MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

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

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P R O C E E D I N G S

MR. HACKBARTH: Good morning everybody.

This is our last public session before our June report, and so we will be having a number of votes on recommendations, including votes on I think all three of the issues we'll be discussing this morning: the mandated study of Medicare Advantage payment areas and risk adjustment and then a series of policy issues on Medicare Advantage. And then finally, before lunch, some issues on payment for dialysis services.

Dan, would you lead the way on the first issue?

DR. ZABINSKI: The MMA directs MedPAC to analyze three issues related to the payment system in the Medicare Advantage or MA program.

First, we are to identify the factors underlying the geographic variation in adjusted average per capita costs or AAPCCs in fee-for-service Medicare. Second, we are to identify the appropriate geographic area for payment of MA local plans. And third, we are to assess the predictive accuracy of the risk adjustment system, the CMS-HCC, that CMS began using for payments to MA plans in 2004.

Highlights from the results of our analysis

include that about 15 percent of the variation in AAPCCs is due to geographic differences in input prices and IME, GME and DSH payments. The remainder of the variation is primarily attributable to differences in service use that is affected by providers practice patterns and beneficiaries preferences.

Second, payment areas for MA local plans should be larger than the current county definition which presents some problems, that I will discuss in a minute.

And then finally, the CMS-HCC model predicts costs much better than a demographic-based adjuster that CMS has used for a number of years. This is true for both beneficiaries who are in good health, as well as for those who are in poor health.

Our work on the second issue here, the payment areas for MA local plans, resulted in two draft recommendations. The rest of my presentation will focus on this issue, closing with those two draft recommendations.

We have identified two problems with using counties as the payment area for MA local plans. First, we found that many counties have small Medicare populations resulting in unstable AAPCCs in fee-for-service Medicare.

This is important because the Commission recommends paying equally between the fee-for-service and MA sectors. But if we can't get stable AAPCCs, there is some uncertainty over whether we can pay equally in those two sectors.

Second, we found that adjacent counties often have very different AAPCCs which are often used as county payment rates for MA local plans. If adjacent counties have very different payment rates, plans may offer less comprehensive benefits in the county with the lower rate or may avoid that county altogether, creating appearances of inequity.

We found that we can mitigate these two problems by combining counties into larger payment areas but creating an appropriate payment area involves more than just simply combining counties.

In particular, we used three criteria to guide our assessment of alternatives to the county definition of payment areas. First, we should avoid making payment areas too large. Indeed, some counties in the Western U.S. are already quite large. In a large payment area, the cost of providing care can vary widely. Plans may find they are more profitable in some parts of a payment area and unprofitable in other parts. If a plan is required to serve

the entire area, the potential losses in some parts of the payment area may cause them to avoid the payment area altogether.

Second, payment areas should be reasonably good matches to the market areas served by commercial lines of business for managed care organizations. If payment areas do not accurately match the plan market areas, plans may find they are profitable in some parts of a payment area and unprofitable in other parts.

And finally, payment areas should have enough Medicare beneficiaries so that we can obtain stable AAPCCs.

We used these three criteria to evaluate three alternatives to the county definition of payment areas, all of which use the county as the building block. In one alternative, we grouped urban counties into metropolitan statistical areas, or MSAs, and then we grouped the remaining non-urban counties in each state into a statewide non-MSA area.

In a second alternative, we grouped all counties into what I'll call health service areas, or HSAs, as defined by researchers at the National Center for Health Statistics. These HSAs are collections of counties that are

relatively self-contained with respect to short-term hospital stays among Medicare beneficiaries.

At the March meeting, commissioners discussed the issue that HSAs are based on fairly old data, 1988 to be exact. And we responded with a draft recommendation for an update to HSAs, which I'll present later.

Then finally, we created a hybrid of the first two alternatives, grouping urban counties into MSAs and non-urban counties into HSAs.

Then, in all three of these alternatives, in the instances where an MSA or an HSA crosses a state border, the portion in each state serves as a distinct payment area. Our rationale for doing this is that plans face different laws, rules and guidelines in different states.

A summary of our evaluation of these alternatives is that first we found that the MSA/state non-MSA definition provides the largest beneficiary populations and most stable AAPCCs.

Second, that the MSA/HSA definition is the best match to plan market areas and we found this is true both among Medicare Advantage plans and private sector HMOs.

And finally, we also found that the MSA/HSA

definition has the smallest geographic variation in terms of the cost of serving fee-for-service beneficiaries.

So in response to those results, we have developed this draft recommendation. Payment areas for MA local plans should have the following characteristics. Among counties and metropolitan statistical areas, MSAs, payment areas should be collections of counties that are in the same state and same MSA. But among counties that are outside MSAs, payment areas should be collections of counties that are in the same state and that are accurate reflections of health care market areas such as health service areas.

The spending implication of this recommendation is that it should have no direct effect on program spending.

The effect on plan participation is not clear. Using larger payment areas will increase the stability of payments but it also changes the size of the areas they must serve, which can affect their decision on whether or not to serve an area. Expansions and contractions of plan service areas are both plausible. And because of the uncertain effect on plans, the effective of this recommendation on beneficiaries access to MA plans is ambiguous.

As I mentioned earlier, an issue the commissioners

discussed at the March meeting is the age of the current definition of the HSAs. If HSAs are chosen as a payment area, they must be updated before being used and renewed periodically thereafter to reflect changes in health care market areas that occur over time. We did an investigation that reveals there is no plan for an update to HSAs and that an update and renewals would require more resources than are currently allocated.

The Secretary should assure that the update and renewals are done in the future and we have developed a second draft recommendation encouraging the Secretary to act.

That is, the Secretary should update health service areas, HSAs, before they are used as payment areas in the Medicare Advantage program. In addition. the Secretary should make periodic updates to HSAs to reflect changes in health care market areas that occur over time.

The spending implication of this recommendation is that it should have no direct effect on program spending. Also, there should be no effect on plan participation or beneficiaries' access to plan.

Now I turn things over to the Commission for

discussion.

MR. HACKBARTH: Questions or comments? John?

DR. BERTKO: I think staff again has done a good job on this.

My one comment would then just be to reemphasize the comment about particularly the MSAs areas not being too large. From the last time we had the discussion, I think the MSAs are probably in about the right shape. But just perhaps some back and forth with the industry at the time they were going to be actually used might be useful to make sure there were no glaring inequities perhaps in the way the MSAs were rolled out.

DR. CROSSON: A question on the second recommendation. One of the considerations we've talked about, looking towards 2006, is the number of moving pieces that are going on with respect to MA. And I wonder, has there been an estimate of how long it would take the Secretary to update the HSAs? And is that something that's a matter of a couple of months or 18 months or what?

DR. ZABINSKI: The investigation that we did, the people that would handle it said it would take them about a year to do it. Their primary concern is actually resources,

but they said it would take about a year.

MR. HACKBARTH: Although I don't think necessarily the research time is the critical variable on the time line. I think it there would be a policy judgment to be made about when to make the change. So even if the research could be done tomorrow, Congress either might itself say effective at some point in the future or say to the Secretary to be implemented at the Secretary's judgment with regard to the timing.

I think that's probably a little bit more detailed than we need to get into for purposes of this recommendation. We could acknowledge that in the text, that the implementation issue is something to be thought about carefully when the time comes.

DR. CROSSON: I would recommend that.

To take this as an isolated recommendation, given the fact that many of the other recommendations that we're going to be talking about are considered and have been described in the context of the complexity of what's going on with respect to MA payment, it would seem appropriate to have this one in the same way.

MR. HACKBARTH: So what we'll do is in the text

say that the decision about implementation needs to take into account the practical considerations.

Any other questions?

DR. STOWERS: Dan, I just have a question, and I hope it's not overly simplistic, but it seems like in recommendation number one we went to separating the MSAs and non-MSAs as a payment area. Is there a considerable difference in the amount of payment in those two areas?

And I'm looking back to the incentive to have the plans be provided both in the MSA and out of the MSA. In other words, would we have been better to combine the MSA, the urban and rural or non-MSA? Is there a big variation between the two that might lead to lack of or increased incentive later to get plans throughout the entire states?

DR. ZABINSKI: I would think that in the MSA areas that the payment rates would be higher than in the non-MSA areas that would be, in this case in our recommendation, encompassed by the health service areas.

To the extent that there is an issue of the payment rate being high enough to attract plans in a rural areas, that could be an issue.

MR. HACKBARTH: Ray, let me take a crack at this.

In trying to decide the appropriate payment area you're trying to balance multiple goals that may, in fact, be in conflict with one another. First of all, you want areas that are large enough to be stable in terms of making the calculations that need to be made.

Second, ideally you'd have areas that reasonably track with actual plan market areas.

Third, you want to avoid abrupt cliffs as you move over boundaries where there's a dramatically different payment level on one side of the border versus the other.

And then finally, and this is the point that gets to your issue, you want as much homogeneity within the underlying costs as you can get. If you have really heterogeneous regions, you end up with potential problems with plans wanting to serve only one corner of the market where the low-cost people are in the heterogeneous region. Or alternatively, you have to require plans to serve a whole large area, as we've done with the regional PPOs. But if you impose that sort of requirement on local MA plans, it may be a significant barrier to participation.

So these different considerations sort of bump into one another at various points in time. Here, what

we're saying is that we don't want to just say everybody in a big lump, rural areas and urban areas, because the heterogeneity of the region would be too great. So this is a break, it's not a perfect rate, going MSAs and local health service areas, but I think it's a reasonable balance among these competing policy objectives.

Others?

Okay, I think we're ready to move on to a vote. So on draft recommendation number one, all opposed?

All in favor?

Abstentions?

And then on draft number two, all opposed?

All in favor?

Abstentions?

Is there anybody who voted no or abstained on either of the issues? We had some slow hands or low hands. Did anybody vote no or abstain on either the issues?

I think we have unanimous votes on both. Thanks.

Thank you, Dan.

So next up is Medicare Advantage, a variety of policy issues. This is Nial's debut. He got a haircut.

MR. BRENNAN: Today, myself and Scott are going to

present you with draft recommendations on a number of policies related to the Medicare Advantage program. I'm going to talk you through two draft recommendations on quality measurement requirements for the fee-for-service program that would facilitate comparison with MA plans and the regional PPO stabilization fund. After that, Scott is going to present four draft recommendations on payment rates, geographic adjustment for regional PPOs and risk adjustment.

I'd like to just take a moment to recap for you the Commission support not only for private plan choices for beneficiaries but also the Commission's stated belief that private plans can improve the efficiency and quality of health care delivered to Medicare beneficiaries What we have on the slide are two quotes taken from our March 2004 report to Congress that I think illustrate this position.

The overall theme of our presentation today is based around the concept of neutrality or a level playing field. Neutrality can be viewed in a number of different ways. Neutrality between fee-for-service and MA plans or neutrality among MA plans. When we speak of neutrality we primarily mean financial neutrality, the concept that

Medicare would pay the same for each beneficiary regardless of their choice of delivery system.

As you all are aware, the Commission is an advocate of quality measurement in both the fee-for-service program and the MA program. Additionally, the Commission supports linking quality measurement to pay for performance programs.

To quickly review, HEDIS and CAHPS are the two major instruments available for measuring quality in the Medicare program. Most MA plans repost on most HEDIS measures but the fee-for-service program does not.

The CAHPS survey is administered to the beneficiaries in both MA plans and the fee-for-service program, but lacks some of the clinical measures that make HEDIS an effective comparison tool.

Our first draft recommendation is that CMS should begin to calculate certain HEDIS members for the fee-for-service program that would permit comparison of the fee-for-service program to MA plans on select measures.

We do not anticipate this recommendation will have spending implementations and believe that CMS could meet this requirement using existing data sources. We also

believe this recommendation will be a positive development for beneficiaries as it will furnish them with an additional tool with which to compare the fee-for-service program and MA plans.

As we outlined in the March presentation, the MMA changed many aspects of the Medicare Advantage program, including the introduction of a regional PPO component to the program beginning in 2006. In order to encourage regional PPOs to participate in the program, the Congress also created several additional incentives solely for regional PPOs. These include a system of risk corridors and a regional PPO stabilization fund.

The regional PPO program employs a system of risk corridors for 2006 and 2007. If a plan's actual costs exceed a certain threshold, plans receive additional payments from Medicare. Similarly, if a plan's actual costs fall below that same threshold, the plan must return payments to Medicare.

This slide illustrates in a little more detail the mechanics of the risk corridor program. For a hypothetical MA plan with the risk corridor target of $700. For example, if you look at the second bar from the right on the graph, a

regional PPO that was paid $700 per member per month but that spent $735 in benefits would receive an additional $7 per member per month under the risk corridor formula, but would also lose $28. The vertical lines representing the $28 and the shaded area representing the $7.

By contrast, if you look at the far left bar, a regional PPO that was paid the same amount per month but had actual costs of $630 would end up remitting $29 back to the Medicare program but would retain $41 in additional profits.

MedPAC believes that this risk corridor system is a logical approach that adequately accounts for the uncertainties regional PPOs may face in the initial years of the program.

The regional PPO stabilization fund provides an initial $10 billion in funding to encourage regional PPOs both to enter markets and to remain in them. This funding starts in 2007 and ends in 2013. In addition to the $10 billion dollars in initial funding, the fund will be augmented with half of the government's 25 percent share of the difference between regional plan bids and regional benchmarks.

Scott is going to go into a little more detail on

the bidding system later.

Payments from the fund may be available in the following circumstances. The regional PPO plan or plans that become the first national plan or plans serving all regions of the country will receive a one-time bonus amount.

In the event that no national plans are offered, the Secretary may increase the benchmark for a regional PPO plan that is the first to serve in the region. This extra amount will be determined by the Secretary.

And finally, if a regional PPO plan intends to depart from a region, the Secretary may increase the benchmark in order to retain these plans.

Our second draft recommendation is that the Congress should eliminate the stabilization fund for regional PPOs. As I stated at the beginning of the recommendation, MedPAC supports a level playing field, not only between MA plans and the fee-for-service program but also among different types of MA plans. The PPO stabilization fund explicitly makes available additional funds to regional PPOs that are not available to other MA plans. While we understand that the intent of the stabilization fund is to encourage participation by regional

PPO plans and that plans may be unsure of the risk they face if they participate in the program, as we've already shown you today regional PPOs will be shielded from excessive risk in the first two years of the program through the risk corridor system.

As for the implications of this draft recommendation, there will be no effect on federal spending over one year because payments will not be made from the stabilization fund until 2007. The recommendation is likely to decrease federal spending by $1 billion to $5 billion over five years.

The implications of this draft recommendation on beneficiaries and plans are less clear. It's possible that the lack of a stabilization fund could potentially discourage regional PPOs from entering in certain regions. Similarly, certain PPOs might exit regions in the absence of plan retention payments from the stabilization fund.

To the extent that this does occur, beneficiaries in certain areas may have fewer or no private plan options to choose from, although the majority of beneficiaries would likely still have access to a local MA plan.

With that, I'd like to turn it over to Scott.

DR. HARRISON: You've seen the new plan bidding process and let me just give you a quick reminder.

Rather than plans being paid administratively set county rates, the county rates will be benchmarks that the plans will bid against. Plans will submit a bid for the basic Medicare benefit and it will be compared with the benchmark. If the bid is higher than the benchmark, the plan is paid the benchmark and the members would pay the difference in a premium. However, if the bid is below the benchmark, the plan is paid its bid plus 75 percent of the difference and the remaining 25 percent of the difference is retained by the Medicare program. The plan is then obligated to rebate its share of the difference to its members in the form of supplemental benefits or reduced premiums.

The bidding process is a little different for regional plans. The bids of the regional plans within a region are averaged, along with the MA rates in that region, to calculate the regional plan benchmark. Another difference is that the regional benchmarks are averaged based on the geographic distribution of the population of Medicare eligibles in the region while the bids that are

compared with the benchmarks are made based on the geographic distribution of the plan enrollees.

Our understanding of the law, supported by conversations with some plan representatives and Hill staff, was that a geographic adjustment would better align the bids and the benchmarks. After examining the final regulation, we recognize there will not be such an alignment.

I'll go through an example that will illustrate a potential problem with this disconnect between the bids and the benchmarks, and the basic problem is that there will be an uneven playing field between local and regional plans and among regional plans.

In this highly simplified example, we assume that a region contains only two payment areas. One low rate area, perhaps representing rural areas, contains 20 percent of the beneficiaries in the region and the MA rate there is $600. The other area is a high rate area that contains 80 percent of the beneficiaries and that rate is $900. There are regions that look somewhat like this but this is highly simplified.

In this case, the average MA rate would be $840. We have just assumed, for mathematical simplicity, a bid of

$715. In that case we get a regional benchmark of $815. A plan bidding $715 would get its $715 bid plus $75 in a standard rebate across the region for a total of $790 per month.

Now keep these values in mind when we move to the next chart where we look at four examples in this simplified region.

This chart shows how different geographic distributions of enrollees can affect payment rates to regional plans facing the same benchmark. On this chart, we assume that all plans bid $100 below their respective benchmarks, giving each plan $75 with which to rebate to attract beneficiaries by providing extra benefits or lower premiums. The payment levels here are the bid plus the rebate.

The yellow bars represent local plans in these two hypothetical areas. In the $600 area, the local plan would bid $500 and get $575, including the rebate. Similarly, the local plan in the $900 area would get $875. The other three plans here are all regional plans that bid the $715 and would receive $790. So that dotted line, all plans will receive $790.

I also want to note here that all of these payments would be risk adjusted.

Under the final regulations method for geographically adjusting payments, the three regional plans here would see different payment amounts although they all bid the same and against the same benchmark. The adjustment assures that the payment rate across the enrollees from the two payment areas would average $790 no matter what population the plan was actually bidding on.

The payment rates in each of the two areas, however, vary depending on the relative enrollment from each area. If a plan is successful in attracting enrollees disproportionately from low payment areas, and that plan here is illustrated by the red bars, then payment rates can be higher than competing local plans and even higher than all of the local benchmarks.

We are concerned that local plans in these low rate areas would be at a large competitive disadvantage to the regional plans and could be threatened. Now to be fair, if a plan got a different distribution of enrollees, represented -- with lower portions of beneficiaries from low rate areas -- by the green and blue bars, you would have

different results. And in fact, if a plan actually drew more from the high payment areas, they would end up at a competitive disadvantage. So we don't know how long a plan that did that would last.

As I said before, this situation was a surprise to us and there has been some confusion about the MMA's intent. So we are recommending that Congress should clarify that regional plan bid submissions are to be standardized for the MA eligible population of the region, basically to align the bids and the benchmarks.

The implications. The recommendation would decrease Medicare spending relative to current law by $200 million to $600 million over one year and by $1 billion to $5 billion over five years. You might ask why. The reasons that there are savings attached to this recommendation is that CBO feels the scenario illustrated by the red bars is likely to occur in some regions which would increase regional plan enrollment and payments above current levels.

For beneficiaries and plans, this recommendation could lower payments to regional plans in some areas. Therefore, this recommendation may cause regional plans to reduce the extent of their participation in the MA program

and may reduce plan choice for some beneficiaries.

Now we want to shift from discussing issues related to plan versus plan playing fields to the plan versus fee-for-service Medicare playing field. As Dan discussed, beginning in 2004 CMS began transitioning from risk adjusting plan payments based on a demographic model to adjusting payments based on a health risk model. For the last three years, CMS has estimated that aggregate plan payments adjusted with the new health risk model would be lower than payments adjusted with the old demographic model.

CMS is applying proportional increases to county payment rates so that, in aggregate, plans would be held harmless for the effect of switching from the old model to the new more accurate model. The net effect of this policy is that aggregate payments to MA plans are equal to what they would have been if 100 percent of payments were adjusted with the old demographic system.

The president's most recent budget proposal includes an $8.3 billion phase out of this hold harmless policy from 2007 to 2010. The effect of the phase out would be to increase risk adjusted payments by progressively smaller proportions from 2007 through 2010 and thus

completely eliminate the policy in 2011.

Whether this policy is continued in full force or phased out, any policy that increases risk adjustment payments prevents risk adjustment from addressing the risk profile differences between beneficiaries in the MA and fee-for-service Medicare. The end effect is that payments for MA enrollees will be systematically higher than if those same beneficiaries were enrolled in fee-for-service Medicare.

At this point, the Commission recognizes that payment reductions, especially when combined with other recommendations you may hear today, the reduction here that would occur by removing a hold harmless policy immediately would be steep. In addition, some plans claim they have not yet been fully successful in collecting all of the diagnostic information that feeds into the health risk model. These plans believe that their payments under the new system do not reflect the true health risk of their enrollees.

Therefore, we have the following recommendation to consider.

The Congress should put in law the scheduled phase

out of the hold harmless policy that offsets the impact of risk adjustment on aggregate payments through 2010.

Even though the risk adjusted payments would be higher then without this policy, there are savings because the phase out would be locked in and CBO had assumed that it would not otherwise occur. So this recommendation would decrease Medicare spending by more than $1.5 billion over one year and by more than $10 billion over five years relative to current law.

Because the president's budget includes this policy, plans are likely to have expected the implied per member payment levels and should not change their offerings to beneficiaries and thus, there shouldn't be any effects on beneficiaries.

We've talked about financial neutrality and the current bidding system and we found that the system is not financially neutral for two reasons. First, the benchmarks currently average about 107 percent of the costs of covering demographically similar beneficiaries under fee-for-service Medicare, so plans in some areas may be paid above fee-for-service costs.

Second, the bidding process is not financially

neutral because plans that bid below the benchmark will be paid less than the benchmark, which means that some plans may be paid less than fee-for-service costs. In fact, our very rough simulations show that after accounting for savings from the bids below the benchmark, we might expect net payments to average about 104 percent of fee-for-service costs.

At any rate, payments are not equal between plan choices and fee-for-service Medicare.

Also another issue with the current system, as we've discussed in previous reports, is that it does not currently provide strong enough incentives for plans to focus on improving the quality of care.

Let me just focus on the benchmarks for a moment. There are several sources of the difference between the benchmarks and the cost of fee-for-service Medicare. About two points of the seven point difference is due to the treatment of indirect medical education payments to hospitals, IME payments. Even though the Medicare Advantage program makes separate IME payments to hospitals on behalf of Medicare Advantage enrollees, the cost of those payments are included in the plan payment rates based on measures of

the cost of fee-for-service Medicare. In effect, the Medicare program is making IME payments on behalf of MA enrollees twice, once to the plans and once to the teaching hospitals.

There are other differences with the benchmark. Fee-for-service calculations might underestimate the cost of Medicare services provided to beneficiaries because some beneficiaries receive services from Veterans Administration facilities that would otherwise be covered by Medicare. CMS was instructed to add the cost of these services when calculating county fee-for-service cost but it has not yet been able to do so. We would urge that it implement the VA adjustments as soon as it is able.

The other major source of difference is the result of the two floor rates created by Congress to raise rates in the low rate counties. About 30 percent of Medicare Advantage enrollees live in these floor areas and payment rates there average about 20 percent above fee-for-service Medicare.

We have a couple of draft recommendations that would promote our principal of financial neutrality. The first is consistent with our position in our March 2002

report that supported removing graduate medical education costs from plan rates and making payments directly to teaching hospitals that treat plan members. The Commission wanted to help ensure the plans have incentives to direct enrollees to use teaching hospitals when appropriate.

In that spirit the draft reads the Congress should remove the effect of payments for indirect medical education from the MA plan benchmarks.

This recommendation would decrease Medicare spending relative to current law by $200 million to $600 million over one year and by $1 billion to $5 billion over five years.

This recommendation would lower payments to plans in some areas. Therefore, this recommendation may cause plans to reduce the extent of their participation, the generosity of benefits offered, or whether or not they participate at all, and thus plan choice for some beneficiaries could be reduced.

Our last draft recommendation is actually a two-step recommendation to address two barriers to financial neutrality. The Congress should set the benchmarks used to evaluate MA plans at 100 percent of the fee-for-service

costs in each payment area. The Congress should also redirect Medicare's share of savings from bids below the benchmarks to a fund that would redistribute the savings back to MA plans based on quality measures.

There are some considerations with this policy. Financial neutrality is really a long-term principle that the Commission has espoused and the Commission recognizes that Congress has wished to encourage plan participation in more areas of the country. And the Medicare Advantage program is just beginning so we recognize we don't want to derail the process. So Congress may not wish to reduce benchmarks in all areas immediately.

On the spending implications, if it were fully implemented for 2006, this recommendation would decrease Medicare spending by more than $1.5 billion over one year and by more than $10 billion over five years relative to current law. So if it were phased in, obviously these numbers would come down.

I want to note that it's possible that the quality pool could get very large from bids being well below the benchmarks. In that case, the Commission realizes that it might wish to reconsider what Medicare does with all of the

savings and perhaps we might change the recommendation of where the money could go.

This recommendation would decrease average payments to MA plans but some plans may receive higher payments through pay for performance bonuses. It is likely that some plans would choose not to participate in some areas, leaving some beneficiaries with fewer choices. Plans would have greater incentives to improve quality and could lead to better quality of care for beneficiaries.

Thank you.

MR. HACKBARTH: Good job.

Let me just make two quick observations. One, for both the commissioners and the audience, all of the budget numbers that have presented need to be used with care because these numbers are interactive. So you couldn't simply just add the budget implications from recommendation one to those from two and say that the cumulative effect is one plus two. They do interact with one another. And so be careful about that.

The second comment is that I want to underline a theme in both Nial's and Scott's presentation, which is that although we've taken up Medicare Advantage and its

predecessors, Medicare+ Choice, many times in the past, we do so today in a different context. Significant decisions have been made by Congress on these issues, embodied in MMA. And those are judgments that need to be respected. And I do respect those judgments.

But in addition to that, the real world has changed as a result of them. And so, the world in which we now consider these recommendations is one where plans are actively gearing up their offerings for 2006. And even if Congress were to say MedPAC has raised some good points on these things and the program ought to be modified or adjusted, that couldn't happen today without colossal disruption of the system. And so that needs to be reflected in our thinking and in our report.

Having said that, I do believe that our role as an independent commission is to provide Congress our best judgment about issues and where the program ought to be headed. Then they can make decisions, as they must, about whether to embrace the recommendation or the timing as to implementation of it.

I don't think that we ought to hold back and not highlight issues that we think are of critical importance to

the program and to the beneficiary it serves simply because there's recent legislation. I think our obligation to the Congress and to the program is to give our best advice, our best thinking about where things ought to go in the future.

So that's an opening thought about the context. Questions or comments?

Actually, let me say a word about organizing this. We covered enough ground here in this presentation, on a fairly diverse set of issues. I think it would be helpful to organize our discussion by issue. So as opposed to bouncing around, I'd suggest that we start with the regional PPO-related issues of the geographic adjustment and the stabilization fund. I guess those are the only two recommendations on the regional PPOs. Let's start with those recommendations and ask for comments or questions about those.

DR. SCANLON: I think actually something I'm going to say is going to apply a little more broadly and I won't ask to repeat it again later, but I think the idea of neutrality, it certainly has incredible appeal. But I think we have to be very careful about the context in which we apply it.

Probably I was exposed to it first in terms of individual services. Do you get an endoscopy in an outpatient department or do you get it in the physician office? And the question of should we be paying the same for that? The answer there is perhaps relatively simple to come to a conclusion, though we actually had to do a study once of whether or not there was greater risk of doing the service in the physician offices.

As you move to bigger and bigger bundles of services, it becomes more difficult to ask yourself the question of are we actually talking about the same kinds of things. I think we are in that context in terms of Medicare Advantage. It's not even just a question of Medicare Advantage versus fee-for-service. It's Medicare Advantage. We have within Medicare Advantage the fee-for-service plans, the PPOs, as well as the traditional HMOs. And conceivably we're buying different products from each of those and we should be asking ourselves the question of what's the appropriate price to pay.

That's the context I think that applies here in terms of the regional PPOs but also it applies when we start to talk about the local plans.

In terms of the stabilization fund, I think that the idea of saying it should be repealed at this point is potentially premature, given that we are just at the point which you indicated, on the verge of learning a lot more about how the regional PPOs are going to work.

One aspect of the stabilization fund is to reward someone for having a national plan. If I have a regional PPO or multiple regional PPOs in every one of the regions except for two, do I really want to reward somebody strongly for coming in and filling in those two regions? Or do I want to target things on those two regions, if that's my goal, is to have coverage nationally.

So I'm of the mind that we might be better delaying until we had more information and having a more specific targeted recommendation that would deal with how best, if you're going to have money set aside, to try and promote participation, how do you best target that money to promote participation?

MR. SMITH: I won't respond to the larger questions Bill raised. I think they more appropriately come with other recommendations. But let me just talk a little bit about the stabilization fund.

I think, Bill, we could spend $10 billion before we knew enough. That point is perhaps right. But the other way to think about it is we could spend as much money as it takes to correct for the market signals that the plans were reading. And I think the point here is that we ought to be clear that we think that's unwise.

The obverse of you get less of something by raising the price of it, by lowering the price of it -- excuse me, raising the price of it -- is you get more of it by raising the price. We could subsidize an uneconomical national plan that no one in their right mind would offer if it weren't for the bonus or bribe, more accurately, that we propose to pay them for a limited amount of time. We don't get a national plan forever. We don't get increased benefits forever. What we get is some fraction of what $10 billion will buy is to get something which the market otherwise wouldn't signal to a play they ought to do.

It's unwise and at the end of the day we haven't learned anything except that you can get something by spending $10 billion that you can't get if you don't spend it. That's not worth learning. We already know it.

DR. BERTKO: Just a couple of quick comments to

follow up what Bill's were in the context of the regional PPO, perhaps applied to this one and others. Number one, there is a lot we don't know and we will know in a relatively short period of time because the bids are due in June and then the enrollment will have happen January 1st.

Secondly, in expanding to new areas there is a start up cost. In the case of the regional PPOs, in contrast to the stand-alone prescription drug plans, the cost is substantial because there's a lot of contracting that has to be done, a lot of back and forth. And perhaps that just should be a part of our thinking on this.

MR. MULLER: Given all of the topics we discuss in the course of year and in the course of years about the costs of the Medicare program and concerns about appropriate and inappropriate utilization and concerns about the costs of many of our services. I too, like David, find it ironic that we want to be paying even more to run this program through these plans.

If anything, the advantage of Medicare Advantage should be that they run the program for less, not that we should pay more to reform a program that has a lot of concern about cost and quality.

So I find it bizarre that we would engage in a policy or that anybody's engaging in a policy to pay more for a program that already has severe concerns about its cost and utilization.

So I, too, think that the principle that we've endorsed in the past of neutrality makes sense and we should stick with it. And certainly, to be thinking of bringing more administrative costs into a program where the American system is by and large seen as having too high administrative costs also strikes me as the wrong direction to be going.

DR. CROSSON: Given the complexity of the math behind draft recommendation three, I'm almost loathe to ask a question but I want to anyway.

It seemed to me from the discussion that we had and the graphic representation that if Congress did clarify its intent and that ends up to be different from what the staff thinks the current rule suggests, that that clarification would have the net impact of perhaps making it more likely that plans would enter and serve the regions. And the net effect of that would be more choice for individuals in rural areas.

At least that's how I interpret -- the rural or noncentral metropolitan areas, let me say. That's what I thought I heard. Is that correct?

DR. MILLER: I'm just going to take a shot here. You guys need to pay attention. It's very likely wrong. It's different than usual, if you guys could please pay attention.

[Laughter.]

DR. MILLER: I have two answers.

DR. CROSSON: Yes and no.

[Laughter.]

DR. MILLER: Okay, and I hope that was helpful and let's move on now.

[Laughter.]

DR. MILLER: I think that the answer to this goes like this. There are some plan people at the table, so you should feel free to also -- I think that our discussions of this, out in talking to people that we know in the industry, suggested that the industry was not planning on what we think is the wrong interpretation of it, the one that would give a plan a windfall if they ended up selecting from the low-cost areas. That if you ask the average plan person

they thought no, it's the way you guys are describing it.

So in that sense, one way to answer your question is to say if we made this clarification, at least from the plan offering perspective, it shouldn't change the environment a lot. That most people thought that the intent of the legislation was the way that we have described it. And the anomaly in the reg is really only just now -- not anomaly. The interpretation in the reg is only just now coming to the surface.

So we don't think, at least as it stands, if you made this change it would necessarily change the plan offerings. That's a view and that's why I'm being fairly tentative here. But I'm not sure that was precisely your question.

MR. HACKBARTH: But as the presentation pointed out, the policy, as outlined in the reg, has different implications depending on the patterns of enrollment. And whether the regional PPOs tend to draw disproportionately from the lower cost areas within these large diverse regions or higher.

I think a common assumption, and I assume it's the assumption underlying the CBO estimate, is that the regional

plans might tend to be relatively more attractive in the lower cost areas of the regions if only because there's less local MA plan competition in those areas. But that's an assumption, not a known fact.

DR. HARRISON: There's also a slight advantage to serving -- a regional plan would have a slight advantage in the lower cost areas because the rebate portion is not adjusted by geography. The purpose of the $75, in our example, that you're given back in rural areas would look a lot more attractive than the $75 given back in urban areas.

MR. HACKBARTH: Just to continue it another step, one might say well, that's a reasonable policy consistent with the concept of regional PPOs. At least part of the intent here was to get offerings, private plan offerings, into areas of the country, many of them lower-cost rural areas, where there are not existing MA plans. And I can understand that.

My concerns are then what are the implications of doing that? I am, in particular, concerned about the implications for the local MA plans that then face this competition from the regional plan.

So imagine your large regional area. You won't

just have the big city and then the really low-cost rural areas. It will be a variety of things. You may have multiple cities, a very high cost city and sort of a medium cost city in the region. In some of those markets within a big region, there will be local plans trying to compete. And they could face a regional plan that is getting a significant additional subsidy based on this feature of the payment formula. That's a policy that I am concerned about.

DR. WOLTER: I was going to say it kind depends on the details of how network adequacy ends up being defined. But a sleeper issue is that in terms of the competitive landscape between regional plans and local plans, particularly in areas of the country where there are sole community providers. If CAHs don't want to sign on because they want their cost-based reimbursement versus fee-for-service reimbursement, local plans can't sign them up. But it sounds like regional plans have the option of moving ahead without having signed contracts.

So I think that might need some attention as we see how this unfolds in certain regions in the future.

DR. REISCHAUER: I basically agree with the recommendations but at the same time I sort of have the

feeling some of this doesn't require the loss of sleep that some of the discussion is focusing in on.

The example you used for the extremes, where 80 percent of the folks were in the high-cost area and 20 percent were in the low-cost but the plan was able to do 50/50, implies either that the regional plan has relatively small enrollment or it can soak up a huge fraction of the available beneficiaries in the low-cost area, which is not an easy thing to do, especially because we've written a number of reports saying how hard it is to operate in these areas anyway.

So I think there are some countervailing -- and Nick's pointed this out, there are some countervailing forces going on.

I think we should try and lay out at the beginning the levelest playing field that we can. But let's not create too much of a sense of crisis.

With respect to the debate that went on between David and Bill, and John being in the middle can, of course, and being the person with some inside knowledge on this can say whether I'm way off base or not.

I think this stabilization fund is unnecessary

and, in some ways, is a pot of money looking for a problem that we don't know exists at this point. And the right thing to do really would have been to see if there's a problem and a few years later than come and correct it.

But if a plan is out there assuming that it's going to be the only national plan and therefore get the 3 percent, or counting on getting some of this money for a very short period of time. And it's uncertain whether it will continue. I'd want to sell the stock short of that company because it strikes me that they're taking a huge gamble, especially in an era of large deficits and Congress concerned about where savings can be had.

So I think this is, as I said, a chunk of money which if there is a problem, if we see a problem developing, maybe you should want to address and address it in a more efficient way, which is what David said, than this rather than just having this thing sitting out there looking for the Secretary to distribute it.

MS. DePARLE: I, too, wanted to follow up on the colloquy between Bill and David and add a slight gloss to it which is Bob, I agree with you that it's unnecessary to have this additional stabilization fund out there and that the

more efficient thing to do would be to wait and see how this works and if you need it then add additional payments.

The problem I have with putting it out there now is that I think a lot of plans or some plans will take a gamble. And that will be disruptive not only to them but as one of the people, and many people in this room, who lived through the Medicare+Choice launch, a lot of people seemed to think all on the plans will expand to these rural areas with the floors and ceilings and all that complexity.

Not only did that not happen, but they pulled out of a lot of areas. And when you actually looked in the areas they pulled out of, some of their decisions to be in those areas didn't make market sense to begin with. They were in counties with 100 beneficiaries -- we've talked about some of those today -- with unlimited drug plans and things that didn't make sense because the payment rates were so high.

And that was disruptive to them and to their reputations and to their relationships with Congress and CMS/HCFA. But also terribly, terribly disruptive to beneficiaries.

I can speak from town hall meeting after town hall

meeting when beneficiaries were very upset about plans making what were rational market decisions when the payment rates changed from being perhaps overgenerous to being not so generous and they began to see the risk and they pulled out.

I think that's why I would answer Bill's question with why do we act now? I think it's important to send that signal that we don't want to have a situation like that again, that is so disruptive for everyone and that, frankly, I think we're just now beginning to cover recover from with beneficiaries.

MR. HACKBARTH: Let me get some other people in first, Bill. Dave Durenberger?

MR. DURENBERGER: On the issue of the regional versus more local plans, I usually step back from this and look at what is the purpose of the Medicare program and of MedPAC, which is to determine whether or not payment policy advantages beneficiary access to high-quality care. All of this discussion is about health plans and really not about access to high-quality care.

I also think about it in the context that doctors and hospitals make conscious decision to locate in

communities and some health plans do the same thing and other health plans do not. And particularly we've learned that from the experience we've had with the managed care situation in the 1990s.

So it's more difficult today than it might have been in the mid-80s when we get TEFRA risk contracts to determine really what is the value added in rural areas or urban areas or whatever of the health plan which you can't get from clinical systems, doctors, hospitals and so forth.

Having said that, some of us come from a region of the country that has the largest geographic region under this regional approach. There is a very, very real fear, and has been since MMA passed, on the part of a lot of community-based health plans about the disparity -- the predictable disparity -- between regional plans and local plans. I think I left with Mark last night a paper that got developed about a year ago or maybe nine months ago by a lot of the people in several states in the upper Midwest on this issue.

Now we have a situation which really gets to the interplan challenge which has been created by the fact that all of the Blues plans in about seven or eight states in our

region have decided they're going to get together to become the regional plan.

Then the question will be, within BlueCross-BlueShield of Minnesota, which will have to compete with its own local plans, to say nothing of having to compete with the other plans in our community which keep driving the goal of having a plan, access, affordable premiums, high-quality, assessment of one kind or another, to keep that viable.

There's just a really genuine concern on the part of the other plans, including the local BlueCross-BlueShield plan, as to the inequities that would be created in the way in which the policy is literally interpreted.

So on behalf of all of these people, I strongly recommend that we adopt the position that you and the staff have come up with here.

MR. HACKBARTH: In just a minute we're going to have to move on to the next block of recommendations related to the local plan issues. Bill, did you have one last comment on the regional?

DR. SCANLON: Just quickly. I wanted to say that I don't think there's as big a difference between David and myself, at least on the national plan component of the

stabilization fund. And also with Ralph, with respect to our need to save costs.

I think the national plan bonus doesn't make a lot of sense, particularly given that there's been reports that there's a fair amount of interest in regional PPOs and so we're likely to get some pretty good coverage without having to go that far.

That's the most specific part of this provision and therefore plans potentially are making projections on the basis of this.

The other two components, though, are much less specific and I'm not sure that you can plan your behavior on those yet. I think that's where something that will happen in terms of data coming in that plans will be in a better position to decide whether these things are going to make a difference. The Secretary's going to be in a better position in terms of trying to define criteria and actually what the bonus will be.

I would be in support of eliminating the national plan provision, not the entire stabilization fund.

With respect to Ralph, the idea that we're switching gears and we're saying let's spend, spend, spend.

I actually have a concern about taking all of the savings and turning them back in to pay for performance. What we've long -- and this is from a GAO position. We've long argued if we're going to have a managed care program within Medicare, the Treasury should be one of the beneficiaries. If we're going to go out and seek other providers and they say they can do it more efficiently, then we should benefit from it financially and not turn it all into additional benefits.

MR. HACKBARTH: We're now transitioning into the second set and I'll get Sheila in just a second, but I had a comment on that issue.

The way it's set up now is we bid against a high benchmark, higher than fee-for-service, and then say we're going to take 25 percent of the savings for the Treasury.

The alternative way of doing it is say let's reduce the benchmarks, which will produce savings for the Treasury. And then, in the interest of encouraging a robust quality improving private plan program, let's at least initially reinvest some resources in a more robust pay for performance program.

So I want to protect the Treasury, too, but I

think the alternative approach of lowering the benchmark does that, also.

Now we're moving on to recommendations four and beyond on local plans.

MS. BURKE: Just very briefly to close this out, given all of the conversation we've had today, one of my concerns is the issue of how one encourages the development of plans to serve areas in this country is not a new conversation. We keep reinventing or attempting to reinvent or invent new solutions to this problem that has plagued us really since the beginning of the effort to expand Medicare beyond a fee-for-service program.

And so one of my concerns is with each of these new things you create a different set of problems or a different set of initiatives. I think Nancy-Ann's point that we have, as a result, seen a variety of things occur including the entry in and then the exit out and the damage to the beneficiary in the process.

I think in the context specifically of the stabilization fund, but I think this also comes up in all of these other pieces. As you said at the ,outset all of these are linked together in terms of how they interact and what

it is we're trying to do.

I could well imagine a situation where the regional plans suddenly put pressure on the local plans and you suddenly have pressure from the local plans to create a stabilization plan for them to stay in place in order to compete with the regionals. You can see this unraveling in a variety of ways.

I do think, in discussing this and the staff putting together the comments, I think the suggestion, which is that there may be issues that arise, that we do need to understand whether we need to intervene, and waiting to see what that problem is and more reasonably target those solutions, should we decide to intervene in some fashion? With the underlying principle, which is getting to neutrality, which is how ultimately do we create a system where essentially everybody's on a level playing field and one begins to compete.

So I would suggest, not knowing the outcome of the vote on the recommendation specific to the fund, that if in fact there is a majority vote in favor of essentially deleting the fund as we know it, that there be a discussion that suggests that one of the cautionary notes that was

discussed here is the need to have a more fulsome understanding of what the challenge will be to fit the solution to the problem, rather than presume that this sort of a national plan entry, a regional plan entry, that we really try to understand that before we set aside a big chunk of money to begin to put out and then create the expectation and create the resulting entry and exit because people have planned and then make decisions that make no sense for the market.

So I do think that the report needs to reflect the concern that we all want to get to the point where these areas are served, that there are plans participating, that people do have choices. But blindly creating these interventions without a fuller understanding of what interventions ought to be, I think, is part of the concern that's explained here.

It's not that we don't want to get there, it's that we're not entirely sure that we understand fully how. Bill's point that the national adjustment may make no sense, we may need one that is specific to certain kinds of regional plans and entry or retention. But I don't think we know that yet. I think that's the concern. We want to get

there but I don't think we yet know how it is and I don't want to create expectations that people then make a judgment on and create these plans or go in planning this, and then essentially come out a year later because they've essentially gotten their one shot and it didn't work.

MR. HACKBARTH: Other comments? Again, this is all of the local MA issues.

DR. BERTKO: I'd like to go to recommendation six with a specific comment and then to echo Sheila's broader comments.

First off, just to repeat but with more fervor what Bill said originally here, the new bidding process is going to create large new incentives. Scott referenced some estimate of them from the old data from the ACRs which changed dramatically. Now we'll going know a lot. In fact, MedPAC staff can know a lot in the next nine months or so. And that will serve to inform those choices which Sheila others have alluded to.

So my specific comment on this one would be keep MedPAC's general philosophy perhaps of moving to 100 percent, but then stop there. For example, if we deleted the last four words, in each payment area, because there

might be some reason for targeting. This would allow us perhaps a little bit more flexibility than in current.

So as discussed, there could be very good reasons for encouraging plan choice and coordinated care in areas that are currently not served today.

MR. HACKBARTH: If I may, I'd like to leap to the head of the queue just to pick up on John's comment here.

I agree with what you say about the bidding process creating a new dynamic. That makes sense to me. I think the bidding idea is a very good part of MMA. I think we ought to be trying to move away from the pure administered price and get towards models that more accurately reflect competitive prices and more efficient prices.

So I hope you're right, and I think you are, that at least in some markets the bids will be well below benchmarks, especially the inflated benchmarks.

But let me pick up the corollary that you say well, maybe we'll get to 100 percent on average but have it lower than fee-for-service in some places, Miami, and higher than fee-for-service in others.

I'm still not 100 percent comfortable with that as

a policy. Let me start with the areas where the private plan payment is well above fee-for-service.

In that circumstance, if the gap is sufficient, it becomes possible for a private plan to enter, not really do much good stuff for beneficiaries, pay providers at the Medicare fee-for-service rates, and still have sufficient cushion to cover administrative costs and some profit and some additional benefits for beneficiaries.

That policy, in effect, is creating a backdoor way around the basic Medicare fee-for-service payment structure.

Now, how many people go through that door is a function of how big the gap is between the private plan rate and the Medicare fee-for-service rate. We know in the floors right now in some places that gap is getting quite large. The benchmarks, because of the floor process, has gotten quite large.

We also know that the political process faces pressure to elevate that floor. We started with low floors that only affected a few places at the beginning and over the years it goes up and up and extends now not just to rural areas but also some large urban areas, including Montgomery County, Denver, Portland, Oregon and the like.

I'm worried about where that path leads as a backdoor way around the fee-for-service Medicare policy.

If we're not paying properly in those areas, we ought not address it through this backdoor mechanism but rather through the front door of adjusting Medicare fee-for-service so that we can provide access to high-quality care in those communities.

Now I happen to believe that, in fact, we are getting access to high-quality care in Portland, Oregon, for example. In fact, the people in Oregon are very proud of the fact that the Medicare expenditures per capita are low and the quality indicators are high. And they should be proud of that.

But given the challenges that we face in Medicare, we can't react to that by saying what we ought to be doing is moving Portland up to Miami and say Portland's efficient but they're getting less so we have to pump them up. That's a dead end for the Medicare program. The challenge is not to increase payments in Portland, Oregon. The challenge is to reduce payments in Miami.

Which brings me to the other side of this. If we start cutting the rates we pay private plans in Miami way

below fee-for-service, when you lower the price you get less of it. We'll have fewer private plans participating and fewer beneficiaries enrolling as the price is driven down by the competition. I'm ambivalent about that situation.

What I want to do in Miami is exert the maximum pressure on the fee-for-service system that is grossly inefficient. And I want as many private plans as possible in Miami. I want as many Medicare beneficiaries as possible in those private plans to force the fee-for-service system to compete back and change.

DR. BERTKO: If I can just respond quickly to two parts, in reverse order.

In the high payment areas, and you name Miami in particular, the best thing about the bidding construction is that it, in fact, has the incentive to bid as low as you can get to within a reasonable strain and then maximize that particular thing. So while you have some appropriate worries, I have perhaps less because I think it's now a near automatic mechanism.

Back to the other part, and I completely understand and agree with the fact that at some point all of the floors should be re-examined. There's a lot of

uncertainty now.

And then secondly, and I'll call this health plan technical stuff, there's the chicken and egg part which is if you have enough members to start with you can both amortize the contracting parts of it ,and more importantly, the coordinated care infrastructure. Having, for example, nurses on the ground to do discharge planning. In the absence of that, you can never get there.

So I'm only suggesting here keeping our general goal but rather waiting for more information a year from now roughly to inform our choices better and then pursuing a lot of the things that you suggested.

Thank you.

DR. CROSSON: I'd like to speak to draft recommendation four and then the first part of draft recommendation six.

With respect to draft recommendation four, it's just to say that I agree with it. I think it is a well worked out and thoughtful approach to a difficult problem.

Mentioned in the March meeting, removing the phase-out period, I believe, would have a differential impact on organizations that capitate their delivery systems

because of what is recognized in the report. That is, it's going to take some time to train physicians in a billing and coding procedure that they have never been in before. Our experience is that's taking a good deal longer than we thought. And so I support that.

And I also support it for the reason I think that's been mentioned already today. And that is that with the drug benefit and with the competitive bidding process coming on in 2006, there are a lot of moving pieces here for Medicare Advantage plans. And as has been noted, a lot of these have interactions. And so the more variables you get, it's kind of like the patients with 17 drugs instead of two drugs. The more elements you have, the more interactions can occur that aren't predictable.

So I support recommendation four for those reasons.

I'd like to talk again a little bit about the first part of recommendation six, which is to set the benchmark at 100 percent of fee-for-service. I recognize all of the arguments that have been made and there is a lot of validity here. But I think there's a couple of concerns that need to be taken into account.

The first one is that among the floor counties there is a collection of counties. But certainly some of those are rural. And as you mentioned, Mr. Chairman, one of the original reasons for the concept of floors was to improve the payment and therefore access in rural counties. We looked at what would happen if this recommendation were to go forward. In Northern California, where I am, the closest thing we have to a rural county is Fresno in our service area. And based on 2005 rates, payment there would drop by about 23 percent.

And I talked to our colleagues up at Group Health in Washington. And in their three rural counties, Clallam, San Juan and Whatcom County they estimated reductions of 28, 39 and 20 percent respectively.

MR. HACKBARTH: Just a clarification, so that is the difference between the current floor rate and the underlying fee-for-service costs?

DR. CROSSON: That is correct.

So were the recommendation to go forward unaltered and into law, it would have an adverse effect on the original intent, I believe, of setting floors. And that is the difference impact on rural counties. I think that's the

first point.

The second point is just to reiterate some comments at the March meeting, and that is that the competitive bidding process again is new, it's an uncertain process. It's going to create instability by itself. And I think there is an argument to be made, anyway, to not put too many balls in the air at the same time.

The last one I have, and again I think I mentioned this in March and I believe not everybody agrees with me on this. But if you look at the presentation we just received, as a matter of fact the second page of the presentation, it says in respect to MA plans this ability to innovate through financial incentives, care coordination, and other management techniques gives private plans tools to improve the efficiency and quality of health care services delivered to Medicare beneficiaries. That's what we're all interested in.

I believe, having spent my entire career in an organization like this, that it works. And that it's good for Medicare beneficiaries.

I have chosen to view what Congress is doing, at least in some of these design ideas that they've had, as a

conscious attempt to invest in the development of these organizations because at least some of the individuals involved in this believe that in order to get more of these plants and have them more available to more beneficiaries to get the very kind of advantages that our own report in March described, takes investment. And that investment, as it always does, means spending more money for a while in order to get a return.

I realize that's a controversial idea. It also flies in the face of the principle of financial neutrality. But I do believe that people of good intent believe that and that that, at least, lies behind some of these ideas and has a justification whether or not it is generally agreed to.

Thank you.

DR. WOLTER: I am strongly endorsing John's suggestion on the first part of recommendation six. I'm very fearful that being rigid to fee-for-service costs in each payment area may not be good long-term policy. I am worried about the potential for entry of these plans into some parts of the country. I'm also concerned that the financial neutrality principle itself might need a little different wording.

If we were to say that we wanted to be financially neutral with regard to payment for the provision of efficient and high-quality care, that would make me feel better because it may well be that the fee-for-service benchmark in a county with high utilization and low quality measures is not the benchmark we want to be at over the next several years.

And we don't know enough yet. It may well be that, as you said Glenn, there are some issues in the fee-for-service program in other parts of the country that might want us to reconsider adding payment. And so this recommendation, as written, seems to lock us into something that might not be good long-term policy. And so I'm very, very concerned about it.

On another point, I worry that if we target our payment to fee-for-service, high payment areas have an opportunity to deliver benefit design back to beneficiaries that's considerably richer in some parts of the country than it is in other parts of the country.

And we may want to at least acknowledge that because although we clearly want to be careful about payment and financial neutrality in the program, I think ultimately

all beneficiaries want to feel that we're looking at the potential that they can receive roughly comparable choices or comparable benefits.

MR. HACKBARTH: Let me just make a quick comment on that point. In fact, I agree, Nick, that the beneficiary equity issue, if you will, was initially one of the most important drivers behind the floors to begin with. I know Dave Durenberger was involved from the beginning in that. And there was a strong sense among people on the Hill that their constituents were not getting access to the additional benefits that people in other parts of the country were.

Earlier I made my impassioned appeal for using the front door as opposed to the back door. In fact, through the prescription drug provisions of MMA, we were going through the front door. The single most important benefit that the beneficiaries felt they were not getting access to if they didn't have a private plane in the old days was better prescription drug coverage.

I think Congress quite wisely said trying to achieve that goal through the indirect mechanism, backdoor mechanism, of higher payments to private plans was a very inefficient, inequitable way. Let's go through the front

door and incorporate a prescription drug benefit as a main feature of the program. That is an efficient approach. That is a sounder approach to deal with those equity issues, I think.

Trying to do it through subsidies to private plans, I think, has the potential to be a grossly inefficient way to deal with those equity issues. That's my concern.

DR. WOLTER: Just to be clear, I'm not making an argument for the long-term persistent floors whatsoever. I'm just saying that the very concrete statement that we're going to tie, at the level of payment areas, to fee-for-service may not be quite sophisticated enough for long-term policy. It's not to argue for floors, in any way, for long-term policy.

Also, there are so many moving pieces on this, as the CAH cost reports start to flow through, for example, we're going to see, even in rural areas, AAPCCs start to change in ways that may make the floor situation we currently have not all that relevant.

MR. SMITH: You, a minute ago, said a bit of what I wanted to in response to Jay and Nick.

But Jay, I appreciate the belief that a coordinated care -- and agree with the belief that a coordinated care plan, independent of whether or not it includes drugs or includes other benefits which aren't available currently in the fee-for-service system, has much virtue. But I was struck when you talked about Fresno and your Washington counties, that you described the impact of going to 100 percent of fee-for-service entirely in terms of the plans. It wasn't that gosh, there is a drug benefit in Fresno which 10,000 beneficiaries are enjoying and that will be lost because if we have our payments reduced by 23 percent we'll be out of there. And again, in Washington, it was simply a financial impact on the plan.

We ought to be concerned about that only if we know a great deal more, only if we know that there are achieved and recurring benefits that beneficiaries are getting that would not be otherwise available.

The fact that a plan is operating with a very high unsustainable in the fee-for-service or unproducible in the fee-for-service market level of income doesn't tell us anything worth knowing by itself. It may well be that what we can deliver in Fresno cannot be delivered at fee-for-

service payment rates.

But the fact that a plan currently is getting a payment -- I've forgotten the precise number you used as -- but 22 percent above fee-for-service doesn't really tell us anything that we want to know at the end of the day.

MS. RAPHAEL: I guess I want to build on what David just said. From my point of view I don't think that whatever we do here today is going to change the moving parts in anyway in the next couple of months at all. But I do believe we ought to be consistent on the principle of neutrality.

The reason that I feel that way is kind of what I hear sort of two different ways of proceeding. One is you make an investment because you think there may be some benefits down the road, although unproven at the current time. Or you hold off making that investment until you really know much more about what you might set in motion and what you're likely to attain.

From my point of view, the general direction we've been trying to go in across the board is to be more of a value purchaser and to try to target payments much, much more in this system which has very untargeted payments right

now.

As I look at this, that's what I would like to move toward. How do you really become a value purchaser and target payments in this whole area of Medicare Advantage?

I just did with a group a look at does it make a difference if you're in Medicare+Choice in terms of coordination of care and transitions, which we were very interested in. Is the experience going from hospital to home and then from home back to hospital any different?

The study that we did did not show any differences. And we had to say why not? Everything would lead you to think that you have the incentives align and you would have coordinated care.

Now with a few exceptions, in general the health plans were much more focused on hospital days and hospital payments than on anything that happened in the world of transitions and really coordinating care.

So I did not yet discern any great benefits here in the patient experience, in sort of cross-silo, cross-site coordination that I am yet prepared to put funding into.

That doesn't mean that down the road I might not be prepared to target dollars toward that. But for me the

proof is not apparent. And so I go back to right now holding back on this investment and adhering to the principal of financial neutrality.

DR. MILSTEIN: I'd like to speak in support of most of these recommendations, all, and maybe suggest a few minor modifications that I defer to the chair as to whether or not they are appropriate at this point or they also overlap with some later agenda items.

The first principle is one that Jay raised, which is the idea of parsimony and sticking with the smallest number of policy levers aimed at the same goal, rather than many. I think Jay's reference to the drug/drug interaction analogy is good. And so I think we want the plans to serve as a force for improving efficiency and quality of care to Medicare beneficiaries, but I don't think we need -- let's call it the 5 of the 7 percent advantage to achieve that.

Secondly, and I think this is somewhat overlapped with Carol's last comment, that I think it's hard to argue with the idea that major breakthroughs in quality and efficiency of the scale that the IOM is calling for, it's hard to argue that those don't depend on maximizing the synchronization of Medicare incentives for improvement with

private sector. As I think about these recommendations vis-à-vis where the -- I'll call it the leading edge of private sector value purchasing is headed, I think it supports a number of facets of what's just been recommended.

First, the neutrality, wherever there is an opportunity to support level playing field competition.

Secondly, I think that there is an opportunity here, and this is I think something that may overlap with a later agenda item. Here's an opportunity to, rather than subsidize the plans with this 5 or 7 percent supplement, to instead give them some of the supplementary tools they need to deliver more value.

What I'm referring to specifically is access to the 100 percent Medicare claims data file, obviously with total beneficiary privacy protection, so that they can go about the business of delivering incremental value by better recognizing and rewarding those hospitals and physicians who are far superior in their combination of efficiency and quality right now. Most Medicare Advantage plans do not have enough data density in any given geography to have a prayer with any kind of statistical precision identifying which physicians which hospitals or which physician

practices, multi-physician practices, and which hospitals are delivering higher value.

So if we want to help them in a way that costs the Treasury nothing, that's what I would advocate for. I realize it doesn't help Jay very much, he's already got his 100 percent granularity, but anyway.

And I think the third thing that would help bring this -- the thing that I think would bring these recommendations into even better alignment than they already are, because I think they are already quite well aligned with private sector value purchasing, is to support the idea of gainsharing on quality but perhaps to think about -- and you tell me whether it should be at this point or a later point, lining up our definition of quality with a more robust definition than as I understand it to be the measures that we have listed in tab 2/3, which is a relatively narrow list of methodologically robust HEDIS measures.

I think we're at a point now where we have a continuous feed nationally about to occur from the National Quality Forum on a much bigger list of quality measures. It gets us out of this problem of teaching to the test, where you're trying to measure all of American quality with 12

measures. In retrospect, will this be judged to be way too thin a list?

So I support the idea of beginning to incentivize on quality, for a variety of reasons I won't go into, but it happens to be well very well aligned with where the private sector wants to go. But I think we have to recommend simultaneously that a list of quality measures be routinely expanded whenever the National Quality Forum endorses a supplemental set of quality measures.

And secondly, not on this list in tab three, which I think is a diamond waiting for Medicare to pick up off the desert floor, is the so-called Health of Seniors Survey which is the only comprehensive quality measure that we have available to us and historically routinely measured for all Medicare Advantage plans. And also, at one point in time, for the fee-for-service benchmark.

For those who are not familiar with it, it's a measure of risk-adjusted change and patient reported mental and physical functioning over time. It's the only thing that, if you were to talk to the customers of Medicare, that they are accessing health care for in the first place. They want a slower decline in their mental and physical

functioning. We have a measure. It's been conscientiously tracked by Medicare for at least the last eight years.

I think that ought to be on our quality list so we begin to focus of American physicians and hospitals on how you go about delivering on the vision of quality that the customers believe is important, rather than on a narrow list of 15 process measures.

MR. HACKBARTH: I think we all agree, based on previous discussions, that when we endorse pay for performance, for example in this case, we are not endorsing a static set of limited measures but embracing the principle of linking payment to performance with the definition of the performance hopefully getting better and better over time, through broader, more robust measures of quality.

We've also said with a more significant share of the payment over time attached to those measures.

So I think what you're saying there is quite consistent with our previous P-for-P statements and this should not be interpreted as these HEDIS measures are the end of the line.

Let me just pick up on this quality issue, Jay quite correctly pointed to our previous language, and that's

language that I, too, believe very strongly in, the private plans have the potential to do things that Medicare fee-for-service may not be able to accomplish.

There's a difference though between potential and realization. In fact, if you look at the performance of private plans on the available measures, as limited as they may be, the performance is highly variable. Not surprising at all to me, Kaiser Permanente health plans are consistently in the upper ranks. But if you look at the array of scores, they go from a combined HEDIS measure of 10 on a scale of 10 down to 1.33. So that the median in that group is about seven.

So there are truly excellent private plans out there who I'd be happy to pay more than fee-for-service because they're doing more for Medicare beneficiaries. Kaiser is among those.

But I don't think it is an accurate representation of reality to say that all private plans are doing that. The data that we have suggests that they do not. Yet, we're paying all private plans more. To me, that is a very troubling policy.

And that's why I endorse the idea of saying let's

take that 25 percent. Let's not go for the short-term additional few bucks in the Treasury. Let's make pay for performance even more robust and reward those who are doing an exceptional job. And I would count you among those.

MR. DURENBERGER: That reminds me to say why I support neutrality, because when I hear those figures that Fresno's Medicare Advantage is 39 percent above fee-for-service, that tells me the doctors and hospitals in Fresno are being underpaid.

The highest performing medical group in Minnesota today on this diabetes comparison test they just went through with 49 clinics, is 12 docs way up in Northeastern Minnesota operating all by themselves with a community health plan, one of the oldest in the state called Health First. They are so far ahead of anybody else, you can't quite imagine.

But they're also as underpaid as anybody in Minnesota is underpaid. Quality does not depend on a health plan. Quality depends on the Permanente side of this side. And that is why neutrality is important. Get the adequacy of the payment for performance in place and you don't have to do the exaggerated payments to this variety of health

plans.

MR. HACKBARTH: I apologize for yakking more than I usually do. It's because this facet of Medicare is very, very important to me and it has been sort of the central issue of my 25 years involvement in various capacities with the Medicare program. And I believe very strongly in it and I want to preserve it. I want to have the broadest possible support for it. And I want to provide signals and reward for excellent performance in private plans, which I really believe exists.

I would be remiss, though, if I didn't go back to Ralph's comment early on in this discussion about neutrality and why it's important to him.

I am tough on the fee-for-service providers, as Carol can testify. I've pushed recommendations for zero updates for home health agencies as long as I can remember, and for the SNFs. And most recently, for the March report, I made a similarly impassioned plea for lower than market basket update for hospitals. There were two basic elements to that argument. One is I said I believe, and I really do, that we need to exert pressure on providers to improve the efficiency of their operation.

And related to that was I was concerned, and I am concerned, that in the case of hospitals lax payment in the private sector has so increased the flow of dollars into hospitals that they're able to elevate their costs and that's showing up on the Medicare side of the ledger. And Medicare has to stand firm and resist that. Pressure for efficiency for hospitals, I argued, is a good thing.

If you believe that, and I really do, you have to apply the same thing to private health plans. You don't get more efficiency by pumping up rates. You've got to have consistent pressure across the board to move the system forward, to be equitable. And that's something that I just believe very strongly. And that's why neutrality is important to me.

We've gone way over time, largely because of me. So we're going to have our votes on this issue now.

I think we're going to move dialysis until after lunch, just trying to give a heads up to anybody in the audience.

So let's go back to the beginning here. On recommendation number one.

DR. REISCHAUER: Can I just say that I see Arnie's

in distress, and I think the appropriate approach here is to have the text reflect that this is sort of a first step. There's a lot of things coming along and we would assume that this would be expanded as National Quality Forum information becomes available.

MR. HACKBARTH: I'm sorry, Arnie, for sort of plunging ahead. I agree with that. This is basically saying we do have a limited starter set and we ought to move as quickly as possible to being able to compare the two now. But we shouldn't be stopping here by any stretch of the imagination.

DR. MILSTEIN: The Health of Seniors measures is something that CMS has been routinely calculating throughout, and so we do have that in hand. Is there any reason that we couldn't recommend that that also be utilized?

MR. BRENNAN: We looked into the Health of Seniors survey and, you're correct that it was only fielded for one year as a pilot program in fee-for-service. And there are no plans, according to the folks at CMS at least, to refield that survey.

MR. HACKBARTH: You're way ahead of us, or at

least ahead of me, in terms of familiarity with the different potential measure sets. I'd be a little reluctant to embody in a bold-faced recommendation something that we haven't collectively mulled over as a group.

What I would suggest is that we include in the text that we look at alternative measures like this one or others, additional measures that could be used.

DR. NELSON: Make it more general. Say that the Secretary should apply the same performance measures to both forms of delivery. And then within the text indicate that this is a rapidly moving thing.

I also was troubled with identification of HEDIS measures as the only measures.

MR. HACKBARTH: So the proposal would be to say that the Secretary should develop comparable measures of performance that would permit comparison of the fee-for-service and Medicare Advantage programs, something along those lines.

MS. DePARLE: Because there are some available. That's what we're saying, HEDIS among others.

DR. MILLER: So what the text would then do is talk about what we think is ready for prime time right now,

the need for a process to bring them online, and then the notion of jump starting the Healthy Seniors Survey. Does that kind of capture everybody's thoughts?

DR. MILSTEIN: I believe it's ready.

DR. MILLER: There's no plans for them to go forward, so we'll urge them to go forward. That's what I meant by jumps tart. Does that capture everybody?

MR. HACKBARTH: Do people understand what we're voting on?

All opposed?

All in favor?

Abstentions?

Okay, number two. Any clarifications?

DR. SCANLON: Can we consider an alternative, which is that Congress should eliminate the use of the stabilization fund for national PPOs and that we, in the text, indicate that we, on the basis of information that we get from this round of bidding, will address the remainder of the stabilization fund in the March report.

MR. SMITH: I would oppose that change, Glenn. It seems to me the arguments against prematurely fixing a probably that hasn't surfaced, that we don't understand, but

promising to throw money at it, doesn't make sense at all for exactly the same reasons that not fixing the national one does.

But I was struck by Nancy-Ann's comments, as well. This is an invitation to ask plans to promise something which they can't deliver when the subsidy goes away, and that is disruptive to beneficiaries most importantly. It also introduces -- it's like introducing an Asian weed into a Florida canal -- into a Minnesota canal, I'm sorry.

DR. REISCHAUER: It will freeze to death.

[Laughter.]

MR. SMITH: It introduces a competitor which distorts the ability of other competitors reliant on real market signals to compete effectively. So not only does it have the effect of potentially being disruptive if someone enters to garner a subsidy and then exit when the subsidy runs out, but it also is potentially blocking of competitors in the market who are willing to read market signals.

So I think, Bill, there's no reason at all, based on what we know, to send a signal that we're prepared to subsidize in order to fix a problem which hasn't surfaced.

I think the arguments which you said you shared

that others had made against subsidizing nationally without knowing much argue against subsidizing regionally without knowing much. And we should leave the recommendation as it is.

MR. HACKBARTH: Help me with how to proceed here. Based on the previous conversation, I think what I'm hearing is that people would prefer to vote on this. But if we want to have an amendment that we vote on, Bill can offer an amendment and we can vote on that first.

MS. BURKE: I think Bill raises a good point. I would agree with David and with Nancy-Ann that there is great sensitivity about sending a message that would suggest that we are going to provide funding that leads people to make decisions that are poorly made.

I think the question is how we send the message that we are interested, when the time is appropriate, in finding ways to address this should issues arise, which is the question that we really won't know until we see, in fact, what the response is and we have the opportunity to -- I think the sensitivity is are we making a decision in either direction today that his preemptive of essentially making a subsequent decision once we find out what the

solution ought to be and whether it ought to be targeted.

I think what Bill was trying to do is narrow -- I don't mean to speak on your behalf -- is trying to identify where there is clearly a strong view that it not occur, which is the national plans. I think that's what Bill is saying, is that he can't imagine any scenario where we would want to subsidize that in a dramatic way with a pot of money, but that there may be instances in other cases where a fund or funds ought to be made available.

So the question is how to send that message, I think is the question that Bill is asking.

Now having spoken on your behalf, you can correct me.

DR. NELSON: I think we ought to be clear on a matter of principle and I would support the original draft.

MR. HACKBARTH: Let me propose that we vote on this. I think we can include some language in the text specifically identifying the national as an area of concern. Almost under any scenario for me, the bottom line is that we be paying, in that situation that we discussed earlier where the PPO enrolls disproportionately from low cost areas, much higher rates to the PPOs than to the local MA plans. And I

can't imagine why we would want to that, is the way I see it.

MR. MULLER: I think the combination of the evidence that we have in other topics we discussed this year, that where there's very high margins people rush in. And then Nancy-Ann's point that when those high margins go away due to policy changes, the beneficiary is the victim -- and we have a lot of evidence in Medicare+Choice -- I think is pretty dispositive to me at least that we should be cautious about sending that signal again.

MR. HACKBARTH: Let's see where we are at this. Let's proceed to a vote.

All those opposed recommendation two?

All in favor?

Abstentions?

Okay, number three. Any clarification required on this? This is the very specific issue of how the payments are calculated for the regional PPOs.

All opposed to recommendation three?

All in favor?

Abstentions?

Any clarifications necessary on four?

All opposed to recommendation four?

All in favor?

Abstentions?

Number five, clarifications? And John, again to your point, in the adjacent text we would refer specifically to the VA issue.

All opposed to recommendation five?

All in favor?

Abstentions?

Recommendations six, clarifications?

MR. BERTKO: This is one where I'm going to reraise the possible deletion just of the last four words until we know more. And it's meant only to wait for more information, along the lines of all of the robust discussion we had.

MR. HACKBARTH: Here my take on the discussion was that there was a number of commissioners interested in this. My read was a little bit different, Bill, than on the regional PPO stabilization fund. I think we're a little bit more divided here.

And so what I suggest is the process is that we vote on John's amendment to the language.

MS. DePARLE: Could I have some clarification first? I guess Scott or Nial, is the first bullet consistent or inconsistent with the position that MedPAC taken in the past about financial equality or neutrality?

DR. HARRISON: It is consistent.

MS. DePARLE: So we said before that it should be 100 percent of fee-for-service costs in each plant areas?

DR. HARRISON: Or we may say local payment areas or something like that, but it's always been that concept.

MR. HACKBARTH: So John's amendment -- and correct me, John -- is that he would drop from the first bullet in each payment area. So that the policy endorsed would be to move to 100 percent in the aggregate, which may mean that in some areas it's less than 100 and other areas it's more than 100. Which begs the question exactly how you would get there and how you would assure that it comes out to 100.

You've outlined a scenario where you might go under 100 due to the dynamics of the bidding process. But getting to 100 means that you've got to have a balanced adjustment elsewhere, and I'm not sure mechanically how you achieve that.

DR. BERTKO: I would only add the two parts that

we don't yet know enough about just that, as well as recognizing your appropriate statements about some of the floors perhaps in some of the payment areas might need to be re-examined. I would just suggest we don't lock ourselves in to this particular recommendation today. And that tomorrow -- namely next year -- we revisit it.

DR. CROSSON: Just to emphasize that I think John's amendment actually preserves the principle and also preserves some flexibility.

DR. SCANLON: These two bullets are very, very different concepts. And I guess the question would be could we vote on them separately, because you might support one and not the other.

DR. MILLER: The reason that they were packaged together is recall that when we had this discussion we were talking about financial neutrality and coming down to it from the benchmarks and up to it when somebody bids under it. So the notion of putting the redirecting in there was to say that if you bid under it, you're not taking the money away from the plans.

MR. HACKBARTH: So a specific concern would be well, if the benchmarks all stay above 100 percent of fee-

for-service and then we're also taking the 25 percent and putting that back in, the other fee-for-service providers where we've been adamant about paying for quality being budget neutral, here we're adding still more money into a system that is above 100 percent of fee-for-service. That's the reason the two are linked.

DR. SCANLON: I guess I'm reacting to the idea that I'm not necessarily buying into neutrality as much as buying into the idea of having efficient purchasing, and that we may want to bring the benchmarks down. And we may not want to give back all the savings.

That if competitors are coming in and saying we can do this for less, the Treasury should be the beneficiary of this. So I may support bullet one with John's modification and not support bullet two.

DR. MILLER: Again, you may not agree with this but just so everybody knows, the way we were going to deal with this was to say -- and I think Glenn made some reference to this earlier -- is to say in the text that this is a short run policy here. That if the bidding produces the kinds of impacts that, for example, John has suggested that this would be revisited. And if that is occurring the

Treasury then should enjoy some of those savings.

MR. SMITH: I think the question that John raises is a complicated one, but I fear that he doesn't address the complication by getting rid of the mechanism that we've used, which is the service area mechanism. The question of what do you do next? How do you decide how you balance above and below isn't addressed at all. And we're clearly not going to address it in the next 10 minutes.

But I don't know why leaving it with the formulation that we've used in the past doesn't preserve our flexibility to say gee, now we know more and we want to modify this formulation that we've used in the past.

But I think simply getting rid of the four words without proposing a way to think about when it would be appropriate to benchmark at higher than 100 percent and who would be benchmarked at lower than 100 percent in order to compensate for it on average, without giving any thought to that, I think would be a mistake to break with the way we've framed this for several years now.

MR. HACKBARTH: Okay, we need to proceed to the votes and we've got two issues on the table about how to structure this. One is whether we ought to separate the two

bullets. And then the second is a modification in the language, the final four words of the first bullet.

You heard my reason for thinking that the two ought to be packaged together. Let me just see a show of hands on who would like to see them separated for purposes of voting. Five.

DR. NELSON: It's usually in order to allow separation of the question, from a parliamentary standpoint. It doesn't mean that they can't be combined in the report. But I think if someone has an objection to one and not the other, that ought to be reflected, since our votes are recorded.

MR. HACKBARTH: Okay. Okay. So we will vote separately on them.

Let's address the issue of each payment area. I already can tell you're a better parliamentarian than I am. I think the proper thing to do it is to allow John to offer his amendment to the language and vote on that.

So let's see a show of hands on John's amendment. All in favor of John's amendment? Nine.

So the amendment is adopted.

Now we're voting separately on each of the bullets

with the first one without in each payment area. All opposed to that?

All in favor?

Abstentions?

Then on the second bullet, all opposed?

All in favor?

Abstentions?

DR. MILLER: On what just happened here, and I'm going to have to go through this because I've got to report this out.

We had a show of hands on people who were interested in removing in each payment area, and there was enough critical mass that we said okay, that's going to be the recommendation.

So then we took a vote on that recommendation which now is the top half of that, minus the last four words. And our record of that is everyone supported that. Is that incorrect?

So does everyone support the top bullet of this without the last four words, in each payment area? That's the question.

Then the second vote we took was on the bottom

half, as written, as a second recommendation. And we recorded unanimous on that. Was that incorrect? We got it? Okay.

That's what I thought happened.

MR. HACKBARTH: Are we ready to move on? That's it.

So it is 12:06. We will have a very brief public comment period. We are, I think, a day-and-a-half behind schedule at this point.

In view of the fact that we're a day-and-a-half behind, we'll have a very brief public comment period with all of the usual ground rules, which I won't repeat since nobody's going to the microphone.

MR. HACKBARTH: We will therefore break for lunch and reconvene at one o'clock.

[Whereupon, at 12:07 p.m., the meeting was recessed, to reconvene at 1:00 p.m., this same day.]

AFTERNOON SESSION [1:12 p.m.]

MR. HACKBARTH: First up this afternoon is dialysis payment.

MS. RAY: Good afternoon. This is the fourth in a series of discussions that we have been having about the issues raised by the MMA and the new regulations with respect to outpatient dialysis payment policy. I'd like to acknowledge the important contributions of Dana Kelley and Margo Harrison in putting together your draft chapter.

Recall that MedPAC has called for modernizing the outpatient dialysis payment system. In 2001, we recommended broadening the payment bundle and adjusting for factors that affect providers' costs. In 2004 we recommended implementing pay for performance for both dialysis facilities and physicians treating dialysis patients.

Together, these recommendations should improve the efficiency of the payment system, better align incentives for providing cost effective care, and reward providers for providing high quality care.

The MMA does take some small steps towards our recommendations, most notably by implementing case-mix and mandating a demonstration of a broader payment bundle that

is mandated to begin in 2006.

But the MMA has created some issues, however, in the current system. Under the new law, freestanding and hospital-based providers continue to be paid differently for both composite rate services and drugs. In addition, we have concerns about the design of the add-on adjustment to the composite rate.

You've seen this diagram before. It shows the post-MMA payment system for outpatient dialysis services as these services are currently being paid in 2005. We're going to be focusing now on the composite rate and the add-on adjustment first, and then the payment for injectable drugs.

We have two concerns with the composite rate payment design in 2005. First, the current policy continues to pay hospitals and freestanding facilities a different rate. This $4 different rate, on average, stems from the 1981 statute implementing the prospective payment system. When CMS implemented and set the composite rate back then, they derived this difference from cost report data from the late 1970s.

If there is still lingering concern that this $4

difference may be about case mix, the difference is not needed because now the composite rate is case-mix adjusted.

Our second concern is the design of the add-on adjustment. If the intent of the add-on adjustment to the composite rate is to address the cross-subsidy then it should be combined together with the composite rate.

We also have a concern with the MMA and how it recalibrates the add-on. Beginning in 2006, the MMA calls for the add-on to be updated based on the growth in drug spending. This may not be good policy moving forward, that the add-on maybe be recalibrated by a factor, the increase in drug spending, that is not linked to efficient providers' costs.

Some stakeholders contend that hospitals should continue to get the $4 difference because of differences in staffing and quality, and we looked at this issue. Our analysis of 2003 cost report data show freestanding and hospitals do use different inputs. This graph compares the percentage of patient care staff that are technicians versus RNs. Now patient care staff includes dietitians, social workers, technicians, RNs, nurses aides and LPNs.

You can see here that a greater percentage of the

patient care staff is composed of technicians at freestanding facilities, by contrast for hospitals a greater percentage is RNs.

Nonetheless, quality is comparable. Here you see, first, the URR greater than or equal to 65 percent. That represents the percentage of patients receiving adequate dialysis. And you can see, it is high for both freestanding and hospital-based facilities. 92 percent of all patients at freestanding facilities are receiving adequate dialysis versus 91 percent at hospital-based.

In addition, we looked at hematocrit greater or equal to 33 percent. and here, 89 percent of all patients treated at freestanding facilities have their anemia under control, versus 88 percent at hospital-based. Nationally, 91 percent of patients are receiving adequate dialysis and 89 percent have their anemia under control. These data were derived from CMS's Dialysis Compare web site that's online.

This leads us to draft recommendation one, that the Congress should direct the Secretary to eliminate the differences in paying for composite rate services between hospital-based and freestanding facilities and combine the composite rate and the add-on adjustment.

This recommendation should result in a more simplified payment system and it's consistent with MedPAC's principle of payment not varying across sites. Although this recommendation combines the composite rate and the add-on adjustment, we of course don't want to lose sight of the big picture that we ultimately want to broaden the bundle.

We will address the budget implications of this recommendation together with our draft recommendations to refine drug payment policies a couple slides from now.

Moving on to issues with the current drug payment policy, we have three concerns. First, under current policies there are multiple ways that Medicare is using right now to pay for drugs: average acquisition payment, ASP+6 and reasonable cost.

The second issue is that payment for drugs other than erythropoietin differs between freestanding and hospital-based facilities.

The third issue is that the AAP, the average acquisition payment data, that is being used to pay for most dialysis injectables right now may not be sustainable over the long-term. CMS derived the AAP data from a 2004 report by the IG. There is no requirement for the IG to update the

pricing data.

And let me just go into AAP a little more. The average acquisition payment was derived, like I said, from the acquisition cost data that the IG obtained from freestanding dialysis providers. The IG went to the four largest chains and obtained the purchase price for the 10 most frequently used dialysis drugs. The IG also went to a sample of other facilities not affiliated with the four largest chains.

As included in the IG's report, the acquisition costs represents the purchase price reported by these providers net of all rebates and discounts.

At this point, I'd like Joan to talk a little bit more about ASP data and contrast ASP to AAP.

DR. SOKOLOVSKY: In response to some commissioner questions last month ago, we thought we'd talk a little bit more about what ASP is and how it would compare with AAP. ASP stands for average sales price but it doesn't actually represent a price that anybody pays. However, it is derived from actual market transactions.

CMS, every quarter, collects from manufacturers the price that they receive for each product contained in

the HCPC codes which are the basis for the Medicare payment system for drugs. This reflects all the discounts, all the rebates, everything that Nancy listed for AAP is also listed in ASP.

Theoretically, these two systems should produce the same results. They don't.

One of the reasons is that ASP also includes whatever money off the top that wholesalers make would still be reflected in the money that the manufacturers got for the drug, which is why ASP would have to be a little bit more than 100 percent of ASP, although the 6 percent is derived from a sample from looking at what the average provider pays and trying to get a range so that prices are included.

When we compare it to AAP, the average acquisition price, again theoretically they both should be the same. They both represent transaction prices. They both include an economic incentive for the provider to try to get the best price they can because if they can get below average they will get the additional money. So there is an incentive for providers to try to get the best deal they can.

Now we start coming into the differences and Nancy

alluded to it before. The main one is the frequency of update. AAP was collected once based on a sample of freestanding facilities and the four chains. That survey was done in 2003. In order to get the 2005 payment rate, rather than doing another sample, it was updated by the PPI for drugs which doesn't reflect the fact that in some negotiations for some drugs prices did not go up that much.

And in fact, as Nancy will show you in the next slide, for most drugs now that we have both prices available, the AAP is actually higher than the ASP+6%.

Another difference between ASP and AAP is what prices it considers. AAP doesn't consider hospital-based prices but it is specific to dialysis facilities. ASP considers the prices that physicians obtain in their offices, hospitals and other sources. It does not include everything. For example, it doesn't include VA prices, which no private purchaser could hope to get.

Theoretically, if the system was including too many irrelevant prices, the CMS and the manufacturers have the ability to limit the number of channels that it includes. Right now it includes all of those channels and that was part of the MMA.

For dialysis, this seems like less of a problem because most of the drugs used by dialysis facilities are only used for dialysis.

But probably for us, the most important reason why we think about using ASP instead of AAP is the ease of collection and comparability with other sites. ASP is something that's already being collected. It doesn't require going out and doing another survey and adding additional burden to any providers. It's based on numbers that there is already a process in place to collect quarterly.

AAP either will continue to be increased by an inflation factor that may have nothing to do with what's actually going on in the market for these drugs or would require more surveys being done periodically.

Additionally, it would put purchasing of dialysis drugs in line with the way we pay for other Part B drugs.

On the other hand, ASP is not a perfect system and I just want to move on for one final reminder. In 2003, when we look at payment for Part B drugs, we looked at the pluses and minuses of different systems and we found there was no perfect system.

One thing that's going to happen in 2006 is that there's going to be a new option for Part B drugs, and that is the Competitive Acquisition Program where some physicians will be able to get drugs from entities that are set out to provide drugs for physicians. These entities would be paid directly by Medicare based on their bids and they would be responsible for collecting the copayments for beneficiaries, and the providers would be completely out of the purchase of drug system. They would write the prescription and the drugs would be brought to them.

As the system develops, there is the possibility that that could be extended to dialysis facilities as well. Right now the physician has the choice of either getting paid ASP+6 or going to this competitive system. You could imagine that some of the smaller dialysis facilities that don't have the bargaining power of the large chains might, in fact, welcome such a system.

So I don't think we're saying that ASP should be the end all, but we think right now it has much to recommend it.

MS. RAY: This table contrasts and compares the average acquisition payment that's currently being paid

right now for the four top dialysis drugs. These four drugs together account for probably about we estimate 93 percent of all drug payments. Epo by itself accounts for about 74 percent of all drug payments.

So in the first column you see average acquisition payment. That's the 2005 payment rate that providers are currently being paid per unit of drug. The next column is the ASP+6% that CMS posted for these drugs for the first quarter of 2005. And then the last column is the ASP+6% for the second quarter of 2005.

Now I'd like to point out, you see $9.76 being paid under AAP for epo. This figure was derived from the 2003 weighted average acquisition costs of $8.98. What CMS did to set the 2005 payment rate is first inflate it by 4.81 percent, which was the PPI between '03 and '04, and then inflate it by 3.72 percent, the PPI between '04 and '05.

You'll notice first that the average acquisition payment is greater than the ASP+6% and thus, may better reflect providers' actual purchase price, the ASP+6%. I would also like you to notice the change between the first quarter and the second quarter average sales price plus 6 percent payment rates.

There have been some changes, some decreases. Again, this suggests that it is reflecting real world negotiation practices.

Another issue to consider is at what level should ASP be set at? We thought about this a little bit and we concluded that the purchase price does vary between dialysis providers. First, we looked at the IG report from 2004 and the IG reported, they found that the four largest chains had drug acquisition costs that were 6 percent lower than the ASP of the top 10 dialysis injectables. And the sample of the remaining freestanding providers had acquisition costs 4 percent above ASP.

We also conducted a survey, NORC Georgetown conducted for us, of small providers, small freestanding providers and hospital-based facilities. Preliminary results from that survey suggest that the small providers used GPOs and wholesalers to obtain dialysis injectables. By contrast, the larger providers negotiate directly with manufacturers.

Finally, we obtained IMS data for the top 10 dialysis injectables to look at differences in the purchase price between freestanding facilities and hospital-based

facilities. And there, we found that freestanding facilities were able to purchase these dialysis injectables for about 4 percent lower than hospital-based providers.

Setting the rate at ASP+6%, as Joan pointed out, is consistent with payment policies for other Part B providers, both provisions as well as the hospital outpatient department. It's also consistent with how CMS pays for dialysis injectables other than the top 10 provided by freestanding providers right now. And setting it at 6 percent may better accommodate the variation in purchase price.

That leads us to draft recommendation two. CMS should eliminate differences in paying for separately billable dialysis drugs between hospital-based and freestanding dialysis facilities; and use average sales price data to base payment for all separately billable dialysis drugs.

Again, this is consist with MedPAC's policy principle of paying the same across different sites of care.

Here are our implications for draft recommendations one and two. In terms of spending, this recommendation is intended to be budget neutral relative to

expected spending in 2006. For beneficiaries, no adverse impacts on their access and quality of care are anticipated. And it is not expected to affect providers willingness and ability to provide quality care to beneficiaries.

Now I'd like to move on to our third draft recommendation and this addresses a technical issue. Recall that hospitals right now are currently paid reasonable costs for drugs other than erythropoietin. To implement our draft recommendation budget neutral, that all drugs are paid using average sales price, it will be necessary to collect the per unit payment data and acquisition cost data for these drugs provided by hospitals. That is, we need to collect data to calculate the impact of paying ASP to hospitals instead of reasonable costs.

One potential source that we looked at are the claims submitted by hospitals. We spent a fair amount of time looking at these claims data but we concluded that we were unsure about the accuracy of the payment per unit data that we derived from the claims data because hospitals are not paid according to the number of units they report.

Now it just so happens that the IG is mandated to conduct a second study on dialysis injectables. This study

is due to the Congress on April the 1st, 2006. And so this would probably provide an excellent opportunity to collect this data.

That leads us to draft recommendation three, that the IG should collect data on the acquisition cost and payment per unit for drugs other than erythropoietin provided by hospital-based providers.

We don't expect, in terms of spending, that this will increase federal program spending relative to current law. No adverse impacts on beneficiary access and quality of care are anticipated. When this recommendation is implemented, some facilities could receive higher payments or lower payments but it is not expected to affect providers' willingness and ability to provide quality care.

We conducted an impact analysis to illustrate the effect of our draft recommendations on aggregate spending for freestanding and hospital-based facilities. In conducting this impact analysis, to the extent possible we replicated CMS's approach that they set forth in the final Part B rule. And our objective was to maintain budget neutrality, as specified in our recommendation, to pre-MMA spending levels in 2006.

So this impact reflects several factors. And actually, before I get into that, let me just say that the table you see in front of you represents total payments in 2006 dollars. The first column that's titled pre-MMA are the payments providers would have received if Medicare had kept on paying according to pre-MMA payment policies. The last column, entitled MedPAC's recommendations, is 2006 spending implementing MedPAC's recommendations.

So the impact reflects, first of all, the changes that have already been implemented by CMS in its final Part B rule when it implemented the MMA. That is, dollars got transferred from freestanding to hospital-based facilities when the add-on adjustment to the composite rate was implemented.

This impact also reflects our draft recommendation of doing away with the $4 difference and spreading that $4 difference across all treatments, and paying according to average sales price plus 6 percent. It also reflects our recommendation of combining the composite rate and the add-on adjustment and, for both pre-MMA and MedPAC's recommendation, we have updated payments using our most recent update recommendation for composite rate services by

2.5 percent.

So the intent is budget neutrality to 2006 to pre-MMA. So you will notice here a $41 million budget neutrality factor, and that is applied to composite rate services. So across both facility types total drug payments will go down by about 13 percent, composite rate payments will go up by about 10 percent, but overall this is being done in a budget neutral fashion.

There is a distributional impact. Payments to freestanding providers will go down roughly by about 0.5 percent. For hospital-based facilities, payments will go up in total by about 3 percent. But again, I want to stress that this impact analysis is purely illustrative. If our draft recommendations were implemented, CMS would have to conduct an impact analysis which would differ, the last bullet point. One of the reasons is because we assumed constant payments for non-epo drugs provided by hospital-based providers. We had no basis of determining what their pre-MMA payment per unit data was.

At this point, I'd like to raise four other issues for you to consider. We raised some issues in your draft chapter about the wage index adjustment. We will be coming

back to you in September with the results of our detailed analysis that looks at the impact of using more recent geographic areas on providers payments.

The second issue is with respect to the current case mix adjustment as implemented by CMS. Providers have raised concerns about how it works, particularly with how age is being adjusted for. It's basically a U-shaped curve, and what I mean by that is pediatric cases using the age adjuster are paid the most. Then patients 18 to 44, and then patients greater than 80 years of age. They have raised concerns about that.

We asked Chris Hogan of Direct Research to look at this data and he ran several regressions for us and confirmed CMS's findings, that indeed the relationship between providers' costs and age is U-shaped. We're going to be continuing to work on this issue, as well as case mix adjusting for the broader bundle, and we'll come back to you hopefully this fall with additional information on that.

The third issue I'd like to talk with you about is an upcoming issue, we think. It's sort of the intersection between Part B and Part D coverage for drugs. The issue here is whether Medicare pays for the same dialysis drug

under both Part B and Part D.

CMS has not finalized their decision about this and we will be following this closely and we may be coming back to you with this issue. This is particularly important specifically as the demonstration starts next year and CMS pays for dialysis drugs under a broader Part B payment bundle.

The last issue I'd like to address is an issue that we commented on in the draft chapter. And this applies for both the current payment system and the broader bundle. In the chapter we included a statement that an annual review of the rates is essential for dialysis given the current low margins. Congress and CMS should not assume, as they did in the 1990s, that regular rate increases were not necessary because of low margins.

That concludes our presentation. Thanks.

MR. HACKBARTH: Questions, comments?

MS. DePARLE: Nancy, thanks for all of your hard work on this.

I want to go back to page 20 or to slide number 20, just to make sure I understand the impact analysis.

When you say that payments to freestanding

providers declined by 4.5 percent and payments to hospital-based providers increased by 3 percent, that's from the combination of all of the policies that we're recommending; is that correct?

MS. RAY: Yes, and that's relative to pre-MMA spending.

MS. DePARLE: I guess what I'm trying to tease out is how much of the impact to freestanding providers or what impact was there on freestanding providers from the decision last summer by CMS about the way that it spread the drug adjustment?

MS. RAY: CMS estimated that it lowered total payments by 0.6 percent. Now the pickup of the --

MR. HACKBARTH: Nancy, that's total payments to the freestanding?

MS. RAY: Yes, sir. So by limiting the $4 difference, what that does in turn is increase total payments roughly by about 0.2 percent.

MS. DePARLE: So the net is 0.5.

MS. RAY: 0.5 but that's actually rounding. It was actually 0.45 or something like that.

DR. MILLER: There some of the drug stuff going on

here, too.

MS. DePARLE: I guess what I want to be certain of, we've talked about this several times and I disagreed with that policy decision that was made last summer. This doesn't make that worse though? This actually improves that slightly?

MS. RAY: Yes, slightly.

MS. DePARLE: And then going forward, what we're trying to do here is create a level playing field for payments so that there would not be, at least theoretically, an incentive for a nephrologist to say choose one versus the other, or a patient, other than their views about quality which are certainly legitimate in a given location, or convenience of the patient or things like that. Is that correct?

MS. RAY: That's correct.

MS. DePARLE: Good, that's what I wanted to be sure.

DR. SCANLON: Thanks. I think you did a great job sorting out a pretty complicated payment system. I agree with you completely about the idea that we shouldn't be paying for these drugs in several different ways.

I guess I'd raise something for us to consider, which is that in the MMA, when the Congress for the Part B drugs adopted average sales price and the plus 6 percent, they also had a provisions saying we're not sure that that's the right number and we want the IG to go and look and see if the people that we're buying from are buying at a different price. And that may have been what you were talking about in terms of channels, that at some future point we could exclude some channels.

But I go back to when we did work on this at GAO and the IG was working simultaneously. Our biggest problem was always access to data and that we really didn't have a good fix on exactly what the distribution of payments or costs to providers were.

I would raise the issue that we consider urging that the IG be given the explicit access to the information on acquisition costs from providers and simultaneously being asked to look at acquisition costs periodically, and maybe using ASP as the inflator benchmark as opposed to the actual number.

Because there's two things about ASP+6% that are potentially an issue. One is if the ASP represents more

market segments than what we're dealing with. And secondly, we don't know what the 6 percent does in terms of covering a share of the distribution of the providers that we're working with. The fact that when you compared those numbers before, you had ASP+6% versus an average alone. And that's kind of telling by itself.

I think we need to know more about the actual distribution of acquisition costs to really set prices well over time.

DR. SOKOLOVSKY: One of the things we're trying to do right now is to find a commercial data source that will enable us to look at prices on different channels and see, in fact, what the variation is, just to address that particular issue.

MR. HACKBARTH: Do you have a slide comparing ASP and AAP that you can put up? Bear with me, I'd just like to go through these one by one and try to compare in my own mind what the pros and cons of the two methods are.

As I think Joan said, in a perfect world, if we had perfect instantaneous information, these two would come together. One is the price as seen by the manufacturer's perspective, and the other is the cost as seen by the

provider who's buying it. In the real world, they need to match up except with regard to the middleman, the issue of the wholesaler in the middle; right?

So on that basis, in a perfect world with perfect information, there would be no inherent advantage of looking at it from one direction or the other. You should be getting the same price signal either way.

The second issue is if you use one or the other do you get better incentives? Do you make the market move towards efficiency better by using one or the other?

And here again, I don't think that one has an inherent advantage over the other. In each case, you're using an average. That's the key. So long as you're using an average, people buying the drug have an incentive to try to get at the lowest possible cost so they can be under the average and get an extra little bonus. In that sense, it operates like a prospective payment system. So it's a wash conceptually on that issue, as well.

Then we get into the frequency of update. As a practical matter, there is a difference on this score right now. The ASP is updated on a more regular basis that the AAP, although it's not clear to me that that's an inherent

difference. You could change the schedules so that you get the same frequency of update either way, although -- and we'll come to this in the last bullet -- it may require an additional investment of resources to get the same frequency through the AAP.

The fourth bullet down, price differences across channels. I think this is an important part of Bill's interest and concern about this. The ASP data, as currently used, blends. And so we're not getting pure signals for dialysis providers about how much it costs them. We're getting a mixed rate. And we compensate for that with this plus 6 factor. Not specifically here but in another setting the plus 6 factor was added as a way to account for the fact that some small purchasers may not get the same favorable rates is the big ones, and then we'd be carrying that over here.

So I understand Bill's concern about the confusion, the distortion of the price signal if you're using the ASP as opposed to something specific. The question that leads me to is can you get the ASP data on a channel specific basis? Is that a resolvable issue?

DR. SOKOLOVSKY: Yes, you can. And in fact, there

was a lot of debate at the time of the MMA about which channels specifically should be included. Right now they've included most channels, although again not, for example, the VA and not for charity care.

There were discussions about whether PBMs should be included or not included but it is possible. You get the channel by channel and manufacturers could include or not include different channels.

MR. HACKBARTH: So for the specific purpose of paying for dialysis services, we could have a channel specific number, not even have to have the plus 6, although there what we lose is we have a different -- you say it. What would we lose by doing that?

DR. SOKOLOVSKY: The problem with doing that, The good part would be we'd also have hospital included, and so that would be a good thing. But the difficult thing is that the channel, in general, is called clinic channel and that would include both physicians in their offices and dialysis providers. I don't know that it is possible to separate those. The way I've seen it, those have been combined.

DR. SCANLON: Given that all we've been talking about today about equality, wouldn't we want to pay the

same, same regardless of setting? I think one of the issues, in terms of trying to get -- because the ASP data is coming from the manufacturer. The question is the manufacture selling to a wholesaler, in some respects, loses track of where the drug goes. And so, if we were trying to refine things beyond -- if we're trying to distinguish physician office from dialysis center, if one wholesaler is serving both we don't capture that; right?

MR. HACKBARTH: I'm not sure I heard all of that, Bill. But you're saying that if you really want to get accurate channel pricing, it's better to do it by surveying the providers as opposed to through the manufacturer channel?

DR. SOKOLOVSKY: The channel, actually the manufacturer is reporting what they get back, not what they sell it for. So they have to add in their rebates, add in their post discounts, add in their volumes. It's not an easy task and it's fairly contentious, but it is after.

DR. SCANLON: I'm just saying their definition of channel may not correspond to what we think of as providers. And it may not be a big issue. This is the king of thing that should be explored to see whether or not it's a big

issue.

I think the other thing that needs to be explored is this idea that if we decide we want to get information from providers, we shouldn't necessarily think that we need to do it every year. We can potentially use ASP as the update factor and it could have a very different result than using the Producer Price Index because that's an aggregate. The AAP is coming in drug by drug.

DR. MILLER: On the basis of some things you said earlier and what you just said just now, I want to see if I'm getting a sense of what you're saying.

At first when you were saying it, I thought that you were concerned that ASP might be a problem because it mixed channels. But then you just made the statement of, but on the other hand, if you wanted to pay neutrally across setting.

And so what I'm hearing are really two concerns, potentially. Is it possible -- this is you speaking -- that ASP might be complicated because you have this wholesaler intervention which you don't have on the average acquisition price, number one?

And number two, because of that and perhaps some

other issues, how you backfit your discounts and so forth into the ASP, you're looking for sort of a periodic check on the provider side using the acquisition costs to figure out whether the ASP is actually tracking.

DR. SCANLON: Right. On the first part, the issue about how concerned I am about channels, it's really coming from the MMA itself, which is the MMA instruction of let's go check out whether the channels matter. It turns out if they don't, then we don't have to worry about that.

In terms of the consistency of our principle of paying the same, that may be different in terms of whether channels matter than if somebody came in and said I do want to pay dialysis centers different than I want to pay physicians offices.

DR. MILLER: We're going to eventually have to get to a recommendation and vote. What I view your comments as saying, and I don't want to lead too much here, that you could go along with this recommendation as long as there were a couple of things, potentially another recommendation -- we're already kind of into this the IG needs to do something anyway bailiwick, and I don't want to get too far out in front here.

But we could boost that a little bit and address your periodic issue. And then would that give you enough comfort with the recommendation on hand?

DR. SCANLON: I think given the IG instruction, but also making clear that we would like the Congress to make sure the IG has the authority to do this. One of the biggest difficulties we had in doing the Part B drug work was we were relying upon voluntary admissions of what they were paying for the drugs. That was very hard to get. I don't know how well the IG did, in terms of the survey, in terms of getting responses from providers. That was the issue that we had and they had in the past.

MS. RAY: I don't recall from the IG's report that they had a problem. Again, they went to the four largest chains. The four largest chains reported their information. And then they went to a sample of freestanding.

DR. SCANLON: We're no expanding this, in some respects this is a Part B drug issue as well as dialysis.

MS. RAY: That's right.

MR. HACKBARTH: Other questions, comments on this?

MS. DePARLE: What is the recommendation now?

MR. HACKBARTH: Mark is drafting as we speak. I

know this is a bit arcane, but it's an important issue and we need to try to get it right.

Anybody know any stories?

DR. MILLER: What I might suggest is that you would like to start talking about the other recommendations. This is number three and maybe I'll have something by the time you get to it.

MR. HACKBARTH: Okay. Does everybody understand this issue, about leveling the playing field? We've got money flowing two directions and the net effect was, as described earlier, a slight reduction for the freestanding relative to pre-MMA.

MS. RAY: No, this is for composite rates it would actually increase freestanding total spend by about 0.2 percent because you're eliminating the $4 difference.

MR. HACKBARTH: I'm sort of packaging along with the regulatory change that spread the drug add-on.

MS. RAY: Yes, that's correct.

MR. HACKBARTH: I keep going back to that because I think that was very important from the industry's perspective.

MS. RAY: Yes.

MR. HACKBARTH: So at the end of the day, when you do the change in the $4, coupled with what the reg did last year in terms of spreading the drug add-on across both freestanding and hospital-based, we have a net effect of those two policies together of a slight reduction in the freestanding of like 0.5 percent, and the 3 percent increase in the hospital-based, all done on a budget neutral basis.

So any questions or comments about this recommendation? If not, are we prepared to vote on this?

All opposed to recommendation one?

All in favor?

Abstentions?

Okay, draft recommendation two. Any questions or comments about this?

MS. BURKE: Glenn, I just have one question and ill reminds me that I asked this question last time. And I just want to reassure myself once again. And that is the extent to which, either using the ASP or the acquisition price, has any demonstrable effect on holding the rate of increase in the costs down on drugs. Does the use of one versus the other have any appreciable impact on how quickly those costs increase? I think the answer to that is no, but

I just want to --

MR. HACKBARTH: It would depend largely on the updating issue.

MS. RAY: If we take average acquisition payment and we just continue to update it using a PPI, there is --

MS. BURKE: No appreciable difference. That would have, but if we don't.

MS. RAY: Where as ASP should better reflect the actual negotiations between manufactures and providers. By using this PPI updated payment rate, it's not going --

DR. REISCHAUER: It's going to be less accurate but you don't know whether it's going to be higher or lower. And if you do, I want to hire you for my consulting company.

DR. SCANLON: The problem with the ASP potentially is the fact that if the manufacturer says to the purchaser don't worry about this price increase, next quarter we're going to submit the data and you'll be getting an increase from Medicare pretty soon.

The problem with the PPI, I think, that you identified is that it's an aggregate number across a whole series of drugs, whereas you were talking about what's happening with some individual drugs which are not

necessarily going up at the same rate.

If we can find a way, maybe using ASP that way, combined with acquisition costs will give us a better track on these individual drugs. But there is that potential through the update. Freezing a base and moving forward with a trend if the trend is restrictive is more of an incentive to control costs.

DR. MILLER: I want you guys to stay with me. I think the answer to this is you can't be sure because there will be negotiations that are taking drugs up and down and there's aggregate versus individual drug affects. But just for the moment, if you took AAP and just inflated it, then basically you have an artificial price. And if that price for any given drug is above the price of what a purchaser's getting, you're right back into the AWP situation where it sort of saying I'll give you a lower price and you can play the spread.

I think that's a risk that we wanted to get away from and some of the reason that we're trying -- whether it's AAP or ASP, trying to track what truly people are picking off as prices.

DR. SCANLON: You're right, it's not quite as bad

as AWP because AWP was totally fictional. The problem here, the reality here is how frequently you update matters because if you can tell somebody -- how frequently you update with real data.

If you would tell somebody don't worry, you're going to get your update based upon what we're charging you now, they're going to be less resistant than if the update is independent. Our PPS systems always make the changes independent.

MR. HACKBARTH: Although even with frequent updates, you still win. You do better if you get a lower price. There's still a reason to resist that. You're always better off bargaining hard.

DR. SCANLON: But your resistance is weakened when you know that you're going to get an increase in the future. You need to keep continuously revisit on some periodic basis what acquisition costs are because that keeps everybody more honest.

MR. HACKBARTH: So to get back to Sheila's question, what I think the answer is based on all of this is that since both are based on average, you still have the inherent incentives and so there's no basis to choose there.

One could be better than the other based on the frequency of updating issue, but which is better is actually indeterminate. You don't know. So it's not a clear basis for choosing one or the other right now. Is that a fair summary?

DR. SCANLON: One last thing. The compromise that happens in states sometimes, when they're trying to deal with this, is they will set a base, trend for a while and then reset the base, using the length of the trend to try and encourage some discipline during that period. The key, of course, is what you pick as your update factor during the trend period.

MR. HACKBARTH: Other questions or comments on this, on number two?

All opposed to number two?

All in favor?

Abstentions?

Mark?

DR. MILLER: We're up to three and I'm assuming that the sentence that I'm going to read to you would continue to just be part of this, as opposed to two separate because we're doing roughly the same thing.

But I think what we would do is we would say the Secretary should be given authority to periodically collect average acquisition price data from dialysis providers to compare with average sales price data.

I went to the Secretary because I'm granting an authority as opposed to asking the inspector general to do an analysis, but presumably the Secretary delegates this to the IG.

One more time slowly, the Secretary should be given the authority to periodically collect average acquisition price data from dialysis providers to compare with average sales price data.

Or some better construction of that sentence.

DR. CROSSON: Just one question. Based on what we heard, would you want to be more specific in terms of the time frame? Because it sounded like, from what we heard, even within a period of a year or two, given the renegotiation, you can get a fairly large deviation between the acquisition price and the sales price. And if you wanted to use this mechanism to get accuracy, maybe something more specific than periodically would be important.

DR. MILLER: I don't know, Bill, if you have an opinion in this, not less than two years, three years?

DR. SCANLON: I'd worry somewhat about the burden on this. There's going to be resistance to this.

DR. REISCHAUER: Put it in the text.

DR. SCANLON: I think stay with periodically.

The one issue I would ask to think about, and maybe it's not today, but is the idea of for all Part B drugs should we be looking at this in the future? This same clarification of the IG's responsibility and authority.

DR. MILLER: Joan and I were actually discussing that and we weren't sure whether you reaching to just dialysis or reaching beyond that.

DR. SCANLON: I think it's a question of Part B drugs. We are trying to do administered prices for Part B drugs. And the question is we'd like data to make those prices as efficient and as rational as possible.

DR. SOKOLOVSKY: Who wouldn't want more data? You're talking to a researcher. It sounds great to me. I just thought, since we haven't really discussed it, whether this was the right time to put it. And given that we will begin with the oncology report.

MR. HACKBARTH: What I would suggest we do is make the recommendation specific to dialysis and we can say in the text that similar issues are raised across the board with Part B.

Okay, are we ready to vote on recommendation three as amended?

All opposed?

All in favor?

Abstentions?

Okay, thank you very much.

Next we have Rachel with the subject of handling costs for drugs delivered in hospital outpatient departments. This is a mandated study, as you will recall.

DR. SCHMIDT: Good afternoon. In March, Chantal and I described work we've done on a study that was mandated by the MMA dealing with payment for hospital pharmacy and nuclear medicine services in the outpatient PPS.

The draft study that it was in your mailing materials will become a chapter in MedPAC's June report and the study is officially due July 1. Today, I will quickly reacquaint you with the topic, describe some additional findings, and then you'll consider two draft recommendations

resulting from this research.

Although I'm giving the presentation today, Chantal Worzala contributed a great deal to this work, as did Sarah Kwon.

The MMA made a number of changes within the outpatient PPS and one of those was to base payments on hospitals' acquisition cost for certain radiopharmaceuticals, drugs and biologicals that have been on the pass-through list. GAO has been asked to estimate acquisition costs for these products by surveying hospitals. We've been asked to determine whether or not the outpatient PPS needs a payment adjustment to cover the handling costs hospitals incur for storing, preparing and disposing of these products. And if so, how should it work?

Previously, payments for these drugs, biologicals and radiopharmaceuticals were based on average wholesale prices. And generally those payments were high enough to cover both the acquisition costs of the drug and pharmacy handling costs. In other words, payments for handling costs was included in payment for the product itself.

But beginning in 2006, CMS will use information from GAO's survey of hospitals and perhaps information about

payment rates to physicians for Part B drugs to set payment rates for these products in the outpatient PPS based on acquisition costs.

So the question posed to us was whether the cost of providing pharmacy and nuclear medicine services are large enough to worry about, that is whether we need some sort of payment adjustment? And if so, what should it look like?

Recall that many of the drugs and biologicals covered in the study are used to treat cancer, rheumatoid arthritis and other conditions. Radiopharmaceuticals are radioactive agents used for diagnostic procedures such as nuclear imaging or therapeutic procedures that target drugs and radioisotopes toward specific types of tissue.

This is just a quick reminder that the study is covering the costs that pharmacies and nuclear medicine departments incur when they store, prepare and dispose of these products. The study is not about how much it costs for hospitals to purchase the products in the first place or the cost of administering them to patients.

For example, we're looking at the costs of preparing a chemotherapy infusion but not the hospital's

cost of acquiring the drugs or costs incurred for the infusion suite to administer the IV to the patient and monitor him or her for adverse reactions.

Here is a graphical depiction of what we mean by handling costs. We mean things like the overall management of the pharmacy or nuclear medicine department including what can sometimes be significant costs for regulatory compliance and quality control. We also include the broad functions of storing drugs and radiopharmaceuticals, preparing them to administer, delivering them within the hospital to where they will be administered, and then disposing of waste products within the pharmacy and nuclear medicine departments. Each of those functions involve some of obvious costs, such as the salaries and benefits of pharmacists and pharmacy technicians, the specialized equipment they use, their supplies and support contracts.

To answer the question of whether a payment adjustment is needed, we built on some previous MedPAC research about hospitals' charge setting practices and we talked with lots of stakeholders and heads of hospital pharmacies. Our conversations with stakeholders indicated these costs are not negligible.

Many of these products has specific storage and preparation requirements. Hospitals also have safety and regulatory requirements with significant costs. From earlier research, we found that most hospitals do not have separate charges to cover their handling costs. Rather they mark up charges for the drugs sufficiently to cover acquisition and handling costs.

Date are scarce on the magnitude of handling costs. We looked at cost report data from the state of Maryland, which has its own unique regulatory structure, as well as data from Medicare cost reports. As your mailing materials show, in recent years the direct costs of labor, benefits and supplies appear to be on the order of 25 to 28 percent of direct costs for pharmacy departments where the remaining 72 to 75 percent is the acquisition costs of the drugs.

So handling costs can be a sizable expense. Based on this information and our conversations with stakeholders, we concluded that a payment adjustment is needed in the outpatient PPS. If Medicare did not include any adjustment, it could affect the distribution of payments. Hospitals that provide a greater share of these products, such as

those that specialize in cancer care, would be more affected than those that provide fewer.

So we think that the answer to the first question is yes, but also that any payment adjustment should be budget neutral. The key reason is that when the outpatient PPS was created, payments were based on hospital charges that included handling costs. So the original payment pool, which is based on hospital charges reduced to costs including handling costs. In recent years, relative weights derived from charges have also reflected handling costs. Arguably then, if CMS makes an adjustment to pay for handling costs more directly, it should redistribute resources among weights in a budget neutral manner.

Here's the first draft recommendation based on those findings. The Secretary should establish separate budget neutral payments to cover the costs hospitals occur for having separately paid drugs, biologicals and radiopharmaceuticals.

This recommendation should not affect program spending if it is implemented in a budget neutral manner. Any effects on beneficiaries and providers are likely to be small. Since it would lead Medicare to pay for handling

costs more directly, it could help to ensure beneficiary access to pharmacy and nuclear medicine services.

The recommendation might also redistribute a small amount of payments among hospitals, depending on the mix of products they provide.

The second part of our study was to think about what a payment adjustment should look like. Last month we talked about these three approaches. A markup over the acquisition cost of drugs would be administratively easy but there is no reason to think that handling costs are directly related to the price of the drug. Drug prices depend on how new they are, whether there are therapeutic substitutes and how scarce they are in the market.

Some new drugs have low handling costs because they're produced in forms that are near ready to administer to the patients while some older the drugs may require a lot of preparation time. For that reason, we think it would be preferable to base payments for handling costs on some measure that more closely reflects real resource use.

Within the outpatient PPS, one could create a handling fee that's tied to each drug or radiopharmaceutical administration that the pharmacy or nuclear medicine

department prepares. However, this would require that CMS set up new codes and set payment rates which could be more burdensome. And hospitals would need to develop charges for their pharmacy services and begin billing Medicare for them.

The last option we talked about was to develop broader payment bundles that include the drugs and radiopharmaceuticals with related services. This option is more in line with the original conception of the outpatient PPS, but it would require legislative action.

Let me quickly summarize the work that we did to test whether the second payment approach is feasible. With the help of the Lewin Group we developed a framework to define what handling costs are clearly, so that there would be a common understanding of what they are from one hospital to another.

Lewin convened a technical advisory panel for us, made up of experts in pharmacy, nuclear medicine, hospital finance and cost accounting. Those experts helped us to group the study drugs, biologicals and radiopharmaceuticals into categories that they thought would have similar handling costs. Then Lewin conducted a small number of case studies to check whether the framework we developed was

understandable and whether the categories of handling costs made sense to practicing clinical pharmacists.

After a few adjustments to the categories, the hospital pharmacists and our expert panel members agreed on what category to put each drug in about 89 percent of the time. The case study facilities also agreed to estimate what their handling costs are for at least one product in each category, so Lewin was able to collect information about handling costs for the same drugs across four different facilities.

This microcosting exercise was time consuming. The case study facilities reported it took them between 16 and 40 hours each to estimate handling costs for about seven to nine drugs, but they were able to collect the sort of information that they would use to develop charges for pharmacy and nuclear medicine services. And this is the same sort of information that hospitals need to gather to set charges for all their other services for which they already bill.

Here is a summary of the results of this test of feasibility. This chart shows you the relative handling costs across seven categories of drugs, biologicals and

radiopharmaceuticals where cost for the second category are equal to 1.0. To give you a sense of these categories, the first one includes oral drugs like simple pills. The second one includes relatively simple injections and sterile preparations where the pharmacist draws up a drug to administer to the patient. Then the categories move into more complicated services like adding drugs to a sterile IV solution, calculating the appropriate dosage for the patient and then compounding a preparation for them, preparing specialty agents that require special handling all the way up to preparation of radiopharmaceuticals.

Our technical advisory panel created these categories by looking at the characteristics of the products that are related to handling costs, such as whether they are radioactive or highly toxic and therefore required special equipment or protective gear, the mode of administration of the drug, and whether they required special handling.

Take a particular look at the last category, which is radiopharmaceuticals. We were not able to collect enough information about radiopharmaceuticals to put an exact magnitude on relative handling costs reliably. This is because most hospitals purchase commercially prepared unit

doses of radiopharmaceuticals that are in their final form, rather than preparing them in-house. And thus, handling costs are included in the acquisition cost of the product.

The small amount of information that we were able to gather from our case study facilities suggest that when hospitals prepare radiopharmaceuticals themselves, the handling costs can be many times higher than those for preparing an injection, that is category two, and higher than all the other products.

But we do not fully understand the circumstances of when it makes more sense for a hospital to compound these products themselves versus buying them already prepared. Certainly, the volume of patients receiving treatment is a key variable. Compounding is likely to be more viable for facilities that treat a large number of patients within a given day.

It's also likely that handling costs for radiopharmaceuticals should be broken into more than one category since they have characteristics that require different levels of special shielding, personnel with specialized training to prepare them, and so on. The Lewin Group is conducting additional interviews with

radiopharmacists around the country to get a better sense of what the logical categories for these might be.

This study argues that a payment adjustment is needed and that a payment methodology that uses a handling fee approach would more closely link payment for pharmacy and nuclear medicine department services to costs.

So here is a draft recommendation developed from this work. The Secretary should define a set of handling fee APCs that group drugs, biologicals and radiopharmaceuticals based on attributes of the products that affect handling costs; instruct hospitals to submit charges for those APCs and base payment rates for the handling fee APCs on submitted charges, reduced to costs.

Again, if implemented in a budget neutral manner, this recommendation would have no effect on program spending. Any effects on beneficiaries and providers would be small. By paying for pharmacy and nuclear medicine services more directly, it could help ensure beneficiary access to those services. Hospitals would incur some expense in order to develop charges for handling costs, but those would be relatively small and they would help to ensure more direct payment for those services.

This mandated study posed a very specific question to MedPAC, whether and how the outpatient PPS should pay for handling costs. We've tried to respond directly to that question with the recommendations we just went through. However, it's also important to step back and consider the issue of unbundling within the outpatient PPS.

Early versions of the outpatient PPS originally bundled payment for drugs and radiopharmaceuticals into related procedures. But over time, a series of legislative and administrative actions have led to more narrowly defined bundles, particularly for drugs.

There is tremendous variation in degree of bundling. For surgeries, the bundle is large and includes cost for all the hospital staff and supplies needed in the operating room and during recovery. By comparison, all drugs that cost more than $50 per administration have their own APC. So we have about 450 APCs that cover clinical visits, procedures and diagnostic tests accounting for about 90 percent of payments, and 300 APCs for drugs that account for less than 10 percent of total payments.

This granular approach to paying for drugs takes away the incentives for efficient use of services that are

built into a larger payment bundle. Broader bundles leave the decisions about the most appropriate and efficient mix of services to use to providers. But as payment categories become unbundled, hospitals have incentive to use more of the drugs for which they are assured a separate payment.

More bundling is desirable from the perspective of creating incentives for efficiency. For example, a bundle might include an episode of chemotherapy treatment rather than having separate payments for each drug, handling fee and administration provided to a cancer patient. This might provide better incentives to let providers decide the most appropriate mix of the component services.

However, creating broad bundles requires some significant research to encompass the appropriate mix of clinically similar procedures and services. Nevertheless, we intend to take up this issue for the future and we hope that CMS will pursue it as well.

MR. HACKBARTH: Questions or comments?

MR. MULLER: Thanks Rachel, and your colleagues, for a very helpful chapter here.

Since part of the initiative here to look at this was to deal with the pass-through drugs and the various new

drugs that are coming on, how would you implement the second one when new drugs come out? Would you assign them to one of these seven categories and have them be there for the while, until you had cost and charge information on them?

DR. SCHMIDT: I don't know that we've thought that through clearly yet, to be honest with you, and we're not really taking a stand necessarily on how to change the pass-through system. But it would require at least -- now, I'm speaking of the handling costs, as opposed to the payment for the drug itself.

MR. MULLER: I understand.

DR. SCHMIDT: I think it might be possible, with some technical advice from specialists, to put new drugs into one of those categories. But again, the chapter itself does not really opine on that.

MR. MULLER: I know it doesn't. That's why I was asking how you would do it.

First of all, getting accurate information is going to be pretty complicated, as you know, implicitly with all these drugs. And obviously on the new ones where there's often a lot of patient desire and physician desire to get them out to the patient immediately. Having that

kind of information you're looking for in recommendation two or option B, I think could take awhile to put together.

There's obviously a lot of virtue, given how we generally approach the payment system, to go toward the bundling. But when you think about how difficult that is to do, in light of all of the other things CMS is working on, my guess is it's far away from getting there. So we're really probably then looking at options A or B.

I can see A is a lot simpler to implement but not fair, the way I read the chapter. And B is fairer, but very complicated to implement, especially with hundreds of drugs coming out in any multi-year period, and how you get that information.

DR. CROSSON: It's my understanding that the handling costs of radiopharmaceuticals has increased and is continuing to increase now because of security concerns because of the potential to weaponize these things in the dirty bomb scenario. So I just wondered whether that specifically is something, as it works through, that needs to be looked at.

DR. SCHMIDT: That's not a comment that we heard much about in the course of interviewing stakeholders. We

did hear some concern generally about securing all types of drugs, biological and pharmaceuticals, those that are in scarce supply. They've been concerned about the safety of those, but not the radiopharmaceuticals in particular.

MR. HACKBARTH: Others?

Are we ready to vote?

MR. MULLER: Let me make this point, that the option we're voting for will make the costs even higher and in a world where we're trying to focus on costs, we probably have more fairness.

But there's a reason why hospitals and other people have routinely marked this up on acquisition, because it's just easier to do. And to get that kind of information we want here takes work and will increase the cost of the program.

I don't know enough about it to know what the trade-off and the virtue is, but there's a lot of work in implementing this recommendation. But I do think it's fairer than option A, so I'm making the point without necessarily knowing what to do about it.

MR. HACKBARTH: Okay, let's proceed to the vote on draft recommendation number one.

All opposed?

All in favor?

Abstentions?

Draft recommendation number two.

All opposed?

All in favor?

Abstentions?

Okay, thank you very much.

The next item is critical access hospitals.

DR. STENSLAND: Good afternoon.

Today we're going to talk about our Congressionally mandated study on critical access hospitals. We will first answer some questions from our last meeting regarding the necessary provider provisions of the CAH program, clarify the difference between CAH payment rates and PPS payment rates, present data on the relationship between CAH volume and quality, discuss how the Medicare Prescription Drug Improvement and Modernization Act of 2003, the MMA, will affect the CAH program, and present draft recommendations for improving the program.

As we told you last time, many small hospitals were facing low volumes, high costs and low margins in 1998.

Following conversion to CAH status, Medicare payments and profit margins increased substantially. With improved profit margins, CAH closures almost ceased. The program has succeeded in helping small hospitals. Which raises the question of which small hospitals are being helped?

Last time I mentioned that the benefits of CAH status were available to almost all of the nations small or rural hospitals due to each state's ability to override requirements that a hospital be 35 miles by primary road or 15 miles by secondary road from another provider. Some of you asked whether CMS felt it had the discretion to reject states rural health plans because they thought the state's necessary provider criteria were too broad. The short answer is no. We contacted CMS and were informed that they believe Congress intended to give states almost complete control over this issue.

In my conversations with individuals from state offices of rural health and with consultants who advise states on their rural health plans, it was clear that many states wanted to set necessary provider criteria broad enough so the program could help as many rural hospitals as possible. That is how a majority of the nations low volume

hospitals, 1,092 at last count, became CAHs.

We can conclude that the CAH program has been largely successful in helping a broad spectrum of small hospitals. As the slide shows, some CAHs are isolated. But we've also identified 151 that are 15 or fewer miles from another provider.

At the last meeting you asked us to compute the difference between cost-based payments to CAHs and payments for those services if the patients went to a PPS hospital in the area, the difference being the net cost of the program. To answer this question, we examined claims for services CAHs provided to Medicare beneficiaries in 2003. We then compare cost-based payments for those services to Medicare PPS rates for those services. In total, cost-based payments for inpatient, post-acute care and swing beds and general outpatient services were roughly $780,000 more for CAH than PPS payments would have been for those same services.

In addition to acute, post-acute and general outpatient services, CAHs also received cost-based laboratory and therapy payments. Unfortunately, we do not have good data on laboratory and therapy payments that is really available. However, based on conversations with

accountants and consultants, we roughly estimate that this may add another $100,000 in benefits to conversion. The sum of the $788,000 and $100,000 would mean that our sample of 498 CAHs received roughly $888,000 more in Medicare payments on average than they would have received in PPS payments for those same services.

What will be the total cost of the CAH program in 2006? After considering the impact of MMA and estimating moderate increases in patient volume and cost per unit of service, we conservatively estimate that the average difference between cost-based payments and PPS rates will increase from the $888,000 mentioned in the previous slide to roughly $1 million in 2006.

We also project that there will be roughly 1,300 CAHs by the start of 2006. Multiplying $1 million by 1,300 CAHs, we projected that the Medicare payments to CAHs will be roughly 1 $.3 billion more than those payments would have been if the hospitals have been paid PPS rates for those services.

While the CAH program increases Medicare costs by roughly $1 million for every hospital that converts to CAH status, the program also generate significant benefits for

the Medicare beneficiaries who live in isolated rural areas. Paying low volume hospitals a payment rate that is higher than standard PPS payment rates improves the hospitals financial viability. These hospitals are critical for maintaining patients' access to emergency care when the next alternative source of care may be an hour's drive away.

In addition, studies have shown that some older Americans prefer not to travel to regional medical centers for care.

Of course, not all CAHs are isolated hospitals. 17 percent of CAH payments go to hospitals that are 15 or fewer miles from another hospital. Most of these hospitals are not truly critical for patients access to care. In fact, Medicare beneficiaries may benefit if some low volume rural hospitals merge with other low volume rural hospitals to form a single hospital that has higher volume and more resources to serve their local patients.

Tim will now discuss the relationship between volume and quality of care in rural hospitals.

MR. GREENE: The Commission has discussed quality of care at inpatient PPS hospitals in its last two March reports. You reported on measures of mortality and adverse

events developed by the Agency for Health Care Research and Quality. The reports examined mortality 30 days after admission to the hospital, as well as incidents of potentially preventable adverse events resulting from inpatient care. We used the AHRQ inpatient mortality indicators and patient safety indicators.

We applied these AHRQ measures of patient safety to rural hospitals in the critical access hospital study. Your mailing material reviews previous studies of quality in rural hospitals and presents the results of our analysis. I'll now present a brief summary of our work.

Limited information is available on quality of care in low volume rural hospitals. The Institute of Medicine notes a general absence of studies of patient safety in rural settings. AHRQ presents patient safety indicator rates measuring adverse events in its annual quality report on all payer discharges with rates at the national, metropolitan and micropolitan levels. However, it does not report PSI measures at small rural hospitals.

Other researchers have studied all payer patient safety data at hospitals in different states. Studies find that rural hospitals have lower rates of adverse events than

urban non-teaching hospitals. Smaller rural hospitals tend to have lower rates than larger rural hospitals.

We examined risk adjusted rates of patient safety indicators for the five most common adverse events in rural hospitals in 2003. These were rates related to medical rather than surgical conditions. We risk adjusted rates for age, sex, modified DRG and comorbidity.

Smaller CAHs, those with 500 or fewer discharges per year, had significantly lower rates than larger CAHs for failure to rescue and three of the four adverse events we display on this slide. However, it's not possible to determine if rates are lower for smaller CAHs due to infrequency of events or due to less complete coding.

The limited literature on risk adjusted mortality at rural hospitals is dated, reported mixed findings and failed to separate out hospitals that are the size of CAHs. We believe our analysis of risk adjusted mortality is the first national study comparing mortality in hospitals with 25 or fewer beds to other rural hospitals.

We examined 30 day mortality rates for the five categories of patients with the largest number of deaths at rural hospitals in 2003. We examined all Medicare inpatient

claims, the 100 percent MedPAR file, and we risk adjusted rates for ages, sex and severity of patient condition using the APR-DRGs.

Smaller CAHs had higher risk-adjusted mortality rates than larger ones for four of five conditions. Their rates were significantly higher than larger rural hospitals for all five conditions.

Why do patient safety measures look good and risk-adjusted mortality measures look poor at smaller CAHs? Measures of adverse events in mortality reflect different dimensions of hospital performance. A facility might perform well in some areas and poorly in others.

It's also possible that better patient safety scores and worse risk adjusted mortality scores could reflect less complete coding at smaller hospitals. These hospitals may record fewer secondary diagnoses, making their patient mix look less sick and their risk adjusted mortality worse.

Finally, it's possible that CAHs may attract patients at higher risk of death who choose these hospitals voluntarily over distant a hospital. This could occur if a patient thought they were too ill to be assisted by a

distant hospital. In other words, if a critical access hospital is seen as a more comforting environment to spend one's last days, it's possible it may attract Medicare beneficiaries whose risk of death is not fully reflected in our models. In this case, the quality of care at these facilities may not be fully reflected by the risk adjusted mortality data we just presented.

DR. STENSLAND: Now we will discuss how the Medicare Prescription Drug Improvement and Modernization Act of 2003, the MMA, affects the CAH program.

One provision of the MMA allows CAHs to have distinct part psychiatric and rehabilitation units with up to 10 beds each. These units are paid prospective payment rates for their services. At the start of 2005, 15 CAHs had psychiatric units and four had head rehabilitation units. The GAO conducted a study of this provision and estimated that it may induce roughly 50 hospitals with distinct part units to convert to CAH status.

After reviewing cost report data, we find the GAO estimate is reasonable. We can conclude that this provision of the MMA will have a modest cost and may help preserve access to psychiatric services in some rural communities.

The University of Southern Maine plans to conduct a study that will evaluate the degree to which this type of distinct part unit can meet the mental health needs of small rural communities.

The MMA also raised the limit on the number of acute care patients that can be treated in a CAH. Prior to the MMA, CAHs could only use 15 of their 25 beds for acute care. The MMA allows CAHs to use all of their 25 beds for acute care.

We have been informed by consultants that some slightly larger hospitals are now converting to CAH status. However, the number of additional conversions due to this provision is expected to be modest for two reasons. First, there are not that many hospitals with an inpatient census between 15 and 25 patients. Second, hospitals may want to keep some beds available for post-acute care in order to better serve their patients and manage patients length of stay. After examining cost report data, we project that this provision of MMA will result in less than 100 additional CAH conversions.

The MMA removes states' ability to declare hospitals necessary providers starting on January 1, 2006.

This is expected to cause new CAH conversions to cease at the end of this year. Existing CAHs are grandfathered into the program. We expect most small rural hospitals in the country will have converted to CAH status prior to the deadline.

There is a question of whether Congress went far enough to restore the CAH program's focus on isolated hospitals. It could be argued that the critical access hospital program should be focused purely on hospitals that are isolated from other hospitals for two reasons. First, the CAH program could then focus its spending on hospitals that materially improve beneficiaries access to care. Second, some may argue that CAHs should not be paid significantly higher rates than neighboring PPS hospitals are paid that they compete with.

This leads us to our two draft recommendations. First, with regard to swing beds, which we talked about last time. As we mentioned, swing bed payments to CAHs are problematic for two reasons. First, payment rates to CAHs are significantly higher than they are for competing SNFs in the same community. And second, current swing bed payment rules are complex and make it difficult for hospital

administrators to compute the net financial benefit of serving one additional post-acute patient.

To address these two problems we have our first draft recommendation.

Congress should instruct the Secretary to pay CAHs a fixed prospective payment for routine services provided to post-acute patients in swing beds and cost-based payments for ancillary services. The payment for routine services would be equal to the average cost of providing routine services to similar patients in freestanding SNFs.

Paying CAHs a fix payment for routine services and cost-based payment for ancillary services is more equitable and transparent. CAH payment rates would be closer to those of SNFs that provide similar services in the area. In addition, hospital administrators are familiar with this payment method and received this type of payment in early 2000.

The implications of this recommendation are that payment rates for post-acute care will decline slightly. However, we do not expect the reduction to be large enough to reduce the number of CAHs offering post-acute services. Medicare spending would be reduced by between $50 million

and $200 million in 2006 and by less than $1 billion over the five years.

Our second draft recommendation. Congress should instruct the Secretary to remove a hospital's necessary provider status if all of the following apply: the CAH is 15 or fewer miles from the nearest hospital; and travel time from the CAH to the nearest hospital is less than 45 minutes; and if the CAH closed, more than 75 percent of its patients would be within a 45 minute drive of another hospital.

This recommendation would make the criteria for being a CAH similar to the criteria for sole community hospitals, which also have to meet either a distance requirement or a 45 minute travel time requirement.

If a hospital lost its necessary provider status, it would no longer qualify for cost-based reimbursement as it currently does. To prevent a financial shock to hospitals that lose their CAH status and hence, lose their cost-based reimbursement, Congress could implement a transition out of cost-based reimbursement.

Which is the second half of this draft recommendation. When a hospital loses its necessary

provider status, Congress could give that hospital the option of either reverting back to PPS status or receiving aggregate cost-based Medicare payments that are capped at the level provided in 2005 without an inflation adjustment.

This transition provision would prevent a decline in payments to hospitals that are currently CAHs. But over time, it would encourage low volume hospitals that lose their CAH status to merge with neighboring hospitals.

The implications of this second recommendation are that some small hospitals that are 15 or fewer miles from another hospital may close or merge with a neighboring hospital. Patient travel times may increase. Medicare spending would be reduced by between $50 million and $200 million in 2006 and by less than $1 billion over five years.

That concludes our presentation.

MR. HACKBARTH: Ray?

DR. STOWERS: Glenn is shocked that I would want to make some comments but before I go any further, I'd like to dedicate my comments to Mary, who I know would love to be here for this today. In due tradition, my comments may take a little longer than what they normally would.

[Laughter.]

DR. STOWERS: But I've got to talk faster.

The first thing I'd like to say about the chapter is that the tone is much better. I think everybody agrees on that.

And also, I want to compliment Mark and the staff for really taking the time during this last month to hear our concerns and listen. So I think all of us, Nick and I and everybody, appreciated that.

I just want to run through a few points. The number one, that I think the community out there is very concerned about, is that the mandate from Congress very specifically focused on specific things that had to do with the critical access program and we're kind of down to page 29 in the chapter before we even get to what the mandate was. So I know there's a lot of concern about whether we get into these other issues that Congress and the industry has really struggled with over time, and that's the mileage limit and the swing bed issue.

The other again, to put it in context, all of this access that we're talking about here, if we made all the changes that we're talking about in both of these recommendations here, is under 0.1 percent of the Medicare

budget that's at stake in this. So I think, even though we are applying lots of other payment principles that I think we have to adhere to here is that we still need to be remember being a prudent purchaser and what kind of access to care and that kind of thing are we getting for our money? So I think everybody agrees the money thing is pretty went off the table as far as really being significant.

As far as the first recommendation on swing beds, and again I compliment staff because a lot of us thought that if there were to be an alternatives that maybe we should go back to something like the old carve-out in looking at that.

There are some things about the old carve-out that I'm not real sure about. One is that we talked about basic and on the local PPS payments or regional or whatever, at that point. The old carve-out was based really more on Medicaid payment rates than it was Medicare. And with all of the states that are going through the crises that they're going through in Medicaid, these Medicaid rates are plummeting out there right now.

And there's no assurance in here of what PPS rates that we're talking about, nor is there any real calculation

of what the impact on these hospitals would be. We talked about there all payer balance being 2.2 percent. But what's the new margins if we do do this?

I agree with you statement. It's difficult the way it is for administrators to really calculate where they're going to be on this. But throwing in this and with no assurance of where these rates are going to be set or by whom or CMS or whatever. I'll stop if you want to...

DR. STENSLAND: I was going to say, the rates would be set for the routine services at the average cost of care for post-acute and Medicare patients in SNFs.

DR. STOWERS: We might want to make that clear because the old payments were Medicaid based. So that word Medicare may be important in there if we proceed with this. Just a thought, because the industry thinks of Medicaid. Maybe I just didn't see it in the recommendation.

MR. HACKBARTH: I think in the latest iteration of the recommendation, it actually refers to Medicare.

DR. STOWERS: And do we know a new margin on the hospitals with this?

DR. STENSLAND: We don't have a new margin with respect to how much --

DR. STOWERS: How much would this lower that 2.2 percent?

DR. STENSLAND: All we have, in terms of the effect on payments, which would be that $50 million to $200 million, somewhere in there. It would not be a huge impact on margins. Because if you look at total payments to CAHs, that's not a big part of that.

DR. STOWERS: The other thing that concerns me a little bit about the margin thing is that 2.2 percent, there are very few of these critical access hospitals that are out there not being supported by some type of outside community support, including tax bases, property tax, local contributions, foundations, that kind of thing.

In fact, many, many of them in our state could not survive without that. So I think we've got to be real careful when we talk about not Medicare margins here, but the all payers. Just another thought on that.

Again, I think it's something we really need to be studying and looking at, and I compliment that to be happening again. But I don't know if we're ready to make this kind of a solid recommendation without knowing the really impact on it.

Another thing it referred to in there was the incentive maybe even of physicians to move patients into the swing beds or whatever. The incentive is actually the opposite. You're getting paid every day while you're seeing the patients in the hospital, but once they go to swing beds you're not. So I think it's a once a week visit is paid or something like that. So the physicians actually have an incentive to keep them in the acute care beds as they're making a decision, if finances have anything to do with it at all.

On recommendation number two, I think even though mileage and isolation was a tremendous input into why we were okaying certain hospitals across the country during this time, but it was also to stabilize the overall Medicare environment within these small communities. Because without those hospitals who are the major provider, physicians leave, home health care goes away, the entire pharmacies close. There's all sorts of ramifications there that Congress was interested in.

I know we focused in here on the 15 mile thing, but sometimes that can be a minor in a world of majors when we're trying to pick a distance and trying to decide which

hospitals are there.

And also, I think we should make note in the chart that even though, evidently, the system didn't screen very well, there was a whole list of other criteria that had to be met, the number of Medicare beneficiaries, the economic status of the Medicare beneficiaries in their service area. In fact, I think there was five or six other, criteria. For us to just drop back to mileage at this point might be really getting more simplistic yet on that.

And again, I've just got to reiterate. Every one of these communities followed the procedure they were asked to by Congress and that kind of thing. And like I said, raised funds and taxes and that kind of thing.

Another thing, we've looked into just what if in a few of our local hospitals. And we found real quick that assuming that I can take two hospitals in Oklahoma, one of which has been studied here in Washington, we looked. If you can go by a back county road, they're 14.1 miles apart. Both of them are county seats, just by the way the geography lays. Both of them have tax support in their local counties. Oklahoma law does not allow tax support for county support to be transferred between counties, so

there's no way that's going to work. Neither facility is big enough to handle the problem. The infrastructure of the old Haliburton Hospital is just not there.

So that's going to mean building a new facility for sure. Where do we go in that type of scenario.

I really wonder, with this 45 rule, if the other hospitals close down, do we really know how many of these 155 would meet this criteria or would not? We don't think these two would meet the 45-minute rule, but yet they're two different counties, two different sets of patients.

DR. STENSLAND: The vast majority of the 151 hospitals that we found that are 15 miles or fewer apart from another hospital, the vast majority of those would not meet any of those three criteria.

DR. STOWERS: Would not. So the majority of the 151 would be -- okay. Kind of what we thought, too, looking at it, that they're not going to meet it.

DR. STENSLAND: There's going to be very few hospitals that are within 15 miles of another hospital but that 15 miles takes more than 45 minutes.

DR. STOWERS: So we're pretty well talking most of the 151 are going to be looking at either being closed or

whatever.

We talk about, again it's a finance thing, but 100 new hospitals of 25 beds coming in is considered to be insignificant in the chapter. But yet taking these really small at-risk hospitals and closing 155 of them is a big deal. So I think we need to resolve the difference there, although I know we're basing it on isolation principals and that kind of thing.

Anyway, I can see us studying this issue? And I hear the examples of a hospital that's two or three miles from a trauma center. And if that kind of thing slipped through the system, then I think we should go back and look at how do we clean that problem up. But it's a handful of hospitals in this country. To just put all of these 151 at risk and their communities and their economics of their community, their medical infrastructure, over an arbitrary distance, I'm just having trouble going there.

The quality thing I really want to compliment. I think that's a big step in the right direction. That's something we personally struggled with. Congress understands that. The Eighth Scope of Work is going to concentrate not only on urban but rural hospitals, which

might want to be noted.

I'm just a little bit nervous about, and you said it in the chapter. Just so people don't just see the mortality rates that are connected with the other and not take into account the coding and that kind of thing. We've just got to make that real clear that there's not anything there.

And then just in the comparison, we make the note that the comparison hospitals are similar and that kind of thing. But yet in the chart it shows that they had 91 percent or what more admissions per year on average. Unless I misread that. That is a pretty significant difference in volume and that kind of thing, when you take into volume allowances and payment and that kind of thing.

DR. STENSLAND: They maybe have twice as many admissions as the average CAH but there are some CAHs that are as big as the largest comparison hospital.

DR. STOWERS: It's just the way it came across, that they were all kind of real alike, but that might want to be pointed out.

Anyway, Glenn, that kind of sums it up. My summary to it is that I think both of these would be great

things to recommend to Congress that they study and look into it, and we come up with definitive impact and that kind of thing. But I just think it's premature to come out with these two solid recommendations.

MR. SMITH: Do we know out of the 151 how many pairs there are? Presumably, the universe of CAHs that are too close to each other to meet your three-part test, some of them are the other part of the pair that makes them ineligible. They would have to be. Do we know how many of those pairs? Because that would significantly reduce, Ray, the number of folks who failed to get over the different hurdle?

DR. STENSLAND: We couldn't find that out. I'm guessing roughly half of them maybe are pairs. So maybe you have a river and there's two towns on each side of the river and they're four miles apart. And you had a CAH in one town and a CAH in the other town. If they did lose their CAH status, then of course there's an incentive for them to decide to become one hospital with 500 admissions rather than two hospitals with 250 each to keep their CAH status. There's a lot of those pairs.

So we're not really talking, in the end, about 151

hospitals losing their CAH status. Maybe more like half that amount, if they could get together, of course, and agree to have a single hospital which is not a small political problem in some of these two towns that might be feuding over other issues for a long time.

MR. MULLER: The combined hospital might be too big, though.

DR. STENSLAND: In some cases, it would be the case. But the average CAH only has 500 admissions. And usually with 25 beds, especially now that you can use all 25 beds for inpatient care, you could probably handle 1,000 admissions in a single CAH.

DR. REISCHAUER: This actually is a segue into questions I had. But I'd like to first add my compliments to raise both on the tone and on the discussion of quality, which I think is very important. I think that you handled that very well.

I was wondering if we had any time series on occupancy rates for these hospitals and occupancy in total swing bed acute for them. And seeing is what has happened strengthening the volume in these, both the Medicare or the total volume in these small hospitals, sort of a question

that might inform us a little bit.

The other question I had is the third criterion here on closing these things was that 75 percent of its patients would be within 45 minutes of another hospital. Is this Medicare patients, total patients? And how would we ever know? Potential patients, actual past patients?

DR. STENSLAND: I think the concern here that people expressed was maybe there's a hospital here and it's 15 miles away from another hospital. But it's really getting its patients away from some distant community. And now they have to travel all the way here that they had to before, plus an extra 15.

So really the burden of proof would be on this little hospital to say oh, you're taking -- no, you can't take away our CAH status because we can show you that the majority of our patients overall are actually coming from this other distant community.

DR. REISCHAUER: So they would provide this information and maybe it would be patients, maybe it would be potential patients, we don't know.

DR. STENSLAND: My thought was that it would have to be past patients. You would say last year this is where

our patients came from and this is how far they came.

DR. REISCHAUER: It's all patients, which is probably what it should be, as opposed to Medicare patients?

DR. STENSLAND: I think originally we were thinking about all patients but certainly that could go either way.

DR. STOWERS: We brought that concept up and I'm totally for that, and especially if we go back and evaluate whether some of these that are real close ought to be kept open or not. I think this kind of a tool could tremendously be helpful in doing that.

All I was getting at a minute ago, to just suddenly draw a 45 minute line or a 15 mile long or that kind of thing. But that's tool, I think, could be very valuable. so I just wanted to echo that.

DR. WOLTER: I think I can be fairly brief, and I also thought that all the work that was done since last time was wonderful, and a very good chapter.

I have a couple of concerns, just to pick up on Bob's question. What's really not clear to me is what the swing bed change might really do. We have fragile margins in a small group of hospitals that, prior to this past

amount of data, had a string of years of negative datas. So I'm worried that without a little bit more information to make the swing bed change might have more adverse impact than we can entirely predict at this time.

Related to that, and I am clearly the Lone Ranger on this issue, but I'm just not comfortable with hospital-based SNF payment. We've had a third of hospital-based SNFs exit the market over the last few years. We've attributed all of this to hospital accounting practices, or maybe they were using the beds for higher pay patients or whatever. But we don't really have good information about what's going on there. And even in our own long-term care chapter, we're starting to raise issues about does the classification system actually capture what's going on in some facilities versus others?

So I do have a lot of angst about the swing bed change happening soon, before we have more information.

And that's another issue. I think timing on these things is somewhat of an issue. This program is so new and people made decisions based on a certain framework that was put in front of them. And are we sure that changing that framework so quickly is going to make sense?

Similarly, with the 15 mile issue -- and on this one I have more mixed feelings because I think it's quite inappropriate if we have great inconsistency across the country and if, in fact, some institutions are a few miles away from another, et cetera. But I don't know if the right framework is in place. Do we know enough to know that the criteria in our recommendation are the criteria that are going to work to deal with what the real problems are?

I'm happy to say in Montana, of our 40-some critical access hospitals, only six or so got there through necessary provider piece. One of them sits in the middle of an Indian reservation and takes care of a very unique population, sits 12 miles away from another critical access hospital, and might fall out based on the criteria we're looking at recommending. But I don't know whether it would be realistic to think that the circumstances they're dealing with could be dealt with easily by just assuming all those patients would travel into the other community.

So there's more information in that 151 hospitals that might be helpful to us in terms of what would be good criteria to get at the real issues that we have.

And timing again. We know that we're not going to

see more enter the market now after January. So would we be better off to do a little more analysis over the next year or to recommend that somebody do that analysis and come up with criteria to create more consistency in terms of location, but we don't get that specific in our recommendation today.

So those have been my thoughts on this chapter.

DR. STENSLAND: Maybe I could just say something about the swing bed effect. The way that works is there is a certain amount of inpatient costs. And it's all about allocating those inpatient costs. The way it stands now is we're allocating a lot of those costs to swing beds. And so the payment that they get for those post-acute patients in those swing beds is rather high.

What this would do is we would allocate a fixed amount to those patients for the routine services, which is based on the average routine cost of freestanding SNFs. So what they're going to be getting paid is going to be higher than the rates currently paid to PPS hospital freestanding SNFs, because it's going to be based on a combination of this fixed payment plus cost-based payment for ancillary services. So it will be a little bit higher than what

competing hospitals get.

The impact of that change, it's going to be very different for different hospitals. Because for example, if you're 100 percent Medicare on your acute side, then all you're doing is taking some of these costs you used to allocate to your post-acute swing patients and allocating them now to your acute Medicare patients on the inpatient side. And you still get all that money because now the costs are just being allocated to the acute side. So then there would be no effect on those hospitals that are 100 percent Medicare.

But as you start shrinking down from 100 percent Medicare to say 80 percent Medicare, for example, now some of those costs are being allocated to all of these acute patients but only 80 percent of them are Medicare. So you still get to get those costs paid to you for those 80 percent, but some of those extra costs we're taking away from our post-acute patients in swing beds are now being allocated to that 20 percent which is non-Medicare. And so you lose that little bit.

Some simulations that were done, at least one accountant provided us a simulation, of estimating that the

reduction for somebody's who's around that 80 percent Medicare would be something on the order of $40 a day reduction in payment per day. That reduction per payment per day gets larger as the Medicare share of your acute stays becomes smaller.

I hope that helped, if it wasn't too confusing. If it's confusing, that's part of the point of why we're trying to change it.

DR. WOLTER: I thought that was a nice part of the chapter, actually, showing that interaction between the long-term care side and the acute side.

What I don't have a comfort level with, though, is exactly how will those simulations affect people in real practice. And if we knew what the range of swing bed reimbursement through this program might be across these 151 hospitals, and how many of them are 10 percent of their Medicare reimbursement is swing bed, or 15 or 20, and then what's their percentage, their payer mix, so to speak.

I'm just worried that some institutions that finally, through a program that took a long time to put together, are at least a little bit above break even might find themselves having may decisions based on a framework

put in place, back in more trouble again. And a simulation and more information about that swing bed mix are two different things. More information would be helpful.

DR. REISCHAUER: Jeff, I think you mentioned once that some of these hospitals are even within metropolitan areas?

DR. STENSLAND: They can be within an MSA and the state has the option of declaring something rural. That's fairly uncommon, but in some cases the hospital really isn't in a rural area by any formal criteria like the Goldsmith criteria. And then the state comes in and says well, we're going to call that rural. Then it can become a CAH. But again, that's fairly rare.

DR. REISCHAUER: How many of the 151? It might be just a couple.

DR. STENSLAND: I think that's going to be maybe 10.

MR. HACKBARTH: Any other questions or comments? Then we're going to have to move ahead.

MR. DURENBERGER: Maybe two quick comments, and a lot of them come from the fact that I've been at this a long time and trying to think, since the early '80s about how do

you transition this rural hospital to something else. We started off with transition grants facilitated and that's part of the point I'm going to make.

When I teach rural docs in an MBA program, and I teach a lot of them, I expose them to something like this. And the reaction I get is Phil Burton 2. If you pay them more, they're going to increase their costs.

They're now beginning, since that's an MBA program, these are docs thinking economics and things like that.

And to a degree I share that. Particularly, as Nick said, if you make this nationwide and you cannot resist it. You have to buy into the program and you have to spend the money. And at 100 percent of cost you know you're going to spend the money.

But the second side of it is more important and the second draft doesn't dwell a lot on rehab, psyche, some of that sort of thing. Which brings to mind the fact that there are -- if you just worried about an emergency response, you need a professional not a building. You really need that -- emergency response means make sure you have professionals available with information. EMS is

probably more important than a hospital. In many cases we don't invest in that.

But the other side of it is there are health and medical services like psych that people would benefit if they weren't shipped 50 miles or 100 miles or something like that for either temporary or longer-term psych treatment.

So that I think what the two things that we might miss in this kind of a message to policymakers. One is the hospital you used to think of is not the way you should think of a hospital today. Emergency response, you should be thinking difficulty about what you support in rural areas.

The second one this matter of other services, like psych, which need a facility base of some kind and they need a professional base in order to attract good people to them.

So I would just think more emphasis on the non-emergency response side, but the important community investment side would be helpful by way of a message to policymakers.

MR. HACKBARTH: Last word, Jay.

DR. CROSSON: I'm just a little unclear in terms of the criteria here. Is there a jurisdiction issue here?

I heard from Ray that it might be a different issue if the two hospitals were in separate counties? And then we heard the example of one hospital being on an Indian reservation, presumably serving that population and another hospital in a different community setting.

Was that question looked at at all?

DR. STENSLAND: The only thing we did similar to that is when looking at -- some CAHs are Indian Health Service hospitals. And that is one option, for the Indian Health Service Hospitals to become a CAH. And we excluded those in looking at our 151 hospitals of who is close to another hospital. So we essentially said if you're an IHS hospital, we didn't include you in that 151 list.

Or if you're a traditional hospital and the closest hospital to you is an Indian Health Service hospital, we also didn't include you as being somebody who's close to another provider.

So we could put another exception in here for Indian Health Service hospitals if that's the concern.

DR. CROSSON: But as the recommendation stands, they would be included?

DR. STENSLAND: Right.

MR. HACKBARTH: Okay. Anybody else? Well, I'm waiting for somebody to make a proposal.

DR. CROSSON: Then as a well-known rural physician, I don't know the exact thing to say, but I guess I would propose at least that the Indian Health Service hospitals not be included.

Does that also mean that a non-Indian Health Service critical access hospital that failed the criteria because of the existence of the Indian Health Service hospital would also have to be excluded, I believe.

DR. WOLTER: Just for information, in the example I cited, both of the CAHs were not Indian Health Service hospitals. One happened, however, to serve a number of the reservation residents.

From my standpoint, and I think we probably heard that from Ray, I think there may be issues with swing bed reimbursement. I'm kind of uncomfortable with making that change so quickly. There probably are a few, at least, issues with the co-location within 15 miles of hospitals.

But could the recommendation be that those issues be looked at more analytically to get to some more formal criteria? We may be in better shape to make these decisions

a year from now. This program is extremely young at this point. And I think that's where we have our discomfort.

MR. HACKBARTH: It's a mandated report with a reporting date of June.

DR. STOWERS: This part was not mandated in the report.

DR. MILLER: Doesn't it ask us to comment on a waiver?

DR. STENSLAND: It asks us to comment on all the aspects of the MMA. And the main thing that happened within the MMA is it said that states no longer have this waiver. This is what is called an interim report that is due in June. And then the full rural report is due a year-and-a-half from then.

MR. HACKBARTH: Say more about that. I lost track of the fact that this is, in fact, a section of a larger report on the impact of the MMA provisions on rural providers. So there is a specific mandate for us to file an interim report?

DR. STENSLAND: Correct.

DR. MILLER: I thought it was, and this is on page five of the paper. It asks us to report in advance of the

rural report on Section 405 that has to do with the critical access hospitals on this date. And then it lays out the issues that it wants us to look at.

DR. STENSLAND: Correct.

DR. STOWERS: I'm trying not to belabor this but the mandate was on whether or not this January 1 ending of the necessary provider. I don't know that the mandate had anything to do with going on and saying 15 miles and 45 minute travel had anything to do with the mandate.

I think we can say that considering the fact that the growth and whatever, that maybe this January 1, '06 change is appropriate. We could say that as a Commission, and that's part of the mandate, to look at what changed in the MMA. There wasn't anything in there about swing beds and there wasn't anything in there about setting new mileage requirements for those already existing hospitals that have been brought into the program.

DR. MILLER: Just to be clear, at least for me, the mandate does ask us to comment on the state's ability to waive and on the mileage requirement; right?

DR. STENSLAND: The mandate just tells us to look at aspects of the MMA that apply to CAHs.

DR. MILLER: And the governors waiver was a waivering of that 15/35 mile limit.

DR. STENSLAND: Right.

DR. MILLER: On so that's how we kind of get to our point that we were being asked to look at these mileage limits. Am I missing something here, Jeff?

DR. STENSLAND: That's correct.

DR. MILLER: I want you to respond but I just want to get this out. It also asks us to comment on cost reimbursement in general, doesn't it?

DR. STENSLAND: It asks us to look at -- it's a pretty broad spectrum of costs and payment and other aspects of things that are affected by these certain provisions of the MMA, such as losing the waiver ability.

DR. MILLER: And the swing bed provision?

DR. STENSLAND: The swing bed provision probably is not directly part of the --

DR. MILLER: It refers to the reimbursement under cost in that.

MR. HACKBARTH: When I hear this, Ray, I don't think it would be fair to say that these things are out of bounds for the study. Clearly, these are issues implicated

by the critical access program and will continue after MMA.

So then the question becomes do we defer final judgment, as Nick has suggested, to study things some more and file an interim report that says something like we have no objection to the fact that now there are 15 mile limits imposed and the governors can't waive them any longer. That's where we are.

And then the next question is should that rule be applied if the existing CAHs within it. And on that question, we want to study it some more. So that's a potential path.

The question is whether spending more time on it is going to lead us to a different place. I guess I'm not quite as optimistic as Nick that we end up in a fundamentally different place. If I could clearly see that spending lots more resources would get us a better answer to a difficult question, then let's kick it down the road and come back to it. But I'm not sure that's this case.

From my perspective, this is not about money. I agree absolutely with Ray. This is a pittance compared to the scope of the Medicare program. Even if every one of the 150 left lost the status, we're talking about $150 million,

roughly, in the additional payments. That's not the issue.

For me, it's not even the question of the incentives created by cost reimbursement, although I find that a little bit more troubling. Again, these are very small institutions.

The issues that concern me are is this the best thing to get the best care in rural areas, to dilute a shortage of resources over multiple very small institutions that are very close together? Is that really how we do best by Medicare beneficiaries? I have real doubts about that.

And I'm also concerned, and I don't have data to substantiate this, that when we create special classes like this in close proximity to PPS hospitals, many of which are themselves small and we hear regularly struggling financially, is there inevitable pressure for then the limits to be not 25 beds but 40 pence or 50 beds? And this spreads like a contagion.

That leads me to think that having firm distance/time boundaries is a very important thing about limiting the spread of this. And keeping it focused on its original intent of serving Medicare beneficiaries in isolated communities

I'm not sure that if we spent another six months that we're going to have better analysis to bring to bear on those questions. I think they're difficult judgments and it will be painful in some communities, but I guess I'm inclined to think we need to go ahead and take our crack. Dave?

MR. SMITH: Glenn, I think I end up in force where you end up. But I listened very carefully to Nick and to Ray, and it seems to me if we think, as I think all of the information is murky, but as you just said you think, that we would be better off if resources were not as dispersed as they are, if some of the advantages which we know well and some of the outcome data confirms, some of the advantages of volume were to be captured more often, we would be in better shape.

But realistically, we're not going to shut down 151 hospitals in the next six months based on what MedPAC says. So if we believe that somehow we need to address the problem of too many, too small, too nearby each other hospitals, we ought to take the time to build this case. The case isn't built in what we've done so far.

It's a very difficult choice for you. In order to

achieve the goal you want to, we can't pass this recommendation and assume that it will have any useful effect. Because the consequences of it are politically simply unimaginable.

So if we do think that there's something to be accomplished, we need to know more. And that requires addressing some of the questions that Ray and Nick have raised.

MR. HACKBARTH: Other thoughts on that?

MR. MULLER: I share the thought that you and David are expressing, in terms of this balance between quality and outcomes, especially since on other fronts over the course of the last year in rural we've been focusing more and more, whether it's on pay for performance or on quality and outcomes.

I think the evidence that you've brought forth today, some of it is intuitive. But it's the first time I've seen it out on paper in terms of better quality outcomes with larger scale. Though as was pointed out, some of the measures are mixed. The mortality measure is more clear, and everyone goes in the other direction.

I could extrapolate, in part, the kind of

preference that people have for having hospitals in the community. They may also have preferences for hospitals that are religiously based. They may have preferences for hospitals that are university based. So there are other things that beneficiaries could express as to what kind of hospitals they want that are independent of quality outcomes and so forth.

So to the extent to which we honor those and obviously we honor it more or in terms of serving isolated communities, that's much more established and entrenched in our program, one should be very cognizant of that and note it and realize that it's something that we've built into the Medicare program to keep these, whether they're sole community providers or critical access hospitals.

I also think, as David has said, building the case that it may be shortsighted to preserve some of these, that there may be better outcomes in having fewer and more concentrated facilities, as painful as it may be to have that conclusion being reached. But there may be better outcomes for the beneficiaries, is something that I think we should keep putting resources into making that case, no matter how we vote today.

But I think that would be a useful part of the debate, especially given our overall theme that is building on let's look at outcomes, let's look at pay for performance. I think this could be a subset of that broader theme.

MR. HACKBARTH: We need to move ahead here.

Could I get just a quick show of hands on the proposal which I think would go like this, that we file an interim report as we're required to. And it would be a brief report. It would say, in essence, that from our perspective the reinstatement, if you will, of a firm 15 mile limit that cannot be waived by the governors -- which was one facet of MMA -- we don't think poses an immediate problem.

And notwithstanding that, however, we have some questions about two issues. And that is whether, first of all, we should continue to have this group of 150 exist in close proximity to other institutions or whether they ought to be rolled back.

And then the second is the appropriateness of the swing bed payment.

DR. REISCHAUER: And then we'll raise these issues

in our final report.

MR. HACKBARTH: And those would be addressed in the final report. The final report, Jeff, is due?

DR. STENSLAND: A year-and-a-half from June, in December.

DR. MILLER: A couple of things. One, you were characterizing it and saying a small or short. What I was envisioning, when we seemed to be moving away from the recommendations, is that we would take the work that we've done in this chapter, file it as the response to the mandate on Section 405, and then say the point that you made, which is we're concluding that the change in current law that says the governors no longer -- all that you said.

And then on these two points, rather than speak of them as recommendations, speak of them as issues that we've identified that probably need further work.

I guess I would be careful about saying we're going to actually answer this question in the next report, because I know we're using the word interim here. But it says we want a report on the rural provisions and what the mandate says is we want a report on 405 by June 8th. And I would want to not imply somehow we're not meeting your

mandate, we're just putting it off.

We can always, as a matter of any of our rural work or anything that we do, come back to these issues and opine on them.

So I wouldn't characterize this as I'm not going to deal with your mandate now, I'll deal with it later. I would deal with this as this is where we are.

DR. REISCHAUER: And we've uncovered some issues.

MR. HACKBARTH: Okay, so let me just see a show of hands. Since it's not a formal recommendation we don't need a formal vote. But I just want to make sure I'm getting the sense of the Commission that that's the path they want to go.

So all in favor of that path, of not having recommendations on these issues, filing the text, raising them as issues to be discussed. All in favor of that approach?

So that's what we'll do.

MS. BURKE: If we, in fact, are going to continue to do some work on this or the potential for work continues, the one thing I didn't find, or at least wasn't clear to me in the course of reading the report in the context of the

swing bed issue, was the acuity of the patients in the swing beds and whether they substantially differ from those that are, in fact, in freestanding.

There is some suggestion that it is not only an issue of distance and availability. There's also an issue of stability or essentially their acuity at that point.

As I recall from the old days, the numbers tended to be relatively small. The occupancy in those swing beds tended to be relatively few patients for -- I think the time frame, as I recall from the report, is dropped from about nine to eight days.

But I would be interested in further understanding the question, whether there really is a substantial difference in the patients between freestanding, which would hopefully help guide us in terms of the payment system, as well.

DR. STENSLAND: I think one problem is there was some debate about the burden of filling out the patient assessment, the MDS, for patients in swing beds. And the conclusion was they didn't have to do that. So we don't have that clinical information even for the comparison group, which are paid the same price.

MS. BURKE: Although arguably, if they've been transferred from the acute to a swing bed, which I think in most cases is the case, they're not admitted generally directly to the swing, I don't believe. There should be admitting data that should inform us to a certain extent.

But the question as to whether or not the payments are far out of touch with what the reality is of the patient, there are lots of reasons to question whether that payment method is right, just simple allocation of costs. But I'd like, if we could, to get some understanding of who those patients are if we're going to go in a different direction in terms of what the payment system ought to be, if we can.

MS. RAPHAEL: I just wanted to say, to me that's an issue, that the assessment is waived and that we really don't know anything about the characteristics of this patient group. In the issue pile, I'd like to add that.

MR. HACKBARTH: The pile is getting deep over there in the corner.

We need to move on. Thank you, Jeff and Tim.

While they're changing at the table.

DR. CROSSON: Just to close the loop, would it be

possible to take a look at the issue of jurisdiction that we brought up in the text?

DR. MILLER: The Indian Health Service.

DR. CROSSON: Counties and the question of whether an Indian Health Service would count against a nearby hospital.

DR. MILLER: I have that.

MR. HACKBARTH: Before we jump into the next presentation, let's just talk about the schedule for a second. We are roughly an hour behind. It's 62 minutes, but who's counting?

To try to finish closer to on time, what we will do is drop the item on the Maryland hospital rate setting system, which was more a matter of information.

Just so nobody was concerned, we're not thinking about endorsing the Maryland all payer system. That's not what that was about. It's something that we can differ and that will help us get a little closer to on schedule

Next up is outcomes and spending for beneficiaries with hip or knee replacement.

DR. KAPLAN: In this session, Melinda Beeuwkes Buntin of RAND and I will present two studies of

beneficiaries who have had a hip or a knee replaced. First, after a brief introduction to the topic, I'll tell you what a physician panel told us about these patients. Then Melinda will present results from a study of outcomes that she and her colleagues conducted for us. To our knowledge, Melinda's study is the first comparing outcomes across settings for patients with hip or knee replacements.

After our presentation, you will have the opportunity to discuss the studies, of course, and also to make comments about the post-acute chapter for the June report.

The 75 percent rule is one criterion that distinguishes inpatient rehabilitation facilities or IRFs from acute hospitals. This rule requires that an IRF have 75 percent of patients admitted for one or more conditions on a list of conditions specified by CMS, such as stroke or hip fracture.

In 2004, the list of conditions changed. Specifically, polyarthritis, a diagnosis by which joint replacement patients were admitted to IRFs, was removed from the list of appropriate conditions. It was replaced by four arthritis-related conditions. Under the new rule, the only

joint replacement patients who could be counted in the 75 percent were those with both hips or both knees replaced, those aged 85 or older, or with a body mass index of 50 or higher.

Hip and knee replacements with the largest and fastest growing condition for IRFs in 2002. In effect, this change means fewer hip and knee replacement patients will go to IRFs each year. This raises the question of whether the alternative settings, staying in the acute hospital longer, going to a SNF, or home with home health or outpatient therapy are appropriate.

We conducted two studies. The physician pane of six orthopedic surgeons and five specialists in physical medicine and rehabilitation discussed the optimal setting for rehabilitation of hip and knee replacement patients. They also discussed whether they'd already seen a change in practice or referral patterns in response to the publication of the new 75 percent rule.

The RAND study compares outcomes and Medicare spending across post-acute care settings for beneficiaries who had a hip or knee replaced between January 2002 and June 2003, the most recent data available. The 11 physicians on

the panel generally were from academically oriented institutions. They practice in different areas of the country. In general, the orthopedic surgeons on the panel replace a large number of hips or knees each year.

The panel told us that ideally patients should go home for rehabilitation from home health agencies or outpatient therapists. They estimate that between 50 and 85 percent of their patients do go home.

They described the characteristics of patients who should go to a SNF or an IRF as being limited in weight bearing or unable to walk 100 feet, being obese, having comorbidities, impairment of one or more joints that were not replaced, diminished presurgery functioning, architectural barriers at home or having no informal caregiver at home. Some of these characteristics are similar to ones that CMS included for joint replacement patients to be counted in the 75 percent rule. However, the physicians also told us that a BMI, body mass index, of 50 was inappropriate and excluded any obese person who might benefit from IRF care.

The panelists also told us that patients who need extra medical attention should go to IRFs for

rehabilitation. Those who need convalescent care or cannot tolerate three hours of therapy a day should go to SNFs. In some communities, surgeons refer based on the qualifications of specific facilities that are available, such as how the facilities are staffed, whether they follow rehabilitation protocols or are convenient for the surgeon to follow-up.

The physicians told us that they are already seeing changes in referral patterns in response to the change in the rule and that some IRFs are already refusing to admit joint replacement patients. They said that they expected IRFs with larger referral bases to have less trouble complying with the new 75 percent rule but that IRFs with smaller referral bases would have more trouble complying.

Now Melinda will talk about the results of the RAND study.

DR. BUNTIN: Thanks, Sally.

As Sally said earlier, the objective of our study was to compare the cost and outcomes of joint replacement patients discharged to three different post-acute settings. We looked at patients discharged after a joint replacement procedure who went home, approximately 35 percent did. This

patient group included patients who were discharged to home health care, outpatient rehabilitation, or without any formal post-acute care. We compared those to patients discharged to IRFs and to SNFs. You can see that patients were distributed relatively evenly across these three categories.

The sample we examined included all elderly or over aged 65 Medicare beneficiaries who had an acute hospitalization for joint replacement. However, we excluded patients whose principal diagnosis in the acute hospital was a hip fracture, because those patients do qualify under the 75 percent rule. We also excluded some other small patient groups, including patients who died in the hospital or who were in a nursing home before they were admitted. Those constituted less than 3 percent of the sample, and I can answer questions about that if you have them.

We looked at two types of outcomes. We looked at health outcomes for patients and payment outcomes. Specifically, because the goal of rehabilitation is to restore patient functioning and hopefully to allow a patient to return to independent living in the community, we looked at whether the joint replacement patient was

institutionalized 120 days after they were discharged from acute care. We also look at mortality.

But specifically, we looked at the joint outcome of an institutionalization or mortality, since looking only at the patients who survived long enough to be institutionalized would be looking at a biased subsample. So I'll talk about that joint outcome and then about mortality alone.

We looked at two types of Medicare payment variables. One, we looked at post-acute care payments, which was just the sum of all types of post-acute care payments. And then we looked at total episode payments, which included the costs of the acute hospitalization.

Of course, the great challenge in conducting this study was that patient populations really differ across PAC sites. Generally speaking, those who go home are the healthiest. They're the youngest, they have the fewest complications and comorbidities. They are less likely be on Medicaid and they include a lot of knee replacement patients.

The patients in the IRF category are in the middle. They're a little older, have slightly more

complications and comorbidities. I should note that they have the shortest acute length of stay.

The SNF patients are the least healthy, in terms of they're the oldest, have the most complications and comorbidities, most likely to be on Medicaid, and have the greatest proportion of hip replacement patients. These patients have the longest length of stay in acute care.

I mentioned the two types of outcomes we were looking at. We looked at a third type of outcome in a qualitative way, and I'll go over that briefly now.

As the Commission well knows, there is no assessment instrument that is common across all post-acute care sites, so it's very difficult to compare functional status of patients discharged to these different settings.

However, we took items from the IRF-PAI and the MDS, which is filled out by SNFs, and we tried to create a psueudo-Barthel Index of functioning. What this showed us was that patients who were admitted to IRFs had higher functional scores at discharge, but they had lower functional scores at admission than patients who were admitted to SNFs.

This is suggestive that in IRFs, patients are

gaining more function than patients who were going to SNFs. However, because the instruments are not directly comparable, they have different items and different response categories, and are filled out at different points during a patient's stay, we only looked at this qualitatively and did not go on to model whether after accounting for selection these differences in functional status persisted.

So as the previous slide showed you, it's really imperative to account for patient selection across post-acute care sites.

Now we do control in our models for all observable patient characteristics of the type that I showed you on the previous slide. However, there's plenty of selection that remains that cannot be captured in these observable factors. And so we use econometric measures to account for the remaining selection.

Specifically, we use instrumental variables models to control for patient selection based on unobservable characteristics. The instruments that we use to effectively randomize patients between sites are the availability and proximity of different post-acute care sites. Throughout the rest of the presentation, I will contrast the results

from these instrumental variables models with standard regression approaches and the raw data to show you how important it is to control for selection in this study.

First, looking at the health outcomes, we found that patients in IRFs and SNFs were more likely to be institutionalized than patients discharged home. To explain this chart, the top bar, the yellow bar on this chart, shows you the raw or unadjusted differences between patients discharged home and on the top patients going to IRFs and on the lower part of the chart patients going to SNF.

The blue bar shows the differences after we adjusted for all observable characteristics of patients, such as age, complications, comorbidities again. The bottom or red bar shows the remaining differences after we've accounted for both observable and unobservable selection using our statistical methods.

You can see that after we do that, IRF patients are still about 0.2 percent more likely to be institutionalized or die than patients going home. And SNF patients are about 0.5 percent more likely.

I should say that we haven't shown here differences in mortality because after we controlled, using

the methods I've described, there were no statistically significant differences in mortality across these sites, implying that the differences we see here on this slide are operating strictly through institutionalization.

You may look at this slide and you may say these are very small differences and, in absolute terms, they certainly are. But this is a very healthy population undergoing an elective surgery. And so the difference of 0.5 percentage points translates into a relative to risk of institutionalization of 2.5 for the SNF patients.

On the payment side, patients in IRFs and SNFs do cost Medicare more than patients discharged home. For the IRF patients, their episode costs were approximately $8,000 more than for patients discharged home. And for SNFs, their episode costs were more than $3,500 greater than those for patients discharged home, even after accounting for observable and unobservable selection.

So in summary, compared to patients discharged home, marginal patients going to IRFs and SNFs are more likely to experience a poor outcome, specifically the poor outcome that they are more likely to be institutionalized 120 days or six months after they're discharged from acute

care.

However, neither IRFs nor SNFs had a significant effect on mortality alone -- I want to reiterate this -- implying that this effect is operating exclusively through institutionalization.

Now I'm sure that some of you on the Commission are thinking what exactly is a marginal patient? And that would be an excellent but tricky question to answer and I'll try and jump ahead and do that, anticipating your question.

In some prior work that I did, we looked at the extent to which joint replacement patients and other types of patients going to post-acute care were swayed in where they went by the availability and proximity of post-acute care. So while I can't answer this question in a clinical sense, I can tell you that in an area that a patient that lives in an area that falls at about the 25th percentile in terms off their likelihood of going to an IRF, so that they live relatively far from an IRF, there may not be many IRFs in their area, for that group of patients about 19 percent of them go to an IRF.

For patients who live at the 75 percentile, in terms of how close and available IRFs are, about 43 percent

of those patients go to an IRF. So patients falling into this marginal patient group or this critical gray area where they could go to one or more of these settings, it's a fairly large group of patients in the large extremity joint replacement category, or the hip or knee replacement category.

Then to sum up the results regarding payments, IRF payments for episodes following a joint replacement were the highest. SNF patient episode payments were lower. And payments for patients discharged home were the lowest.

There are some limitations to our study. First of all, I want to be completely up front that although we strove to control for selection as best we could, controlling fully for selection is very difficult and it is possible that we have not done so fully. We cannot rule out the possibility that some selection remains.

I should also say that the outcomes we analyzed are not the ideal outcomes for this patient group. We would ideally look at functional outcomes. However, they're just not assessed uniformly across all of the settings.

Then finally, Medicare payments don't fully capture costs of care. Of course, payment may not fully

reflect costs. But also, we did not include in our estimates the cost of physician care or outpatient department care.

DR. KAPLAN: We undertook the RAND study to determine the impact of the new 75 percent rule on beneficiaries and the Medicare program. The outcomes we were able to use are suggestive but not definitive. We do know that the differences in discharge to the community, the inverse of mortality and institutionalization, are small but the differences in costs are large. The outcome we'd really like, as Melinda said, is to have improvement in functional status.

If we knew the optimal setting for the different types of joint replacement patients, however, we still would not be able to prospectively identify and refer patients to the appropriate setting.

That's our presentation. We welcome your questions and comments about the studies and about chapter five on post-acute care. Carol Carter, Kathryn Linehan and Sharon Cheng are available to answer any questions you may have about their sections of chapter five.

MR. MULLER: You've got a complicated topic here

and I commend you for taking it on as well as you have.

Let me make sure I understand. The patients that go home and get outpatient physical therapy, they're in the home category in your classification?

DR. BUNTIN: That's correct.

MR. MULLER: You say at the end that the correction or the control for selection, you may, you may not. And so I want to pursue that a little bit because it's generally, I think, perceived -- maybe not by all 11 people on your panel -- that the rehabilitation especially does produce a better outcome. I'm trying to understand, you're saying that the fact of institutionalization may, in fact, mitigate against that perception that you get a better outcome by going through rehabilitation?

DR. BUNTIN: Related to your first point, patients who are in our going home category may be going home and getting home health care or outpatient rehabilitation or some other type of therapy. In fact, we know that 63 percent of them are getting home health care after discharge from acute care.

So it's not that therapy is hurting these people. It's just that therapy in a home setting or an outpatient

setting may be more beneficial for this particular group of marginal joint replacement patients than the institutional care.

MR. MULLER: Can you also speak -- a lot of times we send people to an institutional setting rather than the home setting because they don't have the capacity at home in terms of other caregivers, in terms of their home setting, et cetera and so forth, to really take advantage of going to outpatient physical therapy and so forth.

Tell me how you analyze and control for that because -- oftentimes there's what I'll call the social or sociological reason for putting them into institutional settings, rather than a medical reason.

DR. BUNTIN: That's certainly true and if we could observe that we would have included that in our models. However, we do think our models get around that problem because the natural experiment you can think of that we're conducting here is what's the difference in outcomes between patients who are going to IRFs because they happen to live in an area where there are a lot of IRFs or liver very close to an IRF, and patients who don't go to an IRF because they don't happen to live close to one or there don't happen to

be many in their area.

That's the thought experiment and that's the statistical experiment that we're implementing with our models.

We have no reason to believe that patients who live in areas or live close to an IRF differ on whether there's a lot of social support at home from patients who live further from IRFs. We conducted a number of tests to assess whether patients who lived further from IRFs or SNFs looked clinically any different from patients who lived close to them and we couldn't detect differences of that type.

So that's why we think that these methods are accounting for those unobservable differences in patients that are exactly --

DR. REISCHAUER: But Ralph was talking about the sociological context and they might look different there. I mean, they might be more rural and therefore more likely to be in a two-adult family or have an extended family or something like that.

MR. MULLER: Have social supports, not live in an area that -- may have neighbors willing to transport them,

et cetera and so forth. But oftentimes my experience has been the reason we send people to institutional settings has not to do with their medical need but has to do with the social context in which they live in terms of -- the obvious one is other caregivers -- but transportation, et cetera and so forth.

DR. BUNTIN: And the point is very well taken. So to the extent that that does vary between areas, people who live closer to IRFs and SNFs and people who live far away for example, are people who live in rural areas less likely to have a caregiver, then that would bias our results.

DR. MILLER: I think, Ralph, when you were asking your question, I think that's part of the reason why at the end of the talk, or even thoughout the talk, you were pretty careful about caveating and having clear have you removed all of the effects. I think you guys have gone through a bunch of steps and a lot of good work to try and remove this bias. But I don't think that we're willing to say everything has been cleared out.

The first result is pretty counterintuitive. If you go to a SNF or an IRF, your results on this particular measure, which has its limitations, et cetera, et cetera,

doesn't go the way you would naturally have thought it would go. So there's a couple of competing hypothesis here about what may be going on there. And that's why we're trying to be careful about drawing a conclusion one way or the other.

MR. MULLER: In some ways, and it's hard to do, you almost need a randomized trial as to the way you assign people to the SNF, to the IRF or to home. And then you kind of measure the effect of the setting, but my guess is patients don't want to be put into that kind of randomized trial.

DR. BUNTIN: I completely agree with that and there hasn't been such a trial in the U.S. There have been trials in other countries of that type. And the results are not necessarily inconsistent with these. But I think such a trial in the U.S. would be a great idea.

MR. HACKBARTH: Let me make sure I understood that. Melinda, you're saying that there have been randomized trials of this particular issue in other countries and found results consistent with yours?

DR. BUNTIN: I want to be careful here because we're talking about countries with different medical care systems than ours. Our post-acute care system is rather

unique and was perhaps created by other aspects of our health care system. But there have been trials that have looked at patients discharged home versus elsewhere. Not specifically for joint replacement patients, though. I should be clear about that. For hip fracture patients, which in many cases included hip fracture patients who had joints replaced. But I don't want to go too far down that path.

DR. BERTKO: Melinda, just a quick question about the constitution of the episode. If I saw one of your slides right, it said that functional status improves with IRFs, if I interpreted it right.

DR. BUNTIN: I'll go back to that and explain.

DR. BERTKO: Maybe I can finish my question first. IRFs are more expensive, though. So my question was along the lines of if the function status did improve, it might cost beyond the episode if it wasn't say a full year or so, it would be less overall. That's a constitution of what's inside the episode.

DR. BUNTIN: When we compared functional status as best we could by trying to equate two unequivalent instruments, we saw that lower extremity joint replacement,

hip and knee replacement patients, who were admitted to IRFs had lower functional scores than those who were admitted to SNFs but at a period closer to discharge had higher functional scores, which is suggestive of a greater functional grain with a greater intensity of therapy provided in IRFs.

But the payment per episode information still applies in that those patients, despite perhaps having greater functional gain while they were in the IRF, still did cost more during that 120 day episode.

We do think that institutionalization is closely related. Just a crude measure of functional status. We do think that institutionalization is related to functional status. --

And so in that respect, we did see that fewer IRF patients were institutionalized at day 120 than SNF patients at a higher cost though, and again at a higher rate than those discharged home.

DR. REISCHAUER: But this was IRF versus SNF; right?

DR. KAPLAN: The functional status was IRF versus SNF; that's correct.

I was going to respond to John's question. I think what you were asking is if you took costs over a year or two years, would you then see that there the difference was not as big? Was what I thought you were saying. We did not do that. Melinda collected the payment data for Part A that static period of time but not for a year or two years. And I don't think we can answer that without looking at it.

DR. REISCHAUER: And no Part B, either; right?

DR. KAPLAN: That's correct, there was no Part B.

DR. REISCHAUER: That could change things considerably.

MR. HACKBARTH: Any other questions or comments?

Thank you. And thank you for not bringing a recommendation that hurts my head to think about.

Next is Anne with physician resource use.

MS. MUTTI: This presentation will outline a work plan that explores in greater depth than we have to date issues surrounding Medicare measurement of physician resource use. At the end, of course, we'd love to get your comments, feedback, priorities, that kind of thing.

First, I'll take just a few moments a set a little context and remind you about the work that we've done in

this area and related areas so far.

As you recall, the Commission's position is that Medicare should be able to distinguish among providers on the basis of efficiency. Importantly, we've defined efficiency as both a function of quality and resource use. So certainly, health care is not more efficiently provided if it is delivered with fewer resources but results in a decline in quality.

With respect to quality, we have and continue to explore measurement tools. And where appropriate, we have recommended that CMS use certain measures. For the March report, we looked at hospitals, physicians and home health agencies. Prior to that we had looked at MA plans and dialysis providers. And going forward, we are looking at quality measures for SNFs.

On the efficiency or the resource use side of things, you may recall we spent last fall and the winter talking about physician resource use measurement. And we decided to focus on physicians at the outset because they direct so much of patient care across all settings.

We spent some time talking to plans and employers asking how they were measuring physician resource use. They

told us about their methods and about how they use it.

And in turn, in our March report, we made a recommendation that CMS measure physicians resource use and report that information back to them on a confidential basis only as a way to help them understand how they compare to their peers. Ideally, this would be helpful tool for them to gauge whether they need to make any adjustments in their practice style.

In the text, we allowed for the possibility that if the resource use measurement tool was found to be sufficiently valid, that resource use could be used in tandem with quality measures in a pay for performance program.

Just briefly to refresh your memories, the tool that many plans and employers are using to measure physicians is an episode grouping software. This software is able to comb through claims data across all services and group services related to common conditions like emphysema, hip replacement, that kind of thing. There's hundreds of these episodes.

The episodes can then be assigned to the dominant physician and the dominant physician is that one that is

most responsible for directing patient care. And then the physicians average resource use for treating any type of condition can be compared with that of a peer group.

Ideally, as I said, this information is helpful to physicians. They can look to see, for example, if in treating emphysema patients they used three times as much hospital care but don't use as much prescription drugs or home health care as compared to their peers, they may decide that they would like to better align their care or they may decide not to. But at least they have that information.

So while we decided that the theory behind this approach was appealing, we also recognized a number of thorny implementation issues in our report. For example, how would we identify from claims data the physician most responsible for directing patient care? Private plans seemed to have worked this out. They have a number of rules that they use. But Medicare may be different and we would have to look at that.

Another question is what is the reasonable sample size of episodes before a physician could be validly measured? Does the measurement tool adequately account for differences in the relative risk of each physician's panel

of patients?

All good questions.

So while our initial foray into this area was helpful in understanding the concept, we have not provided much insight into some of the mechanics. So we're proposing to use the software with Medicare claims to get a better look at how this might work.

Specifically, our goals are first to assess the feasibility of using this type of software with Medicare data. For example, how big a problem are the UPIN numbers. We know some physicians aren't always using their UPIN numbers. Is this surmountable or not?

Also, Medicare has a lot of post-acute care moreso than most commercial payers. Do the episodes account for this care in a good way or not?

Second, we want to better understand the implementation issues, and these mostly go back to the questions that I just raised on the earlier slides. We'll be able to take a look at attribution rules, outlier rules and also the appropriate sample size. And we can get a sense of what the trade-offs are if you went one way or another on these kinds of policies.

Third, where possibly we'd like to provide guidance on ways to enhance the validity and effectiveness of this tool. For example, if we were to find that variation was particularly extreme in certain conditions or specialties and we were able to rule out that the data issues were the cause of this, perhaps we would suggest that those would be good places for Medicare to start.

In addition to our claims analysis, we also want to further explore some qualitative issues. And I'll come back to those in just a moment, but first let me go a little deeper into our claims analysis.

We propose using two datasets because there is not a single dataset of manageable size that allows us to look at the wide range of issues we've identified. In both we will be using at least two years of the most recent data available.

The first analysis would use the episode grouping software on claims data across all services for 5 percent of beneficiaries nationwide. This analysis would illuminate the variation in terms of total spending and spending by service, both within and across large geographic areas, for given conditions or specialties. So we could examine

whether variation is concentrated among certain conditions or specialties.

Also, because the data has claims for all types of Medicare services, we can look at the post-acute care question.

In addition, the dataset is sufficiently large so that we would be able to look at quality measures in tandem with the resource use measures to get a sense of how physicians performed on those two dimensions.

This dataset, though, does not let us examine aspects of physician measurement when it comes to attributing that episode to the physician. That's because it is a sample of beneficiaries rather than physicians and the beneficiaries are spread out across the country. So we would never have a concentrated set of data on a given physician in a given geographic area.

DR. NELSON: Would you say that again?

MS. MUTTI: On the first dataset, we're talking about 5 percent of beneficiaries nationwide. If we want to look at physician attribution, attributing each one of those beneficiary episodes to a physician, we would never have one physician having 20 cases attributed to them because we're

looking across a wide geographic area.

DR. BERTKO: Anne, can I jump in for a moment? This is really an important aspect and you have a very ambitious study, which I applaud greatly.

But on this I know in particular from a study I was part of, and I don't have the 5 percent number, but reducing in a state from 100 percent sample to the 20 percent sample shrunk the number of physicians you could see -- and by see I mean have credible episodes -- from about 80 percent down to 30 percent. And probably getting down to 5 percent would shrink it even further.

So my comment would be there are people out there -- I know one at Stanford and Wennberg -- who have the 20 percent sample at their fingertips literally. And perhaps some subcontracting arrangement, even though you might prefer to do it in-house, would be more productive with the same amount of resources so that we learn more.

MS. MUTTI: It does lead us then to the second dataset that we were looking at to try and get around some of these problems, too. And I think it's a good point whether we want to streamline a little bit more or not.

So to look at the attribution of resource use to

physicians, we plan to look at claims data for 100 percent of beneficiaries living in up to six market areas. As a result, we should have nearly all Medicare claims for every physician in the area and then able to look at attribution rules, outlier options and examine the consistency over time of the resource use scores for physicians in physician groups.

This consistency over time is an important thing for us to be able to look at because that's one of the few ways we can get a sense of how valid the tool really is.

We'll also be able to examine the average number of physicians per episode by market area. In fact, we'd be able to do this with either data set. That would be an interesting exercise to get a sense of the challenges involved in coordinating care, and that could relate to some of the other work we're doing, also.

With respect to the qualitative issues I mentioned earlier, there's a few things that have come up since our March report chapter that we think would be useful to look into. One issue that is often brought up when you're talking about measuring physician performance is the concern that despite all of the physicians best efforts, patient

education, cajoling them, reminder phone calls, that the patient doesn't adhere to the physicians' instructions and is noncompliant. To some this does not seem fair to attribute the costs of that episode to the physician when it's largely controlled by the patient's own choices.

With respect to quality measures, we can address this problem by looking not only at outcomes but also process and structural measures. But with resource use there's not such a multidimensional view. So we may want to consider ways of addressing this problem while being very careful not to undermine the incentive for physicians to work with patients to improve their compliance or their self-management.

Another issue to consider is what is the appropriate length of patient care that should be examined? Episodes are longitudinal by definition. Some span a year, some are weeks, some are months. But is that long enough? There's a possibility that a physician may use a lot of resources in one episode and in so doing avoids future episodes. If that were the case then perhaps we need to consider a longer time frame of looking.

And finally, I think we would also benefit from

getting a better understanding of the recent experience of physician groups using this software and how they've made any amendments.

So hopefully, that gives you a sense of where we're going. It probably is ambitious so we welcome any thoughts on priorities. And be certain that I'm not the only one working on this issue.

DR. REISCHAUER: I'm exhausted just listening to you. I think this is all fantastic and I wonder if I'll be alive by the time it's finished.

Why are we doing the 5 percent national? It strikes me that for what we want to learn, which is is this ready for prime time, picking six market areas of very different types, Miami, Portland, a rural state, something like that, and doing the 100 percent sample would get you all you needed to know.

MS. MUTTI: I guess when we were contemplating this, we weren't sure that up to six would get us enough about some national conclusions that we could make or some broader geographic comparisons.

DR. REISCHAUER: I'm not sure you need to make national conclusions, really. Isn't this really sort of can

it be done? What can they add?

DR. MILLER: Can I also take a shot at this?

I think some of what the thinking was is that this is going to be the first time we're going to take this data. I mean, lots of people have looked at geographic variation with 5 percent samples or 20 percent samples. And so what's the big deal?

But I think some of the deal here is we're putting it into these episodes. And then part of the question is when you organize the information that way, and so you start looking at a condition episode and then looking at how that begins to vary, that may also tell you where some of your priorities might be for where you want to begin to measure efficiency and that type of thing. And then we envision the state specific stuff as much more what you said, the mechanical process of how does the stuff work.

MS. MUTTI: I think so. We, at the outset, were only going to look at physician and hospital services on our six areas, not try and link all the other services partly because we don't have a data file that already does that and we do on the 5 percent. So we wouldn't be able to look at post-acute care. That we could with our 5 percent. So

that's one thing we can get.

We also felt more comfortable using quality measures on our 5 percent rather than our six focus areas.

MS. MILGATE: One of the question was how large the regions would be and if you'd be able to run, for example the ACE-PROs, was what we were thinking which are claim-based measures. For physicians, I think it's around 300,000 just at least. And so that would leave out some smaller regional areas to be able to get some of the condition-specific scores. So that was one thought that would limit some of the regions, if we want to look at smaller areas it might limit that for the 100 percent.

DR. NELSON: I think this is a great undertaking.

My questions relate to the patients that internists so often see where they say doc, there's something bad wrong. I've run out of gas and I don't know what it is. And there, of course, there might be a big front end in trying to figure out what's wrong. But that also may be a persistent problem phrased a little differently. The next time it's doc, I've got the dwindles.

And yet the patient is legitimately worried and knows there's something wrong. And that often may generate

all kinds of resource utilization.

I guess my question is I presume that the software can track symptoms and ill-defined things and maybe some things that claims don't get submitted for cleanly, like depression, as well as something that's nice and precise like congestive heart failure, hypertension or diabetes where you know what it is you're tracking? That's a long question but it's a question.

MS. MUTTI: I think that's something that is what we're looking forward to learning about. Yes, as we talk to different vendors of this software, they say that they track symptoms and they are able to ultimately put them in an episode. And in certain cases can't, and that there's a residual that is not put into an episode. We haven't had that personal experience of seeing how it works with Medicare data. But that would be something that we would be looking at.

DR. MILSTEIN: A couple of points.

First, just to reinforce this idea that granted there are some advantages to using the smaller rather than the 100 percent sample. I think if we were to consult with researchers who have looked at this problem, that would say

on balance they'd rather accept those limitations and have 100 percent sample. That's just my intuition about what the researchers who have been actively at this for the last few years would say.

Secondly, I'm not clear based on the comments so far when we say we would do this analysis, who we is. But I would just say, relevant to that question, there are some nationally respected health services and research teams that are very far down the road on answering almost all of the measurement methodology questions that have been raised so far.

And to think about using someone other than national research teams, who have been immersed in answering these very same questions and have published in the peer-reviewed literature, seems to me to be losing a lot of knowledge leverage that's already built up.

And I'm referring here specifically to researchers at -- this is not exhaustive, but for example the University of Michigan/Southern Maine. They've really been kind of the national center of excellence for peer-reviewed publications, including one that's about to be punished in Health Services Research that I think will actually go a

long way toward resolving some of the questions that have been raised. And Stanford and I'm sure that's not an exhaustive list.

And last but not least, relevant to this prior theme I've raised of sort of synchronizing with the private sector and answering questions like to the degree to which physician performance scores on resource use and overall efficiency, are they all the different for Medicare patients and non-Medicare patients? There would be huge advantage to, in selecting the areas in which you're going to perform this test, using as one of your selection variables those communities in which the private sector is already moving ahead with measurement. I'm thinking about Massachusetts, California, St. Louis and a few others that I'm probably not recognizing.

But there are some communities that are already quite far down the line. Some of these have actually already, on a physician de-identified basis, in working with the QIO, simultaneously analyzed the same physician performance, the same physicians with respect to their resource use performance, comparing Medicare and private sector.

So in terms of the leverage that I think we'd all like to see in terms of uniform reinforcement, private sector and public sector, and encouraging physicians on what we're referring to as efficiency, quality divided by resource use, there are some real advantages to focusing this 100 percent sample geography in areas where there's already pretty good progress on the private sector side in measuring resource use at the individual physician level.

DR. BERTKO: First of all, a comment. It's meant to really acknowledge staff here. I'm applauding that MedPAC and staff do that because anything you say will be worthwhile and credible overall. And since this is a big issue, both in Medicare and the commercial side, having staff do it on an unbiased basis is extremely useful. So no matter how big or small your project is, good, go for it.

Number two is there is what I'll informally, a user group, people who have employed the software already and perhaps a short cut on some of your thoughts might be to assemble some of them from the five or six plans.

MS. MUTTI: We'd love to get your input on that. We had a similar thought internally.

DR. BERTKO: Call me.

And then there's a third one which, again, this is scope creep so you can toss it if not. But to know the correlation between results for Medicare and commercial members would be extremely useful because the issues are much the same. And it would be really, I think, useful if not critical to MedPAC, to know this across the U.S. And there might be some positive stuff on both sides here.

DR. CROSSON: I have two comments. Just to echo everybody else, I think this is the right thing to do. This is where it is in terms of getting at the cost issue.

Two questions. When you talk about 100 percent sample in an area, is that in the fee-for-service payment system or does that include Medicare Advantage?

MS. MUTTI: Fee-for-service.

DR. CROSSON: That's what I thought, and I raise this at great risk to my own self.

DR. REISCHAUER: We're waiting for your data.

DR. CROSSON: Because I can't think offhand whether or not it's really doable because we don't have claims data. But we have begun, in some parts of the program, to ETGs and others have also. Of course, there's a benchmarking or comparison potential there that we might be

able to help with.

The last comment has to do with the compliance issue. Again, I think I would tend to down play that. it isn't to say that there aren't uncontrollable variables that physicians have to deal with. There certainly are. Some physicians, depending on where they practice or what kind of practice they have, have very different issues around patient compliance.

But it's also true that patient compliance is very much part of a physicians' responsibility. I think issues around such things as cultural competence and whether physicians have that capability or don't or try to develop it. The simple things like bedside manner, empathy, connection with individuals, the time and effort that that takes. The use of educational material, tag along, take home educational material, follow-up, the whole nature of follow-up. And more recently things like e-mail availability and the like. All of those things are very closely related to patient compliance.

I think somehow carving out patient compliance and saying that's not under the control of the doctors is not the case.

DR. MILLER: Perhaps in a dramatic turning of the tables, the reason that we put this on the list is that when we talk about this in the environment this comes up frequently, whether you're talking to people on the Hill or talking to people out in a provider community.

So I would say that, particularly for the physicians on the Commission, if you can help us with this that would be really appreciated. We feel that this is an issue that gets raised. We've had conversations that have not sounded unlike what you've said, and also the other side of the coin on the other hand, what do you do with a patient that just won't comply.

So we feel like it's an issue. And I would say at this point, in all fairness, probably don't have a whole bunch of ideas other than we feel that it's an issue that we need to drill down on. Because you've raised this.

DR. NELSON: It goes to other side, too. It's not compliant in terms of not following instructions and not receiving needed services. It's the flip side where you say to a patient you're doing really well, I won't need to see you for six months. And you know darn well they're going to call and ask for an appointment every month.

Or you don't really need that screening CAT, that total body laparoscopy. And they say yes, I do.

[Laughter.]

DR. NELSON: And as a matter of fact, the patient's needs -- well, Jay's folks wrote about the worried well and what a burden they were decades ago. And it's still a very real factor, particularly in fee-for-service where you can't tell a patient no, I won't see you. You can't very well say that.

DR. WOLTER: My comment was somewhat along the same lines on the issue of the physicians' role. It would seem to me that if the data is useful we may find some outliers that are ordering a CAT scan for every headache. And we may be able to make some physician specific conclusions about that.

But almost certainly, if the episodes -- particularly if we get into more complex illness and more expensive episodes that require hospitalization, almost certainly we're going to uncover varying patterns of resource use to which the solution is not centered necessarily only on the physician.

That would be part of my explanation out in the

community when this is looked at and when physicians raise questions. Because if you look at chronic illness, it's not best taken care of on a 15 minute visit every 90 days or every 180 days. There's teamwork that goes on in between those visits that often takes nurses or pharmacists or others to coordinate the care. I would hope that as we do this analysis we would, as we look at varying patterns of resource use, we might then want to take the next step of looking at what are the best practices? And those best practices go far beyond just pointing fingers at certain physicians. In fact, many of the solutions to controlling resource use involve physicians as part of a team that looks at delivering care in a different way.

I can't believe we won't head that direction once we start to see this data. Maybe that can be built in when you get criticized for looking at -- I think it's a bigger picture that we're going to be looking at here.

DR. REISCHAUER: Anne, will we ever be able to pick up that kind of thing?

MS. MUTTI: The best practices?

DR. REISCHAUER: I mean the fact that --

MS. MUTTI: Whether a team is used?

DR. REISCHAUER: Whether a team is used and if the care was, in a sense, delivered in a very different way.

MS. MUTTI: I am still probably too new at some of this software to remember how specific the coding is on a provider-specific basis to know if there's an ability to distinguish and whether we would even have that -- even if it's not regularly -- we would have that flexibility to start picking that out. I don't know.

DR. WOLTER: I would think that would be second level analysis. What you might find first of all is patterns of resource use that are different in one region or in one clinic or in one Northern Minnesota physicians' office or whatever it might be. And then we would have to make the decision to take the next step, which is go try to find out why is that happening.

DR. MILLER: I think that's some of what the thinking is of the 5 percent sample.

MR. DeBUSK: You'd be amazed with the resources used in a DRG in the operating room. There's not really near as much variation as you would think. The data shows that it's very, very close in the way of supplies used. Very close. There is a lot of data out there on that.

Some of these information systems have the item master file, of course you have on the doctor preference card you've got the billing materials. And there's a great deal of standardization in those bills of materials. And the resources go all the way back to the actual time that it takes a physician to perform the operation, the number of nurses or assistants or what have you. There's some real good information there on that which identifies a big piece of the cost.

DR. BERTKO: May I add just for Anne's benefit, having a second level of analysis -- that is not this one but the next one -- where you would resort the resulting group software, for example to capture hospital staffs by hospital, is a possibility as well as in some cases -- depending on how the UPINs are, grouping or regrouping small single specialty practices back together. The stuff is very robust once it's processed but the pain is in that first six months of data cleanup.

DR. MILSTEIN: Many of the aspirations expressed for a more refined and more adequately patient characteristic adjusted analyses will in no way be able to be touched, even by any conceivable second quarter analysis

that would give us information in a reasonable decisionmaking frame.

For me it brings us back to an issue that we continuously run up against in almost all of our deliberations that maybe is appropriate for our July retreat, which is what would constitute an adequate dashboard by which both we and CMS and anybody else ought to be to navigate in managing an industrial sector that's 15 plus percent of the GDP.

The kind of questions that have been raised are questions that need to be answered in the analysis. We make a lot of decisions without such a dashboard. I think there's no reason, with respect to this decision, to all of a sudden say we can't make this decision because we don't have an adequate dashboard because we don't have that adequate dashboard for almost all of the -- certainly the kind of variables that Jay is talking about are not available for us to deal with any of the cost basis and resource use analyses that we perform.

So hopefully we can deal with that in July but I don't think it should be the basis for impairing a decision on this.

Secondly, with respect to this question of is this is an area of opportunity for Medicare, I accept the fact that many years of DRGs have reduced within hospital resource use variation among physicians. But as one begins to pull the longitudinal frame out to a whole episode or a year's worth of chronic illness care, I can tell you that even in Seattle, where the Dartmouth team tells us is the world's nerve center of the highest decile cost efficiency in the country, the answer to the question from the private sector modeling that's been done in terms of by how much would total health care spending go down, if you could move the 50th percentile performance in that community up to the 80th percentile performance, holding quality constant, the answer is about 22 percentage points of spending opportunity for savings. It's quite big once you move out to the practice patterns outside of the hospital walls.

And last but not least, earlier when we discussed the Medicare Advantage recommendations, I re-raised this issue that we discussed before but which we haven't yet addressed in any of our recommendations as to are we going to take a position on this issue of release of the Medicare claims data, whether it's to Medicare Advantage plans or to

private sector health plans, as a way of accelerating what I'll call a synchrony between private and public sector efforts to recognize and reward better performing physicians in multiple dimensions not just resource use.

Mark and Glenn, I turn to you, but I keep hoping that at least embedded within some of these is going to be a resolution on that issue because it's been raised and discussed and I sense it's unresolved.

MR. HACKBARTH: I can't remember the context when we last discussed it, but it was an issue that we discussed briefly in the public meaning that it first came up. And then I talked to a number of the commissioners individually about it.

What I found in those individual conversations were that there were some strong feelings among commissioners that that would not be the right first step. If we want to go down the path of resource measurement in the Medicare program we need to take care which steps we take first. And having the release of the database to private payers was not a good first step in the view of a number of commissioners, let's develop the tool, let's get more comfortable with it within the context of the Medicare

program. And then, at a subsequent point, come back to the issue of release to private users.

DR. MILSTEIN: I would ask that we reconsider that decision, particularly in view of some of the alternative solutions to Medicare fiscal control that I believe are a lot worse than this particular alternative.

MR. HACKBARTH: On this and just about every other issue, we can talk about this at the retreat and then spend some more time on it. But I did take the idea seriously the first time, and there was some significant reservations that perhaps can be alleviated.

We need to move ahead. Thank you, Anne, very much.

Next up is hospital resource use and I think now we're getting closer to back on time, as much as we're going to skip the next item. Whenever you're ready.

MS. MILGATE: In our last discussion, you talked about next steps in measuring physician resource use. This session is our first direct discussion on looking at inpatient resource use.

Today we'll identify three key questions regarding this analysis and ask for your advice and guidance. We also

anticipate conducting interviews with others who have measured resource use associated with an inpatient stay and we'll use your guidance and what we learn from those interviews to design an analysis to measure inpatient resource use.

While this discussion does not include quality measures, we do anticipate bringing quality and resource use measures together in future discussions.

So how could information on inpatient resource use be used? As the Commission recommended for physicians back in March, it could be used as confidential feedback to physicians in hospitals for them to look at their own performance. It could also be used, as the Commission has discussed on several occasions, as part of a pay for performance program along with quality measures or to encourage hospitals and physicians to work together to improve efficiencies.

MS. CHENG: In this session, we are seeking your input on three overlapping questions about where to start with our analysis of alternatives for measuring resources associated with inpatient hospital use. The three questions broadly are which actors would you like us to include in our

measure? Which measures should we use? And what is our time frame? So the first question we have on the screen is who.

Which actors do you want us to include in an assessment of resource use associated with inpatient hospitals. We've heard from many sources that hospitals, as well as the physicians that they employ and physicians that work in them, all have potentially substantial impacts on the resources used in an inpatient stay. However, these groups may be functioning very independently of one another.

The strength of a more inclusive measure that reaches hospitals and physicians would be its potential to encourage coordination between hospitals and physicians who work in them to manage resources for an inpatient stay.

The second question -- and these are not exclusive questions, so the answer to one is very likely to overlap with your thoughts on the others -- would be which measure of resource use to use. We can think of at least three basic large umbrella ways of answering this question.

The first would be to draw a box around the DRG. The DRG would include the bundle of services such as staff

to care for the patient what he or she is in the hospital, hospital overhead, diagnostic tests and procedures that happen to the patient while he or she is in the hospital. The cost per unit of service at the DRG level seem to be mostly under the hospital's control, though physicians may have influence in terms of ordering tests and treatments while the patient's in the hospital.

Under the DRG payment system, hospitals already have an incentive to be aware of the costs that are in this particular box and probably to manage those resources well.

We could add a layer to this box and look at physician services that are associated with the inpatient stay. So in addition to the unit cost of services included in the DRG payment, we could also look at costs that are billed separately, such as specialist consults or the interpretation of images. Measuring unit costs at this level could acknowledge the shared impact of hospital and physician decisions on resources associated with the inpatient stay. Producing a measure such as this one could provide some new information to many hospitals and the physicians associated with them, it could launch a dialogue about shared opportunities to make the best use of resources

for patient care.

Our third concept, the broadest measure of resource use, could include both of those boxes and pull the box out a little bit to include resources that are used in post-acute settings, maybe hospital readmissions, or in other ambulatory care that follows but is associated with that inpatient stay.

The global surgical bundle already contemplates this unit of resource because it already includes pre- and post-operative visits in the payment associated with those inpatient surgeries. But perhaps the hospitals and the physicians associated with them should be given credit for the impact that their decisions can have on the resources necessary for a patient in settings outside the hospital as well.

However depending upon the actors, the answer to that who question we might choose for attribution, a unit of measure this large could improperly attribute responsibility to some actors who might not really be able to influence care outside the hospital walls.

The third concept that we'd like to get your feedback on is time period. How long does inpatient care

continue to affect patients' resource use after the discharge? A resource use measure that includes a longer time span could acknowledge the positive impact that more intense resource use on the front end of an episode might have over the span of an episode and the total resources required to achieve patient goals after the patient leaves the hospital.

The paper included examples of time periods and we had a couple of different ways of constructing these. We can imagine a time period with a pre-set ending, a certain number of days, or a condition-dependent ending, the end of an inpatient stay. Even longer time periods could even vary with conditions such as several months for a patient recovering from pneumonia, for example. Again, a longer time frame might imply more responsibility over a broader span of resource use than some actors may truly have.

MS. MILGATE: To help us begin the discussion and to think through how some of these ways of answering the questions might work, we included in your paper three examples. And I'm going to go through this very quickly at a very high level.

The examples each had a different purpose. Two of

them were research projects. The other is more applicable perhaps to what our purposes are here.

The first, the Leapfrog Group, as we've talked before Leapfrog Group is a group of large purchasers and plans. And they are developing a strategy for how purchasers and plans could measure resource use for hospitals. That is they aren't measuring themselves but developing a strategy that their members can use. So this hasn't actually been used yet. They're planning on rolling this out actually next month and to start looking at some early adopters and the experience that they may have.

This also points out, however, the differences between private sector and Medicare in the measures that you might look at. So for example, while the actor here is the hospital, they did not include physician data in this. They look at length of stay. So the measure basically, what you have this as a day measure, the unit of analysis versus any kind of costs or relative value units, which would probably not be what Medicare would look at because of the DRG payment.

But it's an interesting illustration here. what they do is look at the length of stay by five different

conditions. So they break out the resource use by five conditions. They also break the length of stay out by routine unit costs and special care unit costs. They adjust both of those separately by severity and then they multiply that by a readmission inflation number. So they take into consideration the readmission rates within 14 days of discharge from the hospital.

Obviously that's the time period they look at. They look at the stay and then 14 days after because they add in the readmission rate there.

They also add in quality measures on top of this and then use their resource use and quality measures to assign the hospital to four different cohorts, and I won't go into the methodology for how they do that.

The research that Fisher has done really was not designed to look at individual hospitals but to explore the relationship between high intensity and low intensity type care and quality. There again, they looked at academic health centers so it was essentially at the hospital level. Then looked at hospital and physician costs. And they looked over two periods of times. The stay started when the person went into the hospital and six months out. And then

they went from six months to five years, to see what kind of variation there might be across high intensity areas and low intensity areas and where those differences might lie in the types of services.

The final piece of work we looked at really just looked at the physician services around say the DRG payment. So they looked directly at physician service RVUs and used this to look at potential ways to profile physicians based on the fact that they were sort of grouped within the setting of the hospital to look at the way they manage resources in the hospital stay.

So here again, the unit of analysis was the physician, the measures were the RVUs for physician services, and they just limit it to the stay in the hospital.

I didn't give you any of the results of those studies but those were in your paper so I can talk about those if you needed that. This was really just for illustrations for the different way you could actually answer those questions.

That ends our formal presentation and we'd be interested in your guidance on these design issues.

DR. MILSTEIN: One comment and I think this does certainly reflect private sector, including Leapfrog, thinking on this issue is that the answer need not be one of these. It could be a combined, an index of resource use that would be a balanced scorecard across all three units of bundling, whether it's longitudinal bundling or service provider type bundling with or without physician services.

As we begin to think about it on the private sector side, you have this trade-off. The narrower your bundling, that is just what the hospital charged from the time the patient entered to the time the patient left, you have the purest measure of what the hospital is controlling. But you're obviously not capturing resource use outcomes that are extremely important to the Medicare program such as does the hospital fundamentally fix the problem in an enduring way that carries you through six to 12 months or, for chronic illness, five years?

You wouldn't want to not give a hospital credit if it's, in its both inpatient stay and its follow-up, doing an outstanding job of keeping the patient out of resource use and, for that matter, quality trouble.

So the private sector thinking, if we're trying to

do what we can to synchronize with it, would be the answer is not one of the above but actually a balanced scorecard that would take into account the multiple ways in which a hospital can be regarded as excellent on resource use.

DR. BERTKO: Just quickly, I'm a fan of total costs. I think Arnie said he was. I would just point out that if you link up to the work that Anne will do, you can actually use the episode groupers and just clip off the before incident, because they normally are linked to an event, and resort the answers by hospital. I've sorted them by hospital without clipping the front end so I know it's doable.

the other comment quickly, was just to think about outliers because certainly there were a couple of recent instances the last couple of years of some hospital systems abusing the outlier payment system. And rather than focusing only on DRGs, this might be a useful look as well.

DR. CROSSON: A similar comment to John's, I think. The one thing that's not included in the model is whether the patient should have been in the hospital in the first place. Of course, a cost of zero averaged in really gets you some good results.

I assume that, to the extent that it's being considered, is in the other study. That is, in the episode treatment groups. And that hospital costs are included in that; right?

MS. MILGATE: Actually, we probably should have suggested, these two analyses, there's a lot of overlap in the teams so that we are very aware of what the other is doing and we will try to build on each other's work and analysis to the extent we can.

The point with the inpatient resource was to dig in more deeply into that actual episode than you would necessarily get with just the claims data potentially.

DR. MILSTEIN: It would help to clarify as to whether our goal here is to evaluate inpatient resource use efficiency or hospital resource use efficiency for care that either begins with a hospitalization or, to take Jay's point, begins with a risk of a hospitalization. It gets you to a very different conclusion depending on whether or not what we're trying to do is purely measure inpatient resource use efficiency or the impact of an inpatient institution on total resource use.

DR. MILLER: Just to go back to what you were

saying a second ago, Karen, the way I would answer that is I think at this point in what we're working on, we can think of that question either way. In building the episodes on the work that Anne was talking about, you could encompass and look at a profile for a given condition, say diabetes, and see whether you have multiple hospitalizations for a given episode and given physician and talk about whether that resource use is sufficient.

And then these guys are saying now let's focus on the hospital and talk about those resources as it springs from the hospitalization and, I guess to date, thinking about through post-hospitalization. There was some thought to that.

MS. MILGATE: Right, and I think to add, inject, join in is that we thought we could get, through the claims that Anne was just speaking about, a fair amount of information even if we just limited it to those episodes that began with the hospitalization. But one of the questions we're also asking is should we dig into what's inside the DRG? And that would take a different data source. So just to throw that explicitly out on the table.

MR. ASHBY: Although we certainly have the

capability to do so. The question is whether the DRG payment that we already have has sufficient incentive to control costs inside the DRG. And that's kind of an open question.

MR. DURENBERGER: As I reflect on the alternatives Arnie laid out, and I reflect on the purpose of sort of evaluating the efficiency of a payment system, it sounds like you would start where Jay was. You'd start with that and you'd look at the effectiveness of the payment system in rewarding the physician who helps to prevent the hospitalization or the excessive use of whatever it is, procedures. But then there are obvious many situations in which that can't be avoided. So then you move up the line towards his first question.

It's sort of like a vote for all of the above but premising it on the efficiency or effectiveness of the payment system itself, and how does it incent or reward this various kind of performance by the doctors, the hospitals, and whatnot.

MR. HACKBARTH: Okay, thank you very much.

We're coming into the home stretch, the last turn.

The last item for today is the use of clinical and

cost-effectiveness information by Medicare.

MS. RAY: Recall we discussed the use of clinical and cost-effectiveness information by Medicare at the January meeting and at the March meeting Drs. Eddy and Newman specifically addressed the use of cost-effectiveness analysis by Medicare. Based on these two discussions, we've developed a draft chapter for the June report and that was included in your mailing materials.

We're looking for your input regarding its tone and content.

In the chapter we review CMS's process for using clinical information in the coverage process and we conclude with our support of the Agency's efforts and using an evidence-based transparent process, and more recently in collecting clinical evidence as a part of the national coverage process as a means to obtain better scientific evidence.

We also, in the chapter, discuss the more limited use of clinical information in the rate setting process.

The chapter then goes on to discuss the use of cost-effectiveness information by Medicare. Here we discuss what it is, how it has evolved, who uses it and issues

regarding its use. Cost-effectiveness analysis is not explicitly used by CMS. As discussed last month, valid concerns remain about the methodologies. For example, different cost-effectiveness ratios are derived from analyses modeling the same clinical conditions and comparative services.

We discuss in the chapter the unique opportunity CMS has to advance the field of cost-effectiveness analysis. The Agency could advance the field by helping to standardize the methods. CMS's involvement would better ensure that methods were developed in an open and transparent process like the current national coverage process.

Finally, in the chapter we talk about four potential ways Medicare could begin to consider cost-effectiveness analysis. First, the program could begin to collect the information in the coverage process. If feasible, it could be collected when conducting practical clinical trials and data registries.

In addition, manufacturers who have already prepared such analyses could provide them to the Agency. Such analyses could help the Agency better understand the value of a new service. A recent guidance document suggests

CMS is already interested in collecting information about real world outcomes including quality of life and costs when coverage is linked to prospective data collection.

Second, Medicare can sponsor and provide high-quality cost-effectiveness studies to beneficiaries and health professionals. Both beneficiaries and providers are important audiences for information about the value of medical services that cost-effectiveness analysis can provide. Using cost-effectiveness analysis might be a tool to promote the use of appropriate care by providers and patients.

Third, CMS could begin to use available high-quality evidence to prioritize disease management and pay for performance initiatives. As an example, consider a Medicare-covered preventive service such as hemoglobin-A1c for patient with diabetes. Cost-effective analysis could help inform policymakers and providers about how frequently to provide the tests and for which populations to focus.

Lastly, if the field of cost-effectiveness involves and methodological issues are addressed, it might be applied in Medicare's rate setting process. Models for doing so exist but acceptance of cost-effectiveness models

would need to be higher before this could be undertaken.

That concludes my presentation and we'd like your comments.

MR. HACKBARTH: Questions or comments for Nancy?

MS. DePARLE: I guess where are we going, are we thinking we'll develop recommendations for next year? Where are we going?

MR. HACKBARTH: The question is do we envision at some point, not now but some point in the future, making recommendations on this?

I think potentially yes, but I think that we need to do some more thought about that. This, as we conceived it all along, was basically an informational discussion in the June report. But it certainly gave me some ideas about where you might want to begin in going down this path.

MS. DePARLE: I think I interrupted Arnie, but since I grabbed the Mike.

I think we should look at it. I think there should be a sense of urgency about it. As Medicare begins in January the covered prescription drugs, for example, and we launch on a whole new needed but very expensive experiment in spending and buying things, I think it's

extremely important to have this kind of infrastructure of some kind in place.

And I think there is not full support on Capitol Hill for it right now and I think MedPAC's weighing in could be helpful. So I would at least say there should be a sense of urgency around this.

MR. HACKBARTH: The other thing that struck me from our conversation with David Eddy and Peter Newman was their advice that there are ways to approach this that may be easier, where you meet less resistance than trying to do it first through the coverage process, which is -- and Bill Roper tried before you.

I was particularly struck by the pay for performance angle on this. If we're going to start paying bonuses for adherence to certain clinical guidelines or whatever and say this is good care, I'd like to make sure that it's also cost-effective care.

If we don't restrict the coverage process, we will still be paying for things that may be helpful but not cost-effective. But if we're going to make bonus payments over and above that, let's try to target those on things that are also cost-effective.

So I think that's one avenue that I would be interested in exploring.

DR. MILSTEIN: I share Nancy's view about the urgency of this. And specifically would ask that we consider making more specific the first bullet. Irrespective of how we think such information ought to be used, and there certainly is probably a wide spectrum of opinions on that, I think at a minimum we have to recognize two sources of current informational poverty.

Number one is lack of standardized methods in how cost-effectiveness studies are done. And secondly, lack of investment or any foreseeable source of investment as to how this information with respect to treatments might be more routinely generated.

One way of beginning to solve both of those problems would be for us to expand the first bullet of what we may wish us or Medicare to consider, to ask at a minimum that we require as a part -- not as a basis of a yea/nay on coverage but as a source of routine information for a variety of uses. That when Medicare is considering coverage for a condition that cost-effectiveness study relative to alternative treatments at least be submitted, be part of the

process using a standardized methodology so we begin to deal with this problem of poverty of information irrespective of how we think that information may or may not be used going forward.

MR. MULLER: And as we discussed last month and at times in the past, the coverage decision can be very much a green light/red light decision. But then once it's made, I think we've discussed it the most in imaging last year. But it's both the advantage of the technology from the single slice images to 64 now, or whether it's the proliferation of use for other diagnoses, or whether it's the venues in which it's done. So in some ways we focus on that first coverage decision. But once it's open, it can proliferate enormously at a geometric rate.

One of the questions I think we asked Eddy was by and large there's a lot of focus on the drug coverage. But an awful lot of the diffusion of technology is in devices and other technologies. So we should not just look at coverage but look at the whole diffusion of technology beyond that, and whether it's cost-effective in the areas beyond its first introduction into the program.

So I think obviously, like others, I think work in

this area should be highly supported. And everything we see is that the drive towards bringing more and more appropriate innovation into the medical field is only accelerating. Obviously, beneficiaries want it, all the suppliers want it, all the providers want it.

Every pressure is on the side of more and more diffusion.

MR. HACKBARTH: Other thoughts on this chapter? Okay, thank you, Nancy.

We'll now have a brief public comment period. And I'd ask you to please keep your comments brief and, as always, if there are subsequent commenters and you want to say the same thing as somebody who went before you, don't feel the need to repeat it. Go ahead.

DR. WILSON: Hi, I'm Amy Wilson. I'm a physician from Dallas, and I work at an inpatient rehabilitation facility, Baylor Institute for Rehabilitation. It's in downtown Dallas.

First of all, I'd like to compliment the research team for tackling a tough issue.

I wanted to clarify a couple of points. First of all, are the researchers still here? I was wondering, did

your data include the time frame in which certain facilities were still under cost-based reimbursement versus going to PPS? You know, that was phased in starting in probably the fall of 2001. So I was wondering if that cost data that you all reported was mixed data?

MR. HACKBARTH: Could I make a suggestion? For questions of that nature, more technical issues about how research was done, I think the most efficient way is for you to talk to Sally afterwards, as opposed to use the time.

DR. WILSON: I'd be happy to

I also wanted to reiterate, and they acknowledge that this was the case, but their outcome data being institutionalized versus dead is very extremely limited outcome data. And that needs to be brought to the panel's attention.

Also, part of their efforts to evaluate patients functionally was to develop a pseudo-Barthel Index and I wanted the panel to understand that that's not a commonly utilized index in the rehabilitation setting. We participate in a couple of different national reporting data centers, including UDS and Rehab Data. And all of those are FIM-based. So it's kind of not a fair comparison.

I do recognize that there's no way to compare home-based patients versus inpatient rehab patients versus SNF patients, but the Barthel is not routinely used.

And that's my comment. Thank you.

MR. HACKBARTH: Any others?

Thank you very much and we will reconvene tomorrow morning at 9:00 a.m.

[Whereupon, at 5:05 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, April 22, 2005.]

# MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

Friday, April 22, 2005
9:05 a.m.

COMMISSIONERS PRESENT:

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

P R O C E E D I N G S

MR. HACKBARTH: Good morning, everybody. First up this morning is a presentation on monitoring the implementation of Part D.

MS. BOCCUTI: Good morning. Policymakers will need to monitor the implementation of the new Medicare drug benefit to evaluate plan performance and to measure how well Part D meets objectives for cost, quality, and access. In current practice, employers, individuals and government agencies use performance measures to evaluate how well health plans and PBMs manage drug benefits.

MedPAC staff convened a panel of experts to discuss how performance measures are used currently and to identify ways policymakers could use them to monitor the Part D program and to evaluate the performance of participating plans. The panel had 11 members who represented health plans, pharmacy benefit managers, employers, pharmacies, consumers, quality assurance organizations and researchers.

The expert panelists discussed measures among

several broad areas, cost control, access and quality assurance, benefit administration and management, and enrollee satisfaction. CMS will relevant data to construct some performance measures in all these areas. Indeed, CMS intends to use performance measures in the future but has not yet determined what those measures will be and how they will be used.

On the next four slides I'm going to show you some examples of performance measures that are currently used to evaluate the performance of plans and PBMs. Please keep in mind that these examples are only meant for illustrative purposes. Many additional measures are in current use and further research is needed to determine performance objectives for these measures.

So under cost control the panel agreed that group health purchasers rank cost as a top priority in evaluating the performance of their health plan or PBM's drug benefit management. In general, PBMs and health plans control drug benefit costs by negotiating with pharmacies and drug manufacturers and by managing members' utilization.

Performance measures on pharmacy negotiations can include dispensing fees and generic dispensing rates. Other measures on cost negotiations are discussed in your mailing materials.

For measures that examine drug utilization management, examples on this slide includes some that NCQA has developed, including average per member per month spending and prescription costs. Drug utilization activities such as formulary design can also be measured, such as the extent to which members take preferred over non-preferred brand name drugs.

Panelists commented strongly, however, that physician prescribing and patient preferences are major drivers of these kind of rates, but acknowledge that health plans and PBMs have several tools to educate physicians and members on the rationale for distinguishing drugs by preferred and non-preferred tiers. Many group health purchasers as well as individual purchasers also monitor enrollees' out-of-pocket costs as this effects the benefit's value as well as enrollee satisfaction.

Among many other data, CMS will collect information on dispensing fees, generic dispensing rates, aggregate rebates, confidentially, drug claims and drug spending. Much of this information could be analyzed at both the plan and beneficiary level. Thus, the data could be used both to compare plan performance and to determine how well the Medicare drug benefit controls program and beneficiary costs over time. In combination with health claims data, these measures may also be risk adjusted.

A major objective of offering a drug benefit is to provide access to needed medications. The expert panelists noted that developing performance measures for access and quality goals can be complex, but identified several. Pharmacy access is a major factor in selecting a plan or PBM, both for group health purchasers and for individuals purchasing their own drug coverage. Employers often request detailed reports on pharmacy location by ZIP code.

To assess access to medications, purchasers may track turnaround times for prior authorization requests and appeals determinations. Panelists discussed how non-

formulary exception and appeals rates might be a useful measure on access but that it's difficult to interpret. That is, a high share of non-formulary use could indicate that the plan has a flexible exceptions process. Or alternatively, that the formulary is out of date or that physicians do not find it acceptable.

In this same vein, a low exception ratio may mean that the process for granting a non-formulary exception is to onerous. Or alternatively, that the formulary is relatively unrestricted and accepted by physicians. Other access measures purchasers use examine some things such as refill adherence for chronic conditions like hypertension.

In addition to interpreting access to needed drugs as a measure of a benefit's quality, more direct quality measures are also available. For example, NCQA has proposed measuring how well health plans reduce their elderly members' use of drugs such as barbiturates that are contraindicated for the elderly.

As a side note, the expert panelists agreed that the most important and influential component of quality

assurance in drug utilization is physician prescribing. Accordingly, health plans and PBMs are exploring e-prescribing which may assist physicians with safe prescribing decisions, formulary education, and error reduction due to illegible handwriting. Under Part D, CMS will collect data on many of these access and quality measures. CMS will have information on plans' pharmacy networks, formularies, including prior authorizations and exceptions, appeals rates, and of course will have drug utilization data.

Purchasers rely on health plans and PBMs for core administrative functions such as processing prescription drug claims, managing drug ID cards, and coordinating benefits. They're also known as adjudication of primary and secondary payer information. Most drug claims are processed almost instantaneously because health plans and PBMs are linked by electronic communication systems. But delays and errors can occur, particularly if systems are out of date. The experts reported that many purchasers routinely look at accuracy and timeliness of their PBM's ability to process

claims which includes eligibility determinations, and third party effect on cost sharing determinations.

Under Part D, plans will have to assist pharmacies with calculating beneficiary cost sharing at the point of sale because the amount a beneficiary needs to pay depends in large part on how much he or she already spent on covered drugs during the year. The panelists agreed that early monitoring of these administrative tasks could smooth beneficiary enrollment into the Medicare drug benefit. CMS will collect data on claims processing including plans out-of-pocket calculations. CMS may also review the monthly statements that plans provide to beneficiaries explaining their benefit spending.

Our expert panel found that measures to track enrollee satisfaction are a common component of performance guarantees that health plans and PBMs offer to their clients. Individual consumers are also very interested in satisfaction rates. Health plans and PBMs, therefore, provide purchasers with the results of member satisfaction surveys.

Panelists stated that another indicator of considered satisfaction focuses on the performance of customer service call centers. Purchasers commonly examine the length of time callers wait on hold and abandonment rate, which are the share of calls for which the caller hangs up while waiting on hold. Complaint rates or disenrollment rates are other performance measures that purchasers use to judge member satisfaction. Some plans and PBMs also provide purchasers with the average number of member complaints they receive per year.

Under Part D, CMS will conduct consumer satisfaction surveys to provide comparative plan information to beneficiaries when they're making enrollment decisions. With this survey, Medicare will not have to rely on plans to report consumer satisfaction rates. CMS is working with the Agency for Healthcare Research and Quality to develop this survey. Plans will submit data also on grievances filed, which are similar to complaints, and call center performance measures such as abandonment rates and hold times. Panelists suggested that CMS also collect data on call

centers' ability to serve non-English speakers. Finally, CMS will be collecting data on plans' annual retention and disenrollment rates.

So a few conclusions here. From this presentation you can begin to see that CMS will be collecting a large amount of data on Part D, including drug utilization and plan benefit information. With this data, CMS intends to construct and use performance measures in the future, but as I mentioned has not yet selected these measures or determined their use. In addition to CMS's need for this data, congressional agencies will need Part D data to report to the Congress on the impact of the drug benefit on cost, quality and access.

So in consideration of this need we present a draft recommendation for your review. The draft recommendation reads, the Secretary should have a process in place for timely delivery of Part D data to congressional support agencies to enable them to report to the Congress on the drug benefit's impact on cost, quality and access.

The rationale for this recommendation is that

congressional agencies need this data to provide analysis and recommendations to the Congress on Part D.

The spending implication of this recommendation is that it would not increase federal program spending. This recommendation would have no direct impact on beneficiaries. It would also not affect provider cost or administrative burden because it does not require submission of additional data.

A final note before I conclude this representation. In your mailing materials you have a draft chapter which includes material that you have seen before, such as grievance and appeals which Joan worked on with Margo Harrison, and premium information that Rachel has also presented. So we can take comments on the entire draft chapter as well as this presentation.

DR. MILLER: If I could just say one thing on the recommendation. We fully expect that they are going to be providing data. I think the concern here is that agencies like ourselves and other congressional support agencies don't end up waiting 18 months or even a year for the first

pass. I think there's going to be intense pressure from the Hill to want to know what's going on and for us to be able to respond. I think we're just looking for sending a signal that they're thinking about this.

MS. DePARLE: I think this is very important and thank you for the work you've done on it.

I want to go back to focus on where the gaps might be in the data that CMS is going to be collecting. And in particular, slides four and five on the cost and access and quality, because I thought on the administration of the benefit I'm relatively confident that they'll have lots of information about the claims processing. That's a very typical thing for them. And beneficiary satisfaction, I also think they've done a good job there.

But on four, on the cost, for example, to what extent do you think they'll be able to assess whether particular plans are getting a good deal on the drugs that they're purchasing? Will they know by drug? You say they'll have information on the average prescription cost, but will they know by Lipitor or Zocor or whatever it is,

how much people are paying in various plans?

MS. BOCCUTI: Yes, they'll be able to see what is on, because with every drug event there will be the actual drug. The data will collect the drug and the spending that was occurring on that drug, so there will be ability to track how much was paid at the point of sale. Is that your question?

MS. DePARLE: Yes. Is it your understanding in general, to follow up on what Mark said, when you say here that CMS will collect this data, how did you learn that? Is it staff at the agency say they're planning to do that, or how do you know for sure they're going to do that?

MS. BOCCUTI: I think the date is April 12, so just recently they released a final guidance or -- it's a bigger word than guidance. It has more weight to it than guidance. They are the rules on what the prescription drug event file has to include, and it is over 30 items. I imagine that John knows this well, but many of the items will be taken care of at the point of sale that the pharmacist will have to put in.

MS. DePARLE: So plans are told they have to be able to provide this data?

MS. BOCCUTI: Correct. It's a file. It has a file format, and it has much information on the transaction.

MR. BERTKO: Nancy, if I could add. This is going to a data aggregator because to the extent that people change for any reason there has to be a way to coordinate that. So basically plans have to send it into there, it sits there -- and it's in a detailed format with those 30 elements roughly.

So the one comment I would add is this is a big undertaking to collect data on as much as 40 million people so I might expect a few road bumps, speed bumps at the start, but it should all be there eventually.

MS. BOCCUTI: CMS is collecting -- after one month they're going to look at how the data is coming in, and then six months later. So they're going to try right away to see how the data collection is going.

MS. DePARLE: From this list on slide number four, are there any gaps in what you understand they're going to

be collecting and what is best practice of what you think we need in order to assess the drug benefit costs?

MS. BOCCUTI: I think the data set will be rich, and it doesn't concern me. There are not huge gaps.

MS. DePARLE: Good. And on slide five on access and quality, it sounds like you think they're going to be collecting much of the data about the pharmacy networks, and prior authorizations and appeals rates, but what about things like the other two bullets on refill adherence and contraindicated drugs, do you know whether that kind of information will be available?

MS. BOCCUTI: This is where the data that CMS will have, people looking at the data could use it to say, for instance, refill adherence for a chronic condition. Someone using the data that CMS will collect will be able to say by therapeutic category. It will even know whether it's a 30-day drug, a drug or 60 or 90-day fill, how often at the beneficiary level that was refilled as one would assume was indicated. That way someone looking at this dataset could even look more broadly at the Medicare population to see how

is it that Medicare beneficiaries are getting access to drugs, which is one of the objectives of the drug benefit in general.

So you could compare that at the plan level, in general are beneficiaries knowing to access the drugs regularly? Is the plan helping them with that? And then track over time for the whole benefit.

MS. DePARLE: So you don't see a gap there in that?

MS. BOCCUTI: Right. The data is there to make that kind of analysis. It's not necessarily that the plan is submitting it in that kind of a format.

MS. DePARLE: Will CMS be able to look at it at a physician level in terms of who did the prescribing?

MS. BOCCUTI: There is actually a prescriber code associated with the drug.

MS. DePARLE: Because I know we talked about, in our pay for performance discussion around physicians, that it would be useful to have this. So if we think that's important we should say it.

That's very good. Thank you.

MR. BERTKO: Just a nice report. I think you've captured most everything. My only comment would be, in the start-up phase particularly we may want to acknowledge that with the bidding process in the way that things are set, a health plan may pick up anywhere from one to one million members and won't know that until September first or so. So I would personally expect some lumpiness on the call center side and other things, and maybe we could just acknowledge that.

MS. BOCCUTI: We say the implementation, but it doesn't mean the initiation. But that's a good thing to capture, that these kind of measures could be in place as long as the drug benefit is in place.

DR. REISCHAUER: Cristina, I thought you and your colleagues really have provided a service sentence and people will be very interested in this chapter when it comes out. I just have a couple of questions.

One is, was there a mention here that several entities had suggested they we were going to have a national

plan? If you have a national plan, do you have to have a single premium or can you vary the premium by -- so what it is really is an amalgam of regional plans, but the benefits, formulary, et cetera, is constant?

MS. BOCCUTI: Rachel has been focusing more strongly on this so I'm going to make sure I don't misstate the truth here.

DR. SCHMIDT: I think it's likely that they'll have different premiums in each region.

DR. REISCHAUER: They're allowed to, John says.

DR. SCHMIDT: John could probably speak to that. But I think there's an incentive to do that in order to have risk corridors specific to each region. So you're essentially going to put in --

DR. REISCHAUER: So it really is then just a whole bunch of separate plans put together if you're going to have -- you don't even have to amalgam all of your profits and losses across the nation?

DR. SCHMIDT: No.

MR. BERTKO: No, in fact it's the other way

around. From what I understand on some of the bidders' calls, you cannot cross-subsidize across regions. Now I know that's absolutely true on the MA side. I think it's equally true on the PDP side.

DR. REISCHAUER: This is all very interesting because this is handling the equity issue exactly the opposite of how we do in Part B. So it's really food for future Commission discussion that I think will be very interesting to see how this plays out.

MR. HACKBARTH: What about the formulary question that Bob asked? In a national plan would the formulary be constant or would that also --

DR. SCHMIDT: Isn't that a plan decision, John?

MR. BERTKO: Yes, it's a plan decision and you could argue both ways. Getting formularies through the approval process is important and substantial work.

Secondly, there could be positive benefits for having a certain formulary in terms of your discount negotiations. On the other side of it, people have different preferences for drugs and you may decide the New

England one is different than the California one.

DR. REISCHAUER: This is a problem like the CPI. People don't realize but when you do meat in the CPI, the ratio between chicken and pork differs across the regions of the country and what they're pricing, so we're in the same game here.

The rebates. I was just wondering, I'm Pfizer and I'm giving a rebate to Express Scripts and I have to segregate my rebate for the Medicare program from my rebate for the commercial business that Express Scripts is doing, which of course leaves a lot of room, shall we say, for flexibility, to be polite about this. Because it's the same flow of payments and what they really care about is the aggregate amount of Lipitor that Express Scripts sells.

MS. BOCCUTI: What's your question?

DR. REISCHAUER: It's an observation about how inherently difficult all this is.

MS. BOCCUTI: We tried to capture that.

DR. REISCHAUER: I'm not suggesting anything malevolent here in all. It's just that it's going to be an

absolutely impossible thing to really nail down.

MS. BOCCUTI: Absolutely, it's a tricky calculation and I think we acknowledge that in the chapter.

DR. MILLER: Isn't the construction here that plans are supposed to submit that information, make that adjustment, and there's not a uniform -- there's the possibility of look-behind, right.

DR. SCHMIDT: Certainly there's the possibility of some audit. But yes, they have to submit aggregate level rebates and apportion some to the Medicare population.

DR. REISCHAUER: But even an auditor wouldn't have the faintest idea how to go about something like this.

You said that one entity is going to be responsible for keeping track of the out-of-pocket expenditures?

MS. BOCCUTI: The plan is a big participator in helping to figure out -- to adjudicate how much the beneficiary is going to be responsible for out-of-pocket. There is an entity that CMS has an RFP out for and they're going to have one entity that's going to be managing the

software basically. But the plans will have to give them the data to make this -- and I think in the last week I've gotten a better handle on that and we'll punch that up a little bit more in the chapter because I think I made it sound --

DR. REISCHAUER: It sounds like there's one big computer somewhere that's keeping track of every --

MS. BOCCUTI: Exactly. And the plans have more responsibility on making sure the data that this system uses is accurate and correct.

DR. SCHMIDT: Also, the individual enrollees are responsible for saying whether they have other coverage.

DR. REISCHAUER: That's an impossible thing otherwise to get a handle on.

Have other people been talking about the variations in premiums of the order of magnitude that the chapter suggests might emerge?

DR. SCHMIDT: I'm aware that ASPE, for example, has been doing some research on this. I don't think that their research has been made public yet though.

DR. REISCHAUER: That would be interesting.

Thank you.

MR. HACKBARTH: I'm thinking about Bob's early observation that the equity issue, in terms of the premium-setting here is a different approach than under Part B, if they're not permitting cross-subsidization across regions. That set me to thinking about some other comparisons. The sort of information that's being collected here is very different from the sort of information that's collected from private health plans providing Part A and Part B. Much more detailed information here.

I'm not sure what to make of that but it's a striking a difference. It's much more as though you were an employer contracting with a single PBM and saying, I want evaluate their performance in managing my drug benefit, as opposed to a system where we are offering competitive choices to consumers and the letting them judge.

MR. BERTKO: Glenn, I guess I would disagree with that comment in the following sense. This is all prospective, and say the big calculation, for example, is

going to be fairly transparent. Not perfectly, but fairly. To the extent that -- I'll say this is probably the economic leverage and I hope the economists here would agree -- that the company that has 2 million members is likely to get bigger rebates from Pfizer or somebody than the company that has got 20,000 members, and those are going to be, presumably almost entirely passed through to the members which will then be reflected in the prices.

MR. HACKBARTH: But my point is that we don't collect information on the plan contract rates with hospitals to compare the contract rate between health plan A and health plan B in the same market. Or we don't collect information on their call center times and most any of the other variables here. I'm not saying that's better or worse, I'm just saying it reflects a different thinking about the relationship between the government and the plans delivering the product.

Other questions or comments?

DR. MILSTEIN: To follow-up on Nancy-Ann's question. Two comments.

First, the earlier point about making sure that we indeed have unique prescriber identifiers is one that I think is important to nail down. I think the main challenge to that is institutional settings in which in some cases institutional and provider IDs rather than individual prescriber IDs end up being collected. I think for those people who are interested in medical education who would like -- providing feedback to the residents they're training earlier in the process, it would be, I think, important that we establish that whether it's the NPI that we're moving to or the UPIN that we're currently using, but that we use prescriber-specific identifiers, particularly if we want to pull this into any kind of pay for performance and/or medical education use.

Second comment is, looking over the reporting elements there are, as I think John will attest, there are at this point in the country specialist vendors whose job it is professionally to audit whether PBMs are primarily focused on, are they doing everything they can do to optimize the out-of-pocket spending of the beneficiary and

minimize the total cost of the plan, whoever is sponsoring it.

As I look at these data elements and reflect on what are some of the common ways in which these specialists identify shortfalls today between would be considered to be best-in-class performance and middle of the road performance, there's some data elements that look to me to be not present, or at least not what these specialists would want on their scorecard. One being, once therapy has been established, proactive switching to more cost-effective agents, the better PBMs are more successful in that. I don't see that reflected.

This may be too detailed to be captured here. Maybe this is not a full list but what was provided to us. But interventions having to do with duration of therapy was -- therapy that generally ought to only last three weeks and it's now three years into it and it's still being prescribed. From my having listened to some of these specialist vendors, these are some of the tricks of the trade that still to this day account for a five to 10

percentage point opportunity to improve the efficiency of pharmacy spending.

So I guess the idea, should we consider in some of the supplementary language, recommending that CMS before finalizing this list check in with some of these specialized vendors.

MR. HACKBARTH: Are these firms that we would recognize the name of, or are these really boutique operations?

DR. MILSTEIN: These tend to be boutique operations, but they're use by the Fortune 500 and in large state --

MR. HACKBARTH: It would be helpful if you could share some of those names with the staff.

DR. MILSTEIN: Sure.

MR. BERTKO: Glenn, let me add to that. Some of what Arnie is describing may show up in the MTMPs, medication therapy management programs. I don't think you had a direct mention of that in there but it could be added.

MS. BOCCUTI: I didn't. That's a good pickup of

what's not in the chapter. That seems like it's really still in formulation. Even the panel discussed to some extent, it's not clear who they need to have qualify for, because the spending range is so great. So I thought that we would focus on what we know more than what we didn't. But do you see a need to --

MR. BERTKO: Perhaps along the lines of what Arnie is suggesting, a brief mention that these are just what you said, they're in format, or they're being formed.

MS. BOCCUTI: That's a good idea. That might be a component.

MR. BERTKO: Yes.

MR. HACKBARTH: Other questions or comments?

Shall we proceed then to the recommendation?

Any clarifications necessary on the recommendation?

Okay, all opposed?

All in favor?

Abstentions?

Okay, thank you.

Next up is our review of CMS's estimate of the physician update for 2006.

DR. HAYES: Good morning. During this session we hope to address two topics. The first concerns a technical review of CMS's estimate of the payment update for physician services for next year, 2006. We also want to address another topic concerning spending for physician services in 2004. Both topics were addressed in a letter that CMS sent to MedPAC on March 31.

The link between the two topics concerns the way the payment update is calculated. As you know, there is a statutory formula for doing this that includes a comparison of actual spending for physician services with a target based on a sustainable growth rate that's defined in law.

We addressed these two topics in a draft chapter that we sent to you before the meeting, and the plan is to use that chapter to fulfill the Commission's requirement to review CMS's estimate of the payment update for next year.

One note on this review. This will be the sixth such review that the Commission has conducted. It has been

a technical review, one that involves an examination of how CMS has calculated the update numbers they have used in the calculation, and so forth. It's a separate matter, the question of what the update should be, and as you know, the Commission has made a recommendation on that already in the March report.

Turning first to the update estimate, we see that the calculation shows, the numbers shown on the bottom of this slide, an update of minus 4.3 percent. That includes, first, an estimate of the change in input prices for physician services which at this point is 2.9 percent. That's likely to change up or down by a few tenths of a percentage point between now and November when CMS finalizes the calculation.

The other component of this estimate is what's called an update adjustment factor. This is the part of the calculation where that comparison of actual spending and the target occurs. We have two figures shown here. One is a maximum of minus 7 percent. That is a maximum defined in law. When you combine that maximum of minus 7 percent and

the plus 2.9 percent we get this minus 4.3 percent. It's not an additive relationship. It's rather a multiplicative one, so we don't want to try to add the two numbers together to get the 4.3 percent.

The more important point though has to do with the update adjustment factor that's calculated with the formula, and there CMS estimates that that number is a minus 21.1 percent; a big number. It's the update that would occur, the adjustment that would occur without that maximum that's stipulated in law. Because that calculated update adjustment factor is so big, it's very likely that the calculation will produce a result different from the maximum negative update permitted under law. It signals a very wide gap between actual spending for physician services and the target. The numbers that go into calculating that thing would have to change by an unrealistic amount in order for the outcome to be any different from the type that we see here.

This next graph just shows that gap. What we see here is that the gap widened some in 2004. The reason for

that has to do with growth in the volume of services. The target includes an allowance for volume growth which is based on growth in the national economy and actual spending has exceeded that.

That then brings us to the question of, or the matter on the spending that occurred in 2004. As indicated in CMS's letter to us, the growth in spending in that year was 15.2 percent. This is a large increase that cannot be explained by the payment update for physician services in 2004, which was 1.5 percent and just growth in the number of Medicare beneficiaries. So that leaves then volume growth as the primary determinant of this spending growth that was seen in 2004.

I should point out before we leave this slide that there have been questions raised about the spending level, not for 2004 so much. That's acknowledged as a preliminary number at this point. But there's been question about the spending number for 2003, whether it's too low, whether it's understated. That's important for purposely of calculating the change because it would produce a higher change if that

number was understated.

In checking with CMS staff, they see no reason why the 2003 number would be understated, do not believe that it is understated. In some respects it doesn't make a whole lot of difference. If we look at the numbers in different ways you come away with the conclusion that 2004 was an exceptional year. We can see from this chart that the gap between the target and actual spending was the widest it's ever been. We could also look at numbers that are in the report from the Medicare trustees and those are probably the most conservative numbers available, what happened in 2004, and still we see large volume growth in that year, larger than has been seen at least since 1992 when the fee schedule was first used.

Where did the spending growth occur? What services were involved? This slide shows services ranked in descending order of their percentage of spending, and what we see is very high growth for a number of categories of services. In particular minor procedures and imaging, but also the category called laboratory and other tests, and

Part B drugs.

In the letter that CMS sent to us they make a point that, and as I've said already, that what's underlying the spending increase in 2004 is growth in the volume of services. So what we wanted to do was try to look at volume growth by type of service and link the change that occurred in 2004 with numbers that you've seen previously on growth in the volume of physician services. We're able to do that for about four categories of services that you see listed here, visits, minor procedures, imaging, and major procedures. We're not able to do that so readily for some of the other services that were listed on the previous slide.

In any case, what you see is that volume growth for two categories of services was very high: minor procedures and imaging, both growing in terms of volume per beneficiary at 18 percent.

Now there's a caveat that goes with the minor procedures' number. It includes a restructuring of payments for chemotherapy administration, so that could have some

role in the 18 percent increase that we see here. But just to put that in perspective, we looked at the share of spending in this minor procedures category that's attributable to chemotherapy administration. Can't do that yet for 2004, but in 2003 at least that spending share was 3 percent of that minor procedures category.

Also note that volume growth was higher than we've seen previously for both visits and major procedures.

What are the consequences of this volume growth? First off, it puts upward pressure on the Part B premium. As you know, the premium is the source of financing for Medicare Part B. It accounts for 25 percent of that financing. According to CMS, the premium may go by as much as 14 percent in 2006. That would be on top of the 17 percent that's already occurred for this year, 2005.

The volume growth also has implications for taxpayers. They are responsible through the general revenues of the Treasury, responsible for the other 75 percent of Part B spending. The trends that we are looking at here suggest that not only is this going to increase

spending but it also increases the likelihood that general revenues will exceed 45 percent of Medicare spending. According to a requirement in the Medicare Modernization Act, if there's a finding that that will occur in two consecutive reports from the Medicare trustees then the President is required to submit legislation to the Congress in response to the warning, and the Congress is required to consider the legislation on an expedited basis.

Finally, it's worth noting that the magnitude of this increase would raise questions about the value of purchasing of Medicare services because it is unclear whether all these services would represent services that are needed by Medicare beneficiaries.

So the question then is whether all of this argues for some fundamental change, including changes in the way Medicare pays for physician services. In the letter to us, CMS indicates that the agency plans to engage the physician community on these issues. MedPAC, for its part, has already made recommendations in areas such as pay for performance, measuring resource use, reform in the physician

update, developing quality standards for imaging providers.

Other work we have planned involving the services that are included in the definition of physician services includes laboratory services and work on physical therapy. Physical therapy, by the way, is part of that minor procedures category where we saw rapid growth in spending.

Other issues we could consider concern the fee schedule itself, and that brings me to the last slide which lists some topics that we could address during the coming year. In most cases these issues address potential mispricing of services and, therefore, may have some relationship to the volume of the services provided to Medicare beneficiaries. I don't want to go into detail on these right now. They were addressed in the draft chapter that we sent you. Let me just illustrate. In the case of the first topic here it appears that the geographic adjuster in the fee schedule is over-adjusting payments for services surfaces that involve a higher-than-average use of equipment or supplies. Imaging services would be an example of this, and during the coming months we would plan to look at this

issue more closely and report back to you.

Let me also draw your attention to the third bullet on this list, new versus established services. This is part of the general topic of how payment rates are determined in the fee schedule one service relative to another. That's the subject of our next session this morning on valuing physician services.

So I'll stop there and do my best to answer your questions.

MR. HACKBARTH: Could I ask just a question, a reaction from John and Arnie and Jay who see these issues from the private side? How do these trends compare to what you're seeing in your worlds?

MR. BERTKO: I'll start and try to speak industry-wide for what I look at. I have to break it into several components. On the physician side itself there is a much more moderate trend then I think what you're seeing here; 7 percent, 5 percent to 7 percent or so range, and I think that's pretty well acknowledged. On the imaging side and some of the labs --

MR. HACKBARTH: The 5 percent to 7 percent would be the volume and intensity?

MR. BERTKO: For physician services alone, which I think would incorporate the minor and major procedures, and visits. All the stuff that physicians do themselves, including the fee schedule, unit price changes, and the utilization changes in under-65 people.

DR. REISCHAUER: Price changes?

MR. BERTKO: Price and utilization together.

DR. REISCHAUER: Because the 7 percent wasn't that much lower.

MR. BERTKO: But it's both.

DR. REISCHAUER: But it's everything.

MR. BERTKO: It's everything.

On the labs, imaging and I'll put in the outpatient bucket of stuff, which is a whole amalgam. It's probably much closer to the amount seen on these charts, and partly because it's harder to control because there's 10,000 pieces to look at, whereas contracting with physicians involves groups and a little easier to manage perhaps.

MS. BURKE: John, just so I understand. You're suggesting that in the managed care world minor procedures, imaging and lab are similar in trend?

MR. BERTKO: Yes.

MS. BURKE: So similarly high.

MR. BERTKO: Yes.

DR. CROSSON: Of course in our model the financial incentives are a little bit different. We tend to include the cost of physician services which would include units of service and volume, and that's bundled with laboratory services for the most part. The trend there is about a 4 percent to 6 percent year-over-year increase for the whole thing.

I think we have seen increasing pressure because hiring and maintaining physician staffing is pretty much a national marketplace for physicians. We've seen increasing pressure on physician salaries from the echo effect of some of what we've seen here, particularly in the specialty areas, individuals who do procedures who have converted from cognitive over the last five to seven years to more

procedural-based specialties. Incomes have been rising relatively rapidly so we've had a reflected pressure inside of our medical group world in that area. But in terms of the actual utilization of services it's been modest.

MR. SMITH: [Off microphone] You're surmising that the increase in private practice volume [inaudible] yielding greater gross income [inaudible] -- you're seeing that in terms of volume increases.

DR. CROSSON: That's correct.

DR. MILSTEIN: I think the collective perspective from the point of view of the folks who track it in my firm would very much overlap with what John described.

MR. MULLER: I think the way I read this data that's consistent with the kind of diffusion of technology theme that we've stressed at different times, especially with all the product innovation going on in device and drugs and the miniaturization which allows for more and more spread at a reasonable cost of all this.

I saw in what I think were the fairly modest recommendations that were made on imaging in the material

you sent to us there seems to be some outcry already about any kind of limitations on credentialing. I do think we should keep looking in that direction because obviously, any, kind of compounding of numbers of this magnitude will only just be a great accelerant on program growth. In my mind, given all the innovation in the biomedical sphere of the economy this is only going to keep accelerating as long as there is not a macro constraint on spending here. So I think what we did on imaging is a good start, but my sense is as one looks at all kinds of devices, infusion, we need to be looking at those kinds of standards as to under what circumstances it's allowed, what the criteria are. Doing profiling after the fact may just lie too much, so I think we should be looking at this ongoing diffusion.

To have it accelerate so much -- I know we were looking three or four years ago at outpatient in general going up maybe twice what inpatient services were, but this now seems to be three, four times that, if I read that major procedures category correctly. As you said, there may be some classification issue going on.

One would argue that the major procedures shouldn't go up as much, there's a lumpiness to it, you can't replicate that as easy, you can't diffuse it into a doctor's office or an outpatient setting as quickly. But even a small proportion of available program growing at these kind of compound rates they get to be, obviously, big numbers reasonably soon. So I think whatever we can do to understand exactly how that's occurring, is this happening in devices, obviously with Part D coming is it happening in drugs?

As you noted, each of the specialties now are invading, going across the turf of other specialties, whether it's the ENT people now doing endoscopy or the neurologist now doing all the infusion therapy. So I think we should be looking at those to see how much they migrate from the first place in which this is done as an innovation to now then becoming the norm in a whole variety of settings. So any kind of information we can gather on the underlying drivers of these trends I think is important work for us to be focusing on.

DR. REISCHAUER: I find these numbers very perplexing, because if you think of this as -- especially when I hear John say that this is in the non-Medicare world as well, because we have the number of physicians in the nation growing by about 1 percent, the number of beneficiaries and private payer individuals growing by about 1 percent, and then the amount of services being provided in aggregate growing by 7 percent, 8 percent, and presumably everybody was pretty busy in 2003. The implication is they must be a whole lot busier per service provider than they are now or the intensity --

My guess is there should be some kind of correlation between time and complexity. There are other inputs to be sure, human capital, technology, et cetera, but some of it is time as well. These kinds of trends are unsustainable unless something very, very strange is going on. I think we should be looking to see what that is, because it's hard to believe that both intensity and volume per beneficiary should be rising at 7 percent or can rise at 7 percent a year for one year to the next.

MS. BURKE: Arguably, to support Bob's point, one would imagine that there's the intensity, Ralph, that you would suggest given the change in technology. But just the sheer number of visits has to have a correlation between the number of people and the number of physicians. When you're seeing 22 percent increases in the number of visits, in the volume of visits it's not just complexity. So it does see counterintuitive in part.

MR. HACKBARTH: That's an interesting idea, but if you look at the longer term trend -- we've seen an acceleration in volume and intensity recently compared to the late 1990s when it was unusually low. But if you go back and you take a 10 or 15-year perspective at this, we've -- let me ask you this question, what has been the 15-year rate of growth in volume and intensity in the Medicare program?

DR. HAYES: It's been more in the area of about 3 percent, 3 percent to 4 percent per beneficiary per year.

DR. MILLER: But the way that pattern works is it spikes.

Just a couple of quick things. Sheila, the visit volume is actually closer to 7 percent, at least in this recent data, and then the imaging and so forth is more in the 18 percent. But 7 percent is still aggressive, not to miss your point.

But, Kevin, to Bob's point, one of the things that you were thinking about looking at is how the practice expense piece is estimated for how frequently equipment is being used. I'm not saying this very well, but you might want to put that point across to get to Bob's point.

DR. HAYES: Sure. The key issue here is how practice expense payments are changing relative to physician work payments. The question would be something along the lines of whether physicians are able to, in a sense, leverage their time a little more effectively by making greater use of other inputs like equipment, supplies, non-physician personnel. That's the kind of thing that we can look at in terms of trends over time to see how that shift has occurred.

Thinking about practice expense, one of the things

that we want to look at it is the extent to which the utilization of equipment is appropriately or accurately accounted for in determining practice expense payments. Let me give you an example.

If we were to take a piece of equipment like imaging equipment, for example, an MRI machine, in order for CMS to calculate a practice expense RVU for an MRI service they've got to make an assumption about how much that piece of equipment is used. They've got to step down the total million-dollar plus price of that piece of equipment down to a unit cost, a per-procedure cost. In order to do that they've got to make an assumption about how often that machine is used. So one of the things that we intend to look it over the coming here is what assumptions CMS is using and is it appropriate.

To date they have been making an assumption that equipment is utilized at a rate of 50 percent. Now that's in general across the board for all the equipment used in a physician's office. The question is whether that kind of an assumption would be appropriate for some pretty intensively

used pieces of equipment.

DR. REISCHAUER: Can we look at this across states? We know that physicians in California tend to practice in large groups that might have certain kinds of efficiency and be able to access the kind of productivity increases you're suggesting, and in New York they tend to be in smaller groups. Can we look at whether the growth is even across the country or varies radically from state to state and might be related to the structure of physician offices?

MS. BURKE: Just to add to that, I also assume, as you look at this -- Mark, thank you. As I looked at the numbers, the visit number is in fact, as you suggest, 7 percent. I've got to believe also looking at this by specialty -- I mean the issue of the number of visits could in fact be the contributing factor of the non-physician providers. In our earlier discussions -- Bill reminded me of our discussions around the use of staff in offices, and whether that has increased capacity as well. So I would assume an understanding of this by specialty as well will

give us information, because you will tend that in certain offices and not in others, cardiology versus something else. I think it would also be instructive, again as we've done imaging and everything else, to understand where these patterns exist, both geographically and by specialty.

DR. HAYES: Yes, we can do both.

DR. STOWERS: Kevin, I don't know if you can get to this sort or not but I thought it would be interesting with whatever it is, the 7 percent or 11 percent growth in visits, if we could drill down a little bit into what those visits are connected to. Are they connected to increases in cognitive services that we might think we're following our diabetics better; instead of once a year we're seeing them four times a year? Or it may be, I would suspect that it's connected to this increase in x-ray and procedures, that pre-visit before these things are done. If that's the case, then our expansion in these procedures and so forth may need a lot of the E&M added on to it as the cause of our growth. So I think it would be nice to know where that E&M growth is occurring. If it's on the things we're looking for, pay for

performance, that would be one thing. If it's the other, it would be something else.

Another thing I think that would be helpful, the RUC at AMA is going into their five-year review and the E&M is going to be a huge part of that as well as these other procedures so that might be interesting.

Another thing on the visits is that there's been considerable training going on, even more intense than usual, on appropriate coding. The average providers are anywhere from 20 percent -- it depends on who you read -- to 40 percent under-coding procedures in the office on E&M. We all think of it being too high, but really in general there's a lot of under-coding going on.

A lot of the electronic health records expansion in the country is really being financed on the back of improved reimbursement in E&M services when you get into an electronic health record that automatically codes and takes into consideration everything. So a lot of people have a big pick-up in their E&M payments when they get into the electronic health records and that kind of thing. So it

would be interesting to see where that --

And the non-physician thing too, just as a last comment, I think should be looked into. There's a lot of studies out there that increased number of tests and labs and that kind of thing is much higher in the non-physician providers.

DR. HAYES: Can I just ask a follow-up question? On the under-coding, what are you hearing about that? What is the motivation for this under-coding? What do you think we should be looking at in order to --

DR. STOWERS: There seemed to be a huge trend early on about what we talked about in the regulatory thing about the fear of audit, over-coding, so a lot of doctors tend to code that middle number three code, the most common one, level three. Audit after audit after audit has been done that shows there's a lot of level fours in there that do have lab, x-ray, the intensity that's necessary, and electronic health record starts picking up on that. So we've seen a substantial increase in almost everybody we've talked to, of increased income in that area that actually

pays for a good part of the electronic health record.

MR. HACKBARTH: So Ray's observation would help explain Bob's quandary of the rate of growth here. It's not just a rate of growth in activity which takes time. It's also an increase in the effort put into the coding process and maximizing payment there as well. So when we talk about the possibility that constraining fees increases volume, I think it's quite reasonable to hypothesize it not only increases physical volume and intensity but also coding effort.

MR. DURENBERGER: My question is under the category of the second to last Powerpoint which was making the case for fundamental change, and a question of Kevin and the three experts which you identified earlier. My question is this, there is one way to approach the Part B issue which is 700,000 doctors spread across the country by specialty, by state, by whatever. Another way would be to look at our experience with clinical systems within the context of the 700,000 doctors. Maybe the question is more directed at John or somebody like that who might have had experience in

actually making payments to physicians for the same services that we're making payments for. But I'm curious to know whether or not we shouldn't be looking at, I'll just call it clinical systems, which is a combination of the doctor and a lot of other people, and ways in which, that have been mastered already by private health plans in reimbursing for what we would currently call a Part B reimbursement. That's one part of the question.

The second one is simply to raise the issue, again under fundamental change, of paying for effectiveness. I don't know exactly what effective is except there seems to be a lot of researchers in this country that are telling us there are major differences among physicians and among physician groups and so forth across this country. So I want to lay that one on the table. But first the response to the question relative to clinical systems.

DR. HAYES: I would say two things. One, hold that question for our next panel. Bob Berenson has given a lot of thought to that issue of clinical systems and so forth. But let me just put in a plug for one of the items

that we included on our list which was looking at the episode of care that beneficiaries experience and what payment changes might need to be made in order to accommodate the package of services that is typically provided during an episode of care. When we look at things in that way you can begin to see the importance of clinical systems, particularly for beneficiaries with chronic conditions, diabetes, hypertension, whatever it might be.

DR. MILLER: I can also see some of this getting picked up by the conversations we had yesterday when we were talking about the episode analysis.

MR. BERTKO: Just very briefly, to try to answer part of Dave's question. In the PPO environment for commercial members, the episode types of things do show some positive -- and this is still just emerging -- in terms of selecting physicians based on their efficiency. Quality comes tomorrow. I mean that as well as we can.

The differences in some markets can be substantial. They're smaller in other markets. I actually don't know data on your exact market, Dave, but my

impressions have been that the Minnesota doctors generally are more conservative in practice than other parts of the country. So where they're conservative to start with, the shrinking is less. Where they're, let's say -- they bill better -- then you have opportunities for yet greater stuff. There are probably -- Arnie, would you say five carriers around the country with implemented systems and we're all seeing, more or less, similar orders of magnitude, which are substantial. We talked about this earlier. It could be from five to 10, and in some cases possibly up to maybe even towards 20 percent in terms of a step-down.

So this may be a step-down, which is you change the baseline as opposed to the slope. We don't know that answer yet. Or it might change both.

DR. MILSTEIN: If we focus initially just on the blip that's disturbing everybody there are three hypotheses. Number one, which we can reasonably dismiss, is there's some of unexplainable, big increase in level of beneficiary illness. Very unlikely.

Second, this represents more what's been termed

flat of the curve health care. In other words, a relative increase perhaps related to unit price constraints because those kinds of relationships have been demonstrated.

Or this represents a very medically valuable new ways of treating beneficiaries that biomedical miracles now allow that didn't allow the year before.

The fact that Jay's answer, assuming that it reasonably pertained to the over-65 population I think allows us to rule out the first and third causes, suggesting that we're more likely in that middle layer. Otherwise, how is it that his group taking care of the same age people, getting sensational quality scores, didn't experience this same big blip in volume and intensity of services?

This conversation has also drifted into what do we do about it? This maybe is more for our July retreat, but if you boil it all down we can either begin to parse out and shield beneficiaries from services that aren't doing their health any good. We learned from our panel last meeting that that's very difficult to do because we haven't built the information base.

We can do what has become somewhat popular on the private sector side and somehow incentivize the beneficiaries to be prudent. There are many people who are believers in that. I think that's a bit of a blunt instrument and a little bit more difficult to implement for a more elderly population. Or you can begin to meter or monitor resource use at the level at which it is most influenced, which I believe is the physician level, which is the direction we're going.

That in turn can be thought of as potentially generating one of two yields. Either offsetting future volume increases by reducing the existing percentage of flat of the curve care, which is, according to the Dartmouth researchers, running about 30 percent of current spending if they are an order of magnitude right. But more importantly, if we begin to get the incentives right it potentially creates an industry that every year, through improving its productivity and efficiency, begins to offset the incremental volumes associated with tomorrow's medical miracles so we begin to stabilize Medicare spending as a

percentage of total revenues.

DR. NELSON: I come at this from a little different direction than Arnie does. The general internists and family physicians that I talk to are busy as hell. They're busy because they have patients lined up to get in the door, and it's easier to get in the door than it is in Jay's shop, being very familiar with operations like Jay's. They're busy because patients are being told to make sure that they get screened for hypertension and get it managed, get their cholesterol managed, have their diabetes better taken care than they have in the past, get cancer screening. They're hearing that all the time and they're doing it.

So primary care physicians are responding by shortening the visit time in order to accommodate this need. They're hiring non-physician clinicians to assist them. They are finding ways to document a higher level of service, as Ray brought out, responding to the need for E&M documentation but using checklists or electronic health records. So you see a little bit of creep toward the higher-level services in visits.

I guess what we have to do is decide whether or not the investment that we're making in managing these chronic illnesses is worth it in terms of better outcomes and higher productivity. And whether or not -- obviously at some point it has to stop. I'm not saying that it doesn't have to stop. But I am saying that the increase in volume of visits may represent better care than we've delivered in the past, and it may be the kind of investment that we as a nation should make.

DR. REISCHAUER: I think that's a plausible hypothesis and we should examine whether the order of magnitudes are consistent with that, because we do have measures of improvements on these dimensions and you can imagine translating those improvements into doctor visits per year or something like that. We also might at that point, if we did it, say what if we got these quality measures up to the thresholds we think are important for pay for performance, what does that imply about the growth of volume over the next four or five years? It's something we are urging and we want, but then at the same time we

shouldn't turn around and be horrified that, look at this, volume has gone berserk.

DR. CROSSON: Just to respond to Bob's thoughts a little earlier, I think to look at the question of the volume and its relationship to the practice structure is a good idea. My sense of integrated systems is that there are two elements that are required to balance quality and efficiency. The practice design is important. Multi-specialty group practice contains the efficiencies and the resources to make the system work. I do believe from what I've seen that group practices, irrespective of payment mechanism, at least have the capability to be more efficient. Many of them are.

For example, the Mayo Clinic I think demonstrated in Elliott Fisher's recent work that even though you might expect them to be a lot more costly, in fact they are not. Even though they're paid basically by fee-for-service they still have a function of efficiency which seems to be related to their structure and to their culture.

But I think then when you add to that the way the

care is financed, certainly quintessential prepaid group practice, in my estimation, you get the best mechanism. So if we actually want to look and investigate this, it would seem to me that looking at the differences by practice structure and then the differences by the way care is financed -- and there's a good laboratory in the group practice world. There are large group practices across the country that are paid primarily by fee-for-service. There are those that are paid entirely by prepayment, and there are those that are paid partially by one method and partially by another method. It would be interesting, I think, if we wanted to do that, to try to look at those two factors by using the group practice community as a laboratory to sort those things out. I think that can be done.

Then a second point is, and this has been discussed before and it was in the March report, I think it would be worthwhile, as Arnie said at our July meeting, to spend some more time on the issue of whether the existing payment system, the update system could be changed in ways

to actually create the kind of incentives and design elements that would promote the same kind of improvements in productivity and efficiency that we see in the prepayment integrated systems. We've touched on that idea. It's complicated, may be very difficult to do, but I think over time it would be worth the effort to investigate.

DR. STOWERS: I hate to bring this up and I think it was mentioned in the chapter, but it would be really be somehow nice to be able to quantify the amount of defensive medicine that's going on with the PLI crisis in the country and that kind of thing, with procedures. Every child that hits the emergency room with a bumped head getting the CT and MRI, and maybe the need for some practice guidelines that would stand up in those particular situations. But there's a lot out there about that causing increase in a lot of these expensive procedures. It would be interesting to know what percentage of that 18 percent is somehow linked to that increase in the sensitivity out there. That's a hard thing to get your hands around and I understand that, but I think it at least deserves some attention in this chapter,

especially in the time that there is trying to be reform in this area. Everybody knows it's out there, it's just hard to quantify it.

MR. HACKBARTH: Any other questions or comments?

Okay, thank you, Kevin.

So next we have Bob Berenson and Steve Zuckerman from the Urban Institute presenting some research they've done on changes in relative payments for physician services. Welcome, Bob and Steve.

DR. HAYES: Good morning. Our next session concerns changes in relative payments for physician services. In paying for physician services, Medicare uses a fee schedule with rates for over 7,000 services. A central element of the payment system is a resource-based relative value scale which determines payments once service relative to another. In the context of looking at the experience with the physician fee schedule, now that it's been in use for over a decade MedPAC has contracted with the Urban Institute to examine the process for valuing services.

With us today we have two speakers. Bob Berenson,

I'm fairly confident that most of you know Bob. Let me just say that he is a senior fellow at the Urban Institute. He's a physician. He's held high-level positions as the Health Care Financing Administration, worked at the Lewin Group, and he was the founder and medical director for a preferred provider organization here in Washington.

Also we have with us Steve Zuckerman. Steve is a principal research associate at Urban. He's an economist with over 20 years of experience in health economics, including much work on physician payment. He's also worked in Medicaid managed care, insurance coverage and market reforms, and the health care safety net. Prior to joining Urban he was at the AMA's Center for Health Policy Research.

I'll turn things over now to Bob and he'll get us started.

DR. BERENSON: Thank you, Kevin. The person who's not here who's name is first up on our slide is Stephanie Maxwell who is actually the lead on this project, but she had a baby a few weeks ago and is doing more important things than what we're doing here.

But the work is a collaborative. In fact it started over a year ago but got put on the side because MedPAC and then we were asked to get involved with some work on practices and geographic adjustment. But once that work got done we turned back to this kind of work, which is really to look at the impact of the first 10 years of the RBRVS system. It's particularly timely now, and we've worked to get this presentation in today, not only because of the recent letter from CMS to the chairman about what's happening with the spending for physicians, but also because CMS and the RUC, the RBRVS update committee at the AMA is just starting or is in the middle of its third five-year review process for reviewing work and is undertaking a review of a large percentage of the relative values. So getting a little perspective on what we have learned from the first 10 years seems to us pretty appropriate at this time.

I want to thank both CMS and the RUC for being very cooperative with us and providing us files that we needed to do this work. Steve will talk a little bit more

about methodology in a couple of moments. Bill Rich, who's the chair of the RUC, is here today in case we need to get into any discussions of the RUC.

The background basically, as I'm sure you all know, is that the RBRVS-based physician fee schedule was implemented in 1992. One goal clearly was to shift payments from procedures to what at the time were called cognitive services, and I think people have arrived at the term evaluation and management services as less charged. But there was a goal to shift payment to some extent. This came out of a previous payment system which was making payments based on reasonable and customary charges by physicians, and as you all know out of all of the work at Harvard and Hsiao, et cetera.

RBRVS has not been operating in a static world. Service volume per beneficiary has been growing and it has not been growing the same for all services, and we'll shed some light on that. That's the second point. Volume growth has varied across type of services and RVUs have been reviewed, revised and new services have been added to the

fee schedule.

In the first 10 years of the fee schedule there have been two five-year reviews, and in the last four years of that 10-year period the resource-based practice expenses were phased in. That all ended essentially in 2002 so we thought it made sense to get a 10-year -- what happened in the 10 years with all of those changes happening.

It's important to make the point that we are not talking about payment here. We are talking about changes in RVUs, for a couple of reasons. One of the practical ones is that payment changes were -- there was a transition to new payment in 1992, 1993, 1994, a transition period with blends of previous payments and the new payments that came out of the RVUs, and to find a baseline year to do a comparison would be complicated. We also think that most of the work that CMS and the RUC engage in is around RVUs, work units and practice expenses, so it would be good to have that analysis. Later one can lay out what the payment changes were, but our focus is on RVUs.

As you all know, RBRVS is maintained at CMS which

relies on advice from the relative value update committee at the AMA. I've been a member of that committee and it does an excellent job of dealing with new codes, revised codes and it's now, as I mentioned, in its third review of work, which happens every five years. Indeed, between revision of codes and new codes that come on board, the RUC typically submits between 150 and 350 codes to CMS with recommendations for values, and for the most part those recommendations are accepted more than 95 percent of the time in recent years.

So let me just finish my part with the key questions. These are the key questions in our study. Do current RBRVS values reflect the Harvard-based relativities of 1992? Let me just clarify again, in 1992 the Harvard Hsiao, the three phases were completed and we had a new fee schedule. Then for 10 years CMS and the RUC have essentially been responsible for overseeing what's happened with that. So the question is, 10 years later what has happened to those relativities? And if relativities have changed, in what direction and by how much?

Complicating it is the issue of volume, so the question we are asking is to what extent has RVU volume growth varied by type of service? What we're really doing here is trying to sort out for you the effect of the RVU changes from the effect of volume changes, and that's a major part of our analysis.

With that I'm going to turn to Steve.

MR. ZUCKERMAN: Thank you. Let me start by just giving you a little bit of quick background on the data that we used in this study. We tried to keep things relatively straightforward. This can get complicated very, very quickly so we just looked at data from 1992 and 2002 of what are called physician supplier procedure summary files which basically summarize all Medicare Part B payments at the level of the service code and the payment locality.

In addition to that information that we had on payments and service volume, we needed some information on how RVUs were changing, and the AMA and the RUC staff was very kind in providing us with files that allowed us to understand what was going on, in particular during the two

five-year review processes to RVU values at a service level.

Now this process, as I say, is fairly complicated and even in communicating with people at the RUC staff I think that there was a little bit of difference in interpretation in terms of what we needed for this analysis between the first and second five-year reviews, so I will talk about that a little bit as I get to some of those slides. But what looks like a large difference in the nature of the RUC recommendations and the changes that were made in response to the five-year review are a little bit smaller than you'll see here on these slides and I'll point that out.

Into doing this analysis we focused on physician services paid through the RBRVS, so there's a lot of Part B services that are on these procedure summary files that we didn't look at. We didn't look at anesthesia services, we didn't look at clinical lab services, didn't look at durable medical equipment, and we excluded some level two and level three services that were related to dental care and ambulatory surgery claims. So we're really focusing on the

physician side of physician services. What you'll see when we begin to look at some of the type of service categories and we use the what is now pretty standard BETOS type of service grouping that Bob Berenson was involved in developing in the late 1980s, you will see that we have eliminated other services which was sort of a mixed bag. That was a very small mixed bag because of all these service exclusions that we had.

MR. DURENBERGER: So what does that mean?

MR. ZUCKERMAN: BETOS? Berenson and Paul Eggers who was at, at that time, HCFA, developed this type of service classification. You'll see the categories, the major categories in a moment, categories of services.

So we're going to present some fairly simple, descriptive tabulations looking back from 2002 and looking at what happened since I992. There's two measures that you're going to see. One is a weighted average RVU change as recommended by the RUC, and we're largely looking at codes that were increased and you'll see why we compute those averages for that. But we also looked at decreases as

well. Then we're going to be decomposing the RVU growth and I'm going to present the work RVU volume growth between 1992 and 2002 into changes that were due to volume and changes that were due to RVU changes.

Just to reiterate Bob's point about the transition, I think the way to think about it in terms of what we're going to show about work RVUs and what we're going to show a little bit at the end about total RVUs is to really think about 1992 the way we're doing this analysis as if the RBRVS fee schedule were fully implemented at the time.

So how did we classify the physician services that Medicare was paying for in 2002? We used four mutually exclusive groupings. If a code was new; namely, if it was not in use in 1992, we classified it as a new code. If that code was subsequently reviewed or revised by the RUC we didn't then consider it a reviewed or revised code. So new codes are at the top of the pyramid here in terms of the analysis did. You'll see the relative importance of these categories on the next slide.

We then looked at codes that existed in 1992 but then were reviewed as part of the five-year review process. We looked at codes then that would revised under annual updating, and then we looked at codes that had not been reviewed or revised. You can see, if RVUs were changed or added in terms of new codes, or the review or the revision process, then you have a fair amount of movement away from that original Harvard resource-based relative value scale.

Let's look at the pie chart of the left side of this. We basically had 6,500 physician services codes that we were looking at in 2002 and you can see that the majority of them were not reviewed and revised. Just about half of them had not gone through the review process, but 16 percent of them, 16 percent of these codes were added to the fee schedule since 1992. That's the white slice of that bar. Eleven percent were revised at some point during the annual updating process, and almost 20 percent of these codes had been considered as part of the five-year review process.

The pie on the right side shows the distribution of the work RVUs associated with these various categories of

codes. Here I want to edit this pie chart because in getting this presentation together we had a slight coloring problem. That 62 percent which according to the key indicates those are the revised codes, in fact 62 percent of the work RVUs have gone through the five-year review process and 9 percent had been revised. So the light gray and the black slices should actually have the colors reversed, so I apologize for that.

But what that pie chart on the right shows is that a very small percentage relatively speaking, 18 percent, of codes have not gone through review or revision or are not new codes. So in a sense, a great deal of the Harvard resource-based relative value scale that was presented in 1992 has been revised or at least reconsidered.

DR. MILLER: To say it just a little bit differently. Most of the codes were not reviewed, but most of the values that account for the volume of what physicians have done has overwhelmingly either been reviewed or revised.

MR. ZUCKERMAN: Correct.

One thing that we learned as we were doing this, and this is a little bit of an analytic footnote but it's going to be necessary in terms of understanding of what we're going to show about the two five-year review processes, is that in talking about codes that are not yet reviewed or revised and codes that were reviewed but may have been dismissed or not recommended for an update there's a little bit of confusion there. So in fact some of the codes that are in this chart on the not yet reviewed or revised, in fact a small number of them and more of the a second five-year review process, went through the review but were not recommended for a change either way.

Now the first five-year review had 932 codes and 932 codes that were not new codes. So 932 codes were revised and you can see from this that the codes that were reviewed were dominated by major procedures and other procedures, although evaluation and management codes and imaging codes were also considered as well as tests. Codes in every category were considered and the results of this process is that 545 of these RVUs remain the same, of these

932 codes. So in most cases codes were reviewed and not recommended for any change and they were not changed.

However, you can see of the codes that did change, about 285 were increased and 102 codes, the work RVUs decreased. So it's about three-to-one codes are increasing relative to decreasing. Which codes were in fact increasing? The codes that were increasing were largely in the area of major procedures and other procedures.

Of 285 codes, 80 percent of the codes fall into those two categories. And these were not necessarily small changes in work RVUs. The average increase in the work RVUs for the 285 codes that were increasing was about 18 percent. Now of the 102 codes that were decreasing, the average reduction in RVU was also about 18 percent. So in a sense, I could imagine there being a balancing out, but in fact many more codes were increased than decreased, and a lot of the decreases resulted from codes that just seemed out of whack relative to codes similar to them once these increases were put into place.

Here is where I have to apologize for there being

a little bit of confusion with the definition of codes. In fact what you see here is the second five-year review and some of the files that we were using just simply omitted codes that for recommended to remain the same. So there actually should be about 300 additional codes, so almost 700 CPT codes that were reviewed in the second five-year process.

But the important thing is that while the figure up here shows that 99 percent of the codes that were reviewed were either major procedures or other procedures; namely, E&M, imaging were pretty much out of this second five-year review. In fact if we had the codes that were recommended to remain the same in there I'd still be saying about 99 percent of the codes were either major procedures or other procedures. So there's not that much of a difference in not having those codes in terms of the overall story. The second five-year review were really dominated by the procedure services.

You can see that in coming through the process major procedures in terms of the codes whose work RVUs

increased actually dominate the process even more in the second five-year review than in the first five-year review. Here the average increase in work RVUs was about 19percent and very, very few, just some straggler codes had their RVUs decrease and that average decrease was about 11 percent.

So that gives you some idea about what was going on with the RUC review process. Now I want to move to looking at, from what happened to these individual RVUs over time, to exploring how changes in aggregate RVU growth was affected not only by these changes in RVUs but also by changes in volume. We're focusing here on aggregate RVUs, not presented on a per-beneficiary or a per-physician basis. We're looking at work RVUs in this chart because I didn't want to muddle the picture with looking at total RVUs that would begin to incorporate some of the practice expense changes that were taking place over this period as well. In addition, I think work RVUs can be viewed as the basis for payments on behalf of the physician component of physician services.

If you look across these five categories of

services, evaluation and management, imaging, major procedures, other procedures, and tests, you can see that there is quite a bit of variation in the growth of work RVU volume. Evaluation and management services and major procedures grew the least, and tests clearly grew the most in this category, although tests, I will point out, grew from a very small base. It's a relatively small share of the physician services that we were looking at. In the middle you have imaging and other procedures.

Now the dark blue bars on this chart show the work RVU volume growth that was due to increases in service volume. The most important services in terms of service volume growth were E&M and imaging services in terms of the major categories of services. Imaging was growing 4.5 percent a year for this 10 years in terms of aggregate service volume. Service volume was not particularly important in explaining the aggregate growth in RVUs in major procedures.

Looking now at the light blue bars on the right of each of these sets we changes in work RVUs related to the

changes in either revised, reviewed or additional RVUs that were added to the fee schedule related to new services. We can see that those RVU changes were most important in explaining the work RVU growth for major procedures, other procedures, and tests. You can see that major procedures, RVU volume growth accounted for 4.1 percent annual growth out of 5.3 percent annual growth that was occurring over this 10-year period in that service category.

It's really not just the fact that through the review and revision process RVUs were being increased for major procedures or for tests or for any other category. In fact for major procedures a big part of the story is that a great many new codes were added to the fee schedule. You can see here, looking back from 2002 back to 1992, can see the distribution of work RVUs that were associated with new codes. You can see major procedures and other procedures account for about 76 percent of that. So you can see that where codes were being added to the fee schedule, they were really being added in these two procedural categories. That's really explaining a part of why we saw the growth in

major procedures being dominated by growth in RVUs.

Now to try to provide a more overall picture and one that incorporates both work RVUs and practice expense RVUs we're presenting in this chart the impact of changes in service volume and RVUs on the distribution of total services over this 10-year period. So just to walk you through this chart, which admittedly has a lot of numbers on it, we have these five categories of services and after each of the labels for the service category we show you the relative share of total RVUs that were associated with each of these categories. So in 1992, evaluation and management accounted for about 50 percent of total RVUs, imaging 12 percent, major procedures 13 percent, other procedures 23 percent, and tests 3 percent.

Now had there been no RVU changes, had the RUC review and revision process not been involved, and had there been no new codes added, the first column shows you what would have happened just to the distribution of total RVUs had just the volume of services that were being performed in 1992 changed as they did between 1992 and 2002. You can see

that what would have happened is that imaging services became a lot more important, just based purely on volume changes. So imaging services would have gone from about 12 percent of total RVUs. In this a case you can sort of say 12 percent of total payments RBRVS been fully in place, to a little over 16 percent. And major procedures would have lost in relative terms. They would have lost about 2.4 percentage points, and evaluation and management services would have lost also.

Now the changes that were made in total RVUs, work and practice expense RVUs, moved the distribution back in the direction of E&M. This was really driven by the adoption of the resource-based practice expense RVUs. Without those resource-based practice expense RVUs we know that based just on work RVUs E&M's share of work RVUs would have fallen. So some of the gains that major procedures and other procedures made in terms of work RVUs were offset.

You can see that major procedures lost a little bit in terms of RVUs, evaluation and management services gained, tests gained, and imaging services actually lost the

most in terms of changes in total RVUs.

Then the third column shows the combined impact, and you can see that despite the fact that imaging lost in terms of the RVU revision and review process, in fact imaging services gain as a share of total RVUs and major procedures lost the most. There was a small gain for tests that resulted from some of the RVU changes. E&M services in fact ended up being pretty steady over this 10-year period.

So let me summarize quickly our findings. What we conclude is that a relatively small share of the RVUs in the physician payment system reflect the Harvard-assigned RVUs. When looking at the five-year review process we found that more services tended to have increases in RVUs than decreases, and especially in 2002 the increases were somewhat larger. RVU growth, whether its work or total RVU is driven by service volume for some types of services and RVU changes for others. The new codes that were added to the fee schedule tend to shift to volume away from E&M, but the practice expense RVUs that were implemented offset this phenomenon somewhat.

So let me just close by saying that it's quite clear that the RBRVS physician fee schedule is dynamic, the RUC process is influencing RVUs, and volume growth is also having an effect on the distribution of RVUs and payments within the physician fee schedule.

MR. HACKBARTH: Thank you.

DR. MILLER: If I could just also put this in a little context. For the upcoming cycle, you've already heard in some of the presentations that we're going to be looking at some of the guts of the physician fee schedule in various ways. I don't want to strip away too much from this but what I thought was important about this is a couple of things, just to focus the Commission on.

That there is this RUC process that values services. And of course we all know and we've dealt with several times the volume process. Distributionally we've been talking about what about the long run sustainability of the program. But also what's happening here is a sense of how distributionally where we're choosing to spend our money. That can be a product of both the valuation process

that's going on almost the RVUs as well as volume growth. I thought that last slide that shows how E&M stands relative to imaging, for different reasons over that last decade, was an important point to get across.

MR. HACKBARTH: Do you have any thoughts that you'd like to share about the policy implications of these findings? If you were sitting here what you would do with them in terms of thinking about policy.

DR. BERENSON: First let me just make a point and then respond to the question.

We emphasized that only 18 percent of total volume had not been through the RUC CMS review process. This time around CMS is basically giving the RUC all the rest, or the high volume services that have not been reviewed before now in the five-year review. So this summer and fall pretty much the large majority of values will have been through the RUC and CMS process.

I guess the policy implications would be, at the broadest level, on RVU establishment and then on volume. On RVU establishment I think I would make the observation,

having been at the RUC for a number of years as a representative of the American College of Physicians in the first part of the RUC's tenure and then at HCFA on the other end, that the RUC actually does a very disciplined, good job, and a consistent job of dealing with new services. But the RUC is also very dependent upon specialty societies' internal ability to survey its members and to get their best opinions about work, essentially. I think one of the realities in that kind of a model is that specialty societies don't come forward easily with their overvalued services. That's what CMS has to do, and yet CMS tends to not have the workforce to put the kind of, what the RUC is looking for in terms of information, to let them think that a service might be overvalued.

So when I was in the first five-year review, the RUC reasonably, I thought, set up some criteria related to compelling evidence that a service needs to be looked at, and CMS wasn't able with the carrier medical directors to develop that compelling evidence, and a whole bunch of imaging services were essentially dismissed for review

because the RUC said, we don't know what's being argued here.

So I think CMS is doing the best it can. The RUC is doing a good job, and yet I am concerned that in the middle of it it's hard -- that this might be a classic example of downward sticky prices, where something is established and then over a period of years there's a learning curve, ability to provide the service quicker, but the process doesn't allow for those values to come down. So I think it's very important -- the RUC I know is working very hard this year to deal with that issue. Whether they're going to be successful or not I think matters.

Again, just one other point out of the results about new services. There are new, complex major procedures, and not so major procedures that get defined, get put into the system. It is very hard to define new E&M services. That's where I think a lot of attention actually should be spent, especially in relationship to the goals that we're all talking of how to help care coordination for chronically ill. The sense I have is the burden for

identifying new E&M services outside of a face-to-face office visit is a difficult one. But because those services are not well-defined or are not in the system, I would argue, physicians tend to not do what they might be able to do in those areas.

The one exception, which actually looking back what does one accomplish when you spend three years at HCFA, the one thing I can point to is the fact that we decided that physicians should be paid for certifying a home health stay. We assume that physicians are the policemen to unnecessary home health services, and yet up till that moment they were being asked to certify things and not get paid for it. My understanding is that at least some physicians think that it now works better because CMS is sending the signal that this is an important service and you should be paid for your professional time for that service.

I think there's a potential for identifying other E&M. type services that generalist physicians, principal and primary care physicians, can do that would balance this reality that the new services all seem to go to procedures.

I guess the final point would be one on volume. When I last spoke to MedPAC a couple years ago I offered a suggestion dealing with the topic of average cost and marginal cost and I noticed Joe Newhouse rolling his eyes and biting his tongue and letting me get away with whatever I was saying. So for this presentation I went back to a symposium that the chairman participated in, and Steve was in it, and I was in, that AEI put on 15 years ago just as the fee schedule was being rolled out and reviewed, what Bill Hsiao was saying and what Joe Newhouse was saying, and here's the point. That the goal of the RBRVS system is to define the marginal cost for an efficient provider. That's what Hsiao said he was attempting to do.

But in remarks that Joe made, and Steve and I have talked about also, we think that at least part of the fee schedule on the practice expense side is not marginal cost and all. It's really average cost being allocated in a top-down method across services. Whereas the work can be viewed as marginal because it's the actual time at the point of service, the practice expense, at least part of the practice

expense is average fixed cost being allocated.

So when you have a high-growth area like imaging where volume is exploding, it seems to me there's an opportunity through pricing policy to try to do some estimates of the change in -- to try to deal with the difference between the average cost and that marginal cost. So I applaud the Commission's recommendations about practice guidelines. I'm not so sure about certifying people, but I think there's a straightforward pricing approach where you have large volume services, and I don't think the right way is arbitrarily to set a volume performance standard for imaging, but to do some analytic work to try to get some sense of this issue around average and marginal and practice expense. That's at least where I would spend some of my effort, in that imaging and test area.

MR. HACKBARTH: Very interesting research. Did you have an additional comment, Steve?

MR. ZUCKERMAN: I guess the one point that I would make and I think these data show, and I think almost any time you look at data looking at volume growth by type of

service -- you could look at it by specialty, it would be the same thing, or geographic area -- you do see a lot of variation. You tend to see services like imaging, tests, growing more quickly. I think back when the sustainable growth rate was still a volume performance standard and when they were actually three volume performance standards, I think everyone understood that this notion of a single target for a large group of services didn't make a lot of sense either from the standpoint of patterns of spending or in providing appropriate incentives to individual physicians.

I think that it seems pretty clear that the sustainable growth rate is becoming more and more of a problem for policymakers to deal with, and one possibility is to move away from this single target and single conversion factor. You begin, admittedly, to undo the structure of the physician fee schedule with the single relative value scale, single conversion factor, single set of geographic adjustment factors, but I think that given the complexity of this if you're going to try to have these

spending controls it may be something to think about, to have more than one target.

DR. MILSTEIN: This presentation raises for me a number of issues that I hadn't really appreciated before. First and foremost, we're calling this relative value. The question of what is valued intersects with all of our prior conversations. I think when this RBRVS system was contemplated something analogous to a physician or not taking responsibility for superior longitudinal patient outcomes and superior Medicare fiscal outcomes was not even remotely considered. Maybe we're better educated by the IOM and other factors now that maybe we ought to rethink what's in the formula, because I personally think, whether we're talking about the beneficiary's point of view or the Department of Treasury's point of view, that I might want to pay for a physician a whole lot more who was willing to take longitudinal accountability both for clinical and financial outcomes.

The second thing this raises for me is this whole question of the balance of stakeholder interests that both

decide what gets reviewed and what the conclusion of the review is. I think a review like this, one couldn't imagine it going forward without it being informed by the medical specialty societies. Whether the medical specialty societies ought to be making the recommendations, or informed by medical specialty societies somebody whose primary focus is -- or maybe it's some representatives of the beneficiaries themselves might be an alternative formulation for balance of decision-making.

This last issue, and this really leads to a question is, the original formulation would be if we were going to pay for activity we'd want to pay for, as was indicated, marginal cost, and more importantly, marginal cost of what efficient production would cost. Can you enlighten me on the degree to which when these decisions are made there is some relative analysis? So for example, in producing a procedure, we have a clue as to what constitutes the top decile of efficiency in terms of efficient use of a physician's time in turning out a given visit. Do we have any scale of relative efficiency in terms of do we know what

would constitute the top decile of efficiency on the part of a physician in delivering one of these services?

MR. ZUCKERMAN: I don't think we know that but I think to continue the discussion from the marginal cost and average cost, I think that the discussion or the way the Harvard team would have presented this is marginal -- I think they would have argued they were looking at marginal costs hoping they were getting close to the minimum of the average cost curve, which for anyone who taken principles of micro, knows what that picture looks like.

DR. SCANLON: I had a point of clarification too which is in terms of the relative value they certainly were dealing with the averages. But when we actually go to compute fees and we create the conversion factor, the budget neutrality constraint became a factor. And for the practice expense I think the reduction is around 30 percent. So we don't pay full average cost. We pay around 70 percent of average cost. Now that doesn't say that that's marginal cost and there's still potential profit in that intent, and therefore, an incentive to produce more.

DR. BERENSON: As I understand the RUC process now, the people who are surveyed are asked to put down their estimate of what it takes them to perform the service. They're not asked, what is the top 10 percent of efficiency. It is, what is the time and intensity associated with you performing this service, so that we get a representation of the practicing physicians. Is that basically right?

DR. RICH: Basically, we have certain criteria for a valid surveys and we break down all the respondents into quartiles, and probably the average time, except it is a work RVU, is a little bit less than the median value.

DR. MILSTEIN: Could you just help me understand why the original concept of efficient production got dropped?

DR. RICH: My name is Bill Rich. I'm chair of the RUC.

Basically, we have no way of measuring currently in any of our modalities what the marginal time is, what the marginal cost would be. The RUC values basically two parts of the fee schedule, the work RVUs and the practice

expenses. The work RVUs are dependent upon time, mental effort and judgment, technical skill, and iatrogenic risk. We have to have valid surveys, but we have no way currently or identifying who is the top notch surgeon or who is the quickest person providing an E&M service. We do not have that capability of collecting that data.

We obviously don't look at averages. We look at median and -- I'm still surprised at the validity of the survey process. Obviously, people aren't educated; you get a normal skew of responses. But basically most of the services we look historically how they've been valued, they're a little bit less than the median times that are submitted by surveyees.

DR. BERENSON: I would say that I don't think the Hsiao process was much different kind in terms of estimating times and intensity. Bill actually made a comment in this symposium that they just assumed that average cost equaled marginal cost for an efficient practice, but they didn't have any specific technique to try to identify those efficient practices. That was never part of this process.

DR. STOWERS: Having been an original member of the RUC and been through the five-year review process, this has really a lot of interest to me. I'd like to ask it in a little more abstract terms. You started out saying that the goal -- and we were all told that -- in the beginning was to level out or shift payments from procedures to E&M.

So I've got to step back and put my dean's hat on of an osteopathic medical school that's committed to getting doctors into primary care and that kind of thing. The students there have a choice of any specialty, and what we're finding is with the increasing debt of our students coming out now being from $120,000 to $150,000 average across the country that there's tremendous pressure to pick the higher paying specialties. And that's in a day when even the new study the just came out shows that increasing the number of primary care physicians decreases mortality and all of this kind of thing in a particular area. Glenn was asking policy-wise where are we headed with this.

Even having been a member of the RUC, I don't see a lot of bottom line shift out there in the income family

physician compared to other surgical specialties, and yet these specialties are so important to the country and policy, especially in this pay for performance that we're getting ready, and cost containment, obviously, is more economical under these entities.

Where do you see, getting ready to go into another five-year review -- we looked like we were going to make a lot of progress in E&M going up, but E&M that is bundled into the surgical services also went up. So a lot of that effect was ameliorated there, or buffered. Where do you see this going? Is it going to affect the bottom line leveling of different specialties and income in the country?

DR. BERENSON: I think there's no simple answer. Clearly, the primary care doctors I talk to, internists and family physicians, don't think this has been what was advertised as a way of distributing money. In fact it's zero, the shift for E&M has been essentially frozen. I should emphasize that this is after the Hsiao redistribution that did occur towards E&M. So this is not a full picture of -- E&M did do better and we can look at the number of

office visits that make up a CABG surgery and say it's a lot fewer. There has been some shift. But I think this phenomenon of new codes coming in disproportionately being by certain specialties, all those specialties doing established services, and essentially are paying for the new services.

So to some extent I would say this isn't just like a primary care versus specialty discussion. It's a generalist versus subspecialist distinction, where I think general surgeons may not be doing as well in this kind of a payment system because they don't have the newest kinds of -- they're doing more of the traditional services.

I think it would actually be interesting, and I've just done some initial back of the envelope looking at what is the return per hour -- how many RVUs generated per hour by different specialties, to see what kind of order of magnitude differences. When I've looked it looks pretty significant. And not necessarily just surgeons doing well and primary care not doing well. But even within surgical specialties, some doing relatively better, some doing

relatively not so well.

Then there's some other anomalies in the system as well where, again, traditional surgical services tend to have an all-encompassing definition and a single procedure in the operating room, whereas certain other proceduralists get to bill for four or five different CPT codes. We know if you do the work analysis correctly that should even out, but I don't think it does. So I think there's a lot going on. But to the basic point of what you were getting at is, primary care has held its own but at a low level I guess is what I'd say.

DR. MILLER: Could I just ask also, because I thought another part of the answer to that question was embodied in the last table. Another reason that you can't be quite sure where all this is going is because volume growth will occur in different services and different specialties, and that will also influence where relatively a given physician stands.

DR. BERENSON: Yes, again to the point that I think Bob asked in the previous round is, you can't generate

lots more office visits if you're already seeing 25 or 30 patients. You can play some games at the margin around coding. Whereas, I think, as you've identified in your reports, for a radiologist interpreting two MRIs at the same sitting, it's not a lot more work to do two rather than one and maybe some kind of multiple service adjustment might -- you can certainly interpret --

The point is I think there's some differential ability to generate more volume, and physicians don't do unnecessary major procedures. Ultimately, they're professionals. Whereas, it's easy to do unnecessary tests or marginally necessary tests, whether its defensive medicine over whether it's because of income. It all comes together. So you're not doing any harm to the patient, so you're going to see differential behavior effects based on services that might have some potential harm and those that don't. So tests and imaging are easy areas to do more of.

MR. ZUCKERMAN: I suspect that some of the issues, as the fee schedule has developed over the 10 years, may have changed quite recently, because I think that if you

look at evaluation and management, if you looked before the practice expense changes were really fully implemented I think you would have seen a different picture. I think the volume shifts and the RVU changes would have been against E&M services. A lot of that gain in RVUs is because of the practice expense RVUs. So there may be a little bit of a lag here. But there's no question that for a large part of this time period physicians who were specializing were dominating in the E&M category were not seeing this even neutral position as a share.

MR. RICH: May I add a comment? This actually is not expenditures or money. These are RVUs. But there is even a bigger effect, and Steve and Bob and I have talked about it, that occurred in the practice expense and then moved to the single conversion factor at the same time. So the actual expenditures, if you look beyond RVUs, are tremendously more shifted to imaging after the move to the single conversion factor. You had a 16 percent income there.

The big problem that we see with the looming

shortage of primary care physicians is we and you are looking at more efficient models of care that provide chronic care in a quality-based manner. The reality is on the other side of CMS we have very strict documentation guidelines which prevent anyone in the office from increasing their efficiency to incorporate other extenders into the provision of those services. That's why we've had problems with getting new codes for chronic care management. So we have one side of CMS on the research side that is saying, we're going to do this, but on the implementation side we have very strict guidelines that prevent, as a general ophthalmologist seeing chronic care in the office, or Bob as a general internist, we cannot increase our efficiency because we have it -- it's all defined by face-to-face time. So we have a little bit of a policy problem.

MR. HACKBARTH. Other questions, comments?

Okay, very thought provoking. Thank you.

DR. RICH: Glenn, I'd like to add one other thing. The RUC is undergoing the five-year review this year and I know some of your staff are interested in attending. If

they'd like to buttonhole me, that is fine, and I'll talk about the scheduled meetings next week. Also, when Bob mentioned the new volume in this five-year review, the total number of expenditures is actually 58 percent, so it's a big chunk that we're going to be looking at at the five-year review this year.

MR. HACKBARTH. Thank you very much.

Our last presentation is on patient selection and hospital profitability. This is an extension of work done initially for the specialty hospital report.

MR. PETTENGILL. Good morning. In this session we're going to be reporting preliminary findings from our analysis of the relationship between patient selection and hospital profitability under the inpatient prospective payment system. This analysis is motivated by some findings from last year's study of hospitals' payments and costs at the patient level in 2002. In that study we found that relative profitability varies substantially both across and within DRGs, or diagnosis related groups. These differences in relative profitability create opportunities for hospitals

to benefit from patient selection.

Without impugning hospitals' motives in any way, we found in that study that some hospitals experienced favorable selection of patients while others had an unfavorable selection. The implication is that some hospitals could have benefitted financially, or been disadvantaged by their selection of patients. The question now is, whether, and the extent to which hospitals' inpatient profitability was affected in 2002 by their selection of patients. Evidence that selection affects profitability would support payment reforms that tend to make relative profitability more uniform across and within DRGs.

To answer this question we performed two analyses. First, we compared relative inpatient profitability for groups of hospitals with different selection levels. Then we estimated a regression model of inpatient profitability that included payment factors and other factors that affect hospitals' Medicare payments and costs. This model allows us to test the effect of selection while controlling for

these other factors.

I'm going to talk about the descriptive comparisons and then Craig will describe our methods and the preliminary results from the regression analysis. Before discussing the simple comparisons that we made I'd like to describe the measures that we used.

In both analyses we used to key measures, one for selection and one for relative profitability. The selection measure is the one we developed for the specialty hospitals study. It measures the extent to which a hospital's Medicare cases fell in all patient refined DRGs categories that were relatively more or less profitable nationally in 2002. Thus, it tells us whether or not a hospital would have had an advantage from its case mix if it had the national average relative profitability in each APR-DRG and severity class. Other things equal, was the hospital's case mix an advantage or a disadvantage?

The national average for this measure is 1.0. Values below one indicate that the hospital had an unfavorable selection of patients, meaning that most of its

cases fell in categories that were relatively less profitable. Values above one indicate favorable selection.

To measure actual profitability we calculated each hospital's Medicare inpatient payment-to-cost ratio based on the payments and costs it reported under Medicare on its cost report for 2002. We turned this into a relative profitability measure by dividing all of the payment-to-cost ratios by the national aggregate average payment-to-cost ratio. For a sense of perspective about what these numbers means, the national aggregate average payment-to-cost ratio was 1.05. So any payment-to-cost ratio that you will see in a moment that exceeds 0.95 means that the hospital's payments exceeded its costs. I'm telling you that because you are used to looking at margins and by converting them to relative values here they look lower, but in fact they are completely consistent with the margins you've seen before.

To examine the relationship between selection and profitability we sorted the hospitals into hospital groups based on payment factors, location and hospital characteristics. Then we arrayed the hospitals in each

group according to their selection values and divided them into four selection quartiles. The first quartile contains the 25 percent of hospitals with the lowest, that is least favorable selection values. The fourth quartile contains the top 25 percent on selection. Next we compared relative payment-to-cost ratios across the quartiles within each group. If selection and profitability are positively related then the relative payment-to-cost ratio should rise as we move from the first to the fourth quartile.

Now let's turn to the results. The first table shows the extent of the variation in selection among the hospitals in various hospital groups. This was just to disabuse everyone of the notion that it was only specialty hospitals who had favorable selection. In fact unfavorable and favorable selection is everywhere.

For example, if we were to rank the hospitals in large urban areas by their selection values we see that selection varies from 0.95 at the 10th percentile to 1.03 at the 90th percentile. Twenty percent of large urban hospitals, or hospitals in large urban areas, have either

lower or higher values than those. If you look across hospital groups you will see that the differences between the 10th and the 90th percentile generally run in the eight to 10 percentage point range. That may not sound like a lot until you consider that a few percentage points of advantage on your case mix could mean the difference between a profit and a loss for many hospitals. The data in this table illustrate basically that selection varies substantially among the hospitals in all groups.

The next table shows the median relative profitability for hospitals included in each selection quartile by hospital group. Except for the teaching hospitals, median relative profitability generally increases as we move from the first to the fourth quartiles. Thus, for rural hospitals, for example, as we move from hospitals with the least favorable selection in the first quartile to those with the most favorable selection in the fourth quartile, median relative profitability rises from 0.92 to 1.03.

These results suggest, as expected, that selection

affects hospital's actual relative profitability. If selection were the only factor affecting relative profitability then we would expect a positive relationship in every group. However, we know from previous research that selection isn't the only variable affecting profitability. In fact there are a number of factors that contribute to variations in profitability.

So to more fully assess the strength of the selection effect we estimated a regression model and Craig will now describe that model and our preliminary findings to date.

MR. HACKBARTH. Julian, before we leave this one, obviously the row that stands out, or at least one of the rows that stands out is the major teaching not following the expected pattern. Any thoughts about that?

MR. PETTENGILL. That could be for a whole lot of different reasons. We know that various payment factors in the payment system, IME, DSH, the wage index, the case mix index all contribute to differences in profitability across hospitals.

MR. HACKBARTH: That explains the level, but what struck me also was the pattern from least to most favorable is not what you would predict.

MR. PETTENGILL: Right. But another way to think about this, and I don't know whether it would hold if you looked in more detail at the data because I haven't done it, but I think it's quite possible that selection doesn't vary in the same -- is not highly correlated with the level of the IME adjustment or the level of the DSH adjustment. So within selection quartiles you have a lot of variability in IME and DSH payments and that could easily account for this.

MR. LISK: Even if descriptive comparisons Julian just presented suggest that selection is positively related to hospital profitability, they do not tell us much about the strength of this relationship. A regression analysis allows us to assess the impact of selection on provider profitability while controlling for other factors that affect payments and costs. These include payments such as case mix and wage index, the IME and DSH adjustments, as well as other hospital characteristics that might affect

hospital performance such as severity adjusted length of stay and hospital location and market circumstances. This regression analysis will allow us to assess the strength of the relationship between selection and provider profitability.

For this analysis we used a model similar to what we used in our analysis of variation in hospital financial performance in our June 2003 report to Congress. The model uses a technique called seemingly unrelated regressions to estimate simultaneously a payment and cost equation. The payment equation only includes factors that affect payments in the inpatient PPS, including CMI, the wage index, IME and DSH adjustments, outlier payments, and special payments provided to rural hospitals. The cost equation includes all of these payment factors plus variables for selection, severity adjusted length of stay within region, and hospital location.

The preliminary results from our analysis are largely consistent with the findings from our June 2003 analysis. That is, the direction and size of the various

payment parameters included in the regression model were similar, both in this analysis and the prior analysis.

I do want to mention, however, that we are not going to be presenting specific numbers from the regression analysis today because we do have some refinements we'd like to consider down the road. So we don't want to get your mind in one set number here, so the results here are preliminary but the findings, we believe, are going to be fairly strong and consistent.

MR. HACKBARTH. The final version will actually be in the June report, or a more final version?

MR. LISK: No, this is not for the June report. This will be for future work.

DR. MILLER. This just came in in the last few weeks. We put this together after we got past the specialty hospital report, which was a major effort, and then we found we were sitting on this mountain of data and thought that there was an interesting idea here. I'm not exactly sure where to house this but I think the points -- for not putting the regression on, in addition to the fact that

we're still working through it is, putting up a gigantic equations of numbers after already referring to them as seemingly unrelated we figured you weren't ready for or even interested in. But whatever we put together as a final product, we'll put the final regression results in that.

MR. LISK: That's right. So now moving on more specifically, looking to our preliminary findings from our regression analysis and the relationship between selection and profitability we find that the results from our analysis on selection are highly statistically significant and indicate that, everything else held equal, provider profitability rises as the selection of cases they receive becomes more favorable, and that profitability falls the more unfavorable a selection of cases hospitals receive. The common sense of this is that it costs less to treat patients that are less severely ill. Under the current payment system, hospitals benefit if they receive a favorable selection of cases, and are disadvantaged if they treat an unfavorable selection of cases.

Our analysis also looked at length of stay,

measuring the difference between actual and expected length of stay within APR-DRG severity class within regions. Length of stay is found to have a separate and independent effect on provider profitability, and what we find is a coefficient estimate that is again statistically significant. Essentially, profitability falls as length of stay, relative to what is expected, goes up. In other words, profitability is higher for hospitals with lengths of stay relative to what is expected goes up. In other words, profitability is higher for hospitals with lengths of stay below their expected values, and lower for hospitals with lengths of stay above expected values, everything else held equal. The common sense of this is that it costs more to keep patients longer and less to keep patients for a shorter period of time.

In conclusion, the findings from our analysis indicate that Medicare's hospital inpatient payment system provides relatively high profits to hospitals that receive a favorable selection of patients and lower profits to hospitals that receive an unfavorable selection. Improving

payment accuracy, as the Commission recently recommended in its specialty hospital report, would help reduce the variation and selection across hospitals and thereby reduce the variation in profitability that results from this difference in selection of cases that providers receive. Finally, hospital inpatient profitability would continue to be affected by their length of stay patterns along with many other factors that affect their costs.

These results, again, are preliminary and require some fuller examination of some technical issues for refining our regression analysis. We will also be looking at some additional issues with our analysis, for example, looking at the persistence of selection over time. In other words, do hospitals that tend to have an unfavorable selection of patients in one year also tend to receive an unfavorable selection in other years?

We would now be happy to answer any questions.

MR. HACKBARTH: The question for me that immediately comes to mind is, how do the magnitudes compare? So if on the one hand you have variables that are under the

control of hospital management, length of stay potentially being one of those, and then on the other hand you have selection effects that may be less under the control of management, although I know that's not always the case, but are the selection effects swamping the efforts of managers to control their costs? How do they compare in relative magnitude?

MR. LISK: We do believe that they appear to be fairly independent effects, selection versus these other factors. In terms of saying what the magnitude of the selection effect is, it's not one to one. It is less than one in terms of the elasticity for selection. So if you have a 1 percent favorable selection, it doesn't mean you are going to be 1 percent more profitable. But it is still a positively related effect. In some sense, because the hospital is getting that benefit from selection, they may be spending more for those patients. So that could be related somewhat to inefficiency; because they are getting more money they may be a little less efficient.

DR. MILLER: I'll also take a pass at this. A

couple of things, and Craig I think was making this point. You might wonder why are you looking at length of stay of a giant array of variables that you could look at. One of the reasons we wanted to focus on length of stay in this discussion is that if selection were to become a significant variable, you wonder if it eliminates the influence of length of stay. The answer to that is no, they both continue to be important. So that's a first point.

The second point that I think Craig is saying is that both of them in the current estimates -- and this is why we still want to -- these estimates can change -- are less than one. So what that means is if you get a 10 percent increase in unfavorable selection you get something that the parameters are running like half of that for the impact on relative profitability. My sense of those regressions is the impact on length of stay is around that area but perhaps a little less. But those are the parameters that can bounce around a bit when you respecify these equations. Is that about right?

MR. LISK: Yes.

DR. MILLER: I don't think there's swamping one or the other.

MR. LISK: No, they're not swapping one or the other, and the selection effect is likely to be -- I don't want to say what our final number will be because we don't know what that will be, is a little bit higher than, in terms of what Mark is saying, for half. When we look at the different equations we do, it looks to be a fair bit higher than that, but it's definitely less than one.

MS. DePARLE: My head is hurting a little bit. Maybe I'm stuck on the seemingly unrelated thing and I might be committing that same act here and maybe I'm just rushing to a conclusion. But I'm trying to relate this analysis to the analysis we saw around January or so which seemed to indicate that there are 50 to 100 hospitals in the country that have had consistently poor Medicare margins and consistently poor private sector commercial margins? Am I remembering that right, Mark?

DR. MILLER: [Off microphone] I think it's more.

MS. DePARLE: Was it 150.

MR. LISK: The consistent winners and losers in terms of both on Medicare and in terms of total performance?

MS. DePARLE: What was the number?

MR. LISK: If you're talking about that segment that's both on Medicare and total, it was only, I think, about 2 percent of hospitals.

MS. DePARLE: What would the number be? Forty to 50? So 40 to 50.

My impression from that discussion -- we didn't reach a conclusion but the impression I left with was, why is it there are these hospitals that are consistently doing poorly under both systems, and are there factors that explain that? When you start talking about selection, that almost sounds as though it's through no fault of their own or whatever.

So do you relate that analysis to this one? Am I rushing too much --

MR. LISK: No, we don't. You made a good observation. Selection, we're saying it's really the set of cases they get. We're not saying it's the fault of the --

MS. DePARLE: You sort of said that. Who presents, not their own marketing or whatever.

MR. LISK: It's who they get. It may be how the hospital is structured in terms of the types of cases they get and what advantage they get from the current system. In that previous analysis that we presented back in January in terms of the consistency of the people who were consistent losers, one of the things that was important is that they consistently had high cost increases.

MS. DePARLE: And Ralph is reminding me, low occupancy.

MR. LISK: And also low occupancy rates and other characteristics that really were management related issues it appeared.

MR. HACKBARTH: All those comparisons, as I recall, were to peer hospitals in the same market.

MS. DePARLE: So there is no relationship between that analysis?

MR. LISK: No. We haven't done that in this analysis.

MS. DePARLE: There could be.

MR. PETTENGILL: If selection is persistent there might be some role there, but we don't know that yet.

MS. BURKE: I'm like Nancy-Ann, I have a headache. Actually it was the last conversation that gave me the headache.

There is a part of me that suggests that there is no surprise here. Not to underestimate the value of doing the research, but this seems relatively -- this doesn't come as a great surprise to me. But as you continue to do the analysis, my recollection is that there's a certain aspect of this that may also be geographic, certainly with respect to lengths of stay and practice patterns. The traditional shorter length of stay, high intensity in the West pattern compared to the East where you tended to have longer lengths of stay. So I assume as we go forward there will be a certain aspect of this we'll look at in terms of seeing, as well as size there are also geographic differences in terms of our understanding of how hospitals behave.

MR. LISK: You're absolutely right, and that's one

of the things our length of stay variable was actually trying to control within region the hospital's relative length of stay for its cases. We also put in our model a bunch of location variables as well. We can look at what the effect on the parameters are, give you another headache, about what happens when we remove those variables or keep them in. And looking at the length of stay variable, we could look at it nationally rather than regionally and see what difference we see as well. We haven't done that, but what we did do was a regional effect, realizing those effects were in there and we were wanting to capture the hospitals within their own --

MS. BURKE: Within their own markets or similarly situated institutions.

MR. LISK: Correct.

MS. BURKE: I guess the other question as we go further with this analysis is understanding what influence this will have on us or how we would use this information. Whether it's a question of the structure of the DRGs. There are certain aspects to this in terms of selection. There's

a presumption when you say selection that there is -- and I understand that you're suggesting that you're not presuming that there are things that the hospital has consciously done or -- this may be presenting to them. Part of it may be their decisions in terms of the mix of services they choose to provide, whether they have an ER, those kinds of things, or they have coronary -- particular cath labs or whatever it happens to be. So parts of it are decisions that are made by management, others that are presented in the context of their market and where they draw from.

But again I want to understand how this will inform us. I assume as you go further into the analysis we'll have some sense of how much of this we can control in terms of payment decision, how much of it is simply a function of the decisions made by hospitals, the incentives we choose to establish in terms of how we structure the DRGs, or not.

MR. HACKBARTH: Can I take a crack at that and give the real simple-minded, non-technical version of this? To me, the most important immediate implication of this is

that it reinforces the point we made in our specialty hospital report and we made in the testimony which is, even if specialty hospitals did not exist, the recommendations we made about refining the payment system are very important to do. Now it's not the only thing that's going on in the payment system, not the only policy issue that you may want to raise or address as a result of research like this, but that one is squarely on our plates, and Congress's plate, and CMS's plate.

MR. PETTENGILL: Part of the analysis we did at the end of the specialty report was to say, in the policy simulations we did, if you implemented all four of the policies that the Commission recommended, what would happen to the selection variable? The answer is, the selection variable essentially would collapse around one. Not completely, but almost. So what that's telling you is that's the part that you can control. You could control some of these other things but not through the changes that you recommended.

DR. REISCHAUER: Sheila has raised my point and I

was glad to see, Craig, you said we're going to look at this over time, because it's very different from when we did this for specialty hospitals. We're comparing them to other hospitals. But this, you don't now how much of it is random from year to year, and you have no feel.

I don't know if other people have problems with the word selection, but selection makes it sound like the hospital is in full control here. Maybe that is the case, maybe it isn't, for some of this. But what we're really talking about is just the distribution, maldistribution, if you will. I say this looking at the two tables in the book that we received where the largest variation from the bottom quintile to the top or from the 10th percentile to the 90th percentile is within the government hospital group, which should be the group that one would think would be least motivated by these kind of incentives.

MR. PETTENGILL: I think what that reflects is that the government group is an extraordinarily heterogeneous group of hospitals. It ranges from the big inner-city giant teaching hospitals that get everything

under the sun to the little rural government hospital that is owned by the county and supported by a tax district which doesn't do any surgery. So selection can be all over the map there, and it's really a heterogeneous group.

MR. LISK: Our hypothesis on selection probably would be, it's probably related to volume in terms of the persistence of selection. The very low volume hospitals may be more volatile, and the hospitals with higher volume are probably much more stable. But that's part of what we want to take a look at.

I agree with your issue with the term. If people have suggestions, that would be helpful. But we're trying to be very careful when we say selection of cases hospitals receive, for instance, rather than saying what selection hospitals make.

MS. DePARLE: Ray suggested case mix. Would that work? Is that a way of expressing it? Because it is a little more --

MR. LISK: Because case mix is something we're looking at here so --

MR. PETTENGILL: Case mix is different.

DR. MILSTEIN: If we were to draw conclusions and want to make recommendations based on this analysis, one of the elements of this analysis in which I think we'd all want to have a lot of confidence is our severity index, to make sure that imperfections in our severity index, which as I understand are primarily based on administrative data, were not influencing our conclusion. It seems to me that since we're in a development and there is an opportunity here to take advantage of the fact that at least in one state, Pennsylvania, very refined severity on admission indices have been built using medical records information, routinely on all admissions, as opposed to administrative data which tends to always be challenged, especially at the point of a policy recommendation, that it's based on administrative data.

So one of the suggestions I wanted to make was that we take a state like Pennsylvania, take the index that we're currently using to gauge severity and simply validate it against the medical records based severity on admission

information that's uniformly available for every Medicare admission in the state of Pennsylvania, so if at some point we want to go forward with the recommendation we can have confidence that we have a clinically precise index of severity rather than one that may be influenced by coding differences between hospitals.

MR. HACKBARTH: Julian, any thought on that?

MR. PETTENGILL: If we can get our hands on the Pennsylvania data, the Pennsylvania data essentially can be grouped into, using an APR-DRG grouper, and you could make such a comparison.

MR. HACKBARTH: The term administrative data doesn't quite sound right to me in the sense these are pieces of clinical information about the patients. Now it may not be as complete a set as you could get but it's not like these are demographic information.

MR. PETTENGILL: If the diagnoses and procedure codes from the medical record match the diagnoses and procedure codes on the claim then there will be no difference in the severity index.

DR. MILSTEIN: I think the confusion here is that a robust severity index would take into account more than simply the diagnosis and treatment listings. It would take into account issues like patient physiological status, which is what you get in Pennsylvania, uniquely.

MR. HACKBARTH: Again I'm not saying that there aren't more data that you could potentially include, but administrative data in other context connotes demographic information.

DR. MILSTEIN: Not in insurance parlance. In insurance parlance, administrative data refers to the billing data you get from a hospital that includes diagnosis and procedure coding and length of stay and such. Anyway, it's certainly more than demographic data.

MR. HACKBARTH: We don't need to belabor it.

MR. PETTENGILL: The difficulty there would be that you would have to have a patient classification system, a software package that would make use of that information, the information differential, and we don't have one.

DR. MILSTEIN: We have developed a severity

classification system based on the data flows that we have, irrespective of how they're termed, right? We have one. That's how we were able to do the prior analysis.

MR. PETTENGILL: We used the APR-DRGs to do it, yes.

DR. MILSTEIN: And it's based on what's coded on the hospital bill. That's the basis of it?

MR. PETTENGILL: Yes.

DR. MILSTEIN: In Pennsylvania, we have a much richer data set that allows you to actually know something about a patient's physiological status on admission. So the opportunity here is to calibrate what we're using as our severity adjuster against something that is much more robust and accurate than simply a set of diagnostic codes that are coded on a hospital bill, which I think at this point on validation and accuracy level, I think currently the most research I've read are in the upper 80 percent. When you do review retrospectively to ask how accurate are the codes on the hospital billing data they are running around 90 percent, plus or minus.

MR. HACKBARTH: We need to move on. We're down to our last couple minutes. I know Alan wants to get in here.

DR. NELSON: Obviously, hospitals can influence selection through marketing and staff recruitment. I don't know how we would measure that, but it isn't entirely just random distribution.

Without any preconception, it might be informative to break it out according to for-profit and not-for-profit hospitals.

MR. HACKBARTH: Any others?

DR. WOLTER: Just real quickly on the selection issue. I don't known what the right word is either, but I do think one of the policy implications we need to be considering is does a system that concentrates profit in a smaller number of DRGs create behaviors that maybe aren't as good as the behaviors we have if there was a spread? And are there decisions about more cath labs and more cardiac services and relatively fewer mental health services that end up being made?

That's not to attribute bad motives to anyone. I

think that when you have a system that concentrates profitability, you need that profitability to maintain services in unprofitable areas. When these things are not balance it just creates the potential for results that our system would be better off without. So I don't object to the word selection. I don't think it necessarily means bad intention, but we just have to talk through what are the policy implications that might lead us in better directions.

MR. HACKBARTH: Of course that underlines the importance of refining the DRG weights so that we create less of a problem in terms of some DRGs being disproportionately profitable relative to others. We would like to move to a system where maybe less of that is necessary and you get more appropriately paid for what you do.

Okay, thank you very much.

We'll have a brief public comment.

MS. McILRATH: I'm Sharon McIlrath with the American Medical Association.

Since Kevin brought up the 2003 data, I wanted to

just say one word about that, and that is the issue is, yes it's growing either way. The difference is, if you look at the trustees' report, the pattern looks like it is a steady acceleration. If you look at the SGR tracking reports which are in the data that you have in the letter, it looks like things leveled off in 2003, actually dropped from 2002 and then spiked up. I think the reason that that might be important is that it might lead you to look at different things or to make different conclusions about what is happening.

If what you're seeing is some sort of a trend that looks pretty steady, maybe that is just because there are more beneficiaries with chronic disease. If you look at 2001 and 2002, which are the last two years for which we have data, you can see drops of about 6 percent in the number of patients that are dying of heart disease, that are dying of stroke and cerebral disease. All of those patients require continued care. So if it's a trend, maybe a lot of that is that.

If it's a spike, maybe it has to do with all the

legislative changes that we have seen recently, and maybe one of the things that you would want to look at is not simply what was done in the parts of the bill that affected the physicians, but maybe you want to look at what happened over on the Part A side. We know that several years ago what happened was that some of the things in Part A made the physical therapists go out and instead of becoming providers over on the Part A side, they became providers on the Part B side. There's some reason to think that there may be some things with consolidated billing, with the 75 percent rule, some other things that might be affecting some of those numbers.

I guess the other thing that I wanted to say was that I do think you ought to be looking at what is the impact of increases on the physician side on the other parts of the program. Certainly, the Medicare trustees' report also said that there was a smaller than projected increase on the hospital side. Is there a relationship between those two things? Because if you want to go ahead and do pay for performance, and we know or we think it's going to increase

physician services and put us in even more trouble with the SGR, it would be nice to know that there was something happening on the Part A side to offset that so that maybe there's some way that there can be some exchange of funding there.

MR. LANG: William Lang with the American Association of Colleges of Pharmacy. I just would like to support Mr. Bertko's recommendation that you include some mention of the medication therapy management programs in your chapter in regard to monitoring the Part D benefit. CMS mentioned in the final rule that that was a cornerstone of the program yet didn't do a very effective job of describing to the plans what that is, and we would like to ensure that that benefit is made available to at least a small population of the beneficiaries.

MR. HACKBARTH: Okay, thank you very much.

[Whereupon, at 12:00 p.m., the Commission meeting was adjourned.]