR. ASHBY: Yes. It's a difficult trade-off. Like I said, we really wanted to go to a longer period of time but our fear was that we have other things going on during that same period of time and the world really changed rather dramatically. The accounting factors, of course, are one of the things that may have changed but unfortunately there's a world of other things that changed, too.

DR. NEWHOUSE: They may not have changed and yet you still have this kind of variation.

DR. ROWE: A couple things. On unnumbered page number eight where we have urban/rural location, I think we might want to change the first line, if I understand the

first bullet, to say hospitals in large urban areas performed better than average while those in rural areas performed worse, except for those who don't. Because what you have done is excluded the hospitals that are taken out of the PPS because they perform badly. And they get corrected to immunize them.

And if you threw them back in they, of course, perform better than average.

MR. ASHBY: No, they wouldn't perform better than average. They're brought to zero.

DR. ROWE: They're brought to zero. But that changes. Unfortunately, I'm not sure whether you intend this to be an analytical document. Some people might see this as a political document. And I think that, to be fair, this statement neglects those populations that are immunized from being negative and there are already these programs out there, the sole community program, Medicare-dependent hospitals.

So I think that we need to correct this somehow.

MR. ASHBY: So the suggestion is that perhaps we should have left the CAH's in.

DR. ROWE: Yes. That's my point.

DR. MILLER: And in the multivariate analysis you can actually model it as a variable in order to control for its effect, put it back in the database.

DR. ROWE: Yes. Or you could say that for all hospitals, those in large urban areas, et cetera, et cetera. And then you can say for those hospitals that are not included in special programs -- or something like that. But somebody will pick up -- I wouldn't suggest anyone here would do that. But somebody might use that statement in a way it's not intended.

MS. BURKE: Jack, I'd suggest using a term other than perform because it indicates that they're doing something that essentially gets them what they get, which is not the point of what you're saying. The point is the results are different and their margins are better in one than in the other. It's not a question of performance, per se. People will view that word as a code for something.

DR. ROWE: Then the next page, the second bullet talks about hospitals with low patient volume and you get, much later, to the issue of occupancy. I think that there needs to be a closer linkage throughout this of volume and occupancy and length of stay. And there needs to be an

analysis of the intersection of those. Let me just talk about that for a second.

Occupancy is obviously more important than volume. If you have a small hospital that's 100 percent full, it's much more likely to be doing well -- let's say 100 bed hospital that has 100 patients, than a 200-bed hospital with 100 patients. They both have the same volume, one has much better occupancy.

But the other point about length of stay relates to the backfill phenomenon. For instance, there is less pressure to reduce your length of stay if your occupancy is low. If you have 100 percent occupancy and you know that as soon as a patient leaves another patient will come in and there will be another, in the case of Medicare, DRG payment, then there's a great emphasis to reduce the length of stay and move the patients through.

But if you have no pressure, there are many payment systems from private payers where you get a per diem. So you get nothing for an empty bed. And if the patient stays in the bed you get something. So that reduces the pressure on the length of stay. And it's hard to have a hospital that has one set of length of stay initiatives for

the Medicare beneficiaries and another set for the non-Medicare. You can't really do that.

So there needs to be at least some discussion of the relationship and the dynamics between occupancy, volume, and length of stay. So that people get an appreciation for how these might interact.

Nick runs hospitals and Ralph ran big hospitals, and there may be other points of view here, but I think that that would be informative, just to have some stuff about that.

MR. ASHBY: But I want to point out, though, even with an empty hospital, all else being equal with respect to management here, they're still going to benefit from cutting length of stay. There may be opportunities to reduce the --

DR. ROWE: I agree with you, Jack. I just think there's an additional layer of sophistication here we can include.

The last point I would make is about the availability of post-acute care services being under management's influence. I think that is, in many areas, a regulatory issue. Management might wish to have post-acute care services but you can't get approval for additional SNF

beds in a given area because there's an excess of them or whatever. There are a number of regulatory issues. There may even be labor relation issues in some areas, where there's a union for long-term care facilities but the given hospital doesn't have a union.

I mean, there are all kinds of issues which may not be so easily managed by the executives.

MR. ASHBY: We saw in management prerogative, in terms of closing post-acute care units. I mean, we had a bunch of them close in earlier years. But on the opening side, I guess you're saying it's not a parallel --

MR. MULLER: Just briefly, we also know from our data last year that nursing homes that are largely Medicaid have dreadful margins, minus 70 or something like that. So you're not going to built a lot of nursing home beds that are in areas that are Medicaid because they're minus 50 percent margins. So that, in a sense, is to add to Jack's point. It's just not going to happen, high Medicaid areas won't have as many beds.

MR. SMITH: A couple quick points, Jack. Much of what I wanted to say has already been said. But I did find the distinctions that were made on control/lack of control

unsatisfying in a lot of ways. For some of the reasons Jack just mentioned, Ralph's earlier point about Medicaid-avoidance. Even the decision to stay open, you suggest that location is something which is fundamentally out of location's control. Well, when you think about the open/close decision, it's fundamentally within management's control.

So thinking more about the subtlety and complexity of what management can and can't control and the ways in which it's constrained would be helpful.

I want to remake the point that Bob made and that Bob and I make almost all the time. Bed weighting this stuff would help. One hospital, one vote is not a very good way, it seems to me, in looking at the distribution of margins or much else. And if we could get some bed-weighted versions of that, I think that would be helpful.

MR. ASHBY: In most of our work we almost invariably use aggregates that are revenue weighted, is what they are, as opposed to bed weighted, but the same thing. That tells you something about where the dollars are and that's ultimately what we almost always care about.

But in this context somehow it seemed like the

non-weighted approach had some merit because we're really interested in each hospital as an operating entity, as opposed to the flow of dollars in the program.

MR. SMITH: Actually it was sort of the converse of that that led me to wish to see this bed weighted. I don't disagree, and we spend a lot of time -- as does Congress -- thinking about hospitals as teach hospital as an important entity, whether or not we create a special designation for them.

But it would be useful to know that instead of talking about 20 percent of the hospitals we're talking about 6 percent of the beds, or the other way around, in helping us think about how we should set our priorities as we approach this work.

And lastly, I want to underscore Jack's point. It seems to me the variable here that really matters is occupancy, not volume. Perhaps it isn't, and it would be useful to look at that relationship and try to make sure we understand whether or not low volume by itself is the predictor of poor performance that this suggests, or whether it's low volume which turns out to be a proxy for low occupancy. I have a guess about that, but it would be

useful to have a bit more information.

MR. HACKBARTH: Could I go back to the weighting issue for a second? Is it an either/or question? Or maybe we ought to be looking at both. The reason I think that having bed weighting or revenue weighting or something would also be a good take on this is that it's commonplace now for people to argue for more money for hospitals, saying 50 percent of all hospitals are losing money. And at one level that may be a relevant statistic. But it also may be relevant to know that those 50 percent of the hospitals represent 10 or 15 percent of the beds. So I think both cuts could shed light on the problem.

MR. SMITH: I didn't mean to substitute one for the other, but to bed weight use would be additional useful information.

MR. ASHBY: Yet a couple of the other considerations on that question are whether the 15 percent really play some critical role in access to care. That's one important question, regardless of how many dollars they have.

The other is whether the reasons why they're performing, or whatever we're going to call it, why their

result is so poor, really are due to some factors that they might have had a chance to do something about. Should we give them out just because they are at the low end of --

MR. HACKBARTH: That's the basic reason for trying to untangle this web, is to shed light on that question. Maybe they ought to be losing money and it's not a matter of great concern.

DR. WAKEFIELD: Jack, I'd just say I'd certainly agree with the point that Jack made earlier about the urban/rural location chart and the washing out of differences. One would think that, at least hypothetically, it helps to put some precision around certain categories to inform policy. So to the extent that we've got specific categories broken out rather than casting that more general at all rural areas, using that just as an example, it's always really helpful for me anyway to see it broken out by categories, which you've actually done as you were kind of walking through this in different areas. You spoke to Medicare-dependent hospitals, sole community, et cetera, et cetera.

So that's really valuable. And I think it helps all of us be a little bit more precise in terms of how we're

looking at impact of payment policy.

The question I have for you is on the inpatient Medicare margin chart. I'm sure there's an obvious reason for this and it's going to embarrass me by even asking it because it's going to be such an obvious answer. Is there a reason why you didn't mirror the non-DSH categories by large urban, other urban, and rural areas?

In the chart that you showed us up here we've got just urban and rural, in the narrative we had large urban, other urban and rural, and there were some differences in the narrative chart. So that other urban came out of this one. That's just an observation.

But the real question is is there a reason why you didn't break down the non-DSH, where the figures are just a little bit different? Non-DSH is 6.9 up here, it was 6.7 in the table in the narrative. That's not the issue for me, though. Was there a reason why you didn't break out non-DSH by large urban, other urban, and rural, as you did with DSH?

MR. ASHBY: No. The answer is there's no good reason other than that's the way we've generally done it and so those are the numbers that were sitting in front of me. Very unsatisfying answer.

We might, in fact, want to look at that.

DR. WAKEFIELD: Would you mind doing that?

MR. ASHBY: Yes.

DR. WAKEFIELD: I'd be interested to see how that would vary across those three categories. Thank you.

MS. ROSENBLATT: I have a question on three other variables that may or may not be linked to variables that you've already considered, so let me put these out as questions.

The first would be the number of hospitals in a given area, within a certain number of miles, which may or may not be related to urban/rural. But do you think there's a big difference between a one-hospital rural town versus a three-hospital rural town?

MR. ASHBY: Yes, a degree of competition sort of variable.

MS. ROSENBLATT: The second one would be we're looking at each hospital individually, but some hospitals might be part of a large system. I think of the Sutter system, for example. Now that may be linked to your type of control, investor-owned versus non-investor-owned. But I don't know if that would be worth looking at.

And then the third one is the amount of uncompensated care or the uninsured percent in the local area, which again may or may not be linked to the DSH payment. But it would seem to me that hospitals that have a lot of uncompensated care may be the ones with the low margins.

MR. ASHBY: Right. Let me give you a couple of answers to that. The degree of competition, we think, is a very important parameter and we're taking steps already to try to get that into our multivariate analysis that will follow. We just couldn't pull it off in short-term for this.

Unfortunately, it's the same answer on the uncompensated care. I really wanted to have that here, but we don't have the data available to us. Uncompensated care is being added to the cost report this year, so at some point we will have it. But we don't today.

MS. ROSENBLATT: Would uninsured percent for the community be worth -- is that available?

MR. ASHBY: One would think there would be some correlation there. That's a possibility.

DR. REISCHAUER: What would the correlation be the

Medicare margins? Because I would think if you had a lot of uncompensated care you'd run a cheap hospital, probably, so your margin in Medicare would be high.

DR. ROWE: Or you'd be a city hospital and your deficit is made up by the city of New York. So you wouldn't run a cheap hospital. In other words, you'd be a city hospital and you'd run an expensive hospital with a lot of labor force issues, et cetera. And then the city makes it up at the end.

MR. MULLER: A lot of the uninsured are in the -- I want to call them the low DRGs, for which you don't get paid very much. But it doesn't perfectly reflect costs of what you often find in the public indigent hospitals is because their case mix is not as high. They do a lot of babies and other kinds of medical versus surgical cases. They tend to have low payments across the board, not just in Medicare, but higher costs that aren't reflected by the case mix indices. So you wouldn't find high Medicare margins.

DR. REISCHAUER: But it's not affecting the Medicare payment. The Medicare payment is set administratively.

MR. MULLER: No, but they tend to have a case mix

that's in the low part of the Medicare weights, and therefore you don't get much margin on it.

DR. REISCHAUER: The Medicare case mix is low?

MR. MULLER: Yes.

DR. REISCHAUER: Because a lot of Medicare people are having babies?

MR. MULLER: No, because they have more medical versus surgical cases. Surgical cases are the high ones, high DRGs on which you make margins.

MR. ASHBY: But uncompensated care is not what's causing it. It's kind of a useful cross-correlation, I think, is what Ralph is pointing out here, of other factors.

MS. BURKE: Unless it's a teaching hospital.

MR. MULLER: City hospitals, by and large, have very low case mix indices.

MR. SMITH: But for the Medicare population?

MR. MULLER: Medicare as well, because they have more medical cases than surgical cases, by and large. A lot of their Medicare cases are people who age up from Medicaid. And therefore they have multi-system failure, but they tend to have low case weights. That's why you see this correlation of high cost and low payment. I'll bet you the

government-owned hospitals in this country have low Medicare margins.

MR. HACKBARTH: I'm going to ask that we move ahead. Sheila is going to have the final comment. This is complicated stuff. We could talk about it almost without limit, I think, but we need to have one.

MS. BURKE: One point, one question. The point, which I'm sure you've already thought of, is when the time comes and any of this becomes officially public, there will be an enormous amount of interest in knowing who's at the bottom and who's at the top, quite specifically. Who's in that minus 18 and what that actual distribution looks like around types of hospitals and geographic location.

Having done some carve-outs in my life, I can assure you that that will be the case. So we should be thinking about what we say about that.

But the question that I had, and this goes back probably too far, and is embarrassing in that context, it takes me back to sort of pre-233 limits. To what extent do we think or believe at any point size -- all these other things, in some cases, are proxies for size. Is size again an issue for us? Do we know whether there is, in fact --

MR. ASHBY: This gets back to the relationship between occupancy and volume here. We were, in essence, attempting to measure size with case volume here. But there is bed size, as well, that has a different parameter to it, unused capacity.

MS. BURKE: Again, it's something we discarded when we sort of moved away from that model. But really there are really behavioral differences based on the size of the institution, not only its geographic local, urban/rural. Some of that is a rural proxy for small hospital.

But whether or not overall -- and volume will pick up some of that. But whether or not we again look at comparative groups that are literally by size of facility. Whether that has any impact.

MR. ASHBY: Bed size.

MS. BURKE: Bed size, today. I don't know. We haven't thought about it in years and it may not make any sense at this point.

MR. ASHBY: Somehow I have a suspicion that we would see a similar pattern to what we see measured as case volume, which is the very small ones, indeed, have higher per unit costs. And it goes down as you move up. Except

that when you get to the very high scale it no longer goes down. The really large city hospitals begin to pick up other kinds of problems, including some of them that Ralph talked about.

MR. MULLER: Just one more brief technical point. Last year we talked about that we might look at the cost that are not on the cost report. I remember you estimated that could be 3 or 4 percent. Are we going to have any chance to look at that this year?

MR. HACKBARTH: It's not on the agenda right now.

MR. MULLER: Because 3, 4 percent can make a difference.

MR. HACKBARTH: We're going to have to bring this to a conclusion. As good as Jack is, there's probably no way we'll be able to have the definitive answer to all the many questions.

I think we will have made a contribution, even if we can only answer some much more basic questions. I've had several people look at that graph that Jack showed at the beginning, and the wide distribution of margins, and say this by itself is a prima facia case that the system is broken, when so many hospitals are losing money and there's

such a wide range between the best performing and the worst performing.

I'm hopeful that, at a minimum, this analysis can shed light on those questions. I don't think that it is a prima facia case that the system is broken and I think this will help us lay that out.

We've got to move ahead to access to care. So this is a continuation of the discussion we began at the last meeting. For those of you in the audience, and commissioners as well, we're trying to put together a system that will allow us, on a regular basis, to monitor what happens to access to care for Medicare beneficiaries.

Karen, whenever you're ready.

MS. MILGATE: As Glenn said, this discussion is a continuation of last month's on the most effective way to monitor beneficiary access to care.

At the last meeting, the commission discussed the variety of data sources to be considered and determined which types of analyses to pursue. At this meeting, we'll discuss how the monitoring system would work and actually begin to use it. Today Mae will present an overview about what is already known about beneficiary access to care,

looking through direct measures of access which is described as step two in the flow chart that we'll go through in a couple of minutes.

So what do we mean by access? The definition that the IOM developed is the timely use of personal health services to achieve the best possible health outcome. To determine how to measure access, it is also useful to describe its various dimensions, and you may remember some of these from the last meeting.

The first question that is important to ask is whether there is enough capacity to actually meet beneficiary needs. So here you might want to look at the supply of providers, whether the type of providers are appropriate, and match them up with whether in fact those types of providers are able to meet the beneficiary needs.

Even if there is enough capacity to meet the beneficiary needs, there may be other obstacles for beneficiaries to obtain care. So the second question is whether beneficiaries are actually able to obtain services.

And then the third step is whether the services the obtain are appropriate. They may obtain services but, in fact, they aren't the right services.

It's pretty hard to see the screen from here, so you may want to look at the chart that you have in front of you, from the handouts.

So how would MedPAC's monitoring system work? Because the questions asked and data sources used often create very different impressions about beneficiary ability to access care, our monitoring system is designed to look at access from many different angles. In particular, it's important to understand that Medicare beneficiaries access to care is shaped by factors specific to Medicare, but it's also shaped by factors that are not specific to Medicare that impact the entire health care system.

You'll see on the chart here that, on the left-hand side, we've looked at the timing of the analyses. In the middle we have a description of the various analyses. And then on the right-hand side, we look at the outcome of the process or the products that might be created by these analyses.

The first step is that we would look at the health system capacity. So here we would determine whether the system has the capacity to meet beneficiary needs. So it would be important to look at both what beneficiaries look

like and what their needs are, and then also whether the supply of providers and types of providers are appropriate. So we would look at the age of beneficiaries, disability status, insurance status, income, prevalent conditions, and also where they live.

Providers, we'd look at the supply of facilities, physicians, certain specialists, nurses and other health professionals, entry and exit, and perhaps we'd take a special look at any new types of services or settings that may have become important to the Medicare program.

You can see here, too, in this step of the analysis, there would be quite an interaction between the analysis we do for payment adequacy and update purposes and the analysis we do for access purposes. We believe there would be quite a bit of interaction and that the two analyses would actually feed on and enhance the other.

Some of the products that would come out of this would be some information that would be used for payment adequacy in the update framework.

The second step of the process, after looking at whether the capacity is appropriate, is to look at actual direct measures of access. This particular box is

highlighted because this is the type of information we were going to present to you today.

Here we would look at general measures from sources such as beneficiary and provider surveys and utilization data, to get some general sense of access to care. And then it would also be important to break it down into distributional measures such as socioeconomic status, which is an analysis we are intending to do, as well as to do local market analysis.

I want to stop for a moment on the concept of local market analysis, because that was an area that the commission was very interested in and is, of course, very important to get a real picture of access that gets below the national data level.

There we have several efforts underway, but in particular I wanted to highlight some work that CMS is doing that we are talking with them to work with them on. They're taking the CAHPS fee-for-service data, which in fact we talked about last time as being a fairly large sample of beneficiaries, and using that in tandem with some hot spot analysis where they've gotten some information from carriers and their 1-800 number, and some local surveys of agencies

to actually target some specific geographic areas where they might do some more in-depth surveys of beneficiaries to understand the reasons for access problems.

So that's a piece of analysis that we hoped to work with CMS closely on, and that would enhance some of our work in that area, as well.

In addition to looking at distributional measures, we'd also then want to look at measures of appropriate use. So we'll be looking at some data that will give us some sense of use of preventive services and preventable hospitalizations.

These two steps together would give the commission some sense of the types of issues you might want to delve into in some more detail. And so, between those two steps and the second two, which are more of the policy grinding steps, we'd want to stop and say okay, these are the issues that seem to be coming up on their horizon. Let's go and dig in some more detail to understand the reasons for those patterns.

This year the issues that we talked about at the last meeting were looking in some detail in physician office setting, post-acute care, doing the socioeconomic status

analysis so we'd look at the interrelationship between some of those factors, and then a more in-depth analysis of trends in the emergency department to try to get a sense of what they might tell us about access to services outside of the emergency department and also access to services within the emergency department.

So the third step then would be the first step in the policymaking process, is really to determine whether and why a problem exists and how it may be related to Medicare policy. Is this particular problem driven by factors that are outside of the control of the Medicare program? Or is there, in fact, some way that a Medicare policy may be driving the issue?

And then the fourth step would be to analyze policy options and to develop recommendations. So here, whether it was Medicare's policy that was the issue, or something more broad than that, to determine whether in fact Medicare could and/or should try to address the problem.

So those are the four steps of the analysis. And you can see on the right-hand side, the product that we envision coming out of this could include special issue reports if the commission felt there was a particular issue

that we wanted to have an actual report out there on the one issue, but would also feed into our March report through payment adequacy updates, payment adequacy in the update process, other chapters, or it could also be included in the June report to Congress.

Today, as a first step in our analysis, Mae is going to present an overview of what we know about access through looking at types of data that are described in step two or direct measures of access.

DR. THAMER-NALL: Good afternoon. As Karen said, today I will be presenting an overview regarding access to care among the Medicare population.

The most commonly used indicators of access are presented here. As I go along in the presentation, I'll discuss some of the limitations and advantages of using various indicators to access. The following slides provide you with an overview of beneficiary access to care based on the most recent and widely used nationally representative health care surveys.

The next few slides suggest that, in general, most people perceive themselves as having good access to care. I'll start with a comparison of access to care for elderly

persons versus other populations. When we examine specific potential access problems in the future, we hope to always first examine if these problems are also found in the wider health care system, and may not therefore be a result of a specific Medicare payment or other policy.

In general, looking at this slide, the elderly appear to have better access to care compared to younger persons. Adults age 18 to 64 are two or three times as likely to report failing to get care in the past year because of financial barriers compared to older Americans.

In this slide we're showing you data for the first quarter of 2002 for illustrative purposes only. Although it's not statistically significant, it shows you an increase in the percent of women over 65 that report access problems from 2.3 percent to 3.0 percent. I want to point out that this is noteworthy because it runs counter to trends over the past decade that have been observed in this survey as well as others. And therefore it may merit further scrutiny when we get more complete data for 2002.

In other words, this is the kind of timely information that we would be sure to follow up on using our monitoring access database.

DR. REISCHAUER: Can I ask a technical question? Is the 2001 number the average of four quarterly administrations of this question? Or is during 2001 did you not receive care and then you're comparing it to the same question asked at the end of the first quarter of 2002, which includes three-quarters of 2001?

DR. THAMER-NALL: The specific question in NHIS is during the past 12 months was there any time when someone in your family needed the care --

DR. REISCHAUER: Right, but do they collect this information quarterly?

DR. THAMER-NALL: My impression is yes, it's collected quarterly.

DR. REISCHAUER: So the 2001 number, part of it would refer to 2000? Okay, fine.

DR. THAMER-NALL: Yes.

I apologize that this slide is a little difficult to read. The point here is that in addition to having few access problems, on two of the three measures of perceived access to care that are asked in the Medicare current beneficiary survey, access problems appear to be declining between 1991 and 2000. One possible factor in the general

improvement in access to care may be the increase in the proportion of elderly that report a usual source of care over this period. That's gone up from 90 percent to about 94 percent.

Although Medicare has been largely success in ensuring access to care for most beneficiaries, certain subgroups appear to have less access than others. I can see that's very difficult to see from this distance, but hopefully you have it in front of you.

For example, the disabled beneficiaries were almost twice as likely to report trouble getting care, and almost one-fifth reported delay in care due to cost. Low income beneficiaries were also more likely than those with higher incomes to report problems obtaining care or delaying care because of costs.

Similarly and notably, 17 percent of those in poor health said that they delayed care due to costs compared to only 3 percent in excellent or very good health. And 10 percent of those in poor health reported trouble getting care.

Rural beneficiaries were somewhat more likely to report delay in care due to costs compared to urban

beneficiaries. And finally, beneficiaries without any form of supplemental coverage, and that means including employer-sponsored Medigap or Medicaid, and this comprises one out of 10 beneficiaries, have reported serious access problems. 20 percent of those without any supplemental coverage reported delay in care due to costs and 17 percent had no usual source of care.

As you know, most elderly care supplemental insurance, which appears to have a strong influence under access to care, for a number of preventive and clinically necessary services. On this slide, with regard to access to clinically necessary services for the elderly that's shown here and that's been employed by the commission in previous work, significant differences exist.

In order to save time, let me just summarize the findings by reporting first of all the overall use of necessary ambulatory services for specific chronic conditions such as diabetes, congestive heart failure, COPD, is low overall compared to inpatient care for acute episodes.

However, beneficiaries with supplemental coverage are significantly more likely to use the recommended

procedures and, in some cases, have a lower incident of avoidable outcomes compared to beneficiaries without any form of supplemental coverage.

The percentage of elderly without any supplementation to Medicare vary significantly by race. In 1999, according to data provided by my colleague, Chantal, 18 percent of African-American beneficiaries had no additional coverage other than Medicare. That's compared to 14 percent of all Hispanics and 7 percent of white beneficiaries, numbers a little bit different from the stats that were provided in your briefing materials.

DR. ROWE: Is that traditional Medicare?

DR. THAMER-NALL: Traditional Medicare.

DR. ROWE: Not Medicare+Choice.

DR. THAMER-NALL: That's right.

Minority beneficiaries are less likely to have a usual doctor, 91 percent of whites versus 80 percent of blacks and 78 percent of Hispanic beneficiaries. And they're more likely to use a hospital emergency room or urgent care center for their care. That's 2 percent of whites versus 10 percent of blacks and 10 percent of Hispanics.

This is important because beneficiaries may be more likely to receive preventive services and possibly better continuity of care in a doctor's office compared to an emergency department when it's used as a regular source of care.

So in concluding a very brief overview of access to care, I want to make a few points. National estimates of access serve as valuable benchmarks, however they may obscure variations that are based on beneficiary characteristics or geographic regions, which we did not look at here. Although the majority of elderly report good access to care, those without supplemental insurance, minorities with low incomes, and those in poor health may experience access problems. And we plan to analyze the interrelationships among these various factors to better understand what related policy options might be.

The next steps include more depth analysis of trends in emergency departments and the role of socioeconomic status. Finally, we hope to have a draft chapter report for the March 2000 report on access to care by December.

MR. DURENBERGER: Let me ask a question which is

related. I guess the best way to express the question is access to what? And it's sort of like how do people answer questions? How do you phrase the question so you get the answer that you need?

I'll just use an example that's been bothering me because it's reflective of capacity problems in our community. It doesn't seem to vary with whether you're Medicare eligible or something else. But if you look at the rise in the use of concierge care in the Seattle area, where I think it costs something like $4,000 or $5,000 per year to get your own doctor and get some consistency, as people think of it. Or in our community, in Minneapolis in particular, where the startup costs is $3,000 to do the same thing.

The average age of the people enrolling is slightly over 62 years of age, which somehow suggests to me either that those are the only people with the money to pay for access, but behind that it reflects, I think, a dissatisfaction with access, whether it's expressed in being able to get the same doctor each time, being able to have my questions answered, whatever the case may be.

People who are willing to pay that kind of money

in the two communities that I've just mentioned, in order to "get some kind of an assurance" of care in the system, seems to suggest something that I'm not sure these figures would suggest.

I see now you will go into some of the socioeconomic issues and so forth. But I'm wondering if either anybody on the commission or those of you who have been doing this analysis know what's behind the fact that the average 62-year-old, that that's the age average of people going into concierge care in those kinds of communities?

The question I'm trying to ask is the adequacy of the kinds of questions that we ask people, the way in which we measure either satisfaction with "access" or with care or something like that. I don't have the answer. I'm just trying to figure out what's the significance of that in the communities I've talked about.

DR. REISCHAUER: Dave, how many people are there? Couldn't you fit them all in this room? There are small groups of people who engage in strange behavior everywhere.

MR. DURENBERGER: I can't give you the Seattle numbers but it's in the several thousands. But the program

has only been open in Minneapolis for six months or something like that. I don't know whether it's a fad in America or it's a growing phenomenon.

DR. ROWE: One comment on that, it's also becoming increasingly prevalent in Boston, is I think it's important to understand that, in most cases, to my knowledge, is that physicians who have established concierge practices, where they get almost a retainer payment from patients and they have longer visits and less waits and everything else, are generally converting from another practice that they had of internal medicine or family practice or whatever to a concierge practice. And they generally bring their patients with them.

So if you look at the patients who are signing up in concierge practices, they are patients who were in these practices with these doctors before, and are a selection of those patients who can afford it and don't want to lose that doctor, et cetera. That's certainly what happened with Dr. Flyer and his colleagues in Boston.

And so if it's a practice of internal medicine, it may be in fact largely an adult and perhaps even older population. So that may have something to do with it. It's

just not people from the general community who are going and signing up for these things. They're coming with the docs into the practice.

MR. DURENBERGER: The other reason I'm asking the question is that the two cases I'm thinking of are both the major multi-specialty clinics in those two communities, which you wouldn't normally think that's where this sort of thing would get -- at least, I wouldn't think that's where it would get started.

MS. MILGATE: Can I just make a comment on that? I think the way that it does possibly interact with what we're looking at doing is -- I've also heard about some -- I hesitate to call them trends because I don't know if they're really going to become trends or not -- other types of providers trying to find profit-maximizing procedures and then just focusing on those.

And to the extent that might create access problems for Medicare beneficiaries, who then don't have as much ability to obtain other services, I would think that might be an issue. Maybe in some markets, for example, physicians might take fewer Medicare beneficiaries because they have such a good concierge practice. So to me, that's

how it would interact.

MR. DURENBERGER: That's not what's going on.

MR. FEEZOR: One of the things when we do our datasets in comparing the over-65 to the under-64, particularly I guess your first slide that dealt with percentage of persons who failed to obtain care, I wonder if we can we may want to look at trying to subdivide that and say 50-to-64. Those would be people who are likely to have maybe a higher use factor who would have been plugged in to physicians. And it may be a better comparison. So just as a suggestion on that, Mae and Karen.

And then the other thing, I always worry about the snapshot in time, that we only have data through 2000, and I suspect there's been a significant deterioration in some of the access measures, but that's a problem we always face.

I guess the other question I thought I had was somewhat tangential to what Dave's questions were, and the fact that when we talk about access to services we keep thinking of physical or health services or professional services.

If you look at the IOM definition, it very clearly says personal services. This may be a little too

futuristic, but we probably need to start thinking about access, again access to what? Access to information and decision supports that also help individuals, indeed Medicare individuals, better manage and know about their own care.

I think one of the things that the concierge service provides -- and by the way we do have some of that happening in California, but then we're sort of known for our deviate behavior. Interestingly enough, it tends to be physicians who, I think, want a different lifestyle and can sort of capitalize on some either insecurity or their market in taking some patients with them.

But I think it's not just that -- I can probably get the flu shot I need, but it is more of a sense of security that Dave was talking about. And if I have someone who can help me give me that advice, okay it's a concierge doctor practice, it may very well be a nurse 24 line that a lot of the consumer driven products in the under-65 markets are talking about using, information decision support.

And so I think going forward, and again this is out, that when we start talking about access for our Medicare eligibles, we have to start thinking also in

information services because I think increasingly that's what care is all about.

DR. NELSON: I want to commend you for this, for a very comprehensive and broad approach to this. My question has to do with how timely the data will be when we make our March report, and specifically, whether we will be able to capture changes that were reflected in this year's cuts? Whether the current beneficiary survey will be current and be able to reflect '02 data? I presume that the National Center for Health Statistics, the NHI survey, will capture '02 data.

Do you think that we'll be able to give an adequate contemporaneous picture of this to Congress in March?

MR. HACKBARTH: Alan, we do have the survey that Kevin briefed us on last meeting, which was specifically designed to give us some timely data on access to physician services for Medicare beneficiaries.

MS. MILGATE: That's the most recent information we'll have for the March report on physicians, will be our own.

MR. HACKBARTH: The caveat there, of course, is

that we're talking about a relatively small sample and no ability to slice it by specialty or location, because the numbers are just too small. But that's the tradeoff for timeliness.

DR. NELSON: The point that I'm making is the strength of having multiple data sources in our report and the wish that they'll be sufficiently current to carry that strength with it, in addition to our survey. Our own survey is going to be criticized as yes, it's this year but it was early in the year before people had a chance to really digest the impact.

MR. HACKBARTH: Although we do have evidence there that they were -- I can't remember the percentages, but a high percentage of the physicians said that they were aware of the cuts.

DR. REISCHAUER: But it's conceivable that by the time we issue our report there will be another 4.4 percent cut.

MS. MILGATE: We won't have 2002 for the MCBS, but if it's possible to get from CMS, they do have 2001 CAHPS information. They don't have 2002. So that would give us a general picture, but it's not going to give us a 2002 look.

DR. ROWE: I wanted to comment on the finding with respect to race. A couple things.

One is some years ago, I know Bruce Vladeck and others published a paper out of then-HCFA looking at racial and ethnic disparities in Medicare beneficiaries. My understanding was that the variables in that study were importantly influenced by socioeconomic conditions. I think they used both data on income individually and a proxy based on metropolitan statistical area or something like that. And both ways it was significant.

We might comment on that a little bit, that if there is an access problem with respect to race it may be aggravated by socioeconomic conditions. Or just look at that paper.

Secondly, I wanted to point out the general issue of racial and ethnic disparities, there was an IOM report that you no doubt saw called Unequal Treatment or something like that -- in fact, I think my fellow commissioner Alan Nelson chaired, that came out earlier this year on racial and ethnic disparities, which is obviously an apparently durable, sustaining, intractable, serious problem that we have in this country in our health care system.

There have been studies supported by the Commonwealth Fund, by Arnie Epstein recently and others, looking at quality of care and Medicare+Choice beneficiaries. And these people are insured and they have a doctor. And they still found racial and ethnic disparities in usual HEDIS measures of quality of care, beta blockers after myocardial infarction, follow up after mental health hospitalization, et cetera. Really very disturbing findings.

Now what we're finding here, not in the study of quality, but in the study of access in the Medicare program, we're also finding these kinds of issues. I think that it would be good, as you write this up, one of our problems is that we're at risk for looking at the racial and ethnic disparity issues and seeing it in a bunch of silos. So it gets a little mention here and a little figure, because it's access. And then in the quality chapter there's a little mention of it.

But we should point out that this is a problem that spans the program and different aspects of health care. And maybe we can raise it to a level where it will get more attention.

I'm not suggesting CMS isn't very concerned about it, but I'm just saying obviously we haven't solved this problem. I think it's one of the major problems we have. And it would be nice to have some texture around the socioeconomic issues as modifiers. I don't think they're determinants, but they're modifiers of these findings.

DR. REISCHAUER: I agree with you 100 percent that this is a serious problem and a societal problem and it's something that we should face. But it struck me that the focus of what we're doing here is to try and monitor changes in access over time. The reason one would want to look at racial minorities or rural populations or inner cities would be that access problems might show up sooner there than elsewhere. But these are two, in a sense, different issues.

DR. ROWE: The canary in the mine shaft.

DR. REISCHAUER: Yes, right.

DR. ROWE: They certainly are particularly susceptible, apparently. They are at risk, yes.

DR. REISCHAUER: There's good reason to focus on them but the issue isn't that day in and day out their care is less --

DR. ROWE: But if they are going to be identified

as a leading indicator, let's say over time, then it is worth doing the socioeconomic analysis because you could identify the subset, not just at a given racial/ethnic background, but economic that would, in fact, be the most sensitive subset. Right?

DR. NEWHOUSE: Is it right that these have fluctuated more for the minorities than the non-minorities over time? So this is a hypothesis.

MS. RAPHAEL: I just wanted to follow up because I think there are two important things here. One is this not having a usual source of care, I think, is very, very important because that is very costly to the health care system. It just plays out in so many ways, not only using the ER as your primary care center. But in home health care we find we have 10 to 20 percent who don't have a usual physician. You can't get anyone to really oversee the services, to even prescribe the services. Because someone comes in who broke a hip, but there's no physician to whom they're attached. And so I think that really is a very important issue in all of this.

And then I was struck to what extent that connected with the people who were in poor health who were

five times more likely to have issues around access. To what extent are they the same group that don't have the connection or a usual source of care?

MR. HACKBARTH: We're going to have to move on here in a just a second. Let me ask a question about your big picture here.

This is very impressive in the scope and its depth, and doing this sort of work will lead to lots of interesting findings worthy of discussion. And we've got another problem that Bob was referring to, of trying to monitor a fairly large set of services for changes.

So what I'm struggling with is depth versus breadth in what we do. Can we afford to go so deep when we need to be able to identify important changes in access over a large number of services? How do we get the most bang for our resources in looking at access issues?

MS. MILGATE: Let me take a stab at that and then maybe Mark or Lu want to comment, I'm not sure.

The way that we've thought about it on the access team is that we hope that some of this, particularly in step one here where we're doing kind of a scan of the beneficiary needs and supply of services, would become somewhat routine

over time. The first time we did it we would have to find the data sources, collect the data, and paint a general picture. Some of the depth in there would also be done in the process of payment updates, but in general this would become hopefully a little more routine over time.

The same way, in some ways, in number two. Number two, for example, when you're looking at the MCBS and the various beneficiary surveys that are out there on their perception of access are data sources that we can go to on a fairly regular basis, as is true of some of the provider surveys and utilization data.

And then you get a little bit more in depth by looking at the distribution issues, which I don't think we'd look at the same things necessarily each year, but perhaps choose a different one. And the comments that I've heard, at least a few of them, have supported that it's important to look at SES, for example, as the relationship between the factors and how income might drive racial differences and that sort of thing.

And then the other deeper one here we've talked about doing is local market analysis.

After that step, though, would be the place where

we'd really determine okay, where do we want to dig more deeply into this year, and that we wouldn't go into each of these in the same depth each time we would look at them every year.

So hopefully, the first step would become a bit more routinized over time. The second, you're going to dig in a little bit, but then you would try to narrow it down to a few particular analyses where you might do something in more depth. That's how we've thought about it on the access team.

MR. HACKBARTH: All right. Thank you very much.

DR. REISCHAUER: Just one question. The last time we were discussing this we were sort of toying with the idea of whether we could use payment information to provide more contemporaneous index of service utilization, like quarterly office visit claims or something like that.

MS. MILGATE: Claims, for example?

DR. REISCHAUER: Is that too messy?

MS. MILGATE: CMS is actually developing a database to be able to do that on a very real-time basis with physician data. They have county level. And they are still developing that. We're talking to them pretty

regularly about how we might work with them to use that, as well.

DR. MILLER: Just to follow up on Bob's question, isn't in box number two, some of the broad measures and the utilization data, that's where that data would show up?

MS. MILGATE: Yes.

DR. MILLER: So we are contemplating it to the extent that we can get the data and make it --

MS. MILGATE: Yes, and then the specific would be the CMS example.

MR. HACKBARTH: Thank you. Now we're to our last item for today, characteristics of long-term care hospitals and workplan. This is follow up work that came out of a brief letter report, if I recall, to Congress last year, which raised a number of questions. And the purpose of this work is to try to answer some of those questions, right?

DR. KAPLAN: Correct. First, you asked for more information about long-term care hospitals, our LTCHs as the acronym is. I'll very briefly summarize the most recent research on these facilities.

Second, our letter to CMS commenting on the proposed PPS raised questions about these facilities and

I'll provide information about our workplan to answer these questions. I'd like your comments on the workplan and the scope of the proposed research.

As you know, long-term care hospitals provide intensive care to patients with multiple comorbidities for extended periods of time. To be certified as an LTCH, facilities must meet the conditions of participation for hospitals and demonstrate that they have a Medicare average length of stay greater than 25 days.

All post-acute care grew rapidly in the 1990s. However, one reason why policymaker are so interested in long-term care hospitals is because they were the post-acute setting with the most rapid growth. In less than a decade, the number of long-term care hospitals more than doubled and Medicare spending for them more than quadrupled, as you can see on the table on the screen.

The rapid growth in long-term care hospitals within hospitals in the last decade has heightened concern among CMS and other policymakers. Hospitals within hospitals make it easier for host hospitals to move patients out of acute care and into the LTCH without the patient having to leave the building. Because Medicare makes two

payments for the patient instead of one DRG payment, this behavior increases Medicare cost.

Analysts generally have considered long-term care hospitals to be a heterogenous group of facilities whose only common feature was a length of stay greater than 25 days. Recent research for CMS by Corbin Liu and his associates, however, found that these facilities can be characterized by their certification date. They separated long-term care hospitals into three cohorts. Old hospitals, certified before October 1983, which was before the inpatient PPS, middle hospitals certified between October 1983 and September 1993, and the decade after the PPS was implemented and new hospitals certified after September, 1993.

When we look at the map on the screen, we can see the rapid growth in long-term care hospitals. Old hospitals are green dots, middle hospitals are purple dots, and new hospitals are red. This didn't come out well in the black and white forum or media, so that's why we didn't include it in your handout.

Certification cohorts track changes in the long-term care hospital industry. For example, old hospitals

generally are large and located in the northeastern United States. They are generally non-profit or government-owned.

The middle cohort tracks the first entry of for-profit long-term care hospitals, generally medium-sized free-standing facilities located primarily in the south. Many of them specialize in respiratory care.

The new cohort, which is the red dots, tracks the rapid growth of small, for-profit long-term care hospitals. Many are hospitals within hospitals. And they are located mainly in the southern United States.

Cohorts are strongly associated with other characteristics, such as location, ownership, hospital affiliation, payer's share of discharges, average length of stay, Medicare median operating cost per case, and bed size.

Liu and associates also found that most long-term care hospitals specialize. Most specialize in respiratory care, rehabilitation care, or a combination of the two. They also found that three hospitals specialize in treating mental diseases and disorders, and that a small number of niche hospitals had unique patient populations. For example, one hospital provides care to a prison population. In your mailing material I've summarized information about

the four groups of specialty long-term care hospitals.

The primary goal of the Liu study was to provide insight into the differences among long-term care hospitals and other post-acute care facilities. The findings provide some evidence that long-term care hospitals are different from skilled nursing facilities or SNFs and inpatient rehabilitation facilities.

Long-term care hospitals' patients appear to be different. They are younger, more likely to be disabled, and more often dually eligible. They frequently have diagnoses not commonly found in either SNFs or rehab facilities.

In addition, long-term care hospitals receive different ancillary services and different amounts of ancillaries compared with SNF and rehab patients. For example, 10 percent of long-term care hospital patients received blood in 1997 compared with 3 percent of rehab patients and 2 percent of SNF patients.

However, more work needs to be done to distinguish between long-term care hospital patients receiving rehab services and patients in rehab facilities and between patients in the three long-term care hospitals specializing

in mental diseases and patients in inpatient psychiatric care.

We don't know whether acute care hospitals and long-term care hospitals differ. We known that beneficiaries live in areas where there are no long-term care hospitals, as you saw on the map. This takes us to the policy questions we'll be answering with our workplan.

The first question is about what happens to beneficiaries who live in areas where there are no long-term care hospitals. To answer this question we'll identify market areas with and without long-term care hospitals and compare patterns of care for patients who are clinically similar. Then we'll compare total Medicare payments for Part A services and outcomes.

Another important question has to do with acute care hospitals, differences between those that have and don't have strong relationships with long-term care hospitals. Liu and associates found that hospitals within hospitals, on average, receive 62 percent of their cases from their host hospital. Other acute care hospitals, however, have strong referral relationships with long-term care hospitals and may have similar behavior to host

hospitals with onsite long-term care hospitals.

We'll be assessing financial performance for the different groups of acute care hospitals. We'd also like to know what differences exist between free-standing long-term care hospitals and hospitals within hospitals. We'll be comparing financial performance, total Medicare payments, and outcomes for these two groups.

Other questions may require clinical research. For example, we might be able to partly answer questions about rehab and mental disease patients in long-term care hospitals and how they differ from patients in inpatient rehab and inpatient psychiatric facilities respectively. However, these questions may be better answered by clinically oriented research.

I'm happy to answer your questions and hear your comments.

MR. FEEZOR: Were there any, in the Liu study, did they do any correlation between the growth of long-term care or LTCHs and those states that had maybe limitations on their SNF beds in order to keep Medicaid payments down?

DR. KAPLAN: No, they did not. As far as I know, they did not look at the certificate of need states compared

to those that don't have certificate of need. I believe we could put that into a multivariate model as an indicator for the hospitals.

MR. FEEZOR: Just take a look at that, just more of a visceral call as I looked at that.

MS. RAPHAEL: I was just curious, you said most of this population is a younger population that's dually eligible. Yet Medicaid pays for about 10 percent of the cost. I wasn't clear as to why Medicaid covers such a low percent of the cost?

DR. KAPLAN: No, Medicaid basically has a heavy proportion of payments in the old hospitals. I don't think anything was ever really said about how much Medicaid covered. Perhaps I'm mistaken, but I don't remember that.

MS. RAPHAEL: [Off microphone.] I thought I read that Medicaid covered 10 percent of the costs, but I might not have read it accurately. But I would be interested in the payer mix.

DR. KAPLAN: And there is a big difference in the age cohorts. For example, in the old hospitals, the old long-term care hospitals, I believe the Medicaid share is about 25 percent. And by the time you get to the new

hospitals, it's 4 percent. So you have a big difference and the age cohort is definitely correlated with the share of Medicaid patients, discharges.

DR. NEWHOUSE: Sally, I thought this was a really nice research plan, and I only had one minor comment. At one point in our written materials, you suggest that we may want to recommend to the Congress that they request an Institute Of Medicine report. The Institute of Medicine generally doesn't do primary data collection and it seems to me it would be better to suggest that AHRQ do it.

DR. REISCHAUER: Will you have information on where private payers send their similarly diagnosed people? Is this something which is largely Medicare and some Medicaid? From what you wrote, which I agree with Joe, really sounds interesting. It sort of looks like this has spring up almost in reaction to the --

DR. NEWHOUSE: But they have a lot of per diem, which would change the picture here.

DR. KAPLAN: To answer your question, we won't be able to compare similar patients because we aren't going to have the information on the private patient's diagnoses and comorbidities, which is what we're going to use to control

for clinical similarity. So we won't have that, because we don't have the claims for the private patients. We only have the claims for the Medicare patients.

I think the only thing we could do would indicate whether the share of the Medicaid patients that a hospital had.

DR. REISCHAUER: What I'm interested in is the share of private pay folks that they have.

DR. KAPLAN: I'm not sure whether it's on one of your tables in the mailing material, but the share of private patients is on table one in your mailing materials. If you look at the cohorts, the old hospitals have 26 percent, the middle hospitals have 20 percent, and the new hospitals have 16 percent of their discharges being private pay.

So they're not exclusively Medicare animals, but the newer ones seem to be primarily Medicare animals.

MR. HACKBARTH: Thank you, Sally.

We'll now have our public comment period.

[No response.]

And we have now completed our public comment period. Thank you all. We will reconvene at 9:00 a.m.,

tomorrow.

[Whereupon, at 4:34 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Friday, October 11, 2002.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, October 11, 2002
8:58 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA

P R O C E E D I N G S

MR. HACKBARTH: We begin this morning with two items related to post-acute care. The first presentation and discussion will be about skilled nursing facility payment policy; pick up some issues from last year's cycle. Then we're going to have a discussion, a review of the developing post-acute care episode database which is being developed to help provide us with some new data that will allow us to examine some difficult questions in the post-acute area.

Then we will, at 10:30, change gears and have a discussion with an expert panel on improving quality of care for beneficiaries.

Susanne, do you want to lead the way?

DR. SEAGRAVE: Good morning. The purpose of this presentation is to give a brief overview of the SNF payment system and some of the key issues with that system, and to discuss our workplan for the coming year. This sector is undergoing a number of changes and has a lot of uncertainty right now. For these reasons, we are giving this overview in preparation for the more detailed payment adequacy discussions at the next few meetings.

As you know, SNFs provide skilled nursing and rehabilitation services to beneficiaries following an acute care hospitalization of at least three days. About 90 percent of SNFs are part of nursing homes. We call these freestanding. And the rest are associated with an acute care hospital.

About 1.4 million beneficiaries use SNF services each year at a cost of about $14 billion to the Medicare program. That's almost 6 percent of total Medicare spending. CBO's recent estimates indicate that Medicare spending for SNFs will grow somewhere on the order of 9 percent annually over the next 10 years.

Medicare SNF patients differ significantly from the traditional patients in nursing facilities in that they generally require more costly services. Their share of the nursing facility population has been growing over time, as has the share of nursing home revenues financed by Medicare from about 3 percent in 1990 to about 10 percent in 2000. SNF payments per day have also grown from about $98 in 1990 to $236 per day in 2000.

Out of concern that Medicare SNF spending was rising rapidly in the early 1990s, Congress instructed CMS

to implement a prospective payment system for SNFs beginning in 1998. The SNF PPS is a per diem payment system, in contrast to the inpatient PPS which is a per case system. Under the SNF PPS, patients are classified into one of 44 resource utilization groups. We call these RUG groups, based on regular assessments. These groups are then used to determine the payment amount for each beneficiary's care.

The daily payment rate for each RUG group is the sum of three components: a fixed component for routine services, such as room and board, linens, and administrative expenses; a variable amount reflecting the intensity of skilled nursing care patients are expected to require; and a variable amount for the expected intensity of therapy services such as physical, occupational, and speech therapies.

MedPAC has repeatedly raised concerns with the SNF payment system for several reasons. First, the classification system used to group patients into RUG groups fails to collect all the necessary information, including important diagnoses and comorbidity information, to classify Medicare patients appropriately. The patient assessment instrument used to classify patients is also subject to

interpretation, resulting in data that is often unreliable.

Furthermore, because the classification of rehabilitation payments is based on services provided rather than patient characteristics, the system gives SNFs strong incentives to provide therapies when they may not be beneficial. Lastly, as I pointed out in the previous slide, payment rates are calculated based on the nursing and therapy time, but not on the cost of non-therapy ancillary services, such as costly drugs, intravenous therapies, and supplies, for example.

Thus, the cost of these services are only reimbursed through the system to the extent that they correlate with additional nursing staff time. Meaning that access problems could occur for patients requiring extensive use of these types of services.

Because of these problems with the classification and payment system, Congress implemented a series of temporary payment increases, sometimes called add-ons, to the payment rates in both the BBRA and BIPA legislation. The first two add-ons both expired on October 1st of this year. Both houses of Congress have proposed extending the second of these two add-ons, the add-on to the nursing

component in modified form through 2005. The third add-on is scheduled to expire whenever CMS announces a revised classification system.

Now I'll briefly summarize our workplan for the coming year in the SNF area. The bulk of our work in the next few months will center around using the payment adequacy framework to assess SNF payment adequacy for the fiscal year 2004. As always, we will look at margins, provider entry and exit, changes in volume, beneficiary access to SNF services, and SNFs' access to capital in determining whether payments appear to be adequate or not.

We will examine these measures by subgroups, including freestanding and hospital-based, urban and rural, by number of beds, by geographic region, by ownership status, and by affiliation with large nursing home chains.

In addition to our basic payment adequacy framework we will also participate in constructing a post-acute episode database which will be discussed in detail in the section immediately following this one. This database will help us look at the characteristics of patients going to SNFs and to other post-acute care settings, and to examine how these characteristics may have been changing

over time.

We have also obtained a rich episode database from CMS that focuses exclusively on patients receiving care in SNF facilities. This database links SNF claims data with the associated hospital claims data, CMS administrative data, and patient assessment data. This will allow us to analyze quality of care in SNFs since the implementation of the SNF PPS using certain preventable conditions for acute care hospital readmission. These readmission conditions have previously been identified by researchers as being important indicators of possible SNF quality of care deficiencies.

This concludes the overview. I welcome any comments or suggestions from the Commission.

MR. DURENBERGER: I have a question right off the bat because I just don't understand this, but I particularly like the analysis on the problem. What is the influence -- we're looking at Medicare payments, but because Medicaid drives so much of the organization of a skilled nursing facility, particularly the ones that are freestanding, probably much less though on the hospital side. But what is the influence on the organization to deliver care and the

regulatory requirements that surround episodes of care that are influenced state by state by the Medicaid program? And is there a way to incorporate that into the analysis that you're doing here?

DR. SEAGRAVE: Up until now, the Commission has basically -- we haven't looked a lot at how Medicaid figures into the picture for SNFs. The Commission felt that we were looking at Medicare payments and we have not -- frankly, we don't have a lot of information at this point about state to state. In fact that information is difficult to gather, as you may imagine, about what's going on with Medicaid payments on a state by state basis.

MR. DURENBERGER: [Off microphone] My question was premised not on whether we should get into the Medicaid program, but when we talk about service use, resources, service needs and things like that, my experience has been is that a lot of that is dictated by the regulator process that comes with state by state Medicaid programs. It varies from time to time, and it varies even in a state like New York, from one place to the other.

I would think that it would have some substantial influence on what Medicare can or can't do, or influence in

terms of its payment. I'm just trying to figure out how you could do the Medicare separate from some analysis of the Medicaid at this time.

MS. RAPHAEL: I think it is possible to get data on Medicaid expenditures and per capita, et cetera. However, I also do believe the most nursing homes have tried to maximize Medicare payments over the years. Nonetheless, I think the question for the Commission more is one that you raised in the text which is whether or not we even want to look at the issue of compensating nursing homes with Medicaid payments below cost, and cross-subsidizing another payer.

That's something in the past we have decided that we did not want to do. That we felt Medicare should be a prudent services for its own services. But you do raise that as something that the Commission should take a look at, could possibly take a look at again.

MR. FEEZOR: Susanne, thank you. Joe stole my pen so I couldn't write down the figure that you had on what the average per day expenditure was. Is it around, $236, is that what I --

DR. SEAGRAVE: Yes, in 2000 it was $236 per day.

MR. FEEZOR: Just in suggestion, I think in some further analysis that we bring back, following up on the Senator's comment is, I think some figures around what percentage of Medicare enrollees actually in a given year participate in a SNF, something maybe around their average age if that's available, and the duration of their stays might be helpful as well.

DR. WAKEFIELD: Susanne, my guess is you're going to cut your data, to the extent you can by freestanding versus hospital-based SNFs; is that correct? So when we get data like average cost per day over time, we'll see that in those two categories, will we? Or are we focusing just on one category and not the other of SNFs? Are we focusing on both freestanding and hospital-based SNFs with this study?

DR. SEAGRAVE: No. In many cases we're breaking it down by hospital-based and freestanding. In other cases, I'm not sure, particularly with the -- actually I am pretty sure that with the payment per day we will be able to break that down by hospital-based and freestanding. Some variables we may not be able to, but to the extent we can, we certainly will.

DR. WAKEFIELD: Part of the reason I'm asking you

this, and I don't have a good enough sense of this at all myself, but in talking with freestanding SNFs, at least in rural areas in my state, they assert at least that there are payment incentives at play that work against them in terms of SNF patients being held by hospitals for a longer period of time until that reimbursement has been maxed out and then discharges that follow.

I don't know how or whether you're going to be able to track any of that, but to try and get -- to use that old, worn-out phrase, ensuring a level playing field in terms of reimbursement driving inappropriate location of care, et cetera. I was just wondering if there's anything that we're going to see from you later on that would help inform our thinking on the appropriate utilization and the extent to which that playing field is level, for example, between SNFs freestanding and those linked to hospitals.

DR. SEAGRAVE: We certainly will think about that. That's a good point. I think with some of our episode databases, either of the ones that I mentioned, we may be able to tease out some of that.

DR. REISCHAUER: Can I ask you, Mary, something? You're implying that in this area that you're talking about

there's excess capacity of SNF beds and that hospital-based SNFs are keeping patients who more appropriately and cheaper would be served in a freestanding, or more convenient to their family would be served in a freestanding?

DR. WAKEFIELD: Bob, I don't know if that's the case, but I hear that anecdotally. So I was wondering if there's any data that would help us better understand what that dynamic is in terms of where those residents are being served.

MR. MULLER: But doesn't our payment policy indicate that hospitals discharge them early with that transfer --

MS. RAPHAEL: It costs more and has lower --

MR. MULLER: Yes, the payment policy says the opposite.

DR. NEWHOUSE: Because the last day should be the cheaper days.

DR. WAKEFIELD: So you're saying that would drive them out to be discharged out more quickly.

DR. NEWHOUSE: The free-standings are getting the better deal under your story.

DR. REISCHAUER: No, I think what she's saying is

there aren't enough people filling the beds even.

DR. WAKEFIELD: I don't know.

DR. NEWHOUSE: That's your capacity question.

DR. REISCHAUER: That's the capacity question, yes.

DR. WAKEFIELD: And I don't know. It's only what I've heard anecdotally.

MR. HACKBARTH: Susanne, one of the questions carrying over from last year is the difference between the patients in the hospital-based SNFs versus the freestanding. To the best of my recollection, we only have very fragmentary evidence on which to evaluate the differences. Will the post-acute care database help us in any way better understand the differences?

DR. SEAGRAVE: I think either the post-acute care database, or certainly the SNF-specific episode database that we've acquired from CMS should help us be able to track the characteristics of patients going to the two types of facilities.

MR. HACKBARTH: Because that was one of the elements of our recommendations last year that I felt a little bit uneasy about. We had some questions about

whether they were in fact different, thought maybe they were, and sort of threw some money at the problem. I hope we can do better than that.

MS. RAPHAEL: I was wondering, Susanne, if you could give us an update on where CMS is in revising the classification system which we believe is so flawed.

DR. KAPLAN: CMS has decided that they are not going to refine the RUGs, and the research is still ongoing to test alternative classification systems, alternatives to the RUGs for the SNFs. But I don't expect to see anything from them other than a report by January 2005 when it's mandated that it appear before Congress.

MR. HACKBARTH: So it's safe to say that we're years away from any change in the classification system.

DR. KAPLAN: Yes, I think that's pretty clear.

DR. MILLER: Can I ask Sally one thing? And this is because I don't know. Is there a difference between the work they're doing on the refinement versus the alternative? And I wasn't clear which question you were asking. Is that a distinction, and which one was Carol asking?

DR. KAPLAN: There is a distinction, although the work is being done by the same entity. Corbin Liu is doing

the work. But it is different because testing alternatives to the RUGs means that you're testing all kinds of alternatives, or any kind of alternative that you can think of. Refining the RUGs means staying within the structure of the MDS and the RUGs and seeing if you can find other things that are going to make it work better.

DR. MILLER: If I could just ask one other thing. Is the refinement as far out as 2005, or is that expected earlier?

DR. KAPLAN: My understanding is that CMS sent a letter to OMB saying that they would not be refining the RUGs.

MS. RAPHAEL: Does that mean, Sally, that the 20 percent add-on will stay in place indefinitely?

DR. KAPLAN: Until there's a new reclassification system.

MR. DURENBERGER: It's instinct to reinforce Mary's comment and what I tried to say in my comments. I understand that we can approach this at Medicare separate from some of the Medicaid issues, but in my state in Minnesota, and I'm sure, given the information that's coming in on budget deficits across the country, governors and HHS

secretaries and people like that have been sitting down now for the better part of a year or two trying to figure out how to take advantage of Medicare, because it's sort of like the free pot that sits there. You can't not do this.

It's not like the old scams, whatever we called them, in the '90s where the states were gaming the system by upping the charges. I remember it well because somehow I found myself between Governor Richards and Senator Bentsen and never the twain would meet even though they were in the same party.

But literally, this is going on as we speak and it's been going on for quite some time because -- I'll speak only for my state, they're trying to reduce the number of skilled nursing facility beds, just close up some nursing homes, and they keep looking for alternatives and so forth. But there's one pot of public money out there. Two-thirds of it is Medicaid, and 12 percent or something like that is Medicare, and somewhere, as they try to strategize sitting down with the provider groups and other people, try to strategize where are we going with this, there is a fair amount of, what's Medicare going to do? What's Medicare doing? Where can we find the least expensive to the states

place for these patients going on?

I can't describe it any better than that, but it's a reality. It just points to the importance of this work, and the importance, I believe, of being quite knowledgeable about Medicaid and about what some of the states are doing and how they look at these issues.

DR. NEWHOUSE: I'd like to ask one question I've never quite been clear on. Suppose I'm a resident of a nursing home and I go into a hospital, and I have a three-day or more stay and I'm discharged to the SNF, back to the SNF where I was a resident. Now it's clearly in the state's interest to try to bill for the 100-day max. But what are the rules and policies that govern when, if at all, my state shifts back to prior pay or Medicaid, or off of Medicare, or do all of these go to the 100-day max now?

So what determines -- presumably there's something about when my acute care episode ends, but who's supposed to determine that and what are the criteria?

DR. KAPLAN: The criteria are that skilled nursing facility patients have to require or need a daily skilled nursing or rehabilitation care. The FIs basically are very stringent in enforcing that, or so they told me.

Theoretically, the SNF would determine that they no longer were eligible for SNF care, knowing that they will be scrutinized by the FIs. My understanding is it isn't as easy to qualify for skilled care as it used to be.

Now when they first go from the hospital to the SNF, the RUG group basically determines whether they are qualified as a SNF in that first assessment. But the second assessment is basically that they have to determine that they do need daily skilled care or daily rehabilitation care.

DR. NEWHOUSE: This suggests an analysis to me we might want to do, which is an analysis of variation across states or FIs, controlling for DRG, for patients that come from a nursing home, and length of Medicare stay. Because it sounds to me like there's a lot of slippage in this domain.

DR. KAPLAN: The difficulty in the data is identifying the nursing home residents. The MCBS is one way to do this. You can identify the nursing home resident that goes to the hospital, then goes to the SNF, and then goes back to the nursing home. From other sources of data that's very difficult to do because we really don't have claims for

all the states.

DR. NEWHOUSE: So does this post-acute database you're going to describe next solve that problem?

DR. KAPLAN: The claims-based database that we're going to talk about next doesn't solve that problem, but MCBS data can solve the problem.

DR. NEWHOUSE: I suppose for my purpose it would be fine to pool MCBS across years to get the sample size up.

DR. KAPLAN: Exactly. And we are planning to do that although that's not what the focus of the next presentation is on.

DR. NEWHOUSE: Fine. You are planning to do what, the analysis I suggested?

DR. KAPLAN: Yes, I would like to do that. And we are planning on pooling the MCBS as well.

DR. NEWHOUSE: Good.

DR. NELSON: A fairly good percentage of people go to a SNF for a period of a week or two and then go home. The governing determinant on how long they stay there is, they and their family saying, get us the heck out of here.

DR. NEWHOUSE: That's why I started with the person who was resident in the nursing home before they went

to the hospital on the assumption they'd go back to the nursing home.

MR. DeBUSK: I have a question for Sally. Sally, this classification system of 2005, is this a part of the roll-up system for the whole post-acute piece?

DR. KAPLAN: No, actually it's not. There's several different mandates. I think the one you're referring to is the mandate that CMS identify a uniform, functional assessment instrument, and health status instrument to use across all settings in Medicare, meaning acute care hospitals, rehab, outpatient, everything. That is a separate mandate from the mandate to test alternative classification systems for the skilled nursing facilities.

MR. DeBUSK: That's due about the same time, isn't it?

DR. KAPLAN: It is. They're both due in January 2005.

MR. DeBUSK: So how's that going to work?

MR. HACKBARTH: Given that we're going to have to live with this classification system for years into the future, and presumably therefore we'll continue to have the add-on that was designed to offset, ameliorate deficiencies,

is there anything that we can do in the shorter run to analyze whether in fact the add-on is helping, is properly targeted, too much, too little?

DR. KAPLAN: I think that the SNF-specific database that Susanne was talking about will allow us to look at patients by groups and how well payments match costs by RUGs group, and maybe we can target that money more effectively than it's being targeted now. There's a lot of thought that the targeting is not really great, and that might help.

I'm not sure we can do that by March but I think we can certainly try. But since this problem isn't going away, if we can't do it March, it's still an important thing to try and do by June or so.

MR. HACKBARTH: Any other questions or comments?

Okay, thank you, Susanne.

Sally, you're doing the --

DR. KAPLAN: Nancy and I are doing the post-acute episode database.

At the retreat this summer you expressed interest in how beneficiaries have changed their use of post-acute care after the new prospective payment systems began for

skilled nursing facilities and for home health services. Answering this question requires looking across post-acute care.

Let me give you an example. The OIG has consistently found that a group of costly patients has difficulty accessing SNF care. These beneficiaries could be treated in rehab facilities, or long term care hospitals, or could stay in an acute care hospital longer. An episode database would allow us to determine where those individuals go, and hopefully, what their outcomes were.

As you know, the SNF PPS began in January 1998. The home health PPS began in October 2000. The PPSs for rehab facilities and long term care hospitals just began this year in 2002. Rehab began in January and long term care hospitals began on October 1.

The main policy questions we hope to answer with this episode database are on the screen. It is one tool that we can use to answer these questions. In the past, MedPAC has used MCBS data to answer similar questions about post-acute care. ProPAC also built a claims-based database to assess use of post-acute care, and so has MedPAC. However, they were constructed a little bit differently.

We'll be looking at these issues in two ways with the analyses of the episode database, which we also call the claims-based database, and with an MCBS analysis. However, our presentation, Nancy and my presentation focuses on the claims-based database.

MS. RAY: I'd like to talk a little bit about the specifics of the database at this point. We looked at a couple of different alternatives but ultimately decided that using data from 1996 to 2001 would best meet our needs to be able to track people longitudinally over time. We also considered just using two points of time, but with the different dates that the prospective payment systems started, again we felt that the six-year period, to begin with, would best meet our needs to be able to identify post-acute users and follow them over time.

We will be using the 5 percent files. We believe that that will give us sufficient sample size to be able to look at both national and regional trends. We estimate roughly about 50 per year -- using the 5 percent files we would expect about 50,000 SNF users and approximately 200,000 home health users.

Episodes of care will begin with either home

health care use or discharge from a hospital to a post-acute care setting. So again, the definition of the episode differentiates this database from previous work by allowing us to analyze folks coming from the community into home health care. Finally, episodes will end with a 31-day gap of services, hospice admission, M+C enrollment, or death.

I'd like to talk a little bit about the features of the episode database. We are trying to build upon previous Commission work, both with respect to our claims-based databases as well as our MCBS. We will be able to examine use of services before and after the numerous prospective payment systems that have gone into effect during this time period.

Because we are using the 5 percent files we will be able to look at service use for both Part A and Part B services. So for the first time we will be able to look and see what types of patterns of care are going on with Part B services, and the extent to which that has changed before and after the various implementation dates.

We will be differentiating beneficiaries based on their clinical characteristics, partly using the Part B diagnostic data as well as Part A that we will have. We

will be looking at selected outcomes, rates of rehospitalization, rates of hospitalization, emergency department use, as well as mortality.

Finally, we will be merging in the SNF and home health cost report data to be able to estimate cost of care using the cost to charge ratios.

I'd like to talk a little bit about using the Part B services because I'm particularly excited by that. I think it will provide us a lot of new information to look at for our analysis. I'd like to make the point, and I should have previously, that we envision this as a growing database. When 2002 data arrive we will integrate that into the database and keep updating the database.

Using the Part B database will allow us to take a look at a question that I'm sure anybody else has looked at to this point, and that is to look at post-acute care use following outpatient surgery. Does it happen? Has it increased over time? Again, going back to our selected outcomes, we will be able to assess use of emergency department use within the episodes.

DR. KAPLAN: On the screen you'll see some examples of analyses. We plan to compare post-acute users

and non-users, and find out what the differences are. Identify patient characteristics that predict use of more than one post-acute care setting, which has been -- in the past we've basically enumerated the number of beneficiaries that use more than one setting, but we really haven't tried to find out whether there are patient characteristics, or even facility characteristics, that predict that kind of use. Also, compare patterns of care pre and post-PPS, and compare outcomes pre and post-PPS.

We've contracted with Chris Hogan to build the database and conduct some of the analyses. Staff will use the database for other analyses, and we will continue to build and maintain the database as data for future years become available, as Nancy said.

Some of the analyses on the screen will be part of a chapter in the June report. Others will be used in next year's reports. However, I just want to make clear that we will not have any of the results available from this database for assessment of payment adequacy for the March 2003 report, unfortunately. But we're very excited about having such a rich source of data available to answer questions and we're looking forward to reporting results

from the analysis of the episode database.

We're happy to take your questions or comments at this time.

DR. NEWHOUSE: Sally, Nancy, I thought I heard you say you were going to construct this database by starting with either home health users who hadn't been admitted or discharges who used post-acute care. But then you said on the last slide, which I think you want to do, you want to compare post-acute users and non-users. So how are you going to identify non-users unless you include all discharges?

DR. KAPLAN: Okay, we'll have to use all hospital discharges. But we particularly want to capture those people who are referred from the community for home health.

DR. NEWHOUSE: I understand that. This is different.

DR. MILLER: Isn't the question, that's how you trigger an episode? That you'll have people with and without episodes in the database.

DR. KAPLAN: Yes, that's correct. I think what it is, the way the slide read was that people who are home health users who didn't have a hospital discharge, and then

people who are discharged from the hospital.

DR. NEWHOUSE: But the text says, people discharged from a hospital who use post-acute. So you need the non-users of post-acute.

But then I have just a minor question going back to the exchange we had on the earlier session, which I think if you have all the discharges from hospitals, I think the hospital claim has a variable that tells you where they were admitted from. So I think you can then identify with the claims data the people that are coming from the nursing home.

DR. KAPLAN: I think that it does have that variable. I think there's an issue as to how reliable those data are. But we will investigate that because that's a good point, Joe. Thank you.

DR. ROWE: I'm wondering if there is a relationship or a possible relationship here between this database and the database of some of the health plans involved in the Medicare+Choice program. One of the major interventions that is introduced in patients with congestive heart failure, for instance, who have frequent readmissions and home health episodes are disease management programs

that are managed by the health plans, or by vendors that are hired by the health plans.

I'm just wondering whether or not those Medicare beneficiaries in Medicare+Choice programs who would be enrolled in all these disease management programs, whether their data would be in this database and whether that would be potentially helpful or not. Would any of those be included in this?

DR. KAPLAN: Not if they were in M+C. If they're not in M+C, for instance if -- I don't know how that would work, whether you can have disease management independently.

DR. ROWE: Does CMS have disease management programs targeting --

DR. KAPLAN: Demos.

DR. ROWE: -- that would be relevant? Because this would be, obviously, a very rich database to look at in terms of the effect, if any, of these disease management programs.

DR. KAPLAN: I think those demos are just getting off the ground.

DR. MILLER: It won't be in this dataset, particularly for the years in question. That demonstration

is just going. You can't get it, outside of M+C. That's a chronic problem with the claims data that when someone drops into M+C they drop out of the fee-for-service databases.

DR. ROWE: Thank you.

MS. RAPHAEL: A couple of questions. First of all, I think this is a very important and encouraging development that we're trying to construct this database. I've made this point at the retreat and I consider this really important, and you started out by saying this and I don't want to lose what I consider to be one of the most important things we have to look at. You started out by saying that there seems to be evidence that medically complex, clinically complex beneficiaries have trouble accessing nursing home care.

From my observation -- and this is not at all empirically based -- one of the things we have to be wary of with our prospective payment systems is that we're rewarding rehab services and rehab cases. We tend to gravitate to things we can more easily measure. I am concerned that medically complex patients are the ones who are having the hardest time across the post-acute care spectrum.

I'm not sure that I'm comfortable with how we're

defining medically complex because, again, we're looking at things like stroke, vent dependency, et cetera. I think the medically complex patients who are having a hard time are those who have CHF, a variety of pulmonary diseases, or in most cases, more than one, and also have cognitive impairments. Those are the people that I think we have to somehow focus on in looking at this access issue. I'd like to better understand how we're going to ensure that we do that.

Then I think I'm also not entirely clear how we're going to compare outcomes from '96 through 2000 with whatever post-2001, because we didn't really look at outcomes in any structured way in the pre-PPS OASIS environment. So I'm not clear that we're going to be able to do that.

Then you also say you're going to be able to look at what influences choice of post-acute care setting. My own views are that very often this is driven by the need to discharge someone quickly and what services are available in a particular community, or families wanting services that have geographic proximity, rather than any sort of rational look at what are the options and what makes the best sense

for a particular individual. So I'd like to better understand how you think you can contribute to that.

Lastly, on this issue of am-surg. We know that a large percentage of surgeries now are done on an ambulatory basis. What do you see is the significance of looking at that? Why would it matter if more people in fact were coming into home health after am-surg rather than inpatient surgery? What would that tell us?

MS. RAY: Let me start. Let me just say, the selected outcomes we're initially going to be looking at will be rates of hospitalization, rehospitalization, emergency department use, and death. Ultimately, we will -- clearly, we will only be able to look at functional status changes after the implementation of the prospective payment systems, so I just wanted to clarify that point. So any kind of pre versus post-PPS will strictly be hospitalization, emergency department use, and death. That's all that we would be capable of doing with the claims data. That was one point.

Concerning your question about the choice of the post-acute care setting. You're 100 percent correct, there are a lot of other important factors that go into the

decision of where somebody gets placed. In fact in MedPAC's MCBS analysis using the '92 through '97 data we saw that. One of the interesting variables that we saw was the hospital ownership of the SNF had a lot to do with where these folks were going.

So ultimately, with this claims-based database we will be merging that information into the database to go ahead and try to run out those multivariate regression analyses. Clearly, you can't control for everything. You can't control for -- particularly using the claims data, we don't have any information about informal caregiving. That is what we do have with the MCBS, which is why we really -- we're planning that these analyses will be running in parallel because there's some nice things about the MCBS data that you don't have with the claims, and then there's some nice features about the claims data that you don't have with the MCBS.

The ambulatory surgery. We don't know at this point, and I think it's just an open question, to what extent is post-acute care being used following ambulatory surgery. No, it does not replace in any way the inpatient -- looking at post-acute care following inpatient hospital.

This is a question that, probably not for the June report but further down the road we would like to look at.

DR. KAPLAN: Let me address the clinically complex issue and also the choice of post-acute care. Clinically complex, we have asked Chris to basically suggest to us the way he prefers to define clinically complex. We came up with two different ways of defining it. One is the Charlson comorbidity scale. Another way is using case-mix groups from 3M.

So that we would be able to, just using the diagnoses from the acute care claims, for post-acute care claims, and from the Part B claims it is possible to come up with basically a risk score that would say, these people are much more sick, clinically complex, than these people. I know that the 3M basically ranks them in four groups going from one to four, and the people who are in the fourth group are the most sick. So that is one way that we're talking about looking at the clinically complex.

In the mailing, we identified --

MS. RAPHAEL: That scale includes cognitive impairments?

DR. KAPLAN: I'm not sure about that. I don't

know. We need to look into that. But cognitive impairment is very difficult because, unless it's in a diagnosis in the claim, it's not going to be there. The only way you're going to be able to tell it is from the assessment instruments, which mean you'll have it for home health, you'll have it for MDS or for the SNF patients, but you won't have it for the others.

MS. RAY: And you'll only have that post-PPS. Another limitation.

DR. MILLER: Can I ask one question about that? If the person comes from the hospital -- and this is not completely through the database, but if they come from the hospital there can be a diagnosis code attached there, like a dementia code?

DR. KAPLAN: That's true, but it isn't --

MR. MULLER: It won't be the lead one, by and large, so generally you won't get it.

DR. MILLER: Agreed. But if there's any way to reach -- I think what I'm saying is, if there's any way we can troll through the data to see if there is a way to reach to this question. I think you're right about the assessment instruments. But if they come out of a hospital I think you

might be able, somewhere down on the diagnosis code, figure out whether dementia was part of it.

DR. KAPLAN: That's one reason why we're using the diagnoses from all these sources, so that you'll get all of the diagnoses. But you still have a limitation as to how many diagnoses, even on the acute care claim you have a principal diagnosis and then 10, used to be called secondary diagnoses.

Let me also address the issue of choice of post-acute care. I think what we're looking for here are systematic predictors of using a particular site. As Nancy said, there are limitations on that, particularly because caregiving we know is very important in the home health, SNF area, and even in rehab it's been shown to be important. But it will at least give us some idea of if there are systematic predictors of a particular site or not.

DR. REISCHAUER: I think this is a tremendous tool and one that, if we're able to pull it off, will be tremendously useful over a long period of time. It's a huge undertaking and I guess we'll be seeing both of you again and again with progress reports.

In a way you've answered my question, I think,

which is, a lot of the answers to questions depend critically on demography and geography, and the database really won't have any or much in the way of characteristics of the environment in which the patient lives, meaning family status, income, or information about availability of post-acute care facilities in the -- it will? That's great.

MS. RAY: We will be able to -- ultimately, we are planning on merging in and controlling for number of other providers in the area and so forth. But you're right, using the claims data we won't be able to get beneficiary income or educational status. Again, we can look at that using the MCBS data; another advantage of the MCBS data.

DR. NEWHOUSE: I second Bob's views about the usefulness of this. I suspect the world will be beating a path to your door. But my question goes to the use of the outcome variables, death, readmission, and so forth. We know that for many years there's been a downward trend in both mortality and disability in the Medicare population and especially in the very old.

DR. ROWE: That would be a reduction --

DR. NEWHOUSE: An increase in life expectancy. It would seem at first blush that this is confounded, this is

going to confound your analysis of death rates as these prospective payment systems march in through time. How do you plan to handle that?

DR. KAPLAN: One of the things that we thought about using and we're planning on using in the long term care hospital analysis was to use expected versus actual death. But I'm not sure how -- we haven't really worked out the details of that, to tell you the truth, on the episode database.

DR. NEWHOUSE: Because even expected death, that presumably is changing through time.

MS. RAY: I think you're raising a good point and we will definitely get back to you on that.

MR. MULLER: Let me echo the compliments on the potential utility of this database. I think the population that both your brief and Carol referred to earlier, the medically complex and the clinically complex are fascinating cases we want to get to understand more fully.

As people go more into disease management programs, and I suspect that these people we're speaking about here are going to be candidates for that, will we be losing some of the data richness on that, comparable to what

Jack referenced earlier in terms of what you lose when you go to M+C, because all of the sudden now the kind of claims, the kind of granularity of the claims data is no longer available. But in the disease management programs we still get the acute hospitalizations, there's ER, there's ambulatory surgeries, there's all the kind of different episodes of care they have.

MS. RAY: Initially our analysis, the '96 through 2001 -- the disease management demos aren't starting until I guess next year -- this year, next year? So that's not an issue. The only disease management one that's actually completed is the ESRD disease management, and that was a pretty small program.

So ultimately in the future, that could definitely be an issue we consider, is to specifically -- first of all, see the population and whether or not we have sufficient population to look at those folks separately.

MR. MULLER: What I'm suggesting is that as we do the medically appropriate thing and as they bundle care and have people who case manage and otherwise are more responsible for taking care of a vulnerable population that needs a whole array of services, one of the data ironies may

be, however, that we now lose the information on what we're doing. For a clinically appropriate purpose.

So I'm not suggesting that's the wrong way to manage the care, although we may also lose the richness of that data, if indeed the kind of predictions that we'll more and more of these vulnerable populations into disease management programs. Because the kind of people that Carol referenced, the congestive heart failures, the pulmonary cases, the ones that have dementia as well as medically complex needs.

I'm just thinking -- I understand the point that we don't have enough of those programs yet to worry about it. But on the other hand, if that becomes the clinically appropriate way of caring for these people with multiple needs -- and I think there's a lot of speculation, at least in the clinical literature that that's the right way to do it -- we may, on the other hand, want to be attentive to keeping some information about that so we don't lose the kind of information that we lost in M+C. Again, M+C was an appropriate policy choice to make, but then you lose information on patients.

MR. DeBUSK: In the examples of analyses, the

second bullet point, identify patient characteristics that predict use of more than one post-acute setting, will you be looking at the financial aspects of the handoff process there? That's a major issue as to how that takes place at present.

DR. KAPLAN: You're talking about the incentives to transfer somebody to another setting?

MR. DeBUSK: Exactly.

DR. KAPLAN: I think we'd like to, to the extent that we can. I'm not sure whether we're really going to be able to answer that. I think part of what we were thinking about was that we know there's a lot of home health use following hospital use, which is a multiple setting use. So are there patient characteristics that basically predict that? Either particular -- does it happen for particular conditions, and distinguishing between that type of -- that actually is something that's recommended according to the clinical guidelines. So that's a little bit different type of multiple use of the financial incentives say, keep churning them through.

MR. DeBUSK: But these characteristics, patient characteristics, they're all going to play into that as to

what actually happens. I think there would be some trends in your analysis that would probably indicate, here's where these handoffs are taking place, and here's why.

DR. KAPLAN: I think there will certainly be some clues. I don't know that we'll get a definitive answer.

MR. HACKBARTH: Any other questions or comments?

Okay, thank you.

Our next session is our expert panel. We're running about a half-hour ahead of schedule so one of our panelists has not yet arrived. So what we're going to do is take a 15-minute break and reconvene at 10:15.

[Recess.]

MR. HACKBARTH: We have a very distinguished expert panel to help us with our next topic. Karen, do you want to introduce the panelists and the topic?

MS. MILGATE: Sure. This morning we're discussing the possibility of the Medicare program using incentives, either financial or non-financial to encourage providers to improve care. Traditionally, Medicare has used quality assurance and quality improvement requirements to maintain and assure quality in care. However, as awareness of quality problems have increased, some suggest that Medicare

program should do more to find ways to incent providers to improve care.

The Commission supported this concept in the January 2002 report on applying quality improvement standards with the recommendation that the Secretary should reward plans and providers for high quality performance and improvement.

This is not the only forum where the topic is being discussed. In an attempt to create true value-based purchasing, both private and public sector purchasers, including CMS, and individual providers and health systems are considering how incentives might work and experimenting with different designs. Some of these experiments were included in the case examples in your background material.

Here to provide us with a context for how to consider incentives in the Medicare program are three people whose personal dedication and tireless efforts have been instrumental in keeping the need to improve the health care delivery on our nation's radar screen. Not only have they helped articulate the problem, they've also led their organizations to design and implement solutions.

Our first speaker, Dr. Don Berwick, is a

pediatrician by training and he leads the Institute for Health Care Improvement. The IHI holds conferences which are standing room only for thousands of people on specific ways to improve care delivery, and designs workshops that require teams of critical hospital personnel to commit significant amounts of time to reengineering their systems.

Dr. Berwick has contributed his knowledge and experience of provider systems to several key national advisory bodies including, from 1999 to 2001, he was the chair of the National Advisory Council for the Agency for Healthcare Research and Quality. He was on President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. And finally, he was on the Committee on Quality of Health Care in America, the IOM committee which developed recommendations captured in the two most recent IOM reports on quality, To Err is Human, and Crossing the Quality Chasm. The article in your background material was from the latter, Crossing the Quality Chasm.

He's here to provide some context for the discussion and to help us understand why incentives are important.

Our second panelist, Dr. Brent James, is executive

director of the Institute for Health Care Delivery Research at Intermountain Health Care in Salt Lake City, Utah. He's here to bring us the provider perspective on how financial incentives currently work in the system, and ways in which IHC has tried to align the provider and payer incentives to make quality improvements cost effective for all involved.

Because IHC has a physician, hospital and payer component, he's in the unique position of helping us think through how incentives each of the stakeholders in the system.

Dr. James has also contributed his time and energy to several national advisory groups, including the same IOM Committee on the Quality of Health Care in America, and he's also served on the Framework Board of the National Quality Forum.

Suzanne DelBanco has the distinction of being the first executive director of the Leapfrog Group. The Leapfrog Group represents over 100 Fortune 500 companies and other private and public purchasers. These purchasers provide benefits for 32 million Americans and spend approximately $52 billion on health care annually. The Leapfrog goal is to mobilize employer purchasing to initiate

breakthrough improvements in the safety and overall value of health care for American consumers.

We've asked Suzanne to shed some light on the types of incentives purchasers are using, what has worked, what hasn't, and how these incentives might be used by another large purchaser, the Medicare program.

So with that, Don, do you want to start us off?

DR. BERWICK: Thanks a lot, Karen, and thank you for the opportunity to share some time and some thoughts with you. I also want to thank you for the work you do. I know how hard it is to be on this commission, and I know how dedicated you are to the work. It's really a privilege to get to have some input.

It's also intimidating because I'm way out of my areas of expertise here. I know a lot about improvement but not a lot about financing. So all I can do is tell you some of the things I think I'm seeing and perhaps assist in a conversation in which both you and my colleague panelists are more competent than I.

I run an organization, a non-profit organization that's trying to improve care worldwide, but focused largely in the U.S., and we continually run into the barrier of

leadership will. The will in the health care industry for improving care is insufficient.

The motivation and spirit of the workforce is great. You can trust the people. They want to do better. But as a matter of strategy for the industry at the corporate and possibly even at the political level, the concept that improvement of care ought to be the core of the strategy is still not sufficiently imbedded in the industry. I don't know why not. I try to understand it all the time. I think there are some skills barriers, there are some issues in technique. But there is a problem in alignment of the interest of organizations on the one hand with the improvement of care for people on the other. That's what I'm here to try to discuss with you a little bit.

I'm sure Brent will add to what I want to say at the outset, which is just to remind everybody how big the gaps are between what care could be, even given current knowledge, let alone advancing biomedical knowledge, compared to what care is. We have the pedigree of the Institute of Medicine reports, the President's commission, the National Cancer Policy Board and others who really have been very diligent across a wide array of initial political

positions in reviewing literature, understanding the research base, and making what I think is an evidence-based comment on health care that it could be a lot better. Not marginally better, a lot better than it is given current knowledge, but that it isn't moving quickly enough in that direction.

The IOM outlined for us all six dimensions in which improvement could occur, and in each of those dimensions, safety, effectiveness, avoiding overuse and underuse of care, patient centeredness, timeliness, efficiency, and equity, the gaps are not small. They're large.

I brought along some data that gives us knowledge of the degree of gaps. I think probably your commission is very familiar with this stuff, but just in case let me briefly give you some examples. This is information from the Dartmouth Atlas of Jack Wennberg, who is our greatest student of variability in the use of resources in the country. Jack has 30 years of experience and sophisticated models.

But here, for example, is a -- he calls this a turnip diagram, showing for hospital service areas, using a

model that allocates patients to hospitals based on the apparent catchment area, the probability that one of your beneficiaries, Medicare enrollees, gets admitted to a hospital with congestive heart failure in a particular year. We pick here '95-'96, but it hasn't changed in the data we have. Depending on where you are in the United States, if you're in Medicare, the probability that you'll be admitted to a hospital for congestive heart failure varies from about seven per 1,000 to, in some cases as high as 40 per 1,000. That's a 600 percent difference in the probability you will get into the hospital with that disease.

It is not credible to those of us who study the industry, nor does any data support the notion that you're seeing here some kind of latent variation in the underlying wild state; that they see different patients or different circumstances. This is variability in care. This is, for one reason or another, some places in the country are able to support people with congestive heart failure without putting them in a hospital, others unable to do that.

Here's the same data for where patients die. We know from the Robert Wood Johnson Foundation support study that people who die, the majority of people who die with a

chronic illness don't want to die in the hospital. And even those that want to die in the hospital do not often want to die intubated, or on IVs, or with invasive therapy. This is the proportion of people who die in Medicare in a particular year who die in an ICU compared to in the community. The range here is from about 6 percent of the decedents to well over 30 percent of decedents. There's about a 400 percent variation in the probability that one of your beneficiaries will die in an ICU, despite the fact that we know that the vast majority of them wish otherwise.

There's a national database on cystic fibrosis care. These are not Medicare beneficiaries. They're younger people. We know a lot about how to treat CF. There are 160 or so CF centers in the country. They voluntarily submit data to a centralized database run by the CF Foundation. By the way, under the condition that their identities not be revealed.

The national rate of poor nutrition in CF patients is about 25 percent, but it varies center to center in this country from 7 to 60 percent. The median length of stay for clean-outs is nine days, but it varies from two to 16. FEV1 is a measure of lung function, so a higher percent means

more preservation of lung function. These numbers reflect a preservation of breathing in children, which nationally is a lung function level of 73 percent across all age groups. The varies from 70 to 104 percent in latency age kids, and 40 to 85 percent in young adults.

Somebody knows something on this curve that others don't know, and there is no national agenda for moving the knowledge about excellence from the best places to the places that need to get better. In fact there's a prohibition against moving that knowledge because the data here are locked in a box.

This is perhaps the most interesting diagram I'll bring you. This is work being done in my office by our senior fellow this year, Sir Brian Jarman. Brian is, I think, the leading general practitioner in the U.K. He has just stepped down as chair at St. Mary's in Imperial College. He's the author of the Jarman index, which is what the NHS uses to adjust compensation to postal code areas based on the deprivation of the population in those areas. The NHS makes sure that money goes where people are the sickest and the poorest.

Jarman has become very interested in large

database management to study outcomes, and we've been here before, back in the days of Bill Roper and Glenn Hackbarth at HCFA. We tried as a nation to publish our mortality data. We did it for a while. We did well, and then lost our heart.

This is the same thing again now with a more sophisticated model, one that I've looked at very deeply. You're looking here at a pretty good signal to noise ratio with respect to the probability in an American hospital dies. This is just a random sample of 250 hospitals. You can't put 6,000 dots on a Powerpoint graph; it doesn't look too good.

But if you randomly sample 250 hospitals, using Jarman's adjustments now, this is all cause mortality in the hospital across 180 diagnoses adjusted for age, sex, race, payer, admission source, and type, and then for a set of about eight to 10 demographic variables in the community. It's about as adjusted as you get.

If you look at the vertical axis, the way to read that is that 100 is the standardized mortality rate average in the United States. It's just empirically, if you take all the hospitals, you study their death rates adjusted by

this method and you say, 100 is the national average. That's how it's defined. That's all that means. So no matter what your diagnosis is, adjusted now for the case mix, age, gender, and everything else about the patient being admitted to the hospital that we know, if you're admitted to a hospital that has an index of 100, you have the average chance of dying for an admitted patient.

Now you can see the dots as well as I can. There are hospitals in the country that are functioning stably -- we now have three years of MedPAR data as well the HCUP database here -- at about .4 to .5, and there are hospitals in this country that are at 1.6. Year to year these turn out to be quite stable. We have a 400 percent variation in this country in the probability that a patient admitted to a hospital will die in the hospital.

The horizontal axis is what you're paying them for that care. This is the standardized charge. This is all payer data because it's from HCUP, but if I showed the MedPAR data scatter plot you wouldn't know that I'd switched slides. It's the same. There is a 500 percent variation in the reimbursement per care, with a 400 percent variation in mortality, and there is no regression line at all. This is

a cloud, not a line. So there is no discoverable relationship between the amount you -- we are paying for care overall and a very important index of the outcomes of that care.

The opportunity here is phenomenal, and the momentum is slow, and the will is insufficient, in my view. I became interested in this with Sheila Leatherman and we jointly approached the Commonwealth Fund and asked for a small grant, just for a nine-month project which ended last month. Joe Newhouse was helpful with this project and will probably tell me that I'm reporting it incorrectly, but you can correct me, Joe, please.

I want to describe the project and its findings very briefly and then turn things over to my other panelists. We set out to study the relationship between improvement and the bottom line. We chose to take the perspective of the so-called investing organization, which in almost all cases is a hospital or health plan. We developed seven cases. With the help of my friends on the Strategic Framework Board of Ken Kizer's organization, we selected a set of about 30 evidence-based improvements. None perfectly supported, but things where we know, if a

place does this as opposed to the status quo, things are better for the patient.

We found organizations that either had implemented or were planning on implementing that improvement. We picked seven, just through networking. Then with a team of case writers from business schools and people from the organizations and our investigatory team, we went into those organizations. They opened their books, and we studied the clinical outcomes of the innovation and the bottom line effect as best the finance people could trace it through to us, what was happening to them. Were they making money or losing money, basically.

Now I want to say that nobody in the whole team believes that that's the only reason we would do an improvement. There are many improvements one ought to do for ethical and moral reasons and others. But we had a very confined question here, which is when you put this improvement in place as the alternative to the status quo, does the organization make money or lose money?

The improvements we chose to look at were these: a diabetes management program, a low molecular weight heparin use for patients with deep vein thrombosis, lipid clinic

management for hypercholesterolemia mainly with statin use. This is a nurse-run and pharmacist-run lipid clinic. Group visits as opposed to individual visits for patients with chronic illness, computerized physician order entry, an effective anti-smoking program in a health plan, a cardiovascular risk reduction program, and selected referral to high volume sites.

All but two of these are in health delivery systems. The last two are employers, the cardiovascular risk reduction program at General Motors, and selected referral to high volume cardiovascular surgery sites by General Electric.

This is a little more detail on the sites. The chronic care investigation of diabetes management was done at two sites, Health Partners in Minneapolis, and Independent Health in Buffalo. Independent Health is an IPA, Health Partners is a staff model HMO plus an IPA. We looked at the use of group visits at Luther Midelfort Clinic, which is a community hospital owned by Mayo Clinic in Eau Claire, Wisconsin.

We looked at smoking cessation and prevention at Group Health Cooperative of Puget Sound, probably the most

famous cessation program in America, and the wellness programs at GM to reduce overall risk in selected employees.

We looked at General Electric's attempts to shift cardiac surgery to high volume locations. We looked at Henry Ford Health System's use of low molecular weight heparin in suitable patients. And we looked at plans at Children's Hospital of San Diego to put in CPOE.

Not all the cases worked all the way through, for various reasons which I won't go into. I'll show you some detail but let me first define what we meant by a business case. A business case was narrowly defined. We said a business case exists if the entity that invests in an intervention realizes a financial return on that investment within a reasonable timeframe with a reasonable rate of discount. It's just an ROI calculation. The return could be in dark green dollars, in reduction in losses, or in avoided costs.

The business case we said also exists if the investing entity believes that there's some other important, non-immediate financial effect on organizational function and sustainability in the longer run. So we put a little bit of a soft edge on the definition.

I'll give you some examples. Diabetes management at Health Partners, I will just editorialize and say, I have not seen a better diabetes management program. The results are extraordinary in their staff model component. If you follow patients through that program and you look for cost recovery basically, care they don't have to give, at least in the capitated portion of the organization, because those patients don't get eye disease, renal disease, cardiovascular disease and other complications, it looks like they begin to break even in about year five just in their own operating terms.

The overall return on this program is about 10 to one if you use a human capital approach. That is, the extension of life and function in these patients according to the economic model used by the case writer is very good. But most of that money never shows up at Health Partners. It's returned to employers and the patients.

It took them about 10 years after they started that program to realize any financial return that we can find. It is interesting that at no point, even if the financial return wasn't there, that Health Partners considered not doing the program. They are absolutely

committed to it, and we know from their senior leaders they simply regard it as doing work. They would no sooner stop that than they would stop doing appendectomies. It's just part of health care from their viewpoint.

Tobacco cessation at Group Health Cooperative has been going on for about 20 years. They currently have a program called Free and Clear that's a benchmark program for tobacco cessation. So far as we and they can tell, no money returns to Group Health because of that program. Too much time passes between the achievement of cessation of smoking and the outcomes that would be reflected even in a capitated system. And there's enough churning and turnover in membership that Group Health simply can't count on a particular patient having been in the Free and Clear program remaining in Group Health long enough that the reduction in cardiovascular risk and cancer is retrieved.

Like Health Partners, however, the senior leaders of Group Health do not regard cessation of the smoking cessation program as an option. They believe it is health care and again, they say they would no sooner stop that than they would stop appendectomies. Until we showed up, they had not done a financial calculation of the return on this

program. They didn't regard it as a relevant question for their decision.

The lipid clinic at Henry Ford also has very good effects. When a person has high cholesterol, they should be on certain drugs to lower their cholesterol if it's high enough, and managing those drugs is tough. There are side effects, and compliance tends to be relatively poor. So Henry Ford started a pharmacist-led, nurse-staffed lipid clinic and enrolled patients who would come into that clinic. They only did it in half, in their health plan, not in their affiliated medical practices.

In that environment, the patients that comply -- the patients that are in the program get an 85 percent -- they hit the bar 85 percent of the time compared to the wild state of about 30 percent. So they have a tremendous improvement in lipid control in those patients. However, they have made a decision at the moment, they say, not to extend this program beyond the capitated environment because it will be a definite money-loser for them. It's just they can't afford the investment. Statin drugs are expensive and in the fee-for-service part of their care it's cost added to add this program, despite their enthusiasm for what's going

on.

So it effectively reduced lipid levels, but at high operating cost. Henry Ford is under tremendous financial pressure right now and the short term cost increases for doing this simply are beyond their reach.

One example of the workforce intervention, GM and the United Auto Workers have a terrific program called Life Steps which they do health risk assessment on all their employees, and then they take tier three, the highest risk tier, and they enroll them voluntarily in this Life Steps program. They're able to document considerable reduction in cardiovascular risk. They also have a cost model which shows them how much money is saved when a high risk individuals moves to tier two instead of tier three.

We could not get, nor could GM offer us, the cost structure of the intervention program, so in this particular case it's dropped off the rest of what I'm telling you; we don't know the cost to benefit ratio.

Let me give you the bottom line findings. We can go into detail in discussion. Most of the improvements I just showed you save money. They save money somewhere. In some cases, especially if you use a human capital

calculation, they save a lot of money.

Almost none of the programs returned money to the innovating provider. The exceptions are few. The use of low molecular weight heparin in suitable patients returns money to the provider. However, at the study site for low molecular weight heparin there was a problem in that the low molecular weight heparin was being used off protocol. That is, it went to many patients who shouldn't have gotten it, and it didn't reach, by any means, all the patients that should have gotten it. So the failure to execute the introduction on protocol of low molecular weight heparin prevented that organization from harvesting back the economic benefit. But that was an implementation issue, not an economic barrier.

The United Auto Workers-GM system appears to be a high payoff system in terms of return to GM in worker days. But in almost no other cases that we could find could we find the money -- it was not a positive financial step for the organization to take care of these innovations.

The reasons were five. The returns were there but they came too late or in the wrong place. That is, outside the organization. This is less of a problem in the

capitated environments by far, but it still is a problem for some of them given churning.

Second, any benefit they could have gotten from consumers seeking the better care was confounded by consumers not knowing that the care was better. So nobody with deep vein thrombosis knew that they could get low molecular weight heparin at that site but not across town. None of the diabetics seemed to be aware that Health Partners is probably the national leader in diabetes management.

Third is, you're paying for defects. Many of the disjunctions occur because when you fail to treat, to prevent a disease, in most of the payment environments we studied, those patients end up going into the hospital and the hospital gets paid for it. So it's simple.

The fourth is administrative pricing. Joe and Karen Davis on our policy team added that. Let me interpret what I think it means. Let's take another innovation we didn't look at, e-mail care. I personally believe all patients in the United States should be able to access their physicians and nurses on e-mail. They do not now. I believe a lot of patients would be willing to pay for that a

little bit. If you said, for $10 a month extra or $5, you can e-mail your doctor, I'm sure there would be a tremendous market for that. We have no way to get the market to tell us what it wants because the prices are set administratively. I think that's approximately what that means. Is that right, Joe?

DR. NEWHOUSE: Yes.

DR. BERWICK: Management challenges are like the low molecular weight problem. A lot of times the harvest doesn't go back to the organization, not because of an external problem but because of an internal management failure. The organization is simply unable to deploy the change thoroughly.

A very interesting finding is the difference between the view of a core and the view of an optional improvement. In my view, for MedPAC, this might be the most important finding. Organizations behave entirely differently when they believe that something is part of care, like an appendectomy is. That's what you see with Health Partners in diabetes, with Group Health in smoking cessation. They don't ask the question, should we do it? They only ask the question how to do it, because somewhere,

somehow, in the value system of the organization, from its board, I don't know where, someone said, that's health care.

On the other hand, when you look at Henry Ford, which is a fabulous organization -- none of this is critical of them and I commend them for their transparency -- they feel they can decide not to have a lipid clinic for the fee-for-service group because it's not part of care. It's a frill, it's an optional thing. A nice thing to have, if we can afford it. Completely different behaviors.

I believe MedPAC controls to some extent the psychology of central care versus optional care, and I think it turns out to play out a lot in the behaviors of these organizations. There is no level playing field on this. The same type of intervention, smoking cessation, lipid clinic, or diabetes management is viewed by some organizations as in the core, and by others as optional. Therefore, you see very different kinds of behaviors in the system.

Another important finding I think is that if you separate business case return from economic benefit somewhere in society you quite reliably, with these interventions, find economic benefit somewhere. That's

important. That's an important thing to notice.

So here are the impediments, failure to pay for quality while you pay for defects; the inability of consumers to perceive where something would be better; displacements of return and payoff in time and place; disconnections between consumers and payers, especially around wanted features like e-mail care; and uneven access to providers to relevant information are probably, I guess at managerial levels, problems in executing effective changes.

Policy options were considered by a group that Joe served on which is our policy team. It's a little more complicated. You have quite elaborate tables there which I'm not going to spend time on right now, but basically here are some options. That we should stop paying for defects. I don't know another way to say it. If you find a way to extend the boundaries of time and place for payment you will get more integrated care.

Now I will tell you that that leads logically, not politically, to capitated payment because the systems that have the widest boundaries in time and place are those which are getting paid for care of populations. It just is logic.

If we can make consumers more aware of quality distinctions, it might be in the interest of some of these places.

Administrative pricing is a problem around features that are not in the core but you'd like to make attractive. So if there's something you want to define as not in the core but it should be available, then you've got to let a pricing system develop in which people can say, I want that and I'll pay for it. Right now they can't do that. So very carefully define the core, because by doing that you change behaviors fundamentally.

The tables in your handout are from the policy team in a long two-day meeting. We took stakeholders, patients, clinicians, and organizations and payers and we tried to say, given those five defects, what stuff could you do? Calling this evidence-based would be gilding -- I don't know what the right metaphor it. It's not evidence-based. This is opinions about what might work or might not.

On the patient side it tends to be information. People just don't know what's out there, and the distinctions that could be, and we are basically arguing for a much stronger national agenda for education of patients. I'm not a fan of cost shifting to patients. I'm not a fan

of defined benefit. I think that's a big mistake nationally. But I am a fan of helping people understand what they get and what they don't get, and being more systematic as a country to educate people what they could have, and what they do get that they don't need.

At the clinical level there's a lot of implementation issues which are basically managerial problems. At the defect level, we think that guarantees ought to enter the system. There ought to be promises made by delivery systems and that is part of the business, to begin to understand what it is you promise and deliver.

Then at the government level -- I think what I'll do is not go over these as a list. You can read them now and through the panel and then we'll talk more about them. Let me stop there.

DR. JAMES: Almost exactly two years ago, the Journal of the American Medical Association published yet another study, part of really a genre of studies demonstrating the major academic medical centers in general get better medical outcomes than minor teaching hospitals, which in turn get better medical outcomes than community-based care delivery centers. This particular study examined

acute myocardial infarct. The green bars represent major teaching hospitals, yellow bars minor teaching hospitals, red bars community centers. It's tracking mortality rates following acute myocardial infarct at 30 days, 60 days, 90 days, and two years after the precipitating event.

I should say in passing, if we instead examine the patients experience of care you get exactly the opposite trend, where the community hospitals routinely outperform the minor teaching hospitals, which in turn routinely outperform the major academic centers. It's arguably as, in some instances, even more important.

But in this case we're looking at medical outcomes. What made this study fairly unique was that the authors of the study tracked this difference in outcomes to its causes in care delivery. They tracked four main factors. The rapid use of aspirin -- the far left set of bars -- in the emergency department is a significant contributor to survival, but small and it did not account for a major part of the survival difference you saw in the last slide. Rapid reprofusion performance was similar across the organizations. It, similarly, did not contribute.

The effect that you really see on that last slide comes from the two middle sets of bars. Two classifications of medications that we know from good evidence, randomized controlled trials, are actively lifesaving. They tracked use of ACE inhibitors and beta blockers on discharge from the facility. They measured ideal patients. They attempted to establish patients who met indications but had no contraindications to the drugs. In fact about three-quarters of the effect comes from the third set of bars from the left, beta blockers, that class of medications. So there you see the difference.

The community hospitals managed to deliver those lifesaving drugs correctly 36.4 percent of the time, while the major academic centers did it correctly 48.8 percent of the time. That was sufficient, by and large, to account for the difference in survival that you see.

Of course, the reason I show the slide is to point out that big black gap above the 48.8 percent. Now let me get this straight, our best academic medical centers managed to do this correctly less than half the time? Is that what that's slide is showing us? That's exactly what it's showing us. In fact the Commission on Quality of Health

Care in America and a number of other groups before, we found not just this particular instance but many others of similar performance in the American health care system.

At about the same timeframe a leader within our system, Dr. Donald Lepay, who heads our cardiovascular clinical program began to address that issue. He identified not just beta blockers and ACE inhibitors but three other medications with solid evidence, the use of anti-platelet drugs, usually aspirin in patients with established ischemic heart disease; the use of statins to lower blood cholesterol in patients with established heart disease, secondary prevention; and the use of the drug warfarin to slow clotting and protect patients with chronic atrial fibrillation, from strokes usually.

He found a leverage point in the process of care. It turns out that when we discharge patients from our hospitals, the nurses complete a packet of forms. We call it our nursing discharge packet. And he just added a form to the discharge packet, a simple check sheet where the nurse could check off indications and contraindications for each of those five medications. Basic process, on discharge the nurse would complete the sheet. If the patient met

indications but had no contraindications, the nurse would write the medication order on the discharge sheet.

Now in Utah, as in most of this country, nurses can't write medication orders. They're legally not empowered to do that. It still required the physician's oversight and signature. So it was still under direct full control of the attending physician, and in some instances they changed those orders. They'll choose a different medication, sometimes they know something that the nurse didn't know, they'll cross out a drug.

What this run chart shows though is the impact of that intervention. We drew a valid random sample of all appropriate patients, patients with heart disease, for six months before Don implemented his new approach. This is beta blockers specifically on the chart; 57 percent appropriate use. In the month following the intervention, it increased to 98 percent. At time point two, the second arrow, they rolled it out to our four largest hospitals, deployed the initial pilot. At time point three, we finally got smart enough to have the nurses take full control of it, which also improved care. It needs a time point four off the right-hand edge of the graph when we deployed it to all

of our facilities.

After it had been in place for a year we conducted what's called a quasi-experiment. We took the hospitals where we deployed this intervention and compared them to other hospitals in Utah where it had not been used. So we had a prospective non-randomized controlled trial; fairly rigorous design. Comparing the year before to the year after in light of that controlled trial, our beta blocker use increased from 57 percent to 97 percent for a full year. The column to the far right gives the national statistics for the same year. ACE inhibitors, 63 to 95; statins, 75 percent to 91 percent; anti-platelet medications, mostly aspirin, 42 percent to 98 percent; use of warfarin from 10 percent to 92 percent.

In the quasi-experiment though we also tracked mortality. We used the Social Security death index to track every hospitalized or treated patient within our system long term. We used the state of Utah -- they maintain that locally -- and computer match our patients on a regular basis so we could track mortality rates. We discovered that in conjunction with that change in care, our one-year mortality rates for congestive heart failure fell from 22.7

to 17.8 percent -- a very significant drop statistically. Significant clinically too. It represented about 330 lives per year, people who didn't die in 2000 who would have the year before.

For ischemic heart disease the drop was smaller. It was still significant. It's a larger group of patients at lower risk. Another 125 lives per year. Net savings in lives, about 450 per year. It appears that that change in mortality rate has persisted.

Of course, with proper outpatient management of heart disease, congestive heart failure, and ischemic heart disease using these proven medications, hospital readmission rates have fallen too by just under 900 hospital admissions per year. Rough estimate, you're looking at something on the order of $4 million a year, the net cost for hospitalization in difference between those two.

Another very quick example. This was work that was done by Dr. Kim Bateman. Several years ago he implemented a similar program for community-acquired pneumonia based on an evidence-based best practice guideline. He had to work very diligently on finding a form that would fit smoothly into the flow of practice in the

clinic. But he discovered that.

Again, we did a quasi-experiment comparing the hospitals where Kim originally implemented, 10 small rurals in our system, to 12 adult hospitals where he did not implement. We saw that our proportion of patients suffering significant complications, as reflected in ICD-9 codes on the inpatient side of the equation, fell significantly. In direct conjunction with that, the proportion of patients dying in hospital, we thought that was a fair measure for this particular disease, fell significantly.

That first year in those 10 small rurals, that represented about 20 lives. Today, as this protocol has spread across our entire system we think it represents about 70 lives per year. Not too surprisingly, because we didn't have to pay to treat the complications, our best measure of cost of care fell by 12.2 percent. They're called relative resource units. They are stable in terms of medical price inflation over time. And it also balances cost structural differences across our hospitals. It's kind of like relative value units, but a nice stable measure. That represented about $1.2 million.

Now the reason I show you this one is because it

was the first time in long experience with quality improvement that I actually measured not just cost of care but revenues of care. We had a long experience in some very sophisticated study designs demonstrating that Demming had it right: that as you improve the quality of outcomes of care, the costs drop. My problem was that the administrators working in this system, while convinced of those data, kept complaining that their budgets didn't get better. Initially, for the first couple of years I just whined back. I said, come on, you're the cost experts. Track them down.

But finally, we decided to help them out. It turns out that while our costs had fallen by $1.2 million, our revenues had fallen by $1.5 million in this class of patients. It was all to do with DRGs. If the patient had a complication when admitted with pneumonia, it changed their DRG. Typically they went to DRG 475, long term ventilator support. At that point in time 475 was paying us about $16,400 per case and there was a nice little margin in there of about $600.

When we improved the care, it shifted them back into DRG 89, community-acquired pneumonia. DRG 89 we're

being paid about $4,600 per case but our true cost of operations was about $5,200 per case for that particular set of cases. We not only passed along those savings, back to HCFA at the time, but about an additional $500,000 in what we regarded as IHC operational money, to deliver care to patients within our system.

Now it's again easy to make the case that quality does control cost. That theory has been very well developed in industrial settings, and experience shows that the same holds true in health care as well. The real problem is improvements in cost structure that damage your bottom line, your net operating income. I'm speaking of it the way that a care provider would see it, an individual physician in an office, a clinic, or a hospital or, in our case, a big, integrated delivery system with 22 hospitals and more than 150 outpatient care delivery locations, a charitable not-for-profit.

As we analyzed this more thoroughly we realized that there were three major types of activities that we could undertake to reduce the cost of health care. They're listed on the left of this slide. This is a simple version of the analysis that was actually performed by Mark Barrett

in our finance department.

We thought of a unit of service as any single thing on a transaction bill, activity-based cost accounting bill: a single dose of a drug, a single lab test, a single imaging examination, or an hour of nursing services, those sorts of things. We could decrease the cost of a unit of care. Perhaps we would change our nursing skill mix so the cost of an hour of nursing care was cheaper.

Second activity that we might undertake, we could try to decrease the number of units per case. We could shorten the number of nursing hours to treat a case with a particular disease, a patient with a particular disease, shorten the length of stay, for example, or decrease the number of imaging exams that we performed, or the number of doses of a drug.

Finally, the third alternative, we could manage the care so well in an outpatient setting that they never required hospitalization. We could control their blood sugars so well that they never developed retinopathy or nephropathy, damage to their eyes or kidneys and required that level of treatment. So a fundamental quality improvement-based prevention strategy.

The thing that we hadn't appreciated is how those played out based upon how we were paid. We have four main payment mechanisms as general classes. The most common used in Utah is discounted fee-for-service. The numbers at the bottoms of those columns are the proportion of care delivery payments for our system. A little over 50 percent of all care delivery in Utah, discounted fee-for-service per case payment, that's mostly Medicare for us. There's a few other payers, commercial payers who pay us that way. In Utah, we don't have any per diem payment at all.

The last column is the most interesting. I like to call it shared risk. The simplest version of it is capitation. If you look at the numbers on the bottom it turns out that about 85 percent of all our care delivery happened in discounted fee-for-service per-case payment. The elements of the list on the left that are controlled clinically, are accessible to actual improvements in care, are the bottom two. Administration pretty much entirely controls cost per unit. That's our real source of work.

So if I were to look at it from the clinical quality improvement standpoint, that's where IHC lives, in that red box. The arrows in the graph show the impact on

our net income as we improved care with the aim of reducing cost, as the examples I just showed you in both cases.

So what happened to us when we improved cardiac medications and dropped our admission rate for patients with congestive heart failure and ischemic heart disease? We ended up with about 4,500 extra bed days, empty beds. We saved the variable costs associated with those cases but lost the fixed costs associated with them. It turns out that the cardiac discharge meds project was a net money loser for us. Once again, almost all of the savings flowed back to purchasers.

As we recognized that, we knew that to make our own business case internally that we had to align our contracting strategies so that we could harvest savings back. I apologize to Don. I know you hate it when I say that last statement there, Don. Clinical quality improvement really is a fast way to go broke if you don't have some mechanism in place to harvest savings back.

The reason I think that, we've discussed this before and talked about, you ought to be doing it anyway because it's part of your mission. But it makes it extremely difficult -- you get to the point where you're

targeting improvements and you anticipate their cost impacts you have to say, can I afford it? Can I afford to treat my congestive heart failure patients appropriately? Can I afford to improve my pneumonia care? Because if you drive your organization out of business then you won't be delivering care to anyone. It forces you into a very difficult balancing act.

We eventually evolved three strategies. The first was to target your specific improvement projects. Fundamentally, every time you start a quality improvement team you look at that matrix, you carefully play out the projected cost savings through your payment mechanisms and say, should we do it? Does it hit our bottom line in a positive way or a negative way? It's very, very dissatisfying because you end up leaving so much on the table, so much potential on the table, to the point where, frankly, we don't use it to any great degree.

The second is you can use it in contract negotiations. This is really the work of Greg Poulson, our vice president for planning, who handles our commercial contracting. Greg basically said, look, if you can give me a better cost structure, I can turn that into advantage in

the commercial marketplace through contracting. What it forced us to do was sell on the basis of true price, not on the size of the discount. Most commercial sales in the United States are still based upon size of the discount. It's an easy number to understand.

Happily, some of our competition had pushed us down this road already. For our major competition in Utah, that particular group of hospitals needs to discount 40 percent to meet our base list price, as a not-for-profit. They were playing a little bit of mark it up to mark it down, to artificially inflate the size of the discount. So they had trained many of our commercial purchasers to think in terms of true price. It made it easier for us to go to them and say, last year we gave you a 7 percent discount from billed charges. This year we propose 5 percent. And you know what? You'll be ahead financially, because of the improvements we made in care.

To use that strategy it requires good data systems and long term trusting relationships is what it takes. Greg was quite effective in doing it for our commercial markets within the state.

The third strategy is by far the most attractive.

It's really created by Dr. David Burton and it was based on the right-hand column in that graph where all of the arrows are green. As we discussed it, we decided that we didn't particularly want to move to full capitation. We actually thought we could do very well with full capitation. We really preferred a circumstance though where all the major players had some skin in the game, where we all benefited if we did it together.

Under capitation, we get all the benefits and the purchaser gets none. Under the other, discounted fee-for-service per case payment, it tended to be that the purchasers got all the benefit and we got none.

Under that particular strategy, the way that it worked, we had to reorganize actuarial analysis. It turns out that in most insurance companies actuarial analysis follows some standard accounting principles in terms of the categories they use. We had to reorganize it around families of tightly-related clinical processes of care that define groups of physicians and nurses who routinely work together. Now within out system we call those clinical programs. So it's defined conditions in terms of groups of physicians and nurses who routinely work together.

With some of our insurance partners we began to do that. It was a major retooling on their part to redo their actuarial analysis in that way.

The second thing we did for an identified population of patients, for the cardiovascular clinical program, for example, or women's and newborn, or primary care, we would project next year's expenses, what it should be actuarially.

We then entered into contracts where, as our teams improved care, if we could come in below the projected actuarial cost for that population and show that it related to improvements in care, that we would agree that we would split the cost savings three ways, where one-third of the savings went to the purchaser. They were just that much further ahead than they had any right to hope to be. One-third of the savings came to Intermountain Health Care so we could afford to do this next year. And one-third went to our physician partners, who similarly were being impacted in their practices by those shifts in care.

We have used that model without our own health plan so far for three years on our large employer subsegment and our primary care clinical program. Currently, we're

returning about $3,000 per physician per year, is their share of the savings.

The other key element, we continue to give the advantage, as long as the change is better than the rest of the marketplace. So we don't give the savings just for the first year that it occurred, but as long as that group of physicians and clinicians, nurses, technicians, manage to hold better than the marketplace, we continue to split the savings with them.

It's our favorite approach. You could imagine why I wanted to talk to you, the one group in our world, the largest group in our world in fact is not able to do those kind of innovative contracting strategies with us. So with Medicare at least we still have to think about things in that old, different way.

I think the lessons we learned are this, higher quality can reduce the cost of care. I think we've satisfied ourselves internally that that really is true. But we need to think creatively about ways that we can turn that improved care into benefit for all of the parties involved, for the patients, for the physicians, for the hospitals, for the purchasers, in order to achieve a

solution that really would work for the whole American health care system.

DR. DelBANCO: I'll keep my comments as brief as possible, sort of sail through it so we have some time for discussion. You'll see that there's really no accident that Leapfrog took the approach that it did because two of the people that we consulted about our approach are sitting to my right.

The Leapfrog group, I'll just briefly describe to you a little bit about us. We are now actually 117 purchasing organizations who have come together to use a two-pronged approach of trying to improve health care and improve the health care system. On the one hand, Leapfrog is about an organized effort on the part of purchasers to start buying right, to realign the incentives in the health care system so there is an environment in which providers can make the kind of innovations that we've just been hearing about.

On the other hand, it's about trying to engage and activate consumers to also not only become part of the solution by voting with their feet, in a sense, and reinforcing the superior performance of providers in the

system, but also to enable them as individuals to make better decisions for themselves.

When our members join Leapfrog it's not a typical networking organization or trade association. What they're joining is a common commitment to a set of purchasing principles that emphasize that two-pronged strategy that I just described to you. All of our members agree to inform and educate their enrollees. They also agree to try to create different types of market reinforcement, whether public recognition, or different types of payment strategies, whether those payment strategies have to do with how they pay providers or how they create incentives for their enrollees to make different choices in health care.

As a strategic decision, we are focused solely at this point on inpatient care and patient safety practices within the hospital setting. That has, in large part, to do with the fact of everything we learned from the Institute of Medicine report about what we know about what happens in hospitals, what we know about what interventions are successful.

We basically went to the leading patient safety gurus and quality improvement experts -- and again, two of

them are sitting to my right -- to find out what would be the equivalent of anti-lock brakes, airbags, and seatbelts for the health care system, and came up with three, what we call our safety leaps, which is where we have started. Those are computerized physician order entry, having patient care in the intensive care unit managed or co-managed by doctors with special training in critical care known as intensivists, and evidence-based hospital referral.

The basic idea is referral for patients who have need of select high risk surgeries, or who have certain high risk neonatal conditions, to hospitals where their outcomes are likely to be better. In an ideal world we would be basing that on publicly reported, risk-adjusted outcomes data. But given that that is rarely available, we're using volume as a proxy for those referrals.

Based on these three leaps alone, some conservative estimates done for us by researchers at Dartmouth, led by John Burkmeier, who's also involved in the Dartmouth Atlas, predicted that if every non-rural hospital implemented these practices we would prevent more than half a million serious medication errors each year, save close to 60,000 lives, and $9.7 billion in annual health care

expenditures. That's from a societal perspective, not just the purchaser perspective.

We have created quite a lot of traction in the last couple years. We're a visible movement. We're gaining members monthly. But we're still very much swimming upstream. When I say we, I'm not sure if that's the purchasers or the Leapfrog staff, but we're trying very hard to help purchasers, help our members figure out how to use their role to realign the incentives. What we're finding is that there are limited data. The kind of information we need to create those incentives are hard to find.

Employers are very unsure of what the return on investment will be. Given the economy right now, given the way health care costs are rising, it's very difficult for our members to go to the CFO of their corporation and say, I want to pay X number of hospitals more. That just doesn't pass the sniff test, as some people say. There's fear among our members of getting locked into higher payments. There is fear of employee backlash, certainly when it comes to using different kinds of incentives for enrollees to make different health care choices.

It's also, I think, increasingly understood by

purchasers that it's very difficult to tinker with just one part of the health care system at a time, whether you're just focusing on our three leaps, or you're thinking about our three leaps in terms of how to get physicians to use CPOE. That's not enough because you've also got to think about how to encourage hospitals to install it, and how to encourage consumers or patients to choose hospitals that have those systems in place, and you can go on and on.

There are growing efforts to buy right. Within the Leapfrog effort we have increasingly wide use of common questions that employers use -- I'm sure Jack Rowe can talk to you about this -- when approaching health plans that have to do with Leapfrog questions, Leapfrog efforts and trying to ensure health plan support of employers' efforts to implement Leapfrog. We now have some contract language that we've created that some of our members have put into contract this year, and we expect many of our members to put into contract next year, again that will support Leapfrog activities.

There are some examples of incentives in the system. Empire Blue Cross and Blue Shield, Xerox, IBM, Verizon, and Pepsi are now providing quarterly bonus

payments to hospitals in the New York City area who have fully implemented computerized physician order entry and intensive care unit physician staffing. There are lots of other examples I won't walk you through. They're still very few and far between. This is by no means common behavior.

There's also, I think, some rapidly growing efforts to help consumers make more informed choices. There are many commercial systems out there now that both health plans and employers are contracting with, which provide whatever data are publicly available to consumers through various types of decision support tools to help people make more informed choices. The Leapfrog data are often incorporated into those tools. While you may not look at this immediately as incentives, I think by helping consumers make more informed choices there can be ramifications for providers in the system who are providing higher quality or higher value health care.

Leapfrog has many efforts underway, and one of the ones that I find most exciting right now is our incentives and rewards, what we call our lily pad. It's basically a work group. Unlike our other lily pads, this one is truly multi-stakeholder. We have hospital representatives,

physicians, health plans, consumer experts and representatives, and purchasers sitting around a table to try to figure out how to create some alignment of the incentives when it comes to the three leaps.

We are using sort of a modified six sigma process and being coached by people from General Electric. Essentially what we're trying to do is identify, who are the stakeholders in any incentive and reward program? What are their needs? Meaning, not just what do they want, but what is absolutely fundamental to ensuring their participation in any kind of incentive or reward program? What can we brainstorm in terms of ideas for incentive and reward concepts that might make sense? What actually does make sense from an actuarial perspective? And what is within the purchaser's power to actually implement? Because many of the ideas that the group is most fond of are things that are very difficult for purchasers to do.

Working together we have come up with four main categories where we think there's some promise: creating incentives for both installation of computerized physician order entry by hospitals and use by physicians, creating incentives for hospitals to enlist intensivists in the ICU,

and creating incentives for consumers or patients to make different choices for where they seek care for select high risk surgery or neonatal conditions.

What's been interesting about what we've come up with is often the most popular ideas, through a rigorous ranking process we've used, are not financially oriented, and they're not within the power of the purchaser. They're things like providing family care for a patient who seeks to go out of town for a CABG surgery. They're things like trying to reform how malpractice works. These are all important ideas, but also very difficult for purchasers to actually implement.

The good news for Leapfrog at least is that we've just received a grant from the Agency for Healthcare Research and Quality to continue the work of this multi-stakeholder group. We are hoping to, with the actuarial assistance of Tarish, Perrin and others to flesh out the most highly ranked incentive and reward concepts, develop operational specifications for them, and plan for some pilot tests.

As many of you know, even though Leapfrog is a national effort, we have now 19 regional rollouts, specific

geographic areas where we're trying to put implementation on a fast track. Our hope is to basically ask our regions to compete, to tell us why they think they're going to do the best job at implementing these pilot tests, and then to actually implement the same incentive or reward concept across, let's say, three markets and try and learn more about what works and what doesn't work.

That, I hope, gives you a sense where even some of the most sophisticated purchasers in the private sector are. Even those we think should know how to do this and be able to figure out how to do this are really struggling. We have a lot to learn, and we have a lot of people to convince that this is something that they need to do.

I think there are a lot of opportunities for Medicare, and I want to emphasize the fact that Medicare has been at the table with Leapfrog from the very beginning. We refer to what was then HCFA, now CMS, as a founding frog. We're also working with the U.S. Office of Personnel Management, with the Department of Defense, and many state agencies, and now Medicaid programs.

I think one no-brainer is consumer information. To the degree that we believe that if consumers have

information that's meaningful to them, that they will use it, that that will change the market, that to me is something that can be done without much thought. Of course, there's a lot of debate over what information should be made publicly available, how it should be presented, what caveats need to be given, et cetera.

But that's an area where I think there's a lot of room for collaboration. In fact Tom Scully announced at our press conference last January when we announced the results of our hospital survey, that those data about where hospitals stand vis-a-vis implementation of the leaps will be available through the Medicare.gov site.

Public reporting, similar to consumer information, but obviously public reporting is useful to more than just consumers, purchasers as well, health plans as well. Feedback to physicians for quality improvement. Again, although it may not look like an incentive, I think it can act as an incentive. Looking at ways for Medicare to join on to private sector public recognition programs, whether it's simply broadcasting that PBGH Blue Ribbon Awards this year went to X, Y and Z hospital, or whatever it is, I think that there could be opportunities for Medicare to spread the

word, and obviously the reach is massive.

I would be very excited to see Medicare working with us regionally. For example, if we succeed in piloting some of the incentive concepts we want to try through demonstration projects, partnering together on that would be extremely powerful. Obviously, there's much bigger battles to fight in terms of trying to do what Brent was suggesting around really allowing more creativity in contracting and payments, but obviously that requires more than just a demonstration project.

So I'll just stop there and am happy to answer any questions.

MR. HACKBARTH: Thank you all.

DR. ROWE: Thank you. It's a pleasure. I want to thank all three of our Hall of Fame panelists here.

Don, I had just a couple thoughts about what you shared with us. The first has to do with the expense associated with some of these initiatives that you tracked. Our experience is that some of these initiatives may have differential effects on the acute care medical expenses and the disability-related expenses, and that oftentimes when people are trying to cost out the benefits and the costs of

such initiatives they really focus on the acute care rather than the disability.

It's the cost of the entire health related experience that the employer in a self-insured situation deals with. You may pay a little more on the acute care episode side, but have much less disability cost, particularly related to not only people getting disability-related medical expenses but also being out of work, having to hire temporary personnel to replace them, et cetera. So I don't know what your methodology is, but a comprehensive view of that is, I think, the appropriate one.

The second is, there is one interesting project that I'd bring to your attention as your inventory grows and there is a project under every rock and behind every tree, I hope, in this area. But the Council for Affordable Quality Health Care, which is an organization of health plans, and the AHP, and other organizations, has done one on antibiotic use in patients with upper respiratory infections, which is an obvious case of overuse, and a case in which there are direct financial benefits and there may even be community benefits in terms of prevention of the emergence of resistant strains of microbes, et cetera. That was rather

promising and something we could get you information on, just to add to the list, because it is a different species than some of the others that you have.

The e-mail, there are several health plans, including Aetna, that currently have e-mail projects underway, where we pay physicians X number of dollars for every e-mail interaction with a patient. I think in a defined contribution mode where there's a medical savings account approach, the patients would be able to expend those resources for anything that one could define as a medical expense, that the patients would therefore have an opportunity to in fact buy that benefit if they wished, for those patients who really relied on it and found it useful. So you might think about that as e-mail going forward.

I think with respect to one issue that you touched on that I think was very important is the latency in the benefit. Every time an executive in a health plan tries to push one of these initiatives, the push back is that the heart attack we're preventing is going to occur in 20 years and the financial benefit of some other health plan, because we only have our members for an average of four years, five years, whatever it is. Although there is a subset of

members that in fact we have for a very long period of time in some of these large national self-insured accounts.

I think that that is true to some extent, but I think it's often overemphasized, and I think that you can in fact fractionate the member population, and there's much more persistency than many people think. But that argument really goes away completely when you get to Medicare. Medicare is really the payer who, once they get people, has them forever. I think this is MedPAC here, and I think that we should not be concerned about that latency at all. In fact we should be able to encourage Medicare to step up to the plate with respect to this.

The last thing, and I'll quit because although I have questions of my other colleagues, I want to let the rest of the Commission participate here. I wanted to ask Nancy-Ann whether she thought that -- you know, every time we talked about lifestyle changes and prevention changes in Medicare we always ran up against a need for legislative changes with respect to what you could pay for and who you could pay, because you can only pay for diagnosis for treatment, and you can only pay physicians.

There are two areas that need to be changed, and

wondered whether you thought, Nancy-Ann, based on your experience, that the kinds of initiatives that Don reviewed with respect to quality crossed a line and required that kind of legislative consideration, or whether you thought these were within the current boundaries? Thank you.

MS. DePARLE: I was thinking the same thing. One I know we really struggled with was smoking cessation. Mark may remember, we did announce a demonstration of that finally in 2000, but I don't think it's -- maybe the demonstration is going forward. It isn't a full-scale benefit at this point, is it?

DR. MILLER: No.

MS. DePARLE: And it's for that reason. We struggled with the lawyers over whether we could even do a demo of it.

DR. MILLER: [Off microphone] Generally, that's your mechanism, is a change in the law or a demonstration. If you're going to do a new benefit you generally have to change the law.

MR. MULLER: I too want to compliment the three individuals and your organizations for how much you've pushed the quality agenda forward. I think you've also

identified what I consider to be the central dilemma as to why quality hasn't improved, which is the mismatch between the clinical imperative and the financial imperatives.

I think Brent and Don both gave good examples of that. As Jack said, in Medicare, given that the population in a sense is with us forever once they become eligible, we have more opportunity to think about how to structure these together in a way that's much more difficult in the pre-65 population. Though I would point out even in M+C, even though there was an incentive at the health plan level in a sense to do it right, there wasn't at the level of the doctor and the hospital.

So my kind of sense of where I would urge you to keep going, urge the rest of us to keep going is how to keep working on how to get the financial and the clinical incentives to be working in the right direction. I think you very effectively point out how often, and probably in the majority of the cases, they don't work in the right direction. I think that's why Wennberg's data still is there after 30 years, and that's why we have all these difficulties because --

I know Don is now studying other health systems

around the world and they are health systems where you can line up the financial and clinical incentives. We don't have that here. We're not going to have it here in any kind of major way, just because the way we've grown for 200 years and I don't think it's going to change very much in the foreseeable future.

But I think constant efforts at understanding that the clinical and the financial incentives have to move in the same direction is where we should be putting more and more work, because otherwise we'll just be preaching to the choir in terms of we have to improve quality, and yet there's all this kind of behavior that isn't moving consistently with that because there are, as I think both Don and Brent have said, there are clear financial advantages to having defects.

What we want to do is be thinking, I think both on the positive side of how to reward quality, and also in a sense on the negative side of how to penalize for having defects. I think they have to go in concert so that the wrong behaviors aren't rewarded through financial incentives.

So I would urge us as we move this agenda forward,

to realize that these things, as they've so well demonstrated, do go in concert. I think the defeat of capitation in many ways set us back 10 years in terms of how to think about and how to do this. I think in part the capitation efforts were aligned correctly at the payer level, but they were still misaligned at the level of implementation, at the physician, nurse, the hospital level.

So I think we have to come back to that. I think that's a multi-year agenda for this commission. And I think we just, frankly, have to keep talking about dollars each time we talk about quality because you've so effectively shown they go hand in hand.

MR. HACKBARTH: Just to pick up on what Ralph said, I found the presentations simultaneously inspiring and daunting. Brent at one point said the key to developing new relationships between the providers and payers are things like good data, long term relationships, flexibility, trust, none of which, I'm afraid, are hallmarks of the relationship between the Medicare program and providers. It's a huge sea change in that relationship to be trying to imagine it going in the direction you describe, yet I don't see that we have any alternative but to persist in our efforts.

DR. NEWHOUSE: I'll join the chorus in thanking you for very compelling and clear presentations and say that it was a real pleasure and a learning experience to work with Don on the case studies.

I wanted to try to focus us on the implications for Medicare payment since we are the Medicare Payment Advisory Commission. At the risk, or certainty really of oversimplifying what you said let me say what I took away from the three of your talks on that score, some of which Glenn said. From Don I took away payment system changes. From Brent I took away flexibility in contracting. And from Suzanne I took away consumer information.

Let me try to raise a couple of issues I see that seem to me to be very important here. One was hit strongly in the IOM Quality Chasm report, which is to do much of what you're talking about requires an organized system of care. Traditional Medicare is anything but an organized system of care. In fact our payment systems reinforce the separation among providers.

But what that means in this context, among other things, is that Medicare patients, or many of them, are going to be dealing with multiple providers, multiple

physicians, hospitals, post-acute facilities. That means any outcome-based -- or not any, but many outcome-based measures are going to be affected by the actions of several providers. So the issue then becomes, how do I relate some kind of quality-based payment back to a specific provider? That seems to me to be an extraordinarily difficult problem.

It goes even to the consumer information point. For something like a Picker score where a patient reports their experience in a hospital, I think consumer information makes sense, although it's obviously a limited measure. I mean, one wouldn't want to make that the sole measure of picking a provider or a hospital. But when we get to outcome-based systems I think the problem gets much harder.

The second issue I wanted to raise, even within a provider, was the risk adjustment issue. It seems to me that most of the changes that you are talking about are really mostly process changes. For example, the cardiovascular drugs. And they're mostly inpatient based. That's reasonable. It seems to me that's the easiest place to monitor, and it's probably the most important place to monitor. But those are arguable statements.

Once one gets beyond process measures I think that

are specific to a provider and moves on toward outcome measures, one gets increasingly into the risk adjustment issue. Even for process-based measures one has some of those problems since there are contraindications and so forth. It seems to me most of those risk adjustment measures remain to be developed, particularly for people in the Medicare population that are going to have comorbidities, and that once they're developed we're going to have to have an auditing function that resembles the financial auditing function. So we'll have the equivalent of FASB, the SEC, and now the public oversight board if we're really serious about doing this.

That's a vision of a promised land, but when I stack that up with where are now with 85 percent or more of the patients in traditional Medicare it seems like we're a long ways from there. So any thoughts you have about how to deal with the kinds of problems you're talking about in traditional Medicare would be welcome.

MR. HACKBARTH: Any response?

DR. JAMES: One quick thought, Joe. I could have shown you similar examples from outpatient. It's just that

I happened to choose inpatient. I think Don feels exactly the same experience in outpatient. We have substantially improved our diabetes care, for example. Again, a large contingent of Medicare patients in that group. It turns out to increase the cost of medications, more expensive, tighter control. It increases the intensity of service in a visit, for which we're often not completely compensated.

In the long haul, it takes about three to five years to start to see it in your data, but your hospitalization rates drop fairly substantially, so you lose income on that side. But diabetes turns out to be a beautiful model of the same things happen, where there are major savings. Demmer estimated $2,000 per patient per year for tight control actually, but where the savings go back to the purchasers.

Beeson said something famous in the New England Journal of Medicine some years ago. He said, the only thing that can change care happens at the front line with physicians and nurses, to paraphrase. The concept of aligning incentives so that the financial incentives line up with your professional incentives is such a powerful concept. Otherwise, you force your physicians, your

hospitals, your systems into this crazy trade-off where to do what's good for the patient they have to risk death themselves.

That idea of aligning incentives is such a powerful idea. I realize that it's hard, but I think we have to find some creative thought to move beyond that.

DR. BERWICK: With respect to both Jack and Joe's comments, there's a way to think about it that is just so visible to me after the Chasm committee and the President's commission and this stuff. It's well known to you and I'm probably oversimplifying, but we built the system you run from Hill-Burton days and then the Medicare days of the '60s. The thought there was that what people really need was, when they get sick, they need to be healed and made well and return them to the workforce. So it was like sickness came in these rather short time intervals, and all the payment is about short term.

But that's not the burden. The burden is the 70 percent chronic illness. The remedies involve rather long time trajectories. I guess organized system of care is a structural way to think about it. But the actual underlying thing here is that the need we're trying to meet has time

constants that have nothing to do with the original time constants implied in the way we pay. That's why capitated payment looks so good because it just lengthens everybody's time horizon.

So the basic theme here is, of course, organize the care. But the financial image is the time constant behind the financial payment hasn't anything to do with the burden we're tyring to meet, and it doesn't right now.

DR. NEWHOUSE: But, Don, how can you broaden the unit of payment without giving, in effect, a capitated payment to some actor in the system?

DR. BERWICK: I see no way, Joe. There might be a solution if we could think about paying for populations to be cared for. Now what I'm showing you here is, these are results from the Health Resources and Service Administration which is an absolute diamond in the rough right now. The community health centers of the country are working on care of chronic illness very hard, with thrilling results. This is improving diabetes control in 30,000 patients in a registry in HRSA with about a 20 percent reduction in cardiovascular risk in about 12 months, in 30,000 and about 300 health centers.

It's not because they're an integrated system. It's because they have a population sense, and they think of caring for groups in a way that the fee-for-service does.

The other place that Ralph and I were talking about in the U.K. where I think it might be worth your looking harder at the U.K. right now for a while and seeing what's going on there. They're working very hard on a population basis again. This is improving access in 1,200 primary care sites in the U.K. They have a single budget and a population that they feel fiduciaries of.

Now Jack said exactly right, that's who you are. That's who Medicare is. You have a single budget and a population of people you care for. Now can you get that thinking, which is yours, reflected in the design of a system which has the same way of thinking? Right now there's a voltage drop from what you are to what the system is trying to be.

DR. DelBANCO: I just want to answer part of your question which is about the risk adjustment and how are we ever going to move forward. I just can tell you that the private sector is going to move forward. We're working with the Joint Commission, for example, right now on a 18-month

project to develop a national risk adjustment methodology and reporting program for ICU outcomes. Our plan is that 18 months from now we will still ask about staffing, but we'll emphasize the outcomes.

We're looking for some of the high risk surgeries we're focusing on, just looking at the volumes right now, on existing programs that -- for example, New York State's program on CABG outcomes, and whether or not Leapfrog wants to endorse that on a national basis and allow hospitals to report in to a national database and benchmark against each other.

We've already faced a lot of challenges from the hospitals about what we're doing, but what's been interesting is that the tenor of the discussion -- and this may be temporary, but the tenor of the discussion has changed. In the beginning, of course it was, please go away. Then it was, we really aren't very confident about volume. And then it was, why can't we just report how good we are?

So we're going to try and take advantage of that situation right now and see where we can go with it.

MR. DURENBERGER: Let me begin by just thanking

Don and Brent and John Wennberg and a couple people at this table for being my mentors over the better part of 30 years now that I've been involved in this field. It's just a testimony this morning to the fact that it pays to listen, and I still do and I learn all the time.

There's an old saying someplace that says, when the pupils are ready, the teachers appear. I give that to you just by way of an encouragement. You've all been at this for a long time as have many of the people here, but my sense is that the pupils are getting ready. I gave Alan Nelson this morning an e-mail copy of Dr. William Mayo's speech to the Rush Medical College commencement in 1910 in which he's talking to doctors about, we're not just in the profession of healing, but the art of preventing disease. The time is ripe for action in the medical profession. The people are ready. We must furnish leadership. Way back in 1910.

So part of the question I guess I'd like to ask you is sort of a judgment question. That is, if you look on the face of it, the medical profession is not ready today, but if you look behind not just the people at the table but a lot of people we know, the sense is that if you get past

all the disgruntled dissatisfaction there is a profession that's ready to change and waiting to take leadership.

So I have really a two-part question. One is, given the testimony here today -- and this question goes to the national level role and the local level role. My sense is that, yes, there are things that we need to do at the national level, setting some standards, creating measures and things like that. But that the only way we're going to achieve the goals that you've set out for us in the practical course you've suggested we take is that we start local. If we use the Brent James examples of Utah, or if we come to LaCrosse, Wisconsin or some other place like that, where you have the intersection of the providers whose behavior you'd like to change and the payers whose incentives you'd like to realign. Then also, obviously, the consumers and so forth as well.

Could you give us some judgment about where do you start with this effort, or do we start it simultaneously and just make it clear that there ought to be two specific questions?

And I've got a second question that you don't have to answer because I've already asked too much. But I'm

apprehensive about this consumer-driven health care thing that all the employers, many employers are buying up very quickly, and getting in the way of however you answer the first question that I'm asking you.

DR. BERWICK: Let me take a quick shot. A model I've come to use comes from my colleague Tom Nolan. It says, to change a large industry it's going to take will, ideas, and execution. I think the will is insufficient if it's only local. Medicare, CMS, MedPAC, you're in a leadership position and I think it would be great if you would help build will. I personally strongly recommend that Medicare begin again to publish hospital-specific mortality data.

I think we need a national commitment, a strong commitment. I think the national quality report that's going to come out of AHRQ is an opportunity for you to receive it, to say, there's some findings here and we set an agenda for improvement of the following type for the next two years, and we expect results and we want reports. That kind of will-building will be very helpful.

Ideas also are insufficient if only local. I had an interesting experience last week. I made some comments

about e-mail care. I think it's a very good thing for our country to be going toward. I did it in a speech and then went to a luncheon at which I was slammed by a group of people in the room who said it's impossible. Doctors don't know how to use it. Patients will overwhelm them. It's irresponsible, it's illegal, and on and on. That evening I went to a dinner party with Geisinger Clinic, which now has 2,700 patients in a big pilot study on e-mail and it's going just fine.

So we have to think more globally about knowledge and help the local people who doubt, find the champions who may not be anywhere near their city who have something to offer them. I think that spread of ideas is an untapped reservoir, it's an untapped resource.

I have often thought Medicare should take a leadership role in developing a health care extension service that looks like the agriculture extension service. Where I don't think if you're a 30-bed rural hospital deep in the heartland, you can get help. Someone who knows you and understands you will come there to you, helping you as a matter of the commonwealth.

Execution is always local. What you say is true,

there are doctors and nurses and managers all over this country ready to go for it and really make the kind of gains they're able to at Intermountain Health Care. The values are there with sufficient will and a source of ideas, I really think.

DR. JAMES: Two comments. Two ideas, I guess. I live pretty much at the front line most times, down with teams, physicians, nurses, caring for real patients, figuring out how we're going to put that together. I honestly believe that there are two major changes happening that are going to fundamentally change the nature of health care, and I think that they're well past the tipping point, both of them.

The first is the nature of medical practice is changing fundamentally. How we see ourselves as physicians, as nurses, as therapists, fundamentally changing. It has to do with variation in care, complexity, clinical uncertainty, an exponential explosion in new medical knowledge and how we deal with it. We're fundamentally shifting from the concept of single physician, single patient, that independent, personally autonomous model into one where you work as part of a group, a professional group, around evidence-based best

practice, customized to individual patient needs.

I've been watching that for the last, at least seven years, develop. It just keeps gaining power. It's creating a group of physicians particularly, it's easiest to see, who get it and who like it. They like what it does for their patients. They like what it does for them personally. It's also creating a group of physicians who absolutely hate it. Who see it as the loss of personal power, personal autonomy, of their income.

I think that's true any time you have a major change, a sea change happening underneath. But I think it's going to continue, and as it does the organization of care, the function of our system as a true system is going to fundamentally change. No question about it, it just continue to advance.

The thing that's happening in parallel with that and may actually be an effect of it is the data systems are starting to improve in significant ways. It's not just a matter of buying a bigger, faster PC. It's how you structure the information underneath so that you can be clinically productive with those data systems at the front line. That's the key issue. There has been a fundamental

change sometime in the last five years with that.

As you see those big systems start to roll out, as you see that proof of concept happen not just at one organization but among many, as you see the system start to restructure it's going to require changes at this level too. There's no question about it. It's just a matter of aligning those sorts of changes, understanding them, aligning them, and then appropriately driving them ahead.

I honestly believe that even if we don't accomplish anything here, it will continue to move ahead. It just won't move as fast, it won't move as well, and we'll eventually have to address those problems, because it is fundamentally changing underneath.

DR. NELSON: Brent, as part of disclosure, I'm on the board of Intermountain Health Care. I understand, therefore, that the innovations that you are describing are across the entire patient population. That is, Medicare patients are benefiting from the quality improvement efforts, it's just that Medicare isn't paying its fair share. It's being subsidized by your private sector contract.

I think for us the issue is how to fulfill

Medicare's responsibility to the beneficiaries to be a leader in this, not just a beneficiary.

MS. RAPHAEL: Just building on what Joe said, I'm trying to think about this from the point of view of implications for the Medicare program. I'm very interested in two things, the whole notion of how you extend time and place. But beyond that, I think the key issue is capitation in and of itself is not enough. We know that. We've had capitated payment systems and they have not transformed this landscape.

So I guess one of the questions I have is, how do we build a bridge between the capitated payment system to some entity and what happens on the front line? I've heard one thing which is shared savings in some way. But I was wondering if there were any other models that you have seen that would enable us to build a bridge.

The other thing that I think does help is something you just said, Brent, which is trying to think about information systems from how they can be used as tools for people on the front line, rather than these vast databanks at an administrative level that really can't be used. I know on my front line, we build systems where

someone has to go through 12 systems to get what they need, rather than thinking about how all of this plays out every day.

But I'd just be interested in anything that you have seen that could help us to make this connection.

DR. JAMES: Currently the shared benefits model is our favorite. Probably the next one back is just plain old capitation. We regularly discuss moving into a capitated Medicare environment again. I guess there are some of us within the system who believe it's just a matter of time, unless we're able to work something else out.

The key to making capitation work is good data systems, just in passing. If you have good data systems, you can price it right and you can manage it after you've entered the contract. I think that's the reason that so many capitated models have failed is because those people haven't had their finger on the pulse well enough to actually meet the obligations that they've undertaken in those contracts.

That said, I guess what I'm really asking for, I think that there are a series of potentially creative solutions. Capitate us on the basis of specific chronic

diseases, for example. That would be interesting to talk about. That's what Don is really saying in some sense, relative to payment.

What I would really like to see is enough flexibility that we could sit down together and work out some innovative approaches. That's what I think would be extremely useful. And to experiment a bit and say, what really does make sense in this new developing world that we have coming. I don't want to commit to things too strongly too soon, because I suspect there's a lot of innovative thought waiting to happen as this thing starts to settle out.

So I guess that's what I was really trying to say, to make it more clear, is that ability to experiment a little bit, to understand back and forth. The difference between sitting down with Medicare and sitting down with one of our large purchasers is actually that we never sit down with Medicare, come to think of it. You can't have that conversation. It's a given at the outset, isn't it? It's pretty clear it's not working. It's just not clear how you get to something that does work.

DR. BERWICK: The history here is relevant, and

understanding the history is important. Capitation didn't fail. What failed was, we lost definition of terms. We lost an ability to have a logical discourse about what we were paying for by developing the concept of managed care, broadening what it means, and then linking it to capitation at a very high tier.

I'll tell you what works empirically. Whether we can get there financially, I don't know. But payment for care of populations so that we can broaden time and place, given to systems of care which are truly integrated in the way they view the care of those populations. They can move resources between home care, and the hospital, and the ambulatory setting. Staff and group model HMOs were our best -- still remain our best shot at that.

But if I could wave a wand over the country and change the way you're paying, I would buy care for populations through capitated payment, adjusted for risk, and give the money to staff and group model organized practices. That's the straight shot. How you can from the disaggregated system we have now to that, I have no idea, but that's what works.

MR. SMITH: I want to join my colleagues, this has

been both daunting and challenging in ways that, unfortunately we don't spend enough time at. But one of the reasons we don't, Don, is that in a non-capitated system 85 percent of our beneficiaries are your deficits. When you talked about not paying for deficits, another way to think about that is those are the folks who we are primarily responsible a payment system that provides them with access to high quality health care.

I say that not to make a rhetorical point, but in terms of mission, figuring out how you address the longer term questions of proper alignment of incentives and players while you manage a system which clearly does not meet those tests, is a very difficult task. It takes us, it seems to me, to some of the challenges that Brent raises, which is are there a half a dozen, or one or two, serious, innovative experiments that should we be insisting, and you insisting that Medicare pay for a demonstration providing chronic care managed care to non-Medicare beneficiaries?

The other side of Jack's notion that we're the only institution where you can actually reap the benefits of that is we reap the benefits potentially of decent care for people who are our members, because they're all going to be.

So is there a way to think about, Brent, providing that kind of chronic disease management to non-members which Medicare should be encouraged to pay for as a way of beginning to get incentives lined up? Are there other things of that kind that we ought to be thinking about, because we're not.

We're not going to remake this system in a flash. We're still going to be figuring out how to provide the overwhelming bulk of Medicare's resources to non-capitated beneficiaries. But what can we do that opens up some space in the way, Brent, that you were talking about that gets Medicare to the table? You're not going to get them to the table in a redesign of the system, but you may be able to get them to the table in a conversation about demonstration projects which have some point in that direction.

DR. JAMES: I don't know if I'm really prepared to talk about it fully. We've been hesitant to enter into demonstration projects in the current structure of demonstration projects because they tend to be too short term, and they're fairly severely constrained in terms of how we can try new things. We really felt like we needed some other more flexible approach. That's why sometimes we sit down and talk with Jack Wennberg about some of his ideas

about how we might make that happen.

It's interesting, you realize that we just think about caring for patients really. When we're delivering the care we don't really distinguish between Medicare and the rest of our patients. Many of the diseases we treat, almost all of them, with some exceptions -- we still don't have a large pregnancy, labor, and delivery service under Medicare, for example. Most of them do cut across that age boundary though, so you think of it as a single process of care.

Interestingly, quality improvement is inherently a preventive strategy, just in passing. It's inherently, in the way that it functions, a preventive strategy. Your whole intent is to move upstream, to manage a process of care, the only part you can manage in order to change things downstream, and every aspect of it's preventive, inherently. I suspect that we probably will need some mechanisms of creating laboratories for innovation on these things. I guess that's what I'm really believing in this.

DR. BERWICK: It would be fun to try to spec out the demonstration you're talking about. You'd have to decide how much impact on policy it could have. But just listening to you I started thinking, absent of staff or

group model, what would you want in it? I think you'd want results orientation, so that the success in the demonstration has to be defined in terms of patients better off. There's no other measure of success that would count.

It would have to have transparency involved. No black boxes about how we're doing. It would have to have a population payment thought in it. It would have to say, what we're really doing is buying care for a group of people. Nothing else short of that will work.

It would have to have -- I think it should use the Chasm report as a framework. I think you've got a framework for the results that you want and some of the changes that would make a difference in terms of care at the microsystem level.

And my own vote is I think it would be total cost neutral. I do firmly believe that there's enough money in the system, and I don't really in my heart think Medicare has to pay more total to get better care for this population. So I would not argue for you to be saying, here's a whole lot more money as part of that demonstration. I'd say, here's a whole lot more flexibility in how you use the money you get now.

I think you could probably pull it off. Whether the system could respond outside classical integrated systems, I don't know, but I'll bet it could. I think it might be geographic. Go to the city of Seattle or a catchment area and see -- challenge it. Interesting.

MR. HACKBARTH: We are well over time. I appreciate your help with this. I appreciate the patience of commissioners and the audience. I have two people that I'd like to give a chance to say something, Nancy-Ann and Sheila, and they'll have the final words.

MS. DePARLE: I'll be very quick then. I just want to encourage, Brent, you to sit down with CMS and talk to them about your ideas because I actually agree with what everyone said about the difficulty of working within Medicare structure and the administered pricing systems, but I actually think the agency is very open to sitting down and working on demonstrations. Certainly the ones we've seen and talked about here have not exactly been short term. They may not be as long term as what you would like, but I think there's a lot of room to work together on that as well. There are questions of resources to work on demonstrations, but I think when I was there we were very

open to that.

I also wondered whether Intermountain ever considered the provider-sponsored organization that was made available in the M+C program. That may be a longer conversation, but when I heard you describing it -- and I remember thinking this before -- you were the type of system that we thought might come in and say, we want to manage care for this population, and it didn't happen.

DR. JAMES: There's a long story behind that.

MS. BURKE: This is a longer conversation as well, but building on Nancy-Ann's point, I continue to struggle to figure out where we could best intervene to begin to break the cycle where essentially the capitation payment is based on essentially, fundamentally on a broken system in terms of the basis of the cost that we pay, that reinforce behaviors that encourage the cost to build so that there's never a benefit to you for having done things correctly. As long as the system is built that way, and there is a question as to whether it is -- if we only pay for things to be done the right way, how quickly you get to that when in fact a large percentage of our population are in an environment where it's not being done the right way.

So where we intervene in that process, whether it's at the price, or whether it's at the expectation of what we will pay for, limiting the things we pay for, is a challenge to the fundamentals of how we built that payment system. So it's trying to figure out where you intervene in that.

The other thing I continue to struggle with, and it reflected a little bit here today, is that we tend to think of this largely as an institutional issue. We think of it in the context of how we pay hospitals, as the driver. We tend not to then leap to the issue of how we deal with the doc, and how we incentivize the doc as well as the institutional provider, and how you link those two. We are so silo-based in the sense of how we establish payment systems, and how we link the two, that I think it puts a particular challenge on.

As Nancy-Ann suggested, a conversation with CMS about the flexibility, but our history on the demonstration side in Medicare is not very good. They do tend to be short. We tend to have expectations. The concept of cost neutral is a foreign one to us. We demand it but rarely do we achieve it. Or if we do it's for all the wrong reasons

and all the wrong results. So I think a conversation with them makes sense, but I think there's a much more fundamental issue here about how we build payment and how we create the incentives, Don, that you've talked about for so long, and create it both institutionally and on the individual provider side.

I just can't quite grasp, for our purposes, the Commission's, where we can best intervene at this point in time in terms of beginning to change the system and how we build the payments.

MR. HACKBARTH: Thank you very much. I'm not sure exactly where we go from here. This is very, very difficult stuff but I think it goes right to the heart of what needs to be accomplished for the Medicare program and the health care system at large. So as frustrating as it may be, I think we need to come back to it over and over again, and keep looking for handles on the problem.

Three things that I would like to pursue as the Commission, talk about further. One is a role for the Medicare program in reinforcing the education of policymakers, the public at large about these issues, these problems.

Second is that a possible handle on this may be in the disease management area. I think Don's comment about the problem not being the failure of capitation but really connecting the financing method with changes in the delivery of care I think is exactly right. Maybe if we can go down to a smaller unit, a clinically meaningful unit, we have a better chance at that.

Then third, there may be opportunities for the Medicare program to piggyback on private sector efforts and local efforts that already has some momentum behind them. So we will keep searching.

Thank you very much for your invaluable presentations.

Our last order of business is a brief opportunity for public comments. Do we have any? Given the late hour, Jerry, please keep it brief.

MR. CONNOLLY: Yes, thank you, Glenn. My name is Jerry Connolly and I'm speaking to you today on behalf of Focus on Therapeutic Outcomes. I'm an independent consultant as well as having addressed the Commission before on behalf of the family physicians. But today I'm speaking on behalf of a national outcomes database in the rehab

therapies that is 10-years-old and has over 1.4 million files in its very robust existence.

I want to direct my comments to the session before this. This was extremely valuable discussion of the overall program but what I want to talk about is the post-acute database that MedPAC is going to be developing. I think that it's very interesting to note that the outcome measures that you've talked about are really things like mortality, hospitalization, rehospitalization, when in fact in the post-acute spectrum, the assessment instruments that you have imbedded in the Medicare program are not part of that process really.

What they really measure in the MDS and the FIM and the OASIS are, or attempt to measure, are functional involvement and functional improvement. Really, if you want to pay for results, then there should be a developing a level of interest and a level of quantification of how much improvement there is in any given episode of care.

Not only that, but the way the system is built now, none of the instruments can talk to each other. The MDS is different from OASIS, is different from FIM, and there's nothing on the outpatient arena yet.

Because of this, and because we have reliability problems as one of the staff speakers was mentioning, then what we really need to do is create some sort of standardization within the post-acute spectrum. Now given the fact that there are political considerations, there are other considerations in terms of the MDS and the FIM and how they all got there, it doesn't look like standardization is on the short term horizon.

But in the absence of standardization, I would suggest that the answer lies in co-calibration. Co-calibration is something that can be done in the short term. It would allow MedPAC to look at the spectrum of care post-acutely. It would allow them to quantify the amount of improvement in any of those instances, in any of those sites of service. By virtue of the quantification of that improvement, in any of those given instruments by validating, co-calibrating those instruments, then you can create a value quotient.

So not only can you have the mortality, the hospitalization and that information, which I think is very important, but I think that what you need to do, and I would like MedPAC to consider, is taking one additional step of

co-calibrating those existing instruments perhaps with another instrument in the outpatient arena and have that wealthy database going forward that you seek and upon which you can build decisions and policies.

You can create an incentive-based payment system, not the least of which you can come up with, at least begin to come up with, a replacement for this $1,500 therapy cap which continues to be extended, the moratorium continues to be extended.

So there's a number of features in terms of eliminating the unwarranted variation, coming to grips with what that episode of care is across the post-acute spectrum, and beginning to develop and alternative for the outpatient arena, the cap, and most importantly, being able to pay for results or come up with an incentive-based reimbursement in the post-acute care spectrum.

Thank you.

MS. McKUEN: Hello, I'm Erin McKuen from American Nurses Association. Very briefly, I just want to synergize what we've heard today about nursing home payments and quality of care. Nurses are acutely aware of a number of research projects completed in the last 24 months proving

the relationship between nurse staffing and patient outcomes. I can, off the top of my head, think of a JCAHO report, a HRSA report, GAO report, IOM reports. When looking at patient outcomes in nursing homes, we're well aware of the relationship between R.N. hours and outcomes in nursing homes.

When looking at the quality of care in nursing homes and your quality indicators, we would strong urge you to look at nurse staffing. There is a report recently released by GAO stating that nurse staffing is more important than payment reimbursement in nursing homes in indicating outcomes, and that the two are not necessarily related. We encourage you to look at that.

Thank you.

MR. HACKBARTH: Thank you very much. We're adjourned.

[Whereupon, at 12:21 p.m., the meeting was adjourned.]