MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, September 11, 2003
10:20 a.m.*

COMMISSIONERS PRESENT:

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

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P R O C E E D I N G S

MR. HACKBARTH: Welcome to our guests.

This meeting represents the beginning of another annual cycle for MedPAC, working towards our reports in March and June. In keeping with past practice, this meeting will be primarily about our agenda for the year. And for those of you who follow our work on a regular basis, it will give you a good sense of what will be coming in forthcoming meetings.

A reminder for those of you who do attend regularly, maybe not a reminder but a heads up, our schedule this fall would be a bit different than in the past. In the past we have met each month. This November, there will not be a public meeting. We are making that change in order to accommodate the need for additional staff work on some issues and to give the staff more opportunity to prepare for our meetings in December and January, which are critical meetings for the Commission.

As in the past, we will have a public comment period at the end of the morning and afternoon sessions. As always, I ask that you keep your comments brief and to the point. And if we have a number of people queuing up at the microphone, I reserve the right when I hear comments being repeated to try to move things along so that as many people as possible have the

opportunity to address the Commission.

With those introductory comments, Anne?

The first topic is the context for the Commission's work, the context for Medicare spending. Anne?

MS. MUTTI: As you might recall earlier this year in the March report we had an introductory chapter that focused on Medicare spending characteristics and trends, factors driving growth, trends in beneficiary resources, and comparisons with other sources of health care spending.

We initiated this survey of the health care spending and budgetary environment because we felt that it was important to recognize the larger context in which Medicare operates and we felt that it would help us in our assessment of the potential impact of Medicare's recommendations.

For the 2004 March report we plan to include a similar overview. This year we plan to broaden it to include not only spending trends and characteristics but also information on access to care and more detailed information on beneficiary resources and out-of-pocket spending.

Today's presentation focuses on the spending trends and the availability of supplemental insurance. Supplemental insurance relates both to access and out-of-pocket spending.

But to large extent, today's presentation is an update on material in last March's report. And in following presentations later this fall, we'll get to more detailed information on access and on beneficiary resources and out-of-pocket spending.

Another point to note at the onset of this is that we, like last year or this past year, we plan to highlight our assessment of each recommendation by MedPAC on program spending as well as on beneficiaries and providers. We introduced that last time in the March report and that holds going forward.

I will start out by briefly reviewing some of the characteristics of Medicare spending discussed at the beginning of the paper. Medicare is expected to spend about $272 billion in 2003, and this is just program spending, not what beneficiaries pay out-of-pocket.

The spending is concentrated on certain specific services. 40 percent of Medicare spending goes for hospital services inpatient, another 17 percent goes to physicians, and then M+C, SNF, and home health, as well as outpatient hospital care, are some of the other big service areas.

Depending on the service sector, Medicare can account for about 30 percent of revenue and the supplies for hospitals,

home health agencies, and DME suppliers. And it can be a much smaller factor for other types of providers. For example, it's about 12 percent for SNF, for nursing homes, and about 2 percent for prescription drugs overall, but certainly some prescription drugs rely a lot more on Medicare than others.

The costliest 5 percent of beneficiaries account for about 47 percent of spending in any one year, while the least costly 40 percent of beneficiaries accounts for about 1 percent of spending. We'll try and get these numbers for you over a five-year period, like we did last year. We just don't have those at the moment.

Spending varies geographically, as we talked about for last June's report, with Medicare paying an average of about $3,500 per fee-for-service beneficiary in Santa Fe and about $9,200 in Miami.

Now let's turn to Medicare spending growth. Let me hit a couple of technical aspects first. On this slide, we use OACT, the Office of the Actuary from CMS. We used their numbers for current and historic spending and CBO numbers for projected spending. The OACT numbers are on an incurred basis, and CBO's are on a cash basis. It accounts for some differences in year-to-year growth that you might see on the

two baselines. Again, these are program payments, now what the beneficiaries are spending.

One other point to note, just as you did last year when we were talking about this, is the projections are uncertain. And certainly the further out we get in these projections, the more uncertain they are.

So with that caution in mind, let's just review. After growing an average of about 9.3 percent annually from 2000 to 2002, Medicare spending is expected to grow 4.3 percent in 2003. This relative slowdown is largely explained by the expiration of a number of provisions of the BBRA and BIPA which had increased payments to providers. So now those have expired and payments have gone down. As you can see, spending growth for SNFs and home health agencies is negative. That is particularly where we saw some of those expired provisions.

Between 2004 and 2013, however, the picture quickly changes, resuming more traditional Medicare growth rates of about 6.9 percent over the rest of the projection window.

As you can see in this chart, with projected 6 percent average annual spending growth, Medicare annual spending mounts quickly to about $525 billion nominally by 2013. That's almost double the spending level today.

This chart sort of understates a long-term trend. It ends in 2013 and that's just two years after the leading edge of the baby boomer generation is retired.

These numbers also assume current law. So for example, they do not include a Medicare prescription drug benefit which, as you may recall, CBO has scored to be between $405 billion and $421 billion depending on the bill over the 2004 to 2013 period.

While it isn't on the slide here, let me give you a sense of the projected federal budget deficit during this same period. According to CBO, under current law the deficit is expected to peak in 2004 and then change -- I'm sorry. It peaks at about $480 billion in 2004 and returns to surpluses after 2010. But this could quickly change under an alternative scenario, and let me give you just an example. If all tax provisions were extended and a Medicare drug benefit were enacted, the budget outlook for 2013 would change from a surplus of $211 billion to a deficit of $324 billion.

With this Medicare spending growth comes some other noteworthy statistics. The HI Trust Fund is expected to be insolvent in 2026. This is four years earlier than was projected last year, and it's in part related to some increased

spending assumptions but also largely reduced revenue assumptions.

Medicare is also expected to grow as a percent of the budget from 13 to 15 percent between 2003 and 2013, and Medicare is also expected to comprise a growing portion of the economy, growing from 2.6 percent of GDP in 2002 to 5.3 in 2035 to 9.3 in 2077.

I just want to reiterate the point on the uncertainty about long-term projections by providing example of how even a small difference in the assumption in the long-term growth rate can make a big difference in this statistic. For example, if the growth was assumed to be just a half point percentage faster, Medicare would account for about 13 percent of GDP in 2077 compared to the 9 percent that they're assuming now.

Other sources of health care spending have been and are expected to grow rapidly. Personal health care spending is expected to increase 7.1 percent annually between 2002 and 2012. And at this rate, that means that personal health care spending would comprise about 17 percent of GDP.

Private insurance spending, similarly, is growing fast. It increased about 8 to 9 percent in 2002, which is quite high but it is representing a decrease from one year to

the next. And that is the first time we've seen a decrease in the growth rate on an annual basis in quite a while.

Premiums are also showing signs of hitting their peak, perhaps in 2002 or 2003, it really depends on the survey that you're looking at. But certainly passing the peak of increase provides very little relief. We're still talking about premium increases expected to be in the 14 to 17 percent range in 2004, based upon recent employer surveys.

CalPERS, just looking at some of the other governmental purchasers, are looking at big increases, too. They've just announced a 16.4 average increase for its 2004 beneficiaries. While we don't have the FEHBP increase for 2004, it did increase at 11 percent last year, so they too are struggling.

Just quickly, we can review some of the factors that are contributing to health spending growth. A lot of them are the same regardless of who's paying. Technological change, as well as growing consumer and supplier-induced demand, certainly have contributed to past growth rates and are expected to contribute to further growth.

We just would note that the different payers have availed themselves of different cost containment tools and have

had varying successes with them. Certainly Medicare has relied a lot on legislation recently that has reduced provider payments, while the private sector has had other tools. They've relied on managed care in the 1990s to control costs. And then more recently, with managed care's retreat and further escalating costs, private payers are increasingly relying on increasing beneficiaries' cost sharing. So we've seen increases in the number of payers that have raised their deductibles, the three-tier copayments they're using now, and requiring more beneficiaries to pay a larger portion of their premiums.

Looking across different payers, it's tempting to compare growth rates to gain an insight into which payers are more successful in containing costs. This has certainly been the topic of many articles and public forums. We would just note that this can be a little dangerous because the comparison must recognize some of the differences across these payers.

First, Medicare and private payers cover different benefits. Certainly prescription drugs is noteworthy, that Medicare doesn't cover that to the extent that the private sector has. When this is taken into account, if you just compare physician and hospital spending, for example, it

appears that Medicare grows somewhat slower than private payers over the long run. But this analysis is still compromised by its inability to reflect changes in the generosity of the benefit package over time.

Just to understand this concept real quickly, imagine that the total spending for care is divided between the insured and the beneficiaries in terms of their cost sharing, and just take out premiums for the moment. We're just just talking about spending and who spends.

To the extent that that share of spending shifts between the two parties, spending growth by the insurer will be effective. They're not spending as much if the beneficiary has higher coinsurance. But it says nothing about their ability to contain costs.

So we just really caution you on relying too much on these numbers because they just cannot take into account those kind of fluctuations. We think there have been those kind of fluctuations, especially with the private sector over the last 10 to 15 years.

Also, it depends on the time period that you examine. You can see from this slide that it varies very much, depending on what years you look at, who grows faster.

Another issue clouding this is the fact that some of the private health insurance includes spending for Medicare beneficiaries, in terms of supplemental insurance from employers and Medigap.

Now, I will just switch gears a little bit and turn to data we have on the roll and availability of supplemental insurance. We provide this information because it relates both to access and to out-of-pocket spending of beneficiaries, the two other areas that we're going to talk about in this chapter. Right now, the data that we have is 2000 MCBS data and we're going to be updating that by December. So this is still just a little bit of a preview of what you'll see in future drafts.

Supplemental insurance gives beneficiaries greater access to care. For example, beneficiaries with Medicare only, and that means no supplemental insurance, were more likely to report delay in care due to costs and having no usual source of care than beneficiaries with supplemental coverage. What is somewhat perhaps more counter-intuitive, however, is that beneficiaries with supplemental insurance are not shielded from out-of-pocket spending. Those with employer-sponsored insurance, as well as with Medigap, tend to use more services and have higher out-of-pocket costs.

The most common sources of supplemental insurance are employer-sponsored coverage with about a third of beneficiaries having that, Medigap 27 percent, and M+C has about 18.3 percent. And this is in 2000. 11.6 percent had Medicaid and about 9.3 percent had Medicare only.

It's important to remember that these numbers are only estimates and data from other surveys suggests that the Medicare percentage could possibly be higher than the number here that we report.

Just real quickly, to go over some of the trends in supplemental insurance and its availability. It seems as if employer-sponsored insurance is declining. We've seen this in employer surveys more and more, saying that for future retirees they're not going to be covering them. And a new study has found that in the younger cohort of the Medicare population, the 65 to 69-year-olds, that is starting to show up, that fewer have supplemental coverage from their employer.

M+C enrollment peaked in 1999 and has declined since. And the cost sharing associated with that option has decreased, also. Fewer plans are offering zero premiums and coinsurance is increasing, also.

Medigap premiums are increasing about 10 percent we

estimate between 2000 and 2001 for the two most popular plans. We've seen a small increasing from year-to-year between 1999 and 2000 in the number of Medicare only, from about 8.8 percent to 9.3 percent.

But we're certainly interested in looking forward as to where people are moving to, if they have less access to employer-sponsored insurance, if they're finding mounting Medigap premiums as daunting. And M+C may not be as available. So we'll be looking at that when we get a hold of the 2001 MCBS data.

With that, I think I'll just close here and just ask for any comments that you have on content and tone.

DR. ROWE: Well, just one comment which really echoes what you just said, Anne, about getting the new data. These are changing issues, to be citing what proportion of the Medicare beneficiaries have M+C and using 2000 data, is really a number which as we all know is not the current number. And maybe there are some ways to refresh it up a little bit or make some estimates or something. After all, this is MedPAC and people are going to -- we should be as up-to-date as we can be.

I just have one contextual comment, and that is in your remarks you said that insurers were forcing employees to

pay a higher share of the premium. And I would offer that it is employers who are forcing employees to pay a higher share of the premium. We have a lot of people blaming us for everything but we don't need that MedPAC also blame us. It is really the employer's decision what proportion of the health care cost the employer pays and how much gets pushed across the table. And it's the employer's decision as to the benefit design of the health plan products that they offer their employees when they do offer them.

So I think it would be fair -- --

MS. MUTTI: I apologize for that, Jack. I misspoke there.

DR. ROWE: I didn't take a personally, I just want to make sure we understand.

MS. ROSENBLATT: I like this chapter and I thought it was very well done previously, and I think updating it is a great idea. I think putting it all in context is terrific and I like the fact that you brought in the $400 billion for the drugs.

There is one issue, you gave a lot of caveats about your chart that compares spending among the different private health insurance, et cetera. There is another caveat in that I

believe that we are comparing things that relate to each other. So that if you look at chart 1.2, which unfortunately you didn't have in your overheads but it's in the package we got, as Medicare increases go up, private goes down and vice versa. There's that inverse relationship all the time.

So if you're comparing how Medicare does on controlling costs with how commercial payers do, there's always well, wait a minute. How can we compare something that's really related because if the providers are getting less from Medicare, they're going to try to get more from commercial.

So, I think that might be a good caveat to add.

DR. REISCHAUER: This is a draft that's filled with lots of interesting bits of information and I'm going to be a nit-picker here and, like Jack, defend the roots that I have. And that is sort of your use of some terms like CBO and the trustees forecast that Medicare will grow 1 percent faster than GDP in the future. They assumed that. They don't really forecast it. It's a number pulled out of the sky and everything you have provided later on suggests that it really is in the sky.

Where you talk about Medicare as a percent of federal spending, you say it's going to grow from 13 to 16 percent.

It's expected to. But we all know the base which you're using is woefully unrealistic because it's the CBO baseline. So I think we mislead people.

And similarly, I applaud you for pointing out that the baseline later on is a little fanciful, and then you give a number for the likely deficit in 2013 which is $324 billion if the tax cuts are extended and there's a prescription drug benefit. But that number that you're using also assumes that discretionary spending grows no faster than inflation. And if it grows at anywhere near what the past five years has been, the deficit in the CBO numbers is well over $700 billion. So I think if we're going to strive for realism, we should go all the way.

You have a little statement about specialty hospitals and clinics are flourishing as providers. I guess I could be dead wrong on this, but something I read -- I think it was by Paul Ginsburg's folks -- laid out how many specialty cardiac hospitals there were in America right now. And I think I can count them on the fingers of both hands, and the fraction of total cardiac services that they provide must be absolutely tiny.

It's something new. It's something that's developing

very rapidly. But like the PLI, I it's starting from such a small level that the impact that it's going to have on the great swath of health care in America is likely to be rather limited.

So what I'm saying is I don't think we should make things sound bigger than they are.

MS. MUTTI: Flourishing might have been a poor choice of words.

DR. ROWE: Is that really all there are? There's only a couple of handfuls?

DR. REISCHAUER: Like a dozen or eight. I could be wrong. I mean, there's undoubtedly somebody in the audience who knows what these numbers are.

MS. BURKE: [off microphone] But the point is it's not just those. I mean, you've got LTACs --

DR. REISCHAUER: Cardiac specialty hospitals. There's a bunch on the drawing boards.

MS. DePARLE: It's not as big as I thought.

DR. REISCHAUER: But it says it's small, too.

DR. MILLER: I think the thought that were trying to capture, and we may not have constructed the words right, is if you think of specialty to Sheila's point, more broadly than

just these facilities, like long-term care hospitals and that kind of thing, that is I think the phenomena we were trying -- and we may have put just the words cardiac or whatever we put in there. But I think we're thinking more what Sheila said.

DR. ROWE: [off microphone] It's a small but rapidly growing --

DR. REISCHAUER: But even those are not huge.

I had one question about data which just struck me when I was reading this for the first time, and this was the chart on additional coverage for selected beneficiaries. In all these tables we and everybody else has this employer-sponsored insurance. I was interested in the breakdown that you had by age.

I was wondering if there's any way to ferret out active workers who are getting employer-sponsored insurance, as a way of trying to figure out sort of what the future looks like. Because in these numbers you see that people 65 to 69, a higher fraction of them have employer-sponsored insurance, even though we know employer-sponsored insurance for retirees is a declining benefit. And it must be that what we're picking up in these numbers is a lot of 66-year-olds who are still in the work force have signed up for Part A, at a minimum. And if it

would be possible to take them out of the analysis.

MS. ROSENBLATT: I don't know you can do that but just to your point, I think that what is happening is that employers are not kind off their current retirees. They're cutting off their future retirees.

DR. REISCHAUER: They've grandfathered everybody and often it's everybody over age 55 or over age 60. But we've been talking about this now for about six or seven years, so they should begin to be showing up in these numbers. And I was just surprised that it wasn't more apparent. And you have some other information here, from other sources.

MS. MUTTI: Right, that does show that, looking over a five-year period. And we just have one year right here.

DR. WOLTER: I was just going to suggest maybe, as we continue to work in this context in the future, it's interesting to look at the interplay between Medicare and private insurance and the private sector. We might want to add some information on trends in the uninsured and possibly a little bit more in the Medicaid arena. There's one table that captures some Medicaid data, but a lot is happening there, also. And as we use this to maybe ultimately get at some of the interplay between these various sectors, adding those two

things would be useful, I think, to people.

MS. MUTTI: We had planned to come back on Medicaid, but the uninsured is a new idea.

DR. WAKEFIELD: Anne, when you give us more information about the shift in Medicare only that is the decline in Medigap coverage -- Medicare only increasing 8.8 to 9.3 percent -- will you be able to tell us anything or not about any changes in that group's utilization of health care services or access to care?

MS. MUTTI: Yes, we should be able to.

MS. RAPHAEL: I found this very interesting, in terms of the part where you try to compare the methods used to control future growth in the private sector compared to Medicare's use of legislation. And I was wondering if you have any evidence at all about what the impact is of the private sector employers' attempts to increase cost sharing? Because you allege that we think that shielding employees from cost might lead to greater utilization. At least that's the hypothesis.

So we do we know if the reverse is true? By increasing cost sharing, in fact, utilization of services has decreased?

DR. ROWE: I think I can comment on that. I think it's important to differentiate the forms of cost sharing. If your employer decides to go from 85 percent of the premium paid by the employer to 80 or even 75 on an annual basis out of your paycheck, that has a very different effect on utilization than if they choose a different plan design that has coinsurance or a higher copay or deductible at the point of the clinical service.

So you could, in fact, have two different designs where there's the same reduction from 85 to 75 percent. But one of them influences a decision making at the point of clinical service. Should I get a generic drug or a brand drug? Should I go to the emergency room with my sprained ankle or not? And another doesn't, because it's just out of the paycheck.

And so when you do that analysis or try to answer that question, it's very important to differentiate those two different ways in which employers are increasing the cost sharing. And I think you'd find, with the latter type, where it's the product design that, in fact, you would find reductions in utilization and they're quite predictable actually. Any actuaries can -- well, Alice can comment on

this.

If you do just in terms of the cost sharing out of the salary, then I think it's much harder to demonstrate that. Alice?

MS. ROSENBLATT: I agree. Out of the salary, it's just going to affect who picks what. Whereas out of the benefit plan, it does have decreased utilization. How predictable it is, I'm not sure. But you can look at it and see, the utilization change will be more than the strict actuarial difference of the benefits. In other words, if you change your deductible from $200 to $400 and just expect to see the $200 difference, you're going to see more than that.

MS. RAPHAEL: That's helpful.

DR. NEWHOUSE: This is really comment on Alice and Nick's point about the link between public and private. While it's certainly right that in the short run there's a negative relationship between what Medicare pays and what the private sector charges, in the longer run politics in Medicare dictate that Medicare is going to keep up with private sector or keep some relationship with it to preserve access for Medicare beneficiaries.

So if we're going to talk about the relationship, and

I think we probably should because they are related, we need to distinguish short and long run.

MR. HACKBARTH: And for each there's sort of a cyclical element having to do with underwriting cycle and other factors, maybe on the private side. In Medicare there are political cycles of budgetary stringency and generosity. And so I think any comparison, to be meaningful, would really look at a fairly long period of time. And then it still has all the caveats that have been identified.

MS. BURKE: Two quick questions, one a follow-up to Nick's point about future versions of this perhaps reflecting in greater depth on Medicaid because of the obvious linkages there.

My one cautionary note, this document is enormously useful and it is designed to assist us in looking at the broad context in which Medicare must be considered. I think we need to be careful about how many linkages we create.

To the extent that we do Medicaid, to extend that we do the uninsured, goes back to a much bigger question and that is to what extent should Medicare, in fact, adjust or reflect those behaviors and how it, in fact, deals with the costs that are being incurred by efficient providers.

So I think Nick is exactly right, but the cautionary note is how tightly we create that link. This happened and the cause and relationship with Medicare is just one I think we should be sensitive to. But I do think it would be very helpful to give the broad context.

The other is, in fact, something very nit-picky, and Bob may actually have a thought on this. In the section where you discuss demographics and economic trends, there is a number that has been used largely in the context of Social Security, but is sort of an interesting way to look at what the impact of the changing demographics is. That is the actual number of retirees to workers, in terms of the ratio. I mean again, it's largely used in the context of Social Security, where it began in terms of the contributions and then where it's gone.

But it's interesting, we're down to what, two to one now or three to one? Three to one? I think it's just a quite easy description of how quickly that has changed and how dramatic that impact is likely to be in terms of the financing system.

MR. FEEZOR: Anne, a good chapter. I'm sorry I was not in for your presentation and I have a couple of edits that I'll send you in written form.

One though, just on page three of the materials that you sent us, you talk about the geographic variation in price and a lot of that is really due to practice pattern differentiation. Any way of sort of quantifying what that deviation may be? Say about an average what the aggregate cost would be to the Medicare program? Just think about it.

DR. ROWE: You can always do Miami and Minnesota.

MR. FEEZOR: No, that's -- well, we do New Mexico and something above, Detroit. More in terms of, I think, what the average cost.

One other thing. As we go forward in the subsequent editions of this chapter, are the databases sufficiently sensitive to any tilt towards either MSAs or particular FSAs? And I guess I'm concerned, having I guess a recent IRS ruling which in fact is going to expand the applicability of at least flexible spending accounts to be a lot of non-prescription and a lot of non-things. I've got a whole bunch of herbal drugs that I was, in fact, going to immediately submit on my FSA.

DR. ROWE: Some of those are illegal, you know.

MR. FEEZOR: Fortunately, I brought most of them from California, so I'm still in good shape.

But just as a cautionary note, I think in terms of

our thinking of capturing some of that personal expenditure data going forward, that I think some either expansion or refinement of some of the FSA expenditures may be warranted there as we go forward.

DR. NELSON: Anne, maybe you can help me with some confusion over terms, around the term personal health care expenditures or personal health care spending. Because it appears to me that they are used in two different ways. One, in the comparing growth chart which has personal health care expenditures, and I want to know what you mean by that.

And then, in the Medicare spending characteristics on page one you define personal health care spending as all money spent on clinical and professional services received by patients excluding administrative costs and profit, with Medicare comprising 19 percent of that.

Are they the same? Or is a personal health care expenditure referring to uncovered expenses out-of-pocket by individuals?

MS. MUTTI: No, they are the same. It is all spending on health care services. It sounds technical because we're taking out the administrative costs. We're taking out public health spending because we're looking nationwide. We're

taking out some research money.

So we're trying to just focus on that money which is spent for health care services, clinical services. So it is true then that Medicare is 19 percent of all that money that is spent on that.

And then when we have that other chart where we showed the growth rate of how fast that is growing, it's the same pot of money that we're just showing annual growth.

DR. NELSON: Thank you, that's helpful.

DR. REISCHAUER: I think it's national health expenditures minus construction, research, education, public health, but administrative costs associated with delivery of care are included.

MS. MUTTI: That may be true. I was just looking at the chart right before the meeting to try and figure out what was in there and I may have misread how indented that line was inclusive or not. But I'll go back and double check.

DR. REISCHAUER: I'm not 100 percent sure.

MS. MUTTI: Or the label may have been misleading. I'll double check.

MR. SMITH: Anne, as usual, this is very helpful stuff.

One set of comparisons which we might think about whether or not we could add and the utility of adding, would be the Medicare covered population and everybody else. That what's going on both with insurance and utilization in the rest of the population, partly to Joe's point, that there is a political imperative for Medicare either not to lag too far behind nor to lead.

But there are profound changes going on in the way everyone else is covered. And it might be useful to look at the Medicare covered and the non-Medicare covered population.

To Sheila's Social Security point, it's too easy, I think. The real metric here is personal income, not ratio of workers to beneficiaries. I'd be very careful with that ratio. The issue is personal income, share of personal income. So I'd stay away from that.

MR. HACKBARTH: Okay, thank you, Anne.

Next up is our work plan for assessing quality of care. Karen.

MS. MILGATE: Before I get started, I just want to acknowledge that the work plan you're about to hear about is the result of my work, but also there's two colleagues that I worked very closely with. That is Sharon Cheng and Anne

Marshall. And you'll be seeing more of them at this podium at we go along this fall.

What I'm about to present is a work plan for primarily the product would be a chapter in the March report, whose purpose would be to give a broad overview of quality of care in the Medicare program.

But you'll see as I go along that we hope our efforts to pull together a robust set of indicators to look broadly at Medicare will also support our other quality work.

Our work is being done in the context of a variety of other efforts, private and public, to measure and improve quality. The IOM, as you are all probably aware, issued a report several years ago which really outlined the problem and the scope of the problem particularly in the area of patient safety. And then a couple of years later issued a report, the Quality Chasm Report, that outlined a vision for how to improve quality as well as a framework for how to get there.

We've talked in these meetings before also about the efforts of the large purchaser group called the Leapfrog Group to really push the envelope in terms of quality and particularly safety in some of their identification of very specific leaps, as they call them, in the quality improvement.

In addition, we've also talked in these meetings about the various efforts that CMS is undertaking. They worked with the QIO program to develop measures, to measure quality, and actually work with providers to improve. They have their public reporting initiative which has really engendered a lot of discussion in the settings of nursing homes and home health, as to how to improve quality.

And then they also have their pay for performance demonstrations, which are sort of in line with the recommendations the Commission made in the June report, for how to actually put together payment incentives for improving quality. And there are many other insurer and purchaser efforts.

All of the efforts that I have just outlined, including MedPAC's work, require data on quality. Several sets of indicators are now available that could provide a broad overview of the quality of care for Medicare beneficiaries. In addition, we think they could support some of our other MedPAC work on quality. Here, I just want to outline the various efforts on our agenda that we think that this work could help.

First of all, in terms of overall monitoring, the goal here is to create as robust a set of quality data as

possible to be able to look at quality from a variety of different perspectives. So we're trying to do that and there's obviously a lot of other people trying to create that robust set for their own purposes.

We also think in this area it will be interesting to see how the different indicators sets do or don't move in the same direction. You may see one aspect of quality where it looks different than another aspect of quality, in terms of either trends or in different regions. Or in fact, if we find that they all seem to be moving in the same direction, that's a pretty good indicator that we really are seeing something about the quality of care either nationally or in that particular region.

In addition, for purposes of payment adequacy, we are intending on looking at national trends in certain settings to see if quality has remained the same, improved, gotten worse over time. As well, as we hope to be able to compare urban/rural areas, particularly potentially for settings where there are differences in payment based on urban and rural distinctions.

For our future work on incentives, we're hoping that looking at these various indicator sets will help us target

those incentives. It could possibly help us identify some of the largest gaps in quality, particular types of conditions or particular procedures, or particularly settings that are more problematic than others.

In addition, to help us get a better handle of what kinds of measures are out there and where measures may be best in particular settings. That could help us either in our work, but also in recommendations to Congress or CMS on where they may target future efforts in this area.

While most of the data we'll be looking at this year we don't intend on looking at at the provider-specific level, i.e. a particular hospital or a particular physician, we're hoping by getting more familiar with these various indicator sets, we may be able to identify some that would be useful at the provider-specific level to help us to begin to examine the relationship between cost and quality in particular settings.

So on the last slide what I was hoping to do is give you a sense of how we might use the information that comes out of the data we hope to obtain. This one and the next one I just want to describe the indicators and give you a sense of what they would tell us about quality more specifically.

These various sets of indicators that you see listed

in this chart represent over several hundred indicators of quality which are some in specific settings, some give you a broad program overview, and some are on specific aspects of quality.

To organize our thinking, and as you've seen it on the slide, what we did was organize these in terms of the four domains of quality that IOM identified. Those would be the clinical effectiveness, patient safety, patient-centeredness and timeliness. You can see from the slide that clearly there are more data in clinical effectiveness. You can also see that some of the information we get, for example, for clinical effectiveness is also information that can be used for looking at timeliness of care. So some of these indicator sets give us information in different domains of quality.

You can also see, looking just briefly at the timeliness domain, that the information within a domain can be quite different. For example, the CAHPS for fee-for-service and Medicare+Choice is a beneficiary survey, so it's a beneficiary perception of the timeliness of the care they're getting overall and in some specific settings.

However, the ACE-PRO ambulatory care measures really look at are beneficiaries getting clinically necessary services

in the ambulatory setting? And some of those are based on timing. Are diabetics being seen twice a year? Are those discharged after a certain procedure in a hospital getting a follow-up visit within four weeks? So there are different aspects of quality even within each domain.

There's also one relationship I'd like to point out that I think is an interesting one in the clinical effectiveness domain. We have two indicator sets there that look specifically at ambulatory care, and one looks at the process of ambulatory care. That would be the ACE-PROs. Did beneficiaries receive clinically necessary services in the ambulatory settings? And it kind of counts whether they got the services or not.

And then the AHRQ prevention quality indicators really look at the outcomes of that care. Those really measure whether beneficiaries were admitted to a hospital for conditions that if they had gotten those appropriate clinically necessary services they may not have needed that hospital admission.

So we may see some interesting interrelationships between indicator sets as well.

The last slide I just wanted to go somewhat briefly

over the primary indicator sets we are planning on running. The first is a set of patient safety indicators which looks at adverse events in hospitals. These were developed by AHRQ through a contract with UCSF-Stanford and their evidence-based practice center. There are 16 Medicare relevant indicators that we hope to look at. The beauty of these indicators are they run off of administrative data. So that gives us a lot of ability to look at these from a variety of different angles.

The second set I've listed there is mortality by condition and procedures. And again, that's in hospitals. These were also developed by AHRQ with a contract with UCSF-Stanford. There are six condition-specific ones and eight procedure ones. They basically look at 30-day mortality for these variety of conditions and procedures. Again, they run off of administrative data.

The next two look at care in ambulatory settings. One is the indicators that we've used before here, primarily to look at access. That would be the Access to Care for the Elderly Project, the ACE-PRO measures, which also have implications for quality. So we will tend to use them in both the access world, as we monitor access, as well as looking at quality of care in the ambulatory care setting.

And they look at, as I described briefly earlier, whether beneficiaries are actually getting clinically necessary services in the ambulatory setting. So they identify, for example, diabetics in the Medicare program and look at the types of clinically necessary services they are obtaining.

The next one is the AHRQ set of indicators, as again as I mentioned on the other slide which were also developed by AHRQ. These they call the prevention quality indicators and they measure the percentage of beneficiaries -- is it in a hospital or in an area? But the number of beneficiaries who are admitted to the hospital for conditions that if they had obtained appropriate ambulatory care they may not have needed that hospital visit. For example, amputation for a diabetic is one of those ambulatory care sensitive conditions.

The CAHPS for fee-for-service and M+C, again is a beneficiary survey. It's administered by CMS. That gives us information on how beneficiaries perceive the communication skills overall of providers as well as specific providers. It asks them questions about whether they were actually able to obtain care when they needed it, and provides information both generally but also to specific settings. So we're hoping that will give us some sense of the beneficiary perception of

quality of care, both nationally and then also in specific regions.

In addition to this work, and I also should draw a line here, there is all the other work that goes on through the setting-specific work on payment adequacy that other analysts are doing in their own specific settings to really get some sense of how quality may have changed over time, both in SNFs, for example, Susanne hopes to look at readmissions for particular conditions. Dialysis, we are pretty used to being able to look at quality trends in dialysis. As well in home health, we're hoping to able to look at some outcomes in home health area.

DR. MILLER: Can I say one thing? This is really minor but I just don't want you to get the sense that this is a disconnected process. In fact, all of the quality work is now -- we have a group of people who come together, work with Karen, and all the quality has its own agenda plus it travels out into the payment adequacy area. That's a very conscious change in how we're doing things.

I just didn't want you to get the sense that this was going on in a silo basis.

MS. MILGATE: I have an other there just simply to

note there is a couple of other datasets that are different than these in the sense that we can really only get national data and we intend on looking at, for example, what the QIO program has found over time, as well as the RAND indicators. There was an article in the New England Journal a few months ago. They have indicated to us that it's possible to run those just on Medicare, even though they did an overall look for that particular article. So we're hoping to be able to look at that, as well.

So that concludes my formal presentation. I'm interested in your thoughts on the breadth and scope of what we're proposing here, and any areas you want more work on, or questions.

DR. WAKEFIELD: It's actually one comment and two questions. The comment is more to Mark's last point and that was it was pretty obvious, in flipping through some of the chapters of the prep material that we received, that quality was being teased out and run thematically through some of those sections. I just have to say thanks so much. I think that's just such a critically important focus. So I saw that connection. As a matter of fact, when I was going through, I was underlining it every time I saw it. So it's just a really

nice reflection of the work that MedPAC staff are now doing and the directions that I think you're taking some of this beyond -- linking it to payment adequacy and then moving beyond just payment and access issues in trying to incorporate more of a focus on quality.

Two questions. One, have you had a chance to take a look at all or work with AHRQ's folks as they've been preparing their annual report on quality that's being vetted right now?

MS. MILGATE: Yes, actually I've talked with them a couple of different times about what measures they're going to be using and whether they're going to have Medicare-specific information. I haven't recently though, but yes, I've been in touch with them and I'm planning to have a conference call with Daniel Strier, and he was going to talk to me more specifics as they have gone along.

DR. WAKEFIELD: It just strikes me that as you're trying to key this up and lay out something of a framework, obviously there's going to be a lot of overlap in terms of how you're constructing the framework for this chapter. But it may well be informed by all the work they've put into constructing their report to Congress that I think is going to be released this fall.

So I just wanted to make sure that if it could help jump start even further some of the efforts that you're involved with right now, in terms of the framing of this, that might be really good resource given the intense effort that they've been engaged in their. --

MS. MILGATE: One of the results of our conversations actually is using the IOM framework. They're going one level of detail below what we did, which I don't think is really necessary for what we're our doing. But that is actually one thing that will be similar.

I also have talked to them about making sure that what we're doing is a little unique, so that in fact they're not running all the same thing and getting Medicare numbers. And they have generally told me that they're relying more on breakdowns. They're looking nationally clearly across all payers, but also they're focusing more on certain types of conditions and looking more specifically at conditions.

So I think that the too will actually relate very nicely, theirs coming out then and then this chapter in March.

DR. WAKEFIELD: And then my last question, I see you're using under clinical effectiveness SNF readmissions. Are you looking at all at using MDS-based nursing home quality

measures that QIOs are already collecting, and that are being reported out on Nursing Home Compare? Are you going to use that as a source, at all, Karen?

MS. MILGATE: The issue that we've had with those, and we have thought about that, is that there are very few that are really specific to SNF, and they weren't really designed to capture some of the types of quality issues you might have in SNFs.

The other issue is that the MDS is collected at a point in time, first of all, when beneficiaries will come into SNFs. But then often beneficiaries are released before there's a second one. So you don't get what you'd like to get, which is a change over time in the quality of what the beneficiary is experiencing.

So in our opinion, and this is something we continue to work on, as to how to maybe use that information better in the SNF realm, that you're really capturing more of a description of the patients in the SNF than actually the quality of care. How many have UTIs? How many have pain?

We have tended to feel that the readmission might give us a better picture of quality. I don't know if either of the SNF people would like to add anything to that, Susanne?

DR. SEAGRAVE: In my presentation later on this afternoon, I was going to just best briefly touch on that one of the things that we were planning to try to look at is exactly what you're talking about, and to see if we can identify any changes over time, just nationally in some of the short stay measures on the MDS publicly reported quality measures.

But Karen was very articulate in pointing out all of the problems and the caveats with that. That is part of our agenda, is the first answer to your question.

The other answer to your question is, as you know, those are also changing right now and so we're not sure what those are going to look like in the future. Those could potentially become more useful to us in the future.

DR. WAKEFIELD: I assume you're not collecting them broadly on all nursing home admissions because of the extent to which Medicare is or isn't a payer in that environment? Would that be true?

So I mentioned it in relationship to SNF, that you're choosing to use readmission data there, but in terms of trying to pull broader data on nursing homes, would that be the reason why you wouldn't go there and collect information on nursing --

like use MDS information that the QIOs are using more broadly, not just on SNF but on nursing home admissions across the board?

So what would the reason be why you wouldn't be using that broader set of data?

DR. SEAGRAVE: I think it's not accurate to say we're not using that broader set of data. We actually have that broader set of data and we're looking at it to the extent possible. The problem is that we want to make sure that the quality measures that we use are specific to short stay SNF patients versus the long stay residents, basically nursing home residents.

And that's a difficult process. We also don't have any research at this point on how closely the long stay measures correlate with the quality of the short stay residents. So we're working out all of those kids of issues.

MS. DePARLE: Like Mary, I'm very excited about this agenda and thank you for the work you've done. I think even just laying out all the different data sources that we now have is very instructive. And it does appear we have some rich sources of data now to mine.

I'd be interested in your comments on given our

emphasis on data and current data, where you think we're lacking right now? Or if the staff has some views of that. Where do we still need more data?

And also how current is the data that we have? I know the QIO data is fairly current, and of course that's on a state-by-state basis. But what about the other sources? Is it going to be 2003 report on the experience in 1999? How current are we?

MS. MILGATE: The answer to the currency question is that several of these are run off of administrative data, so we can get pretty current data. It's probably a little bit different for each dataset. But I don't think any of them will go further than 2001, for example.

MS. DePARLE: [off microphone] So they're not linked--

MS. MILGATE: Right. In terms of your other question, I guess that would be something I would -- I mean, I could say something about, but I'm not sure if I shouldn't think a little bit before. Where are the gaps? I don't know if I want to -- you can see from the chart we put there, that clearly there are some gaps in -- I guess I would say one gap would be patient-centeredness. As you probably know, there are

many different efforts to get, for example, of hospital-type CAHPS, a nursing home CAHPS. And there are plans under way to develop those. I think those will be very useful when you get to the specific setting.

But there's other clinical effectiveness types of measures that I think could be useful, too.

MS. DePARLE: What I remember, and this is dated a couple of years, that we didn't have much on fee-for-service and we're moving forward on that. It seems like we have a little more. But physician position office visits, for example, and that sort of physician office setting, was fairly bereft of data. And I don't know whether there's been progress made there or not.

MS. MILGATE: Certainly, as we talked about for the preparation for the June report, there is some progress there in terms of the concept of looking at particular conditions and what's happening at particular physician office.

I think the other issue for us specifically is that those data are not broken down by, for example, ambulatory surgery centers or outpatient. So we have this number for ambulatory care. But we don't know where the care is delivered.

So if you want to talk gaps, I've been frustrated, for example, looking at where can we get data on ASCs and outpatient. Those are big growing areas. They're doing technically sensitive work that could create some quality problems. And yet we don't have measures, let alone data.

And when you talk to people about ambulatory measures, they usually focus on the physician office. So that's a bit of a gap, I believe, particularly for us and CMS.

MS. DePARLE: I would just urge that we spend some time thinking about where the gaps are. I think that's been an important contribution that we've made in our data analysis so far.

DR. MILLER: I think that's completely fair. And Karen, if you said this then I apologize.

The other way you're thinking about your work is as people are focusing on physician and hospitals, the issue there is what data, how deep is it, how useful is it?

Whereas, in some other areas, and Karen thinks about this way, in some other areas that data is deep and the question now is how to use it to begin to incent providers. And I think hospitals and physicians are specifically two areas where you're going to be laying out for people what is known

about those datasets.

MS. MILGATE: [off microphone] Definitely those would be the two areas where I would say -- there's others too, but hospitals and physicians do need a lot of work.

MS. DePARLE: Just one more point. I would also be interested in your comments, if any. There was a New England Journal of Medicine article about quality of care in the VA system versus Medicare that came out a few months ago. And other commissioners might be interested in it as well. Medicare did not compare as favorably as -- and I would be interested in your comments on that.

MS. MILGATE: Okay.

MR. HACKBARTH: Karen, when we look at datasets, some of these big datasets, one story is what's happening on average to the quality of care delivered to Medicare beneficiaries in a particular setting along particular dimensions. Another story is variability across institutions and to what extent the range is growing or narrowing or whatever.

Do we have the ability to talk about both stories or is it just going to be more the former?

MS. MILGATE: You'll need to explain to me a little bit more. Do you mean the range between different types of

hospitals?

MR. HACKBARTH: Yes.

MS. DePARLE: For individual hospitals.

MS. MILGATE: The two large datasets, the indicator sets we have here, the patient safety indicators and the mortality conditions, we are I think through this process going to get a better sense of some of the sample size issues. For example, in the patient safety indicators, you're talking about fairly rare events. So you need pretty significant numbers to build those up.

So whether we would be able to go below like a certain fairly large region and have significant numbers would be a question.

The other issue with both of those is because they rely on administrative data you end up having coding issues, with different hospitals or different types of hospitals potentially coding differently. So for example, a comment I received from AHRQ when I was talking to them about using the patient safety indicators for looking at different types of hospitals was be very cautious about looking at academic versus non, because there may be some coding differences. There may be some coding practice differences between urban and rural.

I guess I wouldn't make any blanket statement now. What we're hoping to do this year is look at a fairly high level, I guess the lowest comparison level we're thinking of going to would be the breakdown of urban and rural areas that we did in our 2001 rural report. And then use the processing to get more information for our own heads about how we might use this in the future to look at different types of hospitals, for example. Does that answer your question?

MR. HACKBARTH: Ideally, it would be down to very small levels. But even if we're talking larger units, aggregations, geographic units, there are multiple stories here. One is the average, another is the distribution, the range across the country. To the extent possible, I think we need to be sensitive to both.

MS. MILGATE: So you're also saying just a range, not just getting down to different types but how much variation is there within a measure?

MR. HACKBARTH: Yes.

MS. MILGATE: I think we should be able to do that, yes.

MR. MULLER: I, too, commend you and the staff for taking this on. I think providing a road map in the whole

quality arena is of critical importance, given how much people have been discussing it over the course of last 10 years. But there are still, as you know, so many different ways of approaching it. And I think the lack of a standard way of talking about quality makes it more difficult for there to be the kind of aggressive measures to improve it, because people look at it in such different ways.

So I have two hypotheses that I want to offer to you. One is that trying to have more standard ways of talking about it, I think, is going to be imperative towards the improvement of quality in health care. I think right now, with such an enormous variety of ways in which people approach it, people will take different tacts, which I think reflects the kind of diversity of health care in America but also makes it more difficult to have a broad movement to improve across certain broad metrics. So that's one of my hypotheses, is until we get more standard ways of talking about, it is going to be more difficult to improve it.

My second hypothesis is that we also need to ultimately understand this at the provider level, at the disease level, and at the population level. And until we have that, it also becomes difficult to take the kind of steps

because there is, just consist with the dialogue that Glenn just had with you, I suspect there's such variation going on -- just like there is in financial performance -- that one really does have to understand it at those very different levels.

The provider level, I think, is very obvious. I think the disease level is also somewhat apparent, because how somebody may treat heart disease at an institutional level is quite different than how they may treat neurological diseases, cancer, et cetera, and so forth.

Third obviously, is the populations that are being served vary so much in their underlying condition that therefore the kind of interventions one makes, either medically or surgically, et cetera, vary quite a bit based on the underlying condition of the population. This does complicate matters.

So one of the things that I will be asking you to be thinking about is until we are ultimately able to put the information together at that level that understands at least those three axes of information, the provider, the disease and the population, we will not be able to take as comprehensive an effort towards improving that.

All that being said, I think MedPAC providing this

kind of road map is very important given that our reports do get the kind of audience that they get. I think having the staff you have devoted to this, and as Mary said, having this be a pervasive theme in our work is something that is broadly appreciated and I'm glad we're doing it.

Could you briefly comment on the provider, the disease, and the population hypothesis?

MS. MILGATE: I was actually going to turn that back to a question to you. I guess I agree. I think those are probably the four levels of analysis that give you the broadest picture. And then, of course, within that you get different ways of looking at quality within each of those which gives you a fairly complex matrix.

What I was wondering if you were suggesting that even though our natural work or focus would be on the provider level, that we should broaden that or have some emphasis in the chapter that goes beyond that? Or are you suggesting that would be kind of a framework?

MR. MULLER: What I'm suggesting is that to ultimately understand the benefit of medical interventions, one has to understand it sort of at the provider level but also has to able to break it down beyond that to understand the variety

of diseases, the variety of conditions being treated, as well as obviously the populations being served.

MS. MILGATE: Certainly, in terms of designing and targeting appropriate interventions to improve quality, if you don't have all three of those you're really not quite sure where you're going.

MR. MULLER: But my point on standardization kind of cuts against that because I think one of the problems in the whole quality measurement efforts has been they are so varied, they are so different, they are so diffuse that people can't get a handle on it. And therefore, I think -- I mean, there's been a variety of efforts in recent years to kind of standardized it and those efforts haven't had as much success as the initiators might have hoped for.

So I think, in some ways, if we almost have a different measure for every last disease and every last provider, and then we don't have a good comprehensive way of talking about it.

One of the points I always make at my institution is we've had 50 years to develop financial reports and people who have a knowing eye know the four or five things to really look for in 50 pages.

When one looks at quality, there aren't four or five things one goes to really look for in any kind of -- whether it's in the Medicare program or whether it's an institution or it's a set of doctors or it's in geography, or it's in a health plan. So I think in some ways that -- I'm not saying MedPAC by itself is going to resolve it, but I do think having a more standard way of talking about it is of critical importance.

DR. NEWHOUSE: I'd actually like to sharpen this point. I think we need to make a meta-point starting out that conceptually quality ought to relate to the patient or the beneficiary. That is how the patient's problem was treated, or in some cases prevented from happening in the first place. That's really, I think, the ultimate test of quality. And that has many implications.

One is that information across the various sites really needs to be combined to have any handle on how the person is being treated. And one link in the chain may be doing fine, but that doesn't mean that the patient is doing fine.

Second, that in the context of traditional Medicare really, conceptually is contrasted with M+C. There are several things that cut against this. One we talked about is the silo

of reimbursement. Even if you give incentives to one link for quality, you may not get it elsewhere. An exception to the possibly is the lack of payment for coordinating across various providers or services.

The second is that, in fact, even the private instruments we have for quality, such as accreditation and certification, really are provider-based and don't really work very well at the problem of how is it from the point of view of the patient receiving services from potentially many providers in terms of how it ultimately all comes out.

It's very hard for me to overstate the importance of that point. It's there in the Chasm report but it tends to get lost because we're so used to thinking about quality in the provider context.

Then there was one sentence that I didn't understand, that you said because the data of the QIO come from medical record review it's hard to use them to compare care in different regions. Is that because they're taking different problems on?

MS. MILGATE: No, it's just because it takes so much effort to get the information out of the medical record that you don't have a sample that's large enough to do any level of

aggregation other than state or national.

DR. NEWHOUSE: That's not really an inherent barrier. That's an issue of the amount of resources you're putting into the entire effort. And if quality is the issue that we all think it is, it surely could use the resources enough to compare across regions. I mean, look at Nancy-Ann and Steve Jencks have the state stuff and that certainly shows a fair amount of disparity.

MS. MILGATE: No, state and national they can do. They just can't do anything urban/rural or at a lower level of aggregation other than state.

DR. NEWHOUSE: But again, it goes --

MS. DePARLE: [off microphone] It's limited by the budget.

DR. NEWHOUSE: That was my point, that it's really a resource issue. It's not a technical issue.

MS. MILGATE: That's right, you could collect more medical records and get a better sample.

MS. RAPHAEL: My point was the point that Joe is making, which I want to embellish somewhat. I think this is terrific, but I think sometimes we get too wrapped up in all the measurement systems in the data. And I think we need to do

a little more to think about what are the questions we're trying to answer here.

And I think we do want to try to get at the patient experience. And I think from the beneficiary's point of view, they would want to know how safe this system is, how much confidence they should have in the system. And I think their experience of the system, as Joe pointed out, from my point of view, is very different than the way the data is currently captured. And I recognize the barriers to try to reconfigure that. But I think we need to be mindful of it. And we said before that these sort of transitions, that when you put all of the parts together they don't necessarily move in tandem, is important issue.

Now you do say you're going to try to answer questions like is quality improving or declining. I don't know how you're going to get at that, but I think that is a legitimate question. And if you focus on an area, does it make any difference? Now that CMS has focused on nursing homes, a year or two later, do we see any impact whatsoever?

So from my point of view, I would like a little more time spent on thinking about the questions we want to answer in this chapter and how the data, even if we really do this well,

is going to be applied and used.

MS. MILGATE: Can I just make a comment on the across setting point that both of you have made? I would definitely suggest that's something we should talk about in the report because clearly that came out in the discussion in the June chapter, as well. But one thing we might want to look at, in terms of a research agenda, is perhaps if there's an ability to link some of these databases by beneficiary. I don't know if that's what you were leading to do, just to look for one beneficiary, does it look a certain way or that kind of thing might be really interesting to look at. So that would be one thought.

Just another point on your under questions, I think that's the tension that everyone that's starting out to to try to measure quality are faced with. Okay, do we define the questions and then try to create the data? Or do we look at where the data are and then make the questions?

So yes, I think that's a really good point and we'll see if we can pull back a little bit and say what are we really trying to answer?

MS. BURKE: Two points. One is to further state the point that's been made, which is navigating through the quality

world is difficult for people who don't live in it. And if we could do nothing more than help people understand the context in what we're trying to measure and what the point of the exercise is, and bring all of these pieces together, I think it would be enormously helpful.

One suggestion, and you did it a little bit in this document but I think it needs to be done more, again looking at who the audience for the materials will be. And that is literally a glossary. There is technospeak that people that do quality talk to each other that people who don't get lost in. Whether you're talking about the CAHPS study or whatever it is, having some glossary so people get some handle on all of the moving parts in this, I think would be very helpful.

And you do pick up some of that in the back when we're talking about the RAND indicators and we're talking about CAHPS and we're talking about QIO. But I think some clarity so people understand the pieces that we're looking at.

The other thing I was struck by is in your key points, as you're looking at what it is that you're going to look at, the first question which I think tries to get at some of what it is that people have been raising, which is what do we know about the gaps? What do we not know? What is it we do

not yet know how to measure? What are we missing, I think would be enormously helpful.

But the reference to the types of people that may be getting worse care than others, I think some clarification of what type means. Does it mean racial disparities? Does it mean age? Does it mean location of service? I think again, clarity as you're looking through these things, assuming the audience may not be as knowledgeable as many others in terms of what the point of the exercise is and how far along we've actually come in terms of understanding these things.

DR. NELSON: Among these quality indicators, ACE-PRO is a little bit unique because we initiated it, as I understand. And my question is what status as it in its development? Has it been piloted? Where are we with that?

MS. MILGATE: They were developed and piloted, and we've use them several times for a variety of different purposes in the last few years. They were developed originally in 1995. And interestingly enough, we're planning on revising them in our coming year.

So we are working on a contract actually as we speak to try to revise and to make sure that they are up to date in terms of conditions, as well as indicators within the current

conditions.

MR. SMITH: Karen, this is very good stuff and I thank you very much.

Mark, I found as I read the mailing materials that the infusion of the quality questions throughout the chapters was impressive. It's a big step forward and I appreciate that as well.

Ralph started with a couple of hypotheses that he suggested sort of ought to guide the way we look at the data. I'd offer another one. My guess is, following up on Sheila, is the patient characteristics, income, health status, residence, probably are going to matter more than delivery institution.

And I'd like to include, as we go through this work, as much of an attempt to match up, whether this is a SNF or a long-term care hospital may not matter as much as whether or not the patient has supplemental insurance or not, or lives alone or not, or is poor, or lives in Idaho.

So if we could work on both sides of that grid, my guess is we'll learn a lot more.

MR. FEEZOR: Following up on Ralph and David's point about focusing on where that patient is coming from and what the starting point is very important. But with that in mind, I

wonder if we looked at, Karen, the number of things that you're going to try to array in the first cut urban/rural, maybe region, and then race as well as trends over time. I would urge us, for a variety of reasons, to go ahead in that first cut to also try to take a look at academic/non-academic.

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

Our last topic before lunch is disease management.

MS. RAY: Good morning. Joan and I are here to provide you a brief overview about disease management, why it's being considered in traditional Medicare. We will also talk with you about our work plan, how we propose to look at this issue.

Our goal is that our June 2004 report will include a discussion of the use of disease management in traditional Medicare.

As outlined in your mailing materials, the objectives of disease management are varied and changing and may include coordinating care across providers, helping patients identify and manage conditions, and encouraging adherence to evidence-based treatment guidelines. The strategies used by the numerous providers are also varied and evolving, ranging from programs being disease-focused versus beneficiary-focused,

whether patients are opting in versus opting out, the extent to which care coordination services are emphasized versus self-care management services. Use of nurse coordinators varies from program to program, as well as the involvement of physicians.

The conditions that these programs often focus on are high cost conditions, and they include diabetes, CHF, COPD, asthma, as well as end stage renal disease.

In your mailing materials, we summarize why disease management is being considered in traditional Medicare. Some of these reasons include many researchers have shown that a small proportion of fee-for-service beneficiaries account for a disproportionate share of Medicare expenditures. Anne's presentation referred to 5 percent of beneficiaries associated with 47 percent of spending.

These beneficiaries often suffer from one or more chronic illnesses and are often repeatedly hospitalized. I guess the example I'd like the point out is, of course, patients with end stage renal disease. Other patients who fall into this group, as well, are patients with CHF and diabetes.

There are also other groups of patients who also incur high cost for a period of time and may also benefit from

some type of intervention. One example here being patients at the end of life.

We talk about, in your mailing materials, why disease management is being considered for patients with chronic kidney disease. Here the thought is that early identification and referral to physician care, not one or three months before dialysis onset but a year before dialysis onset, will enable patients to become better educated about their condition, about their treatment alternatives. It could increase -- because they're being referred to care way ahead of time, it will allow the selection of the right vascular access. AV fistulas, they'll have a chance to mature. It may be result in improved clinical status for the patients because you're starting to manage their comorbidities earlier like malnutrition and anemia as well as their cardiovascular comorbidities.

Some researchers contend that the outcomes of dialysis patients will be improved through such interventions, earlier identification and referral to physician care, and will ultimately lower morbidity and improve their survival once they do become end stage.

As Joan will discuss, this is one of the issues we are planning on drilling down on when we take a look at this

issue. By reviewing the literature, looking at the studies that have been published on this topic, the methods that have been used, how they measure outcomes, and the time frame that they're measuring outcomes, whether it's one year after becoming end stage or five years after dialysis.

The other reason why disease management is also being considered in traditional Medicare, and I'd like to say it's not just traditional Medicare but, of course, other payers as well, is there is little focus on prevention and education. The payment systems don't relate to each other very well. And generally care is not patient-centric.

CMS is implementing a series of demonstrations testing disease management and the ability of these interventions to improve quality of care and control program costs in different patient populations, including folks with chronic heart failure, diabetes, and ESRD. I guess I'd like to highlight the new ESRD disease management solicitation that just came out in June.

It's being offered in both the fee-for-service world as well as the capitated world. I'd like to highlight the four design features of it. Yes, it's testing disease management. In the fee-for-service world it is also testing a broader

payment bundle. In the fee-for-service world, it is testing holding providers partially at risk. And then finally, it's testing a quality incentive withhold. For both fee-for-service and capitated providers 5 percent of payment will be withheld and providers can get back that 5 percent if they improve care within their facility, as well as meet, well exceed national thresholds.

Those quality indicators are for dialysis adequacy, anemia, malnutrition status, bone disease, and vascular access.

So at this point, Joan will take over the presentation and talk about our work plan.

DR. SOKOLOVSKY: As Nancy has told you, we plan to conduct research this year on issues related to the development of disease management and care coordination services within traditional Medicare.

Some of the issues that we've identified so far for particular work include the targeting of program participants, payment mechanisms, including the role of risk in payment mechanisms, and a number of implementation issues including how to measure success, outcomes of disease management programs, and also the availability and timeliness of data.

Our work will include a combination of data analysis,

evaluation of the literature, and interviews with stakeholders.

We have identified a number of potential populations that could benefit from care coordination. You see the list up there, and some of this has already been discussed. Beneficiaries with specific high cost conditions, beneficiaries with multiple chronic conditions, high cost beneficiaries, dual eligibles or beneficiaries needing end of life care.

One of the issues for us to analyze this year are the advantages and disadvantages of targeting Medicare programs to different populations. We also need to consider issues around implementation of population-based disease management programs within traditional Medicare.

As a first step in dealing with this targeting issue, we will construct a database using data from the 5 percent claims filed for a six-year period from 1996 to 2002 and hopefully be able to add data as more data becomes available.

We think that there will be many possible ways that we can use this database once it's constructed but some of the possible things would be to allow us to look at the use of services for each of these different populations, assess the prevalence of comorbid conditions amongst the 5 percent sample, identify characteristics of beneficiaries with very high cost

expenditures.

As data becomes available, we would also like to examine the Medicare and Medicaid claims of a sample of dual eligibles. This will provide us with a more complete picture of total Medicare expenditures of a set of high cost beneficiaries. In particular it would give us the prescription drug utilization and expenditures of these beneficiaries.

Expansion of disease management programs within traditional Medicare would require decisions on a whole set of payment issues. For example, who is paid, how should the payment be set, and what are the role of non-covered services, for example transportation, which is a very important issue among care coordination services.

We plan to examine the implications of different payment options. We also plan to look at the issue of risk. Currently, in some of the private programs we've looked at, performance fees by disease management organizations tend to be at risk but Medicare demonstrations that Nancy spoke about a little bit earlier are testing many different models of risk sharing and we're going to be talking to people at CMS and getting a better idea of the different strategies that are out there.

Finally, there are a wide range of implementation and data issues. Programs require timely and accurate information to identify populations, monitor their conditions, track their use and cost of services, and measure their quality of care. Most available data sources are limited. For example, and this is something that many disease management organizations have pointed out, very few programs have access to lab results in real time, and yet all agree that this would be a really critical source of information for monitoring beneficiary conditions.

Drug data is both timely and accurate and an important indicator of adherence to clinical guidelines and patient compliance. But just from looking at drug data, it is impossible to know what conditions beneficiaries are being treated for.

Currently, in fact, most programs focus most heavily on self-reports by beneficiaries which are again a very important source of data but limited. There are number of programs out there trying to increase the amount of available possible information that can be received from self-reports.

Other implementation issues include the number of programs that could be available in an area. We have heard

from physicians already that they are concerned about receiving frequent and possibly conflicting messages about their patients from different organizations.

Finally if programs are available in a particular area for multiple chronic conditions, what rules would be used to determine in which program beneficiaries with multiple conditions should be enrolled? The way that we understand it currently, disease organizations target people on the basis of a particular chronic condition, but then they are responsible for treating the whole patient with all of their comorbid conditions. On that basis then you would think there could be perhaps a hierarchy of conditions determining which beneficiary would be enrolled in which particular program.

And also, there is the question of the period of time for which a beneficiary would be enrolled.

Our goal is to address these issues for a chapter in the June 2004 report and we'd very much like to have your comments and also some discussion of other issues we perhaps should be including.

MR. HACKBARTH: So in the last discussion, one of the key points was lamenting the fact that our traditional provider-centric approach to thinking about quality misses the

fact that patients move across the different types and it doesn't really capture the patient experience of quality.

The appeal of this, of course, disease management is that it cuts across that and it's an effort to try to look at quality on a different axis.

DR. ROWE: I think this is an excellent set of questions to address. I'm very interested in this issue. I'd like to make a of couple points about it.

First of all, I think that there are basically five elements to disease management programs. It's identifying the patients, some evidence-based intervention, patient education and self-management, a measurement or an evaluation or course adjustment of where we are, and then communication between the providers and the patients and the disease management people. I think it would be helpful to organize this or describe that in the beginning.

The single most important piece, by far, without any question, is the identification of the people that you put in disease management. The disease management protocols, whether it's from the American Diabetes Association or the American College of Cardiology or whoever, are commodities at this point. They are off-the-shelf. Sure, you can implement them

well or badly but it's all about finding people who are at risk.

It's not necessarily the high cost beneficiaries which is a subpopulation you identified. It's the high risk beneficiaries. What you need to do is take the database and interrogate it in such a way to do some predictive modeling, to say who is going to be a high cost beneficiary in the future, not who necessarily is a high cost beneficiary now.

So there are certain characteristics of the individual such as their cholesterol and their hypertension and whatever that puts them at risk as a diabetic, not somebody who's already had the problem. I think the focus should be on high risk people.

And this is not worth doing for Medicare unless the answer to the question on the bottom of age 18 of your chapter is no. You have to start there. If the question is is every Medicare beneficiary in a region going to be eligible for these? If the answer to that question is yes, then we should stop because this is going to tank Medicare. This is only valuable, clinically and financially, if you target the right population. Otherwise, you are doing things to people that have no value and are costly. And I just can't emphasize this

enough.

So the benefit that large health plans have in doing this is that we have databases that includes pharmacy data and laboratory results, yada, yada, yada, and we are able to interrogate these databases.

So when I hire a disease management company to do a diabetes or chronic heart failure or whatever, they'd say okay, we want to every diabetic. Well, at Aetna we have one million diabetics. We say no. And we interrogate the database and we identified something like 225,000 diabetics. And we said we think these are the ones.

It's very, very, very important.

I think we need to emphasize that because otherwise Congress or somebody is going to get pressured into making it available to everyone, in which that's got to be a stop, don't go forward decision.

Secondly, I think that it would be great if we could start to pressure the disease management entities to demonstrate sustained benefit in outcomes rather than in processes of care. Rather than just hospitalization rates, medication rates, et cetera, patient satisfaction measures are generally improved in these cases and programs, but some

functional improvements or something. Let's build in outcomes other than processes of care that really are meaningful to the quality of care.

And I think the third question has to do with the very, very important intersection of the patient and the physician. Who is doing the disease management? Is Medicare hiring a company to go do the disease management? Or is Medicare going to pay the doctor more if the doctor can demonstrate that he or she has got the patient on the ADA disease management program?

Now generally in health plans, we have a couple of demonstrations, one in San Antonio and one in L.A., where we are paying the physician groups to do it which I think is the preferred route. The problem is that a group of cardiologists might have 25 patients to put in the program, whereas nationally I can contract for 30,000 chronic heart failure patients so I get a better price. So it's hard for the physicians in the group of cardiologists to actually do it at something that would be cost-effective. So there are considerations like that.

But what you don't want to do is you don't want to set up an alternative pathway of care. Joan, you said -- and

it was a slip but it's it's an important slip. You said that the disease management programs are taking care of the patient. They are not taking care of the patient, the doctor is taking care of the patient.

The disease management programs are an adjunct to the physician. They are a supplement. They are a nurse calling the patient, making sure you're on the medicines, have you gained any weight? Did you make your appointment? Can I help you, et cetera?

But Medicare can't get caught into even the language of developing an alternative pathway of care for its patients.

So it's really important, I think, to understand that we need to align this in such a way that it is done with the approval and the consent and the involvement of the doctor. And if you do it that way, then it works. If you don't, it's just a wasted expenditure in many ways.

So those are just three points. Specificity with respect to who is included, very disciplined, something clear about outcomes rather than processes, and some clear alignment of the relationship with the doctor would be things I would emphasize. Thank you.

MR. FEEZOR: It's always good to follow the new

Aetna. Actually, a couple of my points are right write off of Jack's.

First off, if we do focus on the ability to identify that high risk individual, we probably need to have some discussions in terms of confidentiality and the tussle that we will have there.

Secondly, Joan and Nancy, I think as you do a study of the literature, I think identifying those programs that seem to have a greater consumer engagement in the area of self-management, and some things that might contribute to that, would be very helpful as far as what we might provide on that.

And then the third, I guess, is a question I would ask for Mark or Glenn. Is the Medicare RX so far down the path that perhaps us talking about how valuable that data segment is, in terms of a really effective disease management, in other wards the ability to integrate. First off, that's presuming that there will be some sort of Medicare RX, and that may not be a safe assumption. But that we might talk about the importance and the use of that data in being able to link up, as Joe said, so that we get back to the individual patient. I think some negative would be very timely on that.

DR. MILLER: I'm really glad you asked that question.

When we do the risk assessment this afternoon, we're going to be talking about the role of drug data in issues like that, and we can have that conversation, and Joe has already begun to give us comments on that. So that will be right on point.

MR. DeBUSK: Most of what I had to say, and then way beyond it, Jack covered. But I noticed, Nancy and Joan, in the back of the chapter here you referred to clinical guidelines are another important source of information and the basis for most care coordination interventions. All disease management programs rely upon clinical guidelines developed by medical specialty societies.

I guess we could substitute protocols for clinical guidelines here. But I think what would be really interesting in your research, if it's available, is to look at what affect protocols have on outcomes, especially with the diabetic patients. There are some 50 million diabetic patients today and the cost, as we know around this table, is just unreal. But diabetes is a very, very costly disease. Although there's a lot of protocols out there, I sometimes wonder how many of them are used. So there's a wide variation here, but if there's any patterns there as to the efficacy, it would be very interesting.

MS. ROSENBLATT: I want to say I also agree with Jack on the question of who is included. I think he made a very appropriate remark and I think that's a big issue.

You touched on this, on the subject of how do you measure this thing. That's a question that I'm really interested in and I think you talk about it's really hard to measure it because it's hard to get a control group. So I'd like to see the final chapter dealing with disease management spending a lot of time dealing with the issue of how hard it is to measure this.

DR. REISCHAUER: I thought this was very interesting presentation. I learned a whole lot from it.

The way it was structured, though, I think you sort of went to the second level without stressing sort of the first level. Like on why consider this for Medicare? There are really three answers. One, it could be good for the beneficiary. Two, it could be good for the taxpayer. And three, BIPA requires it. And then these other things really fit into one of those or the other.

But what I thought was lacking here is some discussion, which admittedly I think could come in later versions of this, which is the obstacles, the hurdles to this.

We have to ask ourselves if this could be good for either beneficiaries or the bottom line why has so little of it been done over the course of history? Jack pointed out one thing, which it's really very hard to do, to identify the right people and develop the right procedures here.

But also, there are some likely resistance on the part of beneficiaries because this might be more intervention, more control, lack of flexibility that they had. There's clearly likely to be some resistance from providers to yet another layer of something intervening in their activity. We do have a Lone Ranger mentality to the medical profession often. It's okay to have Tonto, but you don't want the general at the fort overseeing you.

And we have a payment system that doesn't encourage this. I think there's a real possibility that you could run demonstrations like this and you could find that they're good in one of these senses. And yet, you then have a very hard time rolling this out across the nation. We should just raise that as a possibility.

I think there's also a very good chance that if these are beneficial to the participant, they will end up, over the lifetime of beneficiaries, costing more. That's not to say

they shouldn't be done if they're providing better health care. But reading some of the recent literature it seems like the big problem is under-provision of services as opposed to mis-provision. This is a way of getting appropriate care maybe provided to more people earlier. And if you discount this correctly and add extended lifespans and things like that, it might add to the bottom line.

MS. RAPHAEL: I wanted to follow up on the point that Bob made because I thought that we had to speak a little bit about the barriers here.

We actually have been doing a major demonstration from one of the large health plans for their disease management program where the telephone calls were not successful in altering the behavior of the people in the disease management program who still were having a lot of physician visits and ER visits, et cetera.

So the plan contracted with us to go into the homes of these particular members to see if we could influence their behavior. It was very illuminating. The people that we dealt with were very resistant to being in this disease management program. They wanted to be able to sign something that got them off the hook as quickly as possible. And their first

question is am I required to do this because I don't want any of it.

So I was very surprised with that because that was kind of counter to the conventional wisdom that this really promotes education and self-management and better outcomes and therefore would be received favorably by members. So I think we just need to be aware of that.

And I just had another question about scalability because we don't want another group of boutique programs here that you really can't bring into the mainstream and that aren't scalable. I think this is something we need to take a look at.

DR. ROWE: I'd like to comment on Carol's experience or that plan's experience. I don't know what that plan was and how it was done, but I believe that the experience in the field suggests that that's the kind of outcome you get when the health plan goes to the member and says we're going to enroll you in a disease management program.

But if the health plan goes to the doctor and says we've looked at your patient population who are insured by us and we have identified these patients who we think are at risk. And you're busy. We're going to hire under a nurse to call

them and check with them and check with you and let you know if they run out of medicines and get the pharmacy to deliver things, et cetera, et cetera, et cetera. If you are willing to have this patient in this disease management program, we what you, the doctor, to enroll the patient.

And if you do it that way you get a much greater, I believe, beneficial effect. I don't know how you got to where you were with that case, but this is my point about the alignment with the physician. It's all about that doctor. You know, I'm from the government and I'm here to help you, for somebody in the Medicare program, is just not going to work.

MR. HACKBARTH: Good point. Nick, and then we're going to have to move to conclusion.

DR. WOLTER: I'll try to be brief. I just want to comment on the measures of quality and maybe take a slightly different slant on it than Jack did. This comment would be equally, if not more applicable to our previous discussion on quality.

But I think a lot of the people in the quality movement are looking at processes of care in the sense of either therapeutic or clinical appropriateness of the intervention that's done. Most of these are not measured by

administrative systems. It would be the time from arriving in the emergency room for getting an antibiotic for community-acquired pneumonia. It be the time to cath from arriving with acute MI. It would be whether the antibiotic was delivered within one hour of surgery rather than two or three hours before. And must administrative systems don't pick up that kind of data.

I think as we look at our measurement models, both in the quality work we're doing and in this chronic disease management work, it's going to be important to remember that at the end of the day it's those measures, because they're based on evidence-based medicine, there's prior knowledge that doing those things create a better outcome. So it's not specifically the measure of the outcome, it's a measure of the interventions that are known to create the better outcome.

When those things start to be measured they create changes in behavior amongst physicians, amongst delivery systems. I think it's really what's going to drive a lot of the improvement in quality and health care. It's really going to drive a lot of the improvements in chronic disease management. But these are not easy to measure right now and they're not well measured on the administrative systems. But I

think we should keep our eye on that aspect of the measurement system in the work that we do.

MR. HACKBARTH: Mark is going to sum up what he's heard here.

DR. MILLER: Because there are a couple of things that I thought were particularly interesting here. I wanted to say to Jack, and I can say it to him offline, as well, his emphasis is well taken. But I just wanted him to know that several of the things that he mentioned, we've had discussions about on point in the staff and are very sensitive to. The notion of a typology and even beyond the typology that he talked about is also distinguishing between things like disease management, case management, and care coordination, because that whole spectrum needs illumination.

His point on identifying the patient, we have had several conversations on this and are well aware of the critical feature there. And the notion of what is the measure for them, because I think the literature does say you can get patient satisfaction to change and even processes to change and the literature is much less clear on the outcome. So his point about pressure on sustained outcome is really well taken.

The physician angle is interesting. In my

experience, this question has gone both ways. Physicians who have said don't involve me, and just traffic with the patient and leave me out of it. And then other experiences where the physician has said if I'm not central to this it won't work. And I think probably the trend is headed in that direction, but that will be an interesting question that we will continue to try and sort through.

To Alice's point, we're very interested in that issue and we hope that you can identify some people that we can talk to out in the actuaries' world about those kinds of things or some other people that we can talk to. We have our ideas but we are very interested in that.

I also thought the exchange on the beneficiary resistance was really interesting. Because my experience up to this point has been people are yahoo, I really want to be part of this. And I think this point is really well taken and this may be the key back to the physician issue, as Jack said. And we'll pay particular attention to that. Because coming up to this meeting, I've been under the impression that people are just all happy to be involved in this.

DR. WAKEFIELD: Can I comment on that last point? You might be able to generalize exactly from what was stated on

that point, and actually we had a sidebar conversation here. I'd say that might also play differently, depending on access and utilization of services, that is the responsivity to this set of new services.

Generally speaking, people in rural areas are happy to see the horse that Tonto road in on, if nothing else. So I think the willingness to open the door and invite the assistance might be quite different.

MR. HACKBARTH: We will now have a brief public comment period.

Okay it's over. Did you have -- sorry, go ahead.

DR. HAKIM: Chairman Hackbarth, I wonder whether you would entertain public comments on the next item, of ESRD?

MR. HACKBARTH: We will have another period at the end of the day.

DR. HAKIM: I tried it last year and it was early dismissal so I missed it last year, even though I made the trip all the way here.

MR. HACKBARTH: Okay, go-ahead.

DR. HAKIM: I appreciate and I appreciate the Commissioner's indulgence on this. I'm here as a physician. I'm a nephrologist practicing in Nashville. I'm also the chief

medical officer for Renal Care Group, a dialysis provider.

Again, I wanted the commissioners to understand a number of factors that I'll go through fairly quickly. One is that the providers of dialysis services have not received any update for 20 years. 20 years ago Jack Rowe was a brilliant nephrologist in Boston. That's the last time that changes were made to the payment for the dialysis providers. And it was reduced.

From 1983 until now there has been only a one-time increase at the time that Nancy-Ann DeParle was the administrator of CMS. So for 20 years we have only had 3.6 percent increase in the payments. Dialysis providers have continued to provide excellent service and have improved the quality outcomes by any measure that you want to measure them in. But we cannot continue to sustain the losses that are incurred in providing services to Medicare beneficiaries anymore. That's one.

Two, BIPA 2000 has made a request to CMS to come up with a market basket for dialysis providers. That market basket formulation has been calculated by CMS and we urge the commissioners to ask the MedPAC staff to consider that in their future work as a basis for calculating the increase in the cost

of services that we provide to patients.

Third, there has been clearly no improvement in the efficiency of providing services for dialysis. This is well demonstrated in the MedPAC report in several instances.

In fact, if anything, efficiency is negative because we are providing longer time dialysis to achieve higher doses of dialysis. We have more complex patients. So after you calculate what the market basket should be, please consider not adjusting it for a theoretical efficiency factor which does not exist in the dialysis area.

The final point that I want to make to the commissioners is that there are several areas that we have not had the possibility of improving outcomes. Because of that the patients are suffering. Three specific areas. One is nutrition. The nutrition status of patients on dialysis is deteriorating. And the main reason for that is that complex rules by Medicare do not allow the provision of nutritional supplements to patients on dialysis.

Two, the number of patients with catheters is increasing dramatically. The main reason for that is that there is technology that is available that can prevent or can predict when an access is about to fail and is not reimbursed

when it is provided in the dialysis service, but is reimbursed when the patient is sent to the hospital to be diagnosed by a radiologist at much higher costs.

So I would again plead with the Commissioners to consider the cost-effectiveness of allowing a very simple measurement of blood flow in the dialysis unit that will save Medicare program enormous sums of money.

And the final point is please consider pre-ESRD care and how we can best provide it because the patient who comes to us, more than 60 percent of them have not seen a nephrologist one month before they come to dialysis. And that, I believe, is also something that the commissioners should address.

I will stop here and I appreciate your willingness to listen. Thank you.

MR. HACKBARTH: Thank you.

We will reconvene at 1:15.

[Whereupon, at 12:25 p.m., the meeting was recessed, to reconvene at 1:15 p.m., this same day.]

AFTERNOON SESSION

MR. HACKBARTH: Okay, let's begin the afternoon session. The first issue for this afternoon is the agenda for outpatient dialysis. Nancy, begin whenever you're ready.

MS. RAY: Good afternoon. I'm here to talk to you about two outpatient payment issues, the first one being MedPAC's workplan to assess payment adequacy, and the second one being our comment on the Secretary's report to broaden the outpatient dialysis payment bundle. My presentation is reverse of your mailing materials, just to confuse you.

As you recall how Medicare pays for outpatient dialysis services prospectively, it's called the composite rate, for each dialysis treatment. Then facilities receive separate payment for certain injectable drugs. The payment rate for erythropoietin, as Chantal mentioned, is $10 per 1,000 units and that is set by the Congress, that payment rate. The other covered drugs that facilities can separately bill for, like vitamin D analogs and injectable iron and antibiotics, Medicare pays providers 95 percent of the average wholesale price.

Just some outpatient dialysis data that we calculated. This represents 2001 estimated spending for

freestanding dialysis facilities. That was $3.3 billion in 2001. For injectable drugs that was approximately $2.3 billion. To give you a flavor for how these have increased over time spending, between 1996 and 2001 dialysis spending increased by about 6 percent per year. For injectable drugs that increased between '96 and 2001 by about 16 percent per year.

There are a total of 282,000 dialysis patients in 2001 and they were treated at roughly 3,900 facilities. Approximately 80 percent of those facilities are freestanding.

Set forth in your mailing materials was a proposed workplan for updating payments for outpatient dialysis services for calendar year 2005. This will be published in our March 2004 report. As you recall, we each year make a recommendation about the payment level, the payment update for the composite rate. We will follow our update framework to assess payment adequacy, in the first step, by estimating payments and cost and assessing market conditions. Then the second step we will account for providers' cost changes in the next payment year.

I want to highlight at this point three new analyses that we propose doing. These were set forth in your workplan. I'd be happy at the conclusion of the presentation to take any

other questions you may have about the workplan.

The first new analysis is an outgrowth of our June 2003 analysis that looked at and compared quality of care to providers' costs. Here we want to take this data and we want to compare payments and costs for those high-quality, low-cost providers to those of other providers as a part of our payment adequacy analysis.

The second new analysis we would like to do is to evaluate CMS's recently developed market basket index for composite rate services. As I will be presenting, in the Secretary's report is a market basket index for services that the current composite rate includes. So we would like to compare how well this market basket index predicts providers' costs over time versus the MedPAC/ProPAC one which we have used now since the early '90s.

The final new analysis I'd like to talk about is we'd like to more closely examine the relationship between providers' costs and patient case mix. We touched upon this in our June 2003 report and we would like to extend it a little bit more. We think this is important as a broader bundle is considered by CMS for new information to come to light about the relationship between cost and patient case mix.

So with that in mind I'd like to switch MedPAC's comment on the Secretary's report. A draft comment letter report was included in your mailing materials. Just to give you some background, BIPA required the Secretary to develop a system which includes in the composite rate drugs and laboratory tests that are routinely furnished during dialysis which are currently separately billable facilities. BIPA also required the Secretary to develop the dialysis market basket index which can be used to update the composite rate bundle.

In response to BIPA, CMS submitted a report to the Congress in May which sets forth the issues that the agency will look at as they proceed with designing and implementing the expanded PPS. So the report that does not set forth a broader payment system. It sets forth the issues that the Secretary will consider as he designs and modernizes the dialysis payment system.

As a next step, the agency is contracting with the University of Michigan to develop payment options and specific recommendations for a bundled approach. Just to let you know, the contractor has put together a technical advisory committee. MedPAC is a member of this committee and the first meeting will be in Chicago in November.

As you recall, the BIPA study was prompted by the Commission's concerns about how Medicare pays for outpatient dialysis services. In in March 2000 report we concluded that the payment system did not pay appropriately for outpatient dialysis services because neither payment for services in the bundle nor payment payments for certain services outside the bundle accurately reflected facilities' expected costs. In our March 2001 report we made four recommendations for modernizing the payment system. That was for expanding the bundle, reevaluating the unit of payment, adjusting for factors affecting providers' costs, and refining the wage index.

The draft comment letter report in your mailing materials raises six issues that the Secretary should consider as he modernizes this payment system. These six issues are expanding the payment bundle, refining the unit of payment, adjusting for factors affecting providers' cost, setting the base payment rate, updating, and monitoring for quality. I'd like to briefly take you through each of these six issues.

The first issue is expanding the payment bundle. In 2001 we recommended including widely-used services like injectable drugs currently excluded from it. CMS in its report also believes that all outpatient services that are related to

maintenance dialysis are candidates for inclusion in a bundled PPS, in a broader bundle, regardless of whether those services are provided by the dialysis facility, the lab, or any other supplier.

Our letter raises the issue of potentially including other needed services and also, commonly used services, by dialysis patients. We include three examples, the first one being vascular access services. The 90 percent of all dialysis patients who are on hemodialysis need these services. Vascular access complications are a leading cause of hospitalization. Currently the agency does not permit facilities to bill separately for noninvasive monitoring.

So what we're talking about here is including in the broader payment bundle the noninvasive monitoring of vascular access sites.

CMS's new ESRD disease management demo, one of the options is a broader bundle that includes vascular access care. It's one of the quality indicators that the agency is using.

The second service that we raise in the letter potentially to include in the bundle would be nutritional supplements. Malnutrition is a frequent complication of ESRD, and including medical interventions used to prevent or treat

malnutrition in the bundle may improve patients' outcomes. CMS's clinical performance measures that they've been publishing since 1993 show that a fair number of dialysis patients do suffer from malnutrition and that this measure has not improved between 1993 and 2001.

The National Kidney Foundation has a clinical guideline on nutrition care. Nutritional supplements were furnished to patients participating in CMS's first ESRD demo, and they de facto have to be provided in the second demo because, again, that's one of the quality measures that providers will be held accountable to.

I would like to point out here that CMS may need to revisit its current coverage policy on nutritional supplements because it is restrictive right now.

The third service we also highlight in the letter is including Medicare covered preventive services. The more than half of all ESRD patients who have diabetes are less likely to receive diabetic preventive services, such as lipid and glycemic control testing than the general Medicare population. Including these and other preventive services may increase their overall use, minimize the extent of geographic variation, in long term improve patients' outcomes.

I'd like to raise two important issues related to broadening the bundle. First, broadening the bundle -- and we point this out in the letter -- broadening the bundle for both injectable drugs and other related services, and other needed services, must be coupled with quality monitoring to hold providers accountable.

Second, additional analysis will need to be done to determine whether broadening the bundle requires new money. I think this is an open question. At issue is whether the current pool of dollars, that is the dialysis and injectable drug dollars, is sufficient. What we know right now is that Medicare's payment per injectable drug significantly exceeds providers' costs and that there is wide variation in the use of these injectable drugs based on data from the U.S. renal data system.

Moving on to the second issue is refining the unit of payment. Currently, the composite rate's unit of payment is a single dialysis session. Here I make the same point that we made back in our March 2001 report, and that is, changing the unit of payment to either a week or a month might give providers more flexibility in furnishing care and better enable Medicare to include in the broader bundle services that are not

always furnished during each session.

The third issue is concerned setting the base payment rate and using cost report data. Here I'd like to make to issues, the first one concerning the use of cost report data from hospital-based facilities. Like I said previously, about 20 percent of all facilities are hospital-based. Their cost may be affected by the cost allocation decisions made by hospitals. As you recall, when the CMS set the initial payment rate in 1981 they found that hospital-based facilities incurred higher costs but they attributed that to overhead rather than to patient case mix or complexity.

The second issue concerning setting the base payment rate is the importance of using audited cost report data.

Moving on then, in our letter we talk about the need to adjust the base payment rate for factors affecting providers' costs. These factors include dose, frequency, case mix, and modality. As you recall, the composite rate is only adjusted using two very dated wage indices. I'd just like to briefly take you through these factors.

For dose and frequency, our letter points to the need to collect this information from a representative sample of providers because these data will not be available in

providers' cost reports.

For case mix, our June 2000 analysis and other published literature -- our June 2000 analysis showed that the aggregate cost for composite rate services and injectable drugs varies widely, suggesting that some of the difference in facilities' costs may be explained by the health status of its patients. Again, this is an issue that in our workplan we'd like to look at in greater detail.

Now generally Medicare's -- the composite rate does not vary based on dialysis method. MedPAC's recent analysis of 2000 cost report data shows that providers' costs do vary. The 2000 data show that there's a 10 percent difference, that the cost of providing in-center hemodialysis is 10 percent greater than the cost of peritoneal dialysis. We will be updating that to the 2001 number. There was a technical difficulty in CMS's data.

Medicare makes one exception with payment based on modality. This is an issue that neither the Secretary's report nor our 2001 analysis explicitly considered. Medicare has a higher payment rate for one form of peritoneal dialysis -- it's called continuing cycling peritoneal dialysis -- when patients obtain their care from dialysis suppliers, from suppliers

instead of from a dialysis facility. The payment rate is 30 percent greater when CCPD is provided under method II from suppliers than under the composite rate payment, method I.

There is no evidence to suggest that the cost incurred by suppliers for furnishing CCPD are any different than the costs incurred by facilities. If suppliers incur higher costs for furnishing this modality to a more severely ill patient population, then adjusting payment to account for case mix will appropriately ensure that payments match their costs.

As I point out in your mailing materials, the OIG recently published a report on home dialysis payment method and they found that the higher CCPD payment limites may be driving patterns of care in that there's an increasing trend of patients selecting method II payment between 1997 and 2001. They also point out that the program is burdensome to administer and requires additional program oversight. They calculated that Medicare had paid an extra $15.3 million and beneficiaries paid an additional $3.1 million in copays under method II than method I.

The OIG recommended that CMS limit their method II payments to the composite rates. In response to the report,

CMS stated that their interpretation of the statute is that it intends that the payment limits for CCPD should be set higher, at a higher level than under the composite rate. So at the conclusion of my presentation I will be presenting a draft recommendation for your consideration.

I already talked about setting the base payment rate so let's move on to updating the broader payment bundle. So the issue here is that when we modernize the payment system, broadening of bundle and adjusting for factors known to affect providers' costs, the point we make here is we will need to take the bundled payment and update it over time to account for changes in the costs of services and how they are delivered.

The final issue that we raise is monitoring quality. To ensure quality we will need to hold providers accountable for all of the services that they provide in the broader bundle. CMS will need to develop new measures like for lab tests and for certain injectable drugs like antibiotics. The agency will also need to set up the information systems necessary to collect timely data, and that they should continue their public reporting of data as they have done since 1993.

Now moving on to the second issue covered in the Secretary's report, again, BIPA mandated that they develop a

market basket index, a dialysis market basket index but for the current composite rate payment bundle. Here we have one principal issue, and that is that the report did not mention how frequently the base weights will be updated. For example, in the inpatient hospital PPS, the base weights are updated every five years.

So moving back to the one exception and the higher payment rate for CCPD, this draft recommendation reads that the Congress should give the Secretary the discretion to modify the home dialysis payment rate for suppliers, the method II rate, so that payment can better reflect the cost of efficient suppliers.

We think that this recommendation is consistent with the Commission's position that payment reflect the cost of efficient providers as well as that payment for services furnished in different settings should not create financial incentives that inappropriately affect decisions about where care is provided.

That concludes my formal presentation.

MR. HACKBARTH: What I'd like to do is come back to the recommendation after we've had our discussion. Could I begin the discussion by asking you, Nancy, to help me think

through some of the issues around broadening the bundle? We've said that we would like to see the bundle broadened to include some services that we think may be overused or provided at a cost higher than is necessary. Then there are services where we think they may be underused, vascular access and preventive services, and the like.

Now ordinarily I would think that when you put services in a bundle, what you're doing is creating an incentive to economize and potentially reduce the provision of services. If we've got services like vascular access where we think they're currently underprovided, putting them into the bundle -- I don't know, is maybe a little counterintuitive for me.

Now I did hear your very important qualification that we would like to monitor the actual provision of those services. But for me, that begs the question, what happens when you find that a particular provider is underproviding those services and they're now in the payment bundle? You've paid up front for them. What is the response to underprovision of these desirable services? In a fee-for-service system, if they don't provide them, they just don't get paid, so there's an immediate, automatic response to not providing the desired

services. But I'm not sure I see how it would work in a bundled payment. Did that come out clearly?

MS. RAY: Yes, it did. First of all, going back to our March 2001 report, the thought there was that these injectable drugs are provided some during each dialysis treatment. They're commonly used and that, yes, there was the higher payment. It would provide providers with a better incentive to furnish them as efficiently as possible, and for that reason to include it in the bundle.

That reasoning behind the vascular access is that patients are going into the facility three times a week. That the monitoring for that service can easily be done by the provider. My sense from providers is that this would be done perhaps once a quarter, although that's something that we could follow upon.

So your question, I think you raise a very good question then, both with respect to vascular access monitoring as well as the other services included in the broader bundle. What does the agency do if providers -- if a provider is not furnishing that service? There needs to be some mechanism to hold facilities accountable for. It could be quality-based payment. It could be taking more drastic action.

MR. HACKBARTH: I assume in each case we would be talking about a rate so it's a continuous variable as opposed to they're provided or not. Some might be doing it 99.9 percent of the time, and another 94 percent of the time, and some 64 percent of the time. What are the consequences that attach to different levels of performance?

DR. REISCHAUER: In a sense it would have to be risk or case adjusted, and it would have to be facility by facility to impose an effective mechanism.

Do I have the floor besides commenting on your comment?

MR. HACKBARTH: I saw some other hands. If there were other comments on the issue that I've raised -- otherwise, Bob. Joe, did you have a comment on this?

DR. NEWHOUSE: I was just going to say that, as I understand historical experience, it underscores that because the basis for Epo payment, if I remember right, Nancy, was $40 for 10,000 units from '89 to '91, and there was thinking, although I'm not sure there was any real evidence, that it was being underprovided, so the basis was changed to per 1,000 units; is that right?

MS. RAY: That's right. We raise that in the letter

report. The way CMS originally paid for Epo was a lower payment rate. I forget the exact --

DR. NEWHOUSE: It was a larger unit.

MS. RAY: A larger unit. So what was happening -- and there was very good evidence that what was happening was that providers were underdosing patients. Because of that, the payment rate was changed to the actually $11 per 1,000 units.

DR. NEWHOUSE: Now the problem with going to a separate fee here is that, in effect this is the whole problem of trying to set a price for a drug where you have very low marginal costs and the drug is developed and we're into the drug price control business.

DR. MILLER: Nancy, particularly on things like the vascular access and nutrition, the stuff that we're talking adding to the bundle, after you put the two, the drugs and the current bundle together, isn't it true -- I'm thinking in conversations I've had with you, there's very clear quality indicators associated with those things, are there not?

MS. RAY: Yes, there are. So it's just a matter of going back to Glenn's point, monitoring on a facility by facility basis. That's something that both the CMS and in the partnership the ESRD networks can collect on, monitoring it and

having some sort of mechanism to ensure that providers are improving themselves.

DR. REISCHAUER: I should know this but remind me, what fraction of dialysis patients are paid for by private insurers like Jack? I mean, 10 percent, 40 percent?

MS. RAY: I would say roughly -- the Medicare secondary period right now is for 30 months. I would say probably roughly 20 percent. But I can get a better figure --

DR. REISCHAUER: If it was a large fraction I was going to then say, how do pay for this? Do they do a bundled package? Does it include all of these things, or doesn't it? What do they do to monitor quality? That would be question one.

Question two is, I was wondering is there any reason to provide this service in a hospital? We're talking about the differential payment between hospitals and facilities and for ambulatory surgical centers you can make some arguments on why certain people with more severe instances -- I'm saying is there a reason -- we're trying to figure out whether we should pay the hospital more or the same. In other areas we've said our policy is the same. I'm just wondering whether for particularly frail individuals or for particularly severe cases

there's a reason why it's good to have it done in an outpatient department of a hospital because of the other services that might be available if something goes wrong or something like that.

MS. RAY: Right. I would answer that generally not. The one exception could be perhaps children. I think children are more likely to be treated in hospital-based facilities. A very, very small fraction of the dialysis population patients are kids. Recall that our numbers as well as others show the real decline in the number of hospital-based facilities. Our numbers track it back to 1993. At the same time, CMS's measures for dialysis adequacy and hematocrit have improved since then.

MS. BURKE: I just had a question going back to our discussion about disease management, and the whole conversation about to what extent we want to encourage that, and in what instances and certain high-risk populations. One of the populations that is often noted are in fact ESRD patients, many of whom have comorbidities. The question really is in discussing this issue, that is how we structure a payment, whether there ought to be any consideration given, or reflection on that conversation as well? I mean, whether we

could ever imagine that as we move in this direction for certain population groups whether it would become part of this or whether we would assume it would be outside of the traditional ESRD provider system.

But it would seem to me, having had that conversation that we ought to at least the question or at least think about it, because the things we look at here -- and it's a terrific paper and I thought the letter actually was quite well done. But there is this separate question over the long-term about whether or not we ought to look at the broader context of how we manage these patients and whether we ought to look at this in isolation of that.

MS. RAY: I think that's an issue that we could definitely raise in the comment letter. I think that's a good point.

DR. ROWE: As far as the patients that commercial payers cover, I think it would be really interesting -- I don't know that we have the data, because we have our data and Medicare has its data, but nobody has both -- to do some sort of a tracking of patients as they progress from commercial payments to Medicare, the same patients with different payment strategies, to see how the frequency of dialysis, the amounts

of medications, et cetera, changes. I think that would be very interesting.

And then to see how the dependent variables that we measure as a proxy for quality, such as albumen levels or whatever, change. Of course, patients are getting older and they may have comorbidities that are advancing during this time and all that so you'd have to take that into account. I don't know if that's been done. It may have and I may have missed it, but I think it would be a very interesting analysis.

MR. HACKBARTH: Jack, do you want to address Bob's question about how private payers typically pay for these services, give us a sketch of that?

DR. ROWE: I'm avoiding addressing it because I don't know the answer specifically. We have contracts with a very large number of dialysis providers, and I believe that we pay rates that are negotiated regionally, as opposed to Medicare which is nationally. The network that we have has different providers in different regions, depending on the rates that are negotiated. I believe we pay on the per-dialysis basis. But I don't have all the details of the bundles and stuff. Alice may know for her company. I also think this changes over time, back and forth. But I can certainly get that information.

A couple other questions and comments. Is there still new entry into the marketplace?

MS. RAY: New entry meaning?

DR. ROWE: Dialysis providers.

MS. RAY: You mean like chains? There's four major chains and you can see that over time since I've been tracking that those four chains account for a greater proportion of facilities.

DR. ROWE: I guess it's the number of stations or beds or whatever.

MS. RAY: The number of dialysis stations is increasing and I will be presenting at the December meeting updated information on that, yes.

DR. ROWE: Because one of the variables that we always used in the past when we were trying to decide whether or not there should be changes in the payments was whether there was continued new entry into the marketplace. So the answer is, it appears that there is continued new entry into the marketplace.

MR. HACKBARTH: And consolidation of existing. So these chains are becoming larger and acquiring other existing facilities as well. So they're expanding their investment in

the industry.

DR. REISCHAUER: But the real issue is the number of stations per patient.

DR. ROWE: Right, because the number of patients may be increasing.

DR. REISCHAUER: The number of patients may be increasing and the standard number of times per week may be increasing or decreasing. There's a whole lot of things going on here that would be very hard to --

DR. ROWE: But those are two different questions. It seems to me the number of stations per patient, or 100 patients of whatever it is, who are Medicare beneficiaries or who need dialysis, is a measure of access. Whereas, whether or not the marketplace is seeing new stations at all or a contraction of stations may be more a measure of adequacy of payment. It might be two different things.

MS. RAY: Right.

DR. ROWE: Because if somebody is deciding whether to open a new unit or to add some more stations, they don't really care how many Medicare beneficiaries there are. They care whether or not the use of that station is getting paid in such a way that it's profitable for them.

DR. REISCHAUER: But you'd also want to look at hours, and maybe they're going Saturdays and Sundays or nights. It gets very complicated.

DR. ROWE: I agree. Let me just go on. I've got a couple other little things.

The demonstration project that's been discussed, the new demonstration project in dialysis, fee-for-service, et cetera, should that be discussed or referred to in some way in this letter more than it is? Or is it relevant to some of these questions that are being asked or considered?

MS. RAY: I can highlight it more if you think so. I do raise it when we talk about including vascular access services in the bundle as follows nutritional supplements. Again, in that demo they're going to be using this quality-based incentive payment. We could raise that.

DR. ROWE: I think it would be helpful. It's imbedded deep in this and I think it addressing some of the questions.

A very small point. On page two you make a comment that CMS data show that hemodialysis patients more frequently received intravenous iron, and peritoneal oral iron, like that's a problem. That's an, of course, because the

hemodialysis patients have an IV so they get intravenous. Oral iron, if you've ever taken it, causes cramps and constipation and gastric distress and a whole bunch of other things, but it's not worth starting an IV. So I didn't understand why that was in there.

MS. RAY: Because right now -- I didn't raise it as being a problem. I raised that as being for -- providers right now are paid for the injectable iron, but when a patient takes oral iron they're not. So the bundle of services that you're going to need for the hemo may be different than for the PD.

DR. ROWE: I see. This committee that you mentioned that MedPAC is on, would you remind us what that committee is, and are you the MedPAC representative, or is there somebody else from MedPAC? It sounded like the whole MedPAC team was a representative.

MS. RAY: No, I'm the representative.

DR. ROWE: What is that?

MS. RAY: The University of Michigan is CMS's contractor for both phase I -- that helped them, that helped the Secretary write this current report, as well as phase II as the Secretary drills down to how they're going to modernize the payment system. So they have created an advisory board. This

advisory board will meet twice during the upcoming year to advise the contractor on issues related to modernizing the system.

The best I can recall some of the other folks who have been asked to participate on the advisory board, and I can follow up with you in an e-mail, are some of the major dialysis providers.

DR. ROWE: I'm just wondering about our role. It's often unclear to me what MedPAC's role is vis-a-vis CMS. In other words, how cooperative, how much oversight there is, how much independent analysis in their report to Congress, et cetera. Should we be on CMS committees, or not? This is purely a procedural question. This happens to be dialysis. It's just that if CMS is either by themselves creating an advisory committee or through a vendor or a contractor or whatever and we're here commenting to the Secretary or Vice President or whoever about what CMS is doing, giving comments about the Secretary's report and everything, is it appropriate for us to be sitting on those oversight groups?

MR. HACKBARTH: My off-the-cuff reaction, Jack, is that in general I would welcome the opportunity to participate, and gain information from that, and provide expertise to the

extent that we have it, with the important proviso that if, in this case Nancy is participating, she cannot commit the commissioners of MedPAC and say, this has been blessed by MedPAC and now we can't as commissioners disagree with it. She is participating as a staff person as opposed to as the embodiment of the Commission. So I don't think that we are foregoing our independence in any sense.

DR. ROWE: That is actually precisely -- I thought of that and I agree with that and I think that's great. That's precisely why I reacted to the fact that she said that MedPAC was represented on the committee as opposed to her. I have a lot of respect for Nancy and her capacities and singularity of her abilities here, but I don't think we should be thinking of it as if MedPAC is represented. I don't really care. If it's okay with you, it's great with me. I just thought I'd raise the question.

DR. REISCHAUER: I am about to disagree with you because I think Jack raised a very important issue. I don't know exactly what the structure of this is. Is it the University of Michigan asking you to be on it, or whether it's CMS asking you to be on it. I'm not sure what the University of Michigan is doing, whether it's providing input to the

Secretary who is then going to do something, or it's providing the thing.

But to the extent it was providing the thing, then we get the thing and are asked to comment on. The fact that Nancy has been a party to this is, in a sense, co-opting this unless Jack and Glenn are going to write the draft of the comments of MedPAC on the new reg. I would welcome that; be more interested in it, but it is a problem.

DR. MILLER: I wouldn't say anything different, just perhaps different words. I think that there's lots of these things that go on often where people ask, we're going to put something together. We would like technical assistance. I have pushed also to try and always be connected to the outside environment so that when we walk into here and we get questions and people say, what are other people thinking or doing, we're able to do that.

I think all of this turns on the structure of the entity that we're asked to participate in. So if it's in this instance, the University of Michigan asking Nancy for technical assistance, you're right, we should be careful about the use of the words. I think the only thing that we have to be careful about is to assure that we're independent, and if structure

doesn't look like it allows that, then we step out. I think it's really just looking at each of the instances.

I really would hate to have a blanket policy of we don't do this. I think that would be a real loss of information for us.

MR. HACKBARTH: One of the things that I had asked Mark to do when he became executive director was redouble our efforts to be plugged into what's happening with CMS and other parts of the government, become more involved. Not build walls around ourselves in the name of independence. I think in this case we can have our cake and eat it too, and participate and learn and provide help without compromising the independence of the Commission.

DR. NEWHOUSE: I guess I should, following on this last discussion, raise this with commissioners. I was a reviewer of the ARC report we're discussing tomorrow. I've been on CMS committees to review stuff. I've always assumed I was acting as an individual and that there wasn't an issue, but I should, I guess, raise that because there may well be other people in that situation.

However, the point I wanted to raise was actually a minor point. In a footnote, Nancy, you talk about that there's

a potential bias toward in-center care because they can bill for all drugs but the home patients can only bill for Epo. My question there was, is this a material bias? What proportion of dollars on drugs go to Epo?

MS. RAY: On a per-patient basis, I don't have --

DR. NEWHOUSE: It may be different for in-center and injectable. I'm looking for a ballpark. Is Epo 90 percent of it, or is it half of it, or what?

Before you send the comment letter, maybe we should find out if this is an important bias or not.

MS. RAY: With the $2.3 billion number, Epo is roughly $1.4 billion of that.

DR. NEWHOUSE: Then I might move it out of a footnote.

MS. RAY: Right. But just the issue that's going through my head is that for the subcutaneous, on average the dose is lower than on the IV. But notwithstanding that, yes, Epo is...

MS. DePARLE: I'm just interested, Nancy, in whether you have a reaction to the statement that Dr. Hakim, the nephrologist, made during the public comment period about the lack of pre-ESRD care. I think he used a statistic about most

dialysis patients hadn't seen a nephrologist almost until right before they went on dialysis, which was troubling to me.

MS. RAY: Right. Again that's an issue that we'd like to drill down upon when we look at the disease management. Getting folks with chronic kidney disease into physician care earlier in the process, not a month or two or three months before dialysis onset but a year. There is the potential -- there's some evidence out there in the peer review literature that it may improve their outcomes. We'd like to look at that evidence a little bit more closely, look at how they're measuring it.

But when a patient shows up one month prior to dialysis, the vascular surgeon is not going to be able to put in an AV fistula because it doesn't have a chance to mature. They're going to have to use another type of vascular access. The AV fistula is associated with fewer complications, so that is an issue that we will be looking at more closely.

DR. MILLER: Can I just follow up on that? Does the Medicare secondary care private handoff have anything to do with this or is that a question we would look at? Or is that just not relevant to this conversation? In other words, does somebody not show up with -- shows up at dialysis without

seeing a nephrologist in part because they were handled through a different insurer before they got handed off to Medicare?

MS. RAY: I've never seen any evidence to that effect. I've never seen any of these studies looking at whether or not the patient is MSP or not when they're looking at the pre-ESRD care. That's something that we can look more closely at the studies to see if they've looked at it.

DR. NELSON: Nancy, we talk about what's included in the payment bundle and allude to our responsibility with respect to the 2005 rate, but the other issue, whether the unit of payment should be a week or a month rather than a single episode we refer to in passing in the letter to the Secretary but we don't indicate in our workplan whether it would be useful for us to make a recommendation with respect to that. So I have two questions.

Number one, how do you feel about that? The second is, what do you hear from the provider community with respect to that issue, how they feel about it?

MS. MILGATE: In our March 2001 report we did recommend that CMS reevaluate the unit of payment to see if a weekly payment or even a monthly payment would make more sense. As you know, nephrologists are paid on a monthly capitated

payment. The fact that dialysis is ongoing, three times a week every week, would point you in the direction of a longer unit of payment, either on a weekly basis they way peritoneal dialysis or more frequent hemodialysis is provided, or on a monthly basis.

DR. NELSON: So in the past, I understand that we said, this should be considered. Is it important enough for us to, and are there data that would allow us to make a recommendation with respect to a week or a month, not just say that this is something that ought to be considered?

MS. RAY: I think that's an issue that we could look into in the future in greater depth. I think one of the things, I guess to start out looking at that issue is to drill down a little bit more closely as to the other services being provided, and also getting a sense of how the provider community would feel about that change. Yes, we can certainly include that in our workplan as a future issue.

MS. BURKE: Nancy, I just had a question tracking from the letter to the workplan around the issues of quality. In the letter you note, I think correctly so, that we need to look at what additional or new measures need to be employed in order to determine the quality of services that are being

provided and raise some questions about how we might do that.

In our workplan you talk about monitoring the trends in the quality of care by looking at the current performance measurement project. Do you anticipate that that project will in fact look at not only the adequacy of the current measurements but also what other indicators are likely to be appropriate? Because it would seem to me one of the questions, again to the point of how does one measure whether in fact care is being given appropriately if you begin to bundle in a larger bundle, whether there are things beyond the ones we know of today, whether it's nutritional status or albumin levels or whatever it happens to be, do you anticipate finding other indicators? Is that in fact part of what that project is likely to do, or that we are likely to seek from that project?

MS. RAY: The agency updated its measures back in 2000 and that's when they added measures looking at vascular access monitoring, for example. I would need to check back with the folks at CMS to see if they're thinking of adding anything else right now. I do know that for the demo there are five quality indicators. One is on vitamin D supplements, and they're going to have to develop a measure based on that.

Now we as a commission can start looking at other

potential measures that the agency can use.

MS. BURKE: [off microphone] But I think that, again, as part of the broader quality commitment that we're making, the question of what indicators are appropriate and how broadly are in terms of the mixture of things that you receive, again going back to our earlier conversation about the need for -- whether here as well there are measurements that we ought to think about that are not necessarily specific or narrowly defined but might impact on the essential quality of life. So we may want to think about that.

MR. FEEZOR: Nancy, in any of the valuative criteria, are there any routine surveys of the patients themselves in terms of their experience and satisfaction?

MS. RAY: Done by CMS, no.

MR. FEEZOR: Or by any reliable source.

MS. RAY: I don't know the extent to which the individual provider chains do that. I can follow up with them on that. CMS does not look at patient satisfaction.

MR. FEEZOR: In keeping with our patient-concentric, it would nice to point that out as something that...

MR. HACKBARTH: Shall we turn to the draft recommendation? Do people understand this or would they like a

brief recap of the issue here?

MS. DePARLE: I think I understand the issue but I'm not sure of the context of the recommendation. Is the recommendation going to go in the letter?

MR. HACKBARTH: Yes.

MS. DePARLE: Is that the only thing we're making a recommendation on?

MS. RAY: Yes.

MS. DePARLE: Because it seemed like there were a number of things in the letter that we were commenting on, so it seems odd to just have one recommendation.

DR. MILLER: Isn't some of the nature of the things that we're commenting on is, we think the Secretary needs to pay attention to this, and as the Secretary's going through and developing the next generation, if you will -- I may be using that term a little out of line here. But here, based on work that we've done previously and so forth, we feel fairly clear that the Secretary should have the authority to do ahead and do this? Is that the distinction here?

MS. RAY: Right.

MR. HACKBARTH: Okay. Any other questions or comments about this? Any discussion?

All opposed to the draft recommendation?

All in favor?

Abstain?

Okay. Thank you.

Now we turn to hospital payment issues, both inpatient and outpatient.

DR. WORZALA: Good afternoon. We have a few logistics to straighten out here. We do have three different presentations in this session. I'm going to be presenting our workplan for hospital outpatient issues first. That's a little bit of a change of the usual order. After that, Jack and Julian will go through the inpatient workplan and I will depart stage left and David will come in and do some information on labor markets.

So my own presentation on the hospital outpatient workplan has three parts. First, just providing some background information that will provide context to our update discussion. Then I'll discuss the analyses we propose to conduct as part of our payment adequacy assessment. Finally, I will briefly mention a couple additional outpatient analyses that we already discussed in some detail at the retreat.

As context to the update discussion I wanted to bring

you new information on outpatient spending, and also the services that Medicare pays for in the outpatient department. Outpatient spending is increasing rapidly, as you may have noticed in Anne's presentation this morning. The Office of the Actuary revised their estimate of total spending -- that's program plus bene -- in 2001 for all OPD services from an estimate of $18.4 billion which we used in our March report, to $20.4 billion. So that's a pretty significant revision upward. Part of the reason for the revision was a technical issue of how they assigned payments to different sectors under Part B, but a lot of stems from both increased and increased payment rates. So that was something like a 17 percent growth in one year on hospital outpatient payments.

Of the $20,4 billion, an estimated $18.4 billion was spent on services covered by the outpatient PPS. These increases do mark a rapid resurgence in outpatient spending which grew rapidly in the '80s and early '90s, had moderated in the mid to late '90s and is now picking up again. We do have projections of continued growth in the future.

The second piece of background information is just showing you what services Medicare purchases under the outpatient PPS because I think it's still a little bit of a

mystery. The payment system covers a remarkable array of services, including surgeries, diagnostic tests, clinic and emergency visits, drugs, and immunizations, among other things.

So this chart shows the services that were paid for in 2001. It's based on our analysis of 100 percent claims file. Here we're including both program spending and bene cost-sharing, but none of the transitional corridor payments are included in the total here. The services were grouped into evaluation and management, procedures, imaging and tests based on the type of service indicators that CMS has developed and maintained. Then the other things, the pass-throughs, drugs and devices, and the separately-paid drugs are based on their payment status under the payment system.

To give you an idea of what's in those groups, procedures includes ambulatory surgeries, cardiovascular procedures, eye procedures, radiation therapy, the git stuff. Then imaging includes advanced imaging, the MRIs and the CATs, acography and standard imaging. The tests would include EKGs, stress tests and the more intuitive lab tests that you would think fall under there.

So procedures did account for the largest share of spending, about 42 percent, followed by imaging at 29 percent,

and evaluation and management. We don't have any trend data right now for how these are changing over time, but we can do 2001-2002 since we'll have 2002 data in fairly soon. Just a quick note, in 2001 the pass-through items accounted for about 8 percent of total spending and that's because the cap was not enforced in that year, so that number should shrink in 2002.

To get a little bit more specific, there is a diverse range of services provided and paid for in the outpatient department, but the payments are fairly concentrated on a smaller number of services. The APC that accounts for the greatest share of payments are advanced CT scans at 8 percent. Then if you put the emergency and clinic visits together, that's about a 10 percent of total payments. There's a fuller version of this table in your briefing materials and for the public in our data book.

That's just some background information. Looking now at our workplan for the coming year on assessing payment adequacy, we do plan to conduct much of our payment adequacy assessment for the hospital as a whole. This is both recognition of the fact that although Medicare pays silo by silo, the hospital is really providing these services across the board. It's also a recognition of the limitations of our

cost report data.

So when we look at the current costs and payments and calculate our margins, we will look at the services provided by the hospital, our overall Medicare margin that includes inpatient, outpatient, SNF, home health, and the inpatient PPS-exempt services. Of course, that overall Medicare margin does tend to be the core measure when looking at payment adequacy. We will also generate, however, separate outpatient margins and when we do that we will recognize all the cost allocation issues that complicate the interpretation by service line.

Just a quick preview. When we do our 2001 and hopefully 2002 cost report analyses, these will be the first cost reports that include time periods of full OPPS implementation. So this will be our first check on how hospitals are faring under the OPPS. Then when we look at access to capital, that too will be for the hospital as a whole. I'm not sure that hospitals raise capital separately for one department versus another, so that's a broader context.

Then we look at entry and exit, that's something that we will do both for hospitals as a whole. Are hospitals closing faster in one place than another? What's the trend in capacity? But we'll also look a little bit at outpatient

services specifically. I did include a table about this in your briefing papers looking at the provider of services file. That does show that the share of hospitals providing outpatient services are increasing slight, looking at the provider of services file from '91 to 2001 showed a small increase from 92 to 94 percent of hospitals that provide any outpatient services. Again, a very slight increase, I believe, in the percent providing emergency services which was 93 percent in 2001. But outpatient surgery is becoming more common across the hospitals, from 79 to 84 percent of hospitals providing outpatient surgery.

Then the next facet of our payment adequacy discussion looking at quality of care, we're hoping to do a more extensive analysis this year than in previous years, and Karen discussed this morning some of the data sources that we're going to be looking at that and some of the indicators that we might have at our disposal. Unfortunately, it seems that inpatient services will be much more easy to measure than outpatient services but I'll keep pushing in that direction and see how much we can use ambulatory care measures that have been developed more generically and apply them to the outpatient setting.

In the context of payment adequacy what we'll want to be doing is building a time series for these things to look at, changes in quality over time as well as the actual level.

Finally on access to care, I hope to do a little bit of analysis of changes in volume of certain services from 2001, picking out services where observers and stakeholders have expressed a concern over payment rates that are too low. Here we might look at emergency and clinic visits or services that had large payment declines from 2001 and 2002. If you have any suggestions for that list, please do let me know. A caveat to that whole analysis is that finding a decrease in the volume of the service does not necessarily indicate an access problem, because you may have changes in practice, and you may have services moving to a different setting out of the hospital to another ambulatory care setting. But I think it would be indicative of where we might want to look more closely.

Finally, three more items that we are going to be doing over the next year. First, an analysis of the outpatient PPS outlier policy. The kinds of policy questions we're looking at it is, first, is the outlier policy needed? This is the only ambulatory care setting that has an outlier policy. Second, if it is needed, should it be restricted to a smaller

number of services.

The kinds of analyses we'll be looking at is the distribution of outlier payments among types of services and also among hospitals and groups of hospitals.

The second item here is a study of hospitals' cost allocation and charge setting purchases. The reason that speaks to the outpatient department is that we use hospitals' charges reduced to cost to set the payment rates. So the question is whether or not these practices are affecting the actual payment rates for services. Jack will describe that study in much more detail.

Finally, is hopefully an attempt to look more closely at the hold harmless payments for small rural hospitals, which absent legislation will expire this year. But I should say, our ability to do this analysis is really dependent on data and I'm working on it.

So with that I'll turn it over to these guys unless, Glenn, you want to take questions now or just at the end.

MR. HACKBARTH: Why don't we go through the whole thing if that's okay with you, Chantal.

MR. PETTENGILL: I'm going to begin, as Chantal did, with some brief background context information about the

inpatient setting and Medicare's inpatient payment system and spending thereon. Then I'll talk about the specialty hospital analysis, or specialty provider analysis that we're just starting. Then Jack will follow with the cost allocation study and some discussion of our analyses related to payments for indirect cost of medical education, direct cost of graduate medical education, and payments for treating a disproportionate share of low income patients; sort of the three horsemen of the acronyms or something. Then David will come back and talk about core-based statistical areas.

On the spending, as Anne pointed out this morning, payments for hospital inpatient care account for about 40 percent of Medicare spending. Most of that is in hospitals paid under the hospital inpatient acute care PPS. For most of those providers, Medicare spending averages somewhere between 30 and 40 percent of their total revenues for all services. Spending under the hospital inpatient PPS grew at a little over 9 percent per year over the last three years from 2002 to 2003, so it's now up to almost $100 billion. For what it's worth, CBO projects that it will grow at 6.2 percent per year over the next ten years.

Although the number of acute care general hospitals

that are eligible for PPS has been fairly steady at about 4,900, an increasing number of small rural hospitals have been switching to critical access hospital status, thereby removing themselves from the inpatient PPS. We've gone from about 200 in the summer of 2000 to 806 now, which is brief rapid growth.

Now I'm going to turn to the agenda for the specialty hospital or specialty provider analysis. I keep saying hospital but I don't mean that. Much concern has been expressed recently among community general hospitals about the growth of specialty hospitals that focus on narrow classes of patients such as cardiac procedures, orthopedics, oncology, or general surgery.

The main allegations are two. First, that specialty providers take the most profitable kinds of patients, leaving general hospitals with reduced ability to fund important activities such as providing uncompensated care or maintaining standby capacity, or one of several others. The second allegation is that physician owners can self-refer and thereby select the least complicated patients, again leaving community general hospitals with an unfavorable selection and lower margins. Now these are allegations, not facts.

But I want to point out that specialization is not

new. It's not limited to specialty hospitals providing inpatient or outpatient care. It's been common in ambulatory and post-acute care for many years, and even to some extent in inpatient care. In addition that's shown on the next slide, many motivations may be at work here. So we want to address the potential origins and impact of this phenomenon as broadly as we can.

This slide, I want to spend a moment on the motivations for forming specialty providers because, as the mailing suggested, we have a number of studies here and each of them is attempting to get at one or more of the motivations for doing this. There are two broad groups of motivations here. Some represent potential attractions that might cause physicians and others to want to form specialty providers, and the other group are motivations that may be more a matter of trying to get away from unattractive features of more traditional settings.

In the first group we have, for example, the possibility that some procedures are very favorably priced by Medicare and/or private payers. For example, profitable DRGS. Specialty entities might enter the market in order to take advantage of that and take the money off the table, so the

speak.

Another advantage they may have is that production can be tuned to a limited set of procedures where you can buy the right kind of equipment and hire the right kind of staff and train them to do this limited menu of care, and they can become very efficient at it. In addition, physicians may well have much greater control over the workflow in this kind of environment, thereby increasing their throughput. They may also have many fewer interruptions. If you don't provide emergency care, no one's going to kick you out of the operating room because they need it, so they can perhaps operate on a tighter schedule and maximize their output, thereby increasing their income.

In addition, they may be able to select only patients that are clinically appropriate for a routinized care system, which is also likely to add to profitability. Some of them may be attracted by the opportunity to be an entrepreneur with an ownership stake in the facility, earning not only the physician fees but, in addition, a share of the profits from the operation of the hospital or other specialty provider.

On the other side, physicians may find it attractive because they feel like their incomes have been under pressure.

Many physicians report that their incomes have been declining and this is another opportunity to add to their income. They may be also trying to avoid unattractive features of practicing in a general hospital environment in which they have on-call obligations and they have to travel back and forth among settings to treat patients and so on. All of these represent costs to them.

With those motivations in mind we outlined a number of studies in the mailing that we plan to undertake this year beginning with some descriptive work on what kinds of specialty providers are out there, where they're concentrated geographically, how fast have they been growing over time, what are the characteristics of the market they tend to enter, what are the principal services they furnish to beneficiaries, and how do those services compare with the services furnished by general providers in the same market?

Then we will, in addition, do a second study that focuses on the profitability of individuals -- in the DRGs which specialty hospitals concentrate in. We'll use for that charges from the Medicare claims adjusted by cost to charge ratios from hospitals' cost reports, and then compare the resulting costs with Medicare's payment rates.

We will use the same data, the same Medicare claims data to also look at the issue of the extent to which is specialty providers may be selecting a favorable group of patients, that is lesser severity patients for the same DRGs. A recent study by the GAO found some evidence that they do.

A third analysis will focus on the question of what happens to volume of procedures in markets in which you have fairly high penetration by specialty providers? We're going to use ambulatory surgical centers as the test case for this. Specialty hospitals in cardiology and orthopedics and general surgery and so forth haven't been around long enough to have much data -- either much market penetration or much data on volume to be able to look at so we're going to look at the ASC market instead and try to see what happens there.

We may be able to actually take that a further step later, adding in information about other specialty providers in the same markets and specialty hospitals in the same markets to look at the potential impact that market penetration has on the financial performance of the general hospitals located in those markets. But the question there will be whether we have enough penetration to actually get anything, see and observe an effect.

In addition to that we're going to make some attempt to look at whether the payments for physician services are also to some extent contributing incentives, financial incentives for physicians to concentrate on specific procedures, looking at both the relative value units in the physician fee schedule and also at evidence from studies on returns to specialization in cardiology, for example.

We're also planning to devote some effort to identify useful quality measures. We have up there the question of whether specialty providers have any effect, as they claim, on efficiency and quality of care. It's very hard to talk about efficiency if you can't control for differences in quality. So the quality part of it's very important. I don't know how much we'll be able to accomplish there but we're going to make the effort.

As I said, we'll also try to look at pulling all these studies together. We'll try to get to the question, if we can, of what impact specialty providers have on the community general hospitals, and whether in fact they're suffering adversely from specialty providers taking away their bread-and-butter.

Now I'll turn it over to Jack.

MR. ASHBY: At this point we are turning to our study of hospital cost allocation and charge-setting practices. The first bullet here presents the general policy question, and that is, how do hospital charge-setting practices affect that our measurements of profitability? Then more specifically, how accurately can we measure margins by DRG or APC using Medicare data given the influence of charges on those measurements?

Then essentially the same question by service line, particularly inpatient and outpatient, but also hospital-based home health and SNF, psyche and rehab units. As we've said many times in the past, we tend to think our inpatient margins are biased upwards and our outpatient margins, in fact all other margins, are probably biased downwards. We'd like to find out through this project how much difference that makes.

DR. MILLER: Jack, can you just for them -- in addition to the broader question, there's a direct linkage to specialty analysis that we were just talking about on the profitability of the DRGs. I just want to make sure that that's apparent to everybody. So this links up to a couple of different of things.

MR. ASHBY: Right. We'll get to that a little bit more in the next slide.

First, a little bit of explanation though, how charges do affect margins. If hospitals mark up service units used in one DRG, or for that matter, a set of DRGs like a service, if they mark up units in one DRG more than others, that actually has two different effects. One is that it tends to raise the DRG payment rate for that DRG because the relative weights for the DRG rates are based on charges. But it also results in overstating the cost assigned to that DRG when we use Medicare data because our allocation of costs are also, at least in part, based on charges.

But because hospitals' real cost for the DRG are not affected, Medicare data will tend to understate profitability for that DRG. Then since it's a zero sum game, there will be corresponding overstatements for other DRGs.

We fear that this phenomenon that we've described here will mean that the analysis of profitability for the services that specialty hospitals provide, as Julian described, won't be able to give us an accurate picture of profitability. So we think that this study will be quite important in providing information with which to evaluate the accuracy of our profitability measures by DRG or by service using Medicare data in Julian's project.

In this study --

MS. DePARLE: Jack, just quickly. You said that you were concerned that it wouldn't reflect the profitability of specialty hospitals. But don't you really mean that because of the way this data is constructed and because of the way hospitals do their charges, it may not accurately reflect the profitability of any hospitals, not just specialty?

MR. ASHBY: [off microphone] That's absolutely correct. But it ties into the sense of DRGs. That's absolutely right.

In this study we will select a sample of hospitals that have sophisticated cost accounting systems and that means, among other things, that they make minimum use of charges in their system for allocating cost. Then we will compare the allocation of cost for that set of hospitals by DRG, APC, and also by type of service using our Medicare data on the one hand and using the hospitals' own data on the other. We expect that the sample hospitals will in fact have accurate data because through prescreening we will have ensured that they possess the necessary tools, but also because we can basically assume that they want to have the most accurate estimates possible to support for own decision-making. So they have every incentive

to do it right.

The second part of the project will be a survey of hospital charge-setting practices. This will provide us with direct information on charge-setting through a series of telephone interviews. Among other issues, we will be addressing the actual process that the hospitals use to set charges, external factors that they may take into account like negotiations with players or like new competitors that have come on the scene, such as the specialty hospitals we've been talking about, and whether there are any systemic differences in markups of charges over costs that they intend to place into the system. For example, a higher markup on low-cost items versus high-cost items.

The survey will be conducted concurrently with the cost allocation study and it will include the hospitals that are in the cost allocation study, but we also broaden the sample in an attempt to be as representative as possible.

Turning to other issues, first the combination of IME, GME, and DSH payments. We will examine the distribution of all three of these sets of payments. Then we will analyze the relationship first between the IME adjustment, or more specifically, the ratio of residents to beds and Medicare

costs. That's our analysis of the empirical level that we have done several times in the past. But then along a similar line, we will measure the relationship between the DSH adjustment as represented by each hospitals' low income share, and the same Medicare costs per discharge. Then we will also examine the relationship between DSH payments and uncompensated care.

In the area of labor markets and wage index, the key issue here we expect to be analyzing the implications of OMB's new MSA definitions. Because that is a new issue, David will be on in a moment to give you more information about it.

Lastly, we have the issue of our annual assessment of payment adequacy which leads to an update recommendation. Here I'm not sure that there's anything additional that really need be said, given Chantal's remarks. The only change in our process from last year is going to be an increased emphasis on developing quality measures, again, as Chantal has already covered.

MR. GLASS: Good afternoon. This is more of a heads-up to alert the commissioners that OMB has issued new definitions for geographic regions resulting from the 2000 census, and we wanted to bring up some of the issues that might be raised if the new definitions were incorporated into some of

our payment systems.

The hospital wage index is used to adjust payments to hospitals to account for differences in input prices, and also it's used in other sectors as well. The wage index is computed now for each metropolitan statistical area, and one index is computed for the remaining counties in each state, those that are outside of metropolitan statistical areas. Those are combined into what's called a statewide rural area.

The new OMB definitions have changed several things. First, let me say that all the statistical areas talked about are counties or collections of counties. The composition of some of the metropolitan statistical areas have changed and that's a result of the new census numbers. Some areas have gained or lost population, commuting relationships have changed. To be an MSA, they must have an urban area of over 50,000, and outlying counties are included that have significant economic relations, and that's measured by commuting patterns. So there will be 362 of these metropolitan statistical areas in the U.S. and 49 of those will be new.

Of interest to us are the new geographic areas that have been defined. These are the micropolitan statistical areas. These have an urban area of 10,000 to 50,000 people,

and again adjacent territory with commuting relationship. There's going to be 560 of them. All other counties are outside these two so-called core-based statistical areas, and they're cleverly referred to as non-core based statistical areas. These county-based definitions also now hold for New England which previously had New England city and town areas. Those things are also kept around, but the idea is that all the country will now use -- can be now described in terms of these core-based statistical areas.

So we can see how things have changed. It is a bizarre kind of thing but we'll show you why we think it may have some importance. Basically what happens is, there used to be just -- the old classification was you either had MSAs or you weren't in an MSA. You were either in a metropolitan statistical or not. Now you have three choices. You can be in a metropolitan, a micropolitan, or a non-core based statistical area. So most of the counties that used to be in MSAs are still in MSAs, 805 of them. But the micropolitan areas, 44 of the counties that used to be in MSAs are now in micropolitan and six are now in the non-core based statistical areas.

But on the other hand, 285 of the non-MSA counties under the old classification are now included under the

metropolitan area, and the rest is as shown. The point is, there's going to be 674 counties included in micropolitan areas and the number of counties that are outside of these areas used to be 2,286 and now it's down to 1,377. So these micropolitan areas bring in a large number of counties and take them out of what some people used to refer to as rural, but that's really not a correct definition -- the non-MSA areas.

So what this has done is encompassed more counties in the core-based areas and more of the population; 93 percent of the total population is now going to be in a core-based statistical area. OMB apparently was striving to get more of the nation's population and area into these core-based areas for purposes of describing what's going on in the country.

Now we're looking at the hospital wage index and we want to see how this relates to hospitals. This is the same kind of chart but now we're talking about number of hospitals in these classifications. Again, we're looking at the PPS hospitals, which is not including the critical access hospitals which I think Jack just mentioned, there's a lot of those now. It's over 800. So these are just the PPS hospitals.

Again, you're seeing the same pattern. There are a large number of hospitals that used to be in MSAs and still

are, 2,462. But there are also going to be a total of 749 hospitals in these micropolitan areas.

Now the issues that we think this raises are two. When you try to incorporate the new micropolitan classification into the existing wage index system, depending on how you do it, you're going to run into a number of issues no matter how you do it. If you do it one way similar to how -- if you treat micropolitan areas analogously to how you treat metropolitan statistical areas, you calculate a different wage index for each one of them. Then you run into the problem of you're going to a very small number of hospitals in some of these areas. For the micropolitan areas, over 90 percent of them will only have one or two hospitals in them.

In calculating a wage index based on wages in one or two hospitals raises a lot of issues. It may be unstable or reflect some peculiar circumstances rather than really the underlying wages in the area.

Actually, it turns out that some of the metropolitan statistical areas have the same issue. Under the new definitions, about 14 percent will have only one PPS hospital and another 20 percent have only two. Under the old definitions about 10 percent had one and 19 percent had two.

So we need to think about how many hospitals are enough to come up with an approximation of prevailing input prices.

Now the other hand, if you don't treat them like metropolitan statistical areas but rather put them into what used to be called statewide rural areas, you raise the problem of you're putting all the micropolitan hospitals into these big wage index areas. But over half the hospitals in the micropolitan areas were either in MSAs before or were reclassified into MSAs for payment purposes. So a lot of those hospitals will probably object to being included in a new statewide rural area and will ask to be reclassified, so it will increase the problem probably of reclassification.

What that's basically saying is that it's a reflection of the issue that these very large areas that contain a lot of counties also contain a lot of smaller labor market areas, and they could have very different underlying wage levels. That's what we're trying to do is approximate the input wages.

So as next steps, if the Commission is interested in these issues, over the short-term we could further investigate some of the issues raised by the new definitions. For example, we could see what happens if we include critical access

hospitals in the analysis.

Over the longer term we might want to develop criteria to evaluate some other labor market options and investigate some of those options and available data sources, because there may be other ways of coming up with what we think the input prices are. The idea is, how can you define the labor markets while not creating the boundary problems in the current system, and minimizing the administrative burden on hospitals and CMS, and possibly opportunities for gaming the system.

DR. MILLER: David, just one thing here. There's nothing that happens immediately on this. These definitions have just come out. CMS will start to do thinking and commenting on this. This is not like tomorrow all the systems are going to --

MR. GLASS: No. The idea was, in the event that CMS does decide to incorporate these definitions we want to be able to react at that time.

DR. REISCHAUER: But even if it doesn't, the 174 hospitals that were in non-metropolitan that are now in metropolitan automatically would be in the metropolitan for the wage index, so they're better off no matter what.

MR. GLASS: They would be better off.

MR. SMITH: Chances are, Bob, a number of those have been reclassified.

DR. REISCHAUER: Have been reclassified already.

MR. GLASS: That's probably right.

DR. NEWHOUSE: I have some comments on both the profitability analysis and the wage index issues. On profitability, the cost side is conceptually difficult. There's two different kinds of decisions. One is, do I enter this market at all with this facility, say an ambulatory surgery center? For that, we have a couple problems. One is, I need to know what I'm going to make over my whole book of business, not just my Medicare book of business.

Secondly, I don't observe what people who didn't enter the market thought their costs were. Maybe they thought they weren't going to make money; their costs were higher.

The third thing is the usual issue about cost allocation practices. If I enter the market, while I may allocate a share of my CEO and CFO salary there based on revenues, but since I have a CEO and a CFO on board, how much more time they really spend because I added this ASC may not bear that much relationship to that. So the entry decision is

one thing.

Then the second issue is, given that I've entered, what scale am I trying to run this at? That obviously is a marginal cost question. Then that brings up the question of whether the cost allocation is really relevant at all. Aren't I allocating mostly fixed costs? So there's definitely some traps in trying to do this analysis.

On the wage index, first of all I think it's a really interesting set of questions, but in principle I think you have consider what is the actual labor market? We know in the end we can't draw it exactly, but in in principle there is some kind of actual labor market out there, that is geographically-defined labor market. So if we have what we think approximates a labor market and there's only one or two hospitals in it, maybe we just have to use non-hospital wages for this purpose and forget about trying to get hospital-specific wages. And if there's some categories that are only employed in hospitals, we're just going to say that they just relate to everybody else's measures. I don't really see a very good answer other than that.

You asked, David, how many hospitals we would need statistically to get a good estimate. But I think at least as

important an issue would be, how many do we need to minimize behavioral effects, from turning this into cost reimbursement? Another way to phrase that is, if it there's some threshold below which we're just not even going to consider hospitals wages, where is that threshold? I would have thought we would want to do it on some -- this is now off the top of my head so I want to think about this some more, but what was the largest hospital's market share in whatever thing we were saying approximated the labor market?

So for example, if the largest hospital had more than a 25 percent market share, we would not then consider hospital-specific wages, or be more than 50 percent. I mean, somebody would have to pick a number. But that would be one way to go about this.

MS. DePARLE: My comment follows directly on Joe's. When I was out in Iowa, on the subject of geographic variation, I had a conversation with some very helpful people from, I think it was the Mercy Medical System. Do you remember, David, we talked about this? They made some very interesting points about intermediaries' collection of data, and the accuracy of that, and how much they check it, which if continue on the system it seems to me that's something we need to look at.

But there other point was, why are you using this hospital-specific data? Why not just use something that's already out there like BLS data on a geographic area that's more, they argued, objective; doesn't deal just with healthcare, so that we don't have these arguments all the time about the accuracy of data and all the various appeals to be in different areas, et cetera. It's something David and I have chatted about and I would hope that would be something you would look at. I think it's in the spirit of what Joe's suggesting. Is there some way to get out of this --

MR. GLASS: If it's of interest to the Commission we can pursue this, because the census is now changing the way they collect some of their data. They'll do it continuously rather than once every ten years.

DR. NEWHOUSE: The only problem I see is, although this is a problem no matter what you do, is what is the labor market? Within the New York City MSA there may be many sub-labor markets, and here we are stuck with the New York City MSA plus all the hospitals that have been reclassified into it.

MR. SMITH: It's also complicated by how much of the hospital's staff is actually competing in that labor market, however you define it. It may well be that the folks in Des

Moines on the medical staff are more appropriately thought about in terms of being in the Chicago labor market, whereas the rest of the staff isn't. So it gets back to the questions that we've talked about before about how do we would look at -- how do we adjust for the mix of locally-employed folks? I'm not at all sure that going to the county level wage data, including hospital data, tells you very much about what it costs to get a doc or a nurse to a small metropolitan area. I think it's tricky twice, not just once.

DR. NEWHOUSE: I think the docs are different, but they're not part of this.

MR. SMITH: You're right, but many of the other technical staff and nurses are, and they make up a big chunk of the hospital's wage base, right?

DR. NEWHOUSE: The wages due differ. The rationale for arguing about the national was that, let's take the extreme, you bought supplies like a bed, you bought that at national market. It didn't matter whether you were in Dubuque or New York City. But the wage you had to pay was different in Dubuque than New York City.

MR. SMITH: But that will vary by the occupation for which you're paying the wage. In some cases you will be more

affected by an adjacent or the most proximate MSAs than in others.

DR. NEWHOUSE: In principle and empirically -- you can empirically find out to what degree what you just said is true and I accept it as true. You could measure how much it is. Offsetting that I would say is then the behavioral consequences of converting to quasi-cost reimbursement.

MR. SMITH: That's right.

DR. WAKEFIELD: David, you had mentioned that this isn't imminent, but do you have any sense about how this -- the timing of the application of these new definitions -- a tricky way to get us to stop talking about rural, I might add or using that term. They didn't really have to go through all of this hassle to get some of us to stop talking about rural. I can also say non-core based statistical areas over and over and over, so look forward to that, Bob.

MR. FEEZOR: It just takes longer.

[Laughter.]

DR. WAKEFIELD: I'll get back to my question for David. David, do you have any idea about how these new definitions might come into play related to the work that CMS is doing around occupational mix related to the new labor

related share that's being discussed in the Medicare bills? In other words, how is it likely -- what's the timing that all of these different, fairly significant, potential changes are going to be occurring or applied at roughly the same time, and how are we going to know what the impact of this collective, of these three pretty significant changes is going to be on the wage index?

MR. GLASS: Jack, when is the occupational mix data starting to be collected?

MR. ASHBY: We're at least a year away from, a year or more away from having occupational mix data.

MR. PETTENGILL: They say that they're supposed to have it for 2005. That is next yes. Next spring they will be issuing a proposed rule which they believe will make use of the occupational mix data.

MR. ASHBY: But the point I was going to make is that the one thing that will go ahead is the change in the MSA definition. That's on its own track and it's going forward. But it remains to be seen whether CMS will want to do whatever it is they're going to do with the micropolitans on the same schedule as they try to do the occupational mix change.

DR. WAKEFIELD: And the labor related share will

likely hit relatively soon too, depending on passage of legislation.

MR. ASHBY: Pending legislative issues, yes, that appears to be on its own track as well.

DR. WAKEFIELD: So teasing out the effect of these three different policy changes is not insignificant.

MR. PETTENGILL: But, Mary, the labor share, if they do it, is an across-the-board thing. It will affect all -- if the legislation were enacted as it stands now, it would affect rural hospitals and small urban because the labor share would be reduced to 0.62. It would not be changed for the hospitals in large urban areas. It would stay at 0.71. So you're talking about across-the-board effects. Other than the big break in the distribution between rural and other urban compared to large urban, there's no effect. Whereas, the occupational mix stuff and the labor market definitions can both change the distribution in very subtle ways all over the place.

MR. FEEZOR: Jack, help me a little bit, now that I've switched my perspective a little bit. How do you deal with measuring entrance and exit into the market in those states, or how do you take into account those states that still

have certificate of need requirements?

MR. ASHBY: Entry and exits, you're talking about in the context of the specialty -- oh, on the update. Actually, the short answer to that, which probably is not a very satisfying one, is that we really were not looking at it geographically. We were trying to look at whether in the aggregate there's enough of a change do deduce that much has happened here. So we haven't really gotten down to that level.

MR. PETTENGILL: You may not have any entry or exit of new providers with a new provider number in a market where they have CON, but I've been told that in a number of markets where providers face this restriction they've found ways to change the volume of what they do and build new services into the existing providers and that sort of thing. One of the other things we look at is what's happening to the volume and the mix. So presumably you pick it up that way.

MR. FEEZOR: Second, just an observation. At least a couple of provider institutions that I've now become more familiar with have a binary charging philosophy. I don't know whether this would be helpful at all to think about, is where they in fact both are a tertiary or quantrinary care for a region, and where they also serve as a principal hospital for a

county or a local market, they have two very distinct pricing with respect to their margins. One trying to in fact fulfill the public hospital role in keeping certain services fairly low, and then those that they think they have greater opportunity because they are more exclusive. So for whatever it's worth, you may hit some of that.

MR. ASHBY: That's part of the dynamics.

DR. ROWE: A couple of my thoughts have already been raised but just a couple of others. On page four, Julian, of your presentation you had a list of the factors influencing the growth of specialty providers. I'd like to think about adding one and subtracting one.

One of the pull factors, I think, is a market perception-based factor. That is, if you look at the ads for these places what they say is, this is what we do. It's the only thing we do. There is this kind of marketing prospective, if you got a heart problem, you want to go to a place where every time the anesthesiologist anesthetizes somebody it's a cardiac operation. Every patient the nurse sees is a heart patient. It's this concept of quality or focus. That may be one of the -- to whatever extent that's attractive in the marketplace, that is one of the pull factors.

One of the push factors that you have is charity care. It suggests that these places don't do charity care. To whatever extent they are not community resources like general hospitals might be considered to be general community resources, I guess that's true. But I don't see any a priori reason why some of these institutions wouldn't give charity care. If someone is uninsured or underinsured, shows up in the emergency room of a cardiac hospital with chest pain, they're likely to get treated I would think, particularly in some states they would have to get treated.

MR. MULLER: They probably don't have an ER though.

DR. ROWE: The cardiac ones have ERs. In fact a large portion of the patients are admitted through the ERs.

DR. REISCHAUER: That's true in general, but is that true in the specialty hospitals?

DR. ROWE: I think so. I think Memorial Sloan-Kettering has an ER. These cancer patients with no platelets and they start bleeding, or they get infected and they show up acutely ill -- I think so. I'm not sure. But it's worth asking, right?

MR. PETTENGILL: But they're funny animals in the sense that -- I was driving to work today and on the radio I

heard an advertisement for a cardiac hospital. But it wasn't really a cardiac hospital. It was a cardiac program at a local hospital here. It's a non-profit hospital. They've built their own big cardiac unit and they advertise it the same way that a specialty provider would.

DR. ROWE: Sure. And they have what used to be pavilions in hospitals. This is a little bit like the grocery stores to supermarket. Every hospital is a medical center. What used to be a pavilion is now a hospital. So it's such-and-such hospital at the New York Presbyterian Hospital.

MR. MULLER: What they're looking at is the freestanding ones, not the ones where somebody relabels their wing.

DR. ROWE: That's what they should be.

Just a couple of points around this. They're funny also inasmuch as there's two different categories here. Unfortunately, I don't think the N is going to be large enough to really study it as two different categories. But there is a group of these -- when you're looking at the cost, I think there's a group of these that are very research intensive. Some of these cancer hospitals are extraordinarily research intensive with tremendous NIH grant support and endowments and

world-class research, et cetera. And some of these are purely for-profit, no education and research, high volume, clinical operations. I'm not saying that's not good quality, but when you look at the cost and the accounting and you're trying to compare, they may be so different that it's going to be hard to do that. You might think about a sub-categorization of an academic specialty hospital versus a non-academic specialty hospital.

The last point is with respect to how to measure the quality. I thought your points were good about the concerns about how to do this. I think it would be worth looking at the New York State results because for cardiac procedures New York State has this well-developed program that I think Dave Axelrod started then Mark Chassen developed, and Ken Shine was the chairman of the cardiac advisory committee; very high top brass type people. There are a couple cardiac hospitals in New York like St. Francis in Long Island which I think is a big, very successful one. So there is some public record that has measured the morbidity and the mortality for cardiac programs in big general hospitals, academic and otherwise, and community hospitals, and the specialty hospitals, and that's a public record. It would be kind of interesting to look at that. That

may guide you a little bit as to what comparisons are valid and which ones aren't. There may be other states that do that too. I'm just familiar with New York.

MR. MULLER: I have a question on the workplan that I've raised several times, and that is the way that we're looking at the whole question of cost reporting and the unallowed costs and so forth. Is that going to be a part of our workplan this year or any year?

MR. ASHBY: We had not --

MR. MULLER: I've raised that like three years in a row now, so I do think it can make a difference of 3, 4 percent, at least according to a number that Jack probably mentioned off the top of his head a few years ago and I keep repeating back to him. But I think if we're looking at a world of 3, 4 percent margins, if there's 3, 4 percent costs that aren't allowed we may want to at some point look at those more fully. Since it's the beginning of the year, if there's any way of working that into the workplan and taking some look at that I'd urge us to do so. So that's one point.

Then I have a question about the markups and the charges and so forth. That confused me a little bit. I understand with the attention in the last year or so, I think

largely triggered by what happened -- what Tenet was doing on big charge increases that led to outlier payments and so forth, but I didn't understand that if-- this is on page seven of the Jack, Julian piece. If there is markups in DRGs -- it says, if hospitals mark up certain DRGs, one DRG more than others, this raises the payment rate. I didn't quite understand that because -- could you just elaborate on that?

MR. ASHBY: Yes. The relative weights for the DRGs, which is not the rates themselves but just how they relate to each other, are set using national charge data, and those charges are not even reduced the cost. It's just the charges. So after you standardize your charges for differences in geographic location and the like, it's then as simple as summing up the average charge per case in this DRG versus the average charge per case in that DRG and that establishes the relatives.

MR. MULLER: So if hospitals tend to do cardiac more than cancer, that would --

MR. ASHBY: Exactly. But it does have to be pervasive across all hospitals in order to --

MR. MULLER: But a single hospital is not advantaged except as regard to pattern changes of DRG weights.

MR. ASHBY: Right.

MR. MULLER: So in some sense, if hospitals get a sense that there's DRGs that could be more attractive -- it really has to be --

MR. ASHBY: I think the way to put it is that if hospitals traditionally have seen these areas as -- they want them to be more attractive, they want them to be profit centers, then if hospitals across the country that are involved in cardiac services have set higher markups for the various service units that go into cardiology, then indeed you're going to see a higher markup on cardiology DRGs across the land.

MR. MULLER: So that would take effect roughly a year later when it's recalibrated, or two years?

MR. ASHBY: Two years.

MR. MULLER: Then third, on the outpatient with 2001 being the first full year in which we really had the APC system could you comment a little bit on -- we often have long discussions about data quality but could you just elaborate a little bit more on issues of the data quality using that as the new base year, finally having full data? My sense is we had, in between the corridor payments and the hold harmless payments and so forth, does that affect at all our understanding of what

the payments were for those for the years? I mean when we go to the true APC payments as opposed to having them -- not compromised but added onto by hold harmless payments and corridor payments and so forth? I don't know if my question was clear.

DR. WORZALA: I guess there are two ways that we're using this data in the system. The first would be when they actually calculate the payment rates and the relative weights for the APCs, none of the transitional corridor or TOPS payments are included. That is just looking at the charges for the services reduced to cost.

Then when we do our analysis of payment adequacy, however, and go to the cost reports, the cost reports do include a line for the hold harmless and other TOPS payments, transitional corridors, so it will come in there.

But in terms of the data quality, I thought you were actually going to get to the point of hospital coding and how much coding has had to change from implementation of the system. I do think that each year the data used for setting the payment rates is improving a little bit, and CMS continues to refine their methodologies and there are still some hiccups in the process.

MR. DURENBERGER: My question or comment is -- it's a combination I guess -- for Julian on pages four and five, which is the factors page and the research page. On the factors side -- and I may be capturing some of the existing factors, but if I look at the community that Minnesota is the center of in the upper Midwest, I think we're the only state in the country that forbids for-profit hospitals and things like that. But despite that, if I had to add something to the pull factors it would be the competition.

It would be competition in some cases -- usually this is at the community level, but sometimes it's market to market. It's so prevalent that it dominates all of, especially the capital decisions that are being made that relates to what specialty providers are able to do. But it can be hospital to hospital where hospitals are driving the market for health care or medical services. It can be clinic to clinic. It can be when you get down to the micro MSA level, it's probably clinic versus the specialty. Then in many areas it's market to market where there is a prevalent, let's say a Mayo Clinic with a prevalent tertiary, quatrary, whatever it is, presence and there's a defense in a market in South Dakora and another defense in a market in Wisconsin or something like that. For

marketing and other kinds of reasons, but probably mostly to secure the subspecialty professional services that are needed, this competition is influenced heavily by the ability of a group of subspecialists to create their own enterprise versus the hospital having to compete with them by building or investing in the competitor.

I'm not sure the degree to which that is a research or an analytical factor, but I know it is so prevalent in this community despite the fact that there are some other relative profitabilities, and their production environment and things like that, the real driving force at the decision-making level where you're investing lots of money one way or the other is in that -- I'll just call it competition.

Now related to that is this very interesting research question on efficiency and quality of care. Because I happen to think efficiency is absent from medical care delivery, it's interesting to me that you'd like to incorporate it into the equation.

The people at 3M who do six Sigma and things like that rank, the only thing in medicine they rank anywhere near six Sigma is anesthesiology at five and they put all the rest of the system at about 2.5 or something like that. So if

that's the case, and if trying to determine if it's more efficient to set up a freestanding versus something else, or just if you're looking at what is the real cost of delivering a service, it strikes me that whether it's appropriate for this project or it's appropriate somewhere else, what capacity we have to really dig into the efficiency of each of these hospital-like delivery systems would be very, very important.

My anecdotal experience was going to one big hospital to get an x-ray and the guy who I met over there said, we just paid $22 million to attract a radiologist, to build up our radiology department. After I'd been sitting there for 30 minutes or something like that I said, why does this take so long? He said, because we're getting very close to 3:30 in the afternoon and everybody goes home at 3:30 in the afternoon. I said, suppose I wasn't who I am and I could get in like that? Well, you usually have to wait about a week at this facility.

Now I know in my community there's a guy who's built a national and international radiological business because he considers the patient and the doctor his customers. If somebody calls at 3:00 in the afternoon and wants to be seen at 4:00, they get seen. And the doctor on the other side of the country or the other side of town gets to read the results

almost instantaneously.

To the extent that that little anecdote, to me is a huge example of efficiency, or inefficiency in the first case, over time, I don't know whether the capacity in this project, or where it is, to examine that exists, but it feels like it's a very important part of trying to come to some conclusions about what is the role of the payment system.

MR. PETTENGILL: I guess I would be the first one to admit that our capacity to measure both risk and quality of outcome is extremely limited, and without them we're not going to be able to say a whole lot about who's more efficient or less efficient. We can say who has higher or lower costs, but we can't really tell whether that's more or less efficient. That's the world in which we live at the moment.

MR. DURENBERGER: That's what you said before, but I think I'm asking a different question, which is just examining the underlying efficiency, not just did you both get the same result. Is this what you're saying, if you both got the same result, how much did it cost you to et it versus --

MR. PETTENGILL: Controlling for risk, yes. Maybe we should have a more extensive conversation about that sometime, because I think what you're referring to is using a different

set of --

DR. REISCHAUER: He closes down at 3:30.

[Laughter.]

MR. HACKBARTH: Unfortunately, we are well over time right now. It's past 3:30 right now.

MR. SMITH: As with Ralph, I want to raise an old hobby horse. It would seem to me that the Medicare margin is even less useful to us in many of the specialty hospital situations than it may be in the general hospital. We've got to look at the entire book of business and try to understand what we can about the contribution of Medicare to that. But I think looking at the Medicare margin in an orthopedic hospital is unlikely to tell us what we want to know about the effect of that new orthopedic hospital on the general hospital across the street. So I think we've got to reraise those questions.

David, just very quickly, my guess is that whatever is going to happen is going to be so stop-and-go that looking at the longer-term issues, trying to make some sense out the deeper labor market questions that you raise is a much more useful investment of your time and your colleagues' time than trying to parse out what's going to happen to these 620 hospitals that used to be in the balance of state and are now

all of a sudden in some new unit that nobody understands quite what it is.

MR. HACKBARTH: Thank you. We need to move on to post-cute care. We've got a fair amount of ground to cover. I'm going to ask the presenters to help us by keeping their presentations as brief as possible. In particular, I'd ask you to skip over any background material that reviews things that we've covered in the past.

Also, I don't think you need to spend a lot of time on payment adequacy analysis unless there's something that's real new and different there is well. We are about 40 minutes behind and I don't think we have much opportunity to make up ground later on either, so I really will be pushing you along.

With that, welcome, Susanne. It's good to see you.

DR. SEAGRAVE: I will be very quick. I'm just going to touch on some highlights of what we're going to do in the skilled nursing facility area this year and then I'm going to present a few preliminary results just to give you a flavor of the types of analysis that are progressing as we speak.

So just quickly -- I won't say much at all about this slide, but this just gives you an overview of -- I was only going to say one thing. All right, never mind.

[Laughter.]

DR. SEAGRAVE: The payment adequacy I won't say much about except I wanted to highlight a couple of points that we're going to be stressing this year. The first three bullets on this slide -- we're going to be looking at all six of these issues but the first three bullets we're really going to highlight, especially the quality issue which was alluded to in a previous discussion, so I won't go into depth about it. But we are going to be looking at quality of care by reviewing the literature, by looking at staffing levels, by looking at MDS data, and by looking at preventable readmissions to the acute care hospital. So we really are going to spend a fair amount of time looking at quality of care in SNFs this year.

We also are doing some extra work looking at the relationship of payments to cost, or sometimes we call that margins. The reason I bring that up is because we are going to -- again this year we're going to try to make our margins as accurate as possible in reflecting the higher costs of SNF Medicare patients versus non-Medicare patients. We're actually working fairly hard on that.

Finally, on the access to care issues, since there were two payment add-ons that expired October 1st of 2002 we

want to spend a fair bit of time concentrating on what experience beneficiaries have had accessing skilled nursing facility care since those add-ons expired.

The two special projects that we're going to be devoting a great deal of time to this year involve looking at hospital-based SNFs because a number of questions came up in our payment adequacy analysis last year regarding the role of hospital-based SNFs in the system. Then also we're going to be spending a fair amount of time looking at the RUG-III patient classification system for SNFs and how to improve that system.

So I'll start with our first project, which is looking -- with respect to hospital-based SNFs we'll be taking a two-pronged approach. We'll be looking at their role in providing care in which we'll look at the types of patients who go to hospital-based versus free-standing SNFs. Once we've identified the types of patients, then we can control for the type of patients going to the hospital-based SNFs when we look at their outcomes of care and their cost to the Medicare program to try to identify the role that they're serving.

Next, we want to look at the effects of the closures. As I had discussed last year, we had a significant number of hospital-based SNFs close since 1998 effectively, and we wanted

to look at, first of all, what are the characteristics of the facilities that closed? Were they located in certain areas or what was going on?

Also, what services may hospitals have replaced the hospital-based SNFs with. For example, we heard some anecdotes about the beds being used for other types of services.

And then finally, what effects have these closures had on access to and outcomes of care in the areas they served?

So that gives you an overview on our hospital-based SNF analysis. I just want to briefly tell you about our SNF patient classification system analysis. This will mainly involve reviewing the literature and interviewing researchers who have identified problems with the system and propose potential solutions. So we want to just review the whole range of potential solutions.

We also want to analyze patient populations and financial performance in individual facilities basically to get a handle on how well the system is targeting the payments to particular patients and particular providers.

And finally, we wanted to do a comprehensive review of the additional variables that might be useful in improving the patient classification system.

On to sort of the preliminary data that is coming out of our ongoing research on hospital-based SNFs. The left column labeled freestanding SNFs is simply for comparison purposes so that you can get an idea of the magnitude of hospital-based SNFs relative to all SNFs.

They are a relatively small portion of all SNFs, but of those hospital-based facilities that we identified as being active in 1997, a full 31 percent of them have closed since 1997 or terminated their participation with Medicare. So we wanted to try to look at, as I said, the characteristics of these hospital-based SNFs that have closed.

As you can see, those that were active in 1997 were predominantly urban nonprofit facilities. Whereas, of those that have terminated since 1997, they are disproportionately represented by for-profit urban facilities, which we thought was interesting. So this gives you some idea of who these facilities are.

And finally, I wanted to present some information. We also looked at the hospital-based SNFs' reported per diem costs in 1998. These are what they reported on their annual cost report forms. We found that of those that have closed since 1997, their costs were approximately 43 percent higher

than the ones that have remained open. So this was an interesting finding, as well.

And I'll be coming back to you throughout the year with more findings on our hospital-based research.

With that, I'll turn it over to our next, Sharon Cheng.

MS. CHENG: Moving on to our work plan for home health, here are some background numbers that we've updated for you this year. I'd give you context, but I'm trying to move. Please ask me questions if you would like some background on that.

Our core policy question for March is, of course, are Medicare payments adequate? This year we will apply 100 percent of fiscal year 2001 cost reports to our margin estimate. We've also begun to receive our sample for fiscal year 2002 cost reports, so we're going to be substantially better off this year than we were last year, in terms of the sample for cost reports for our

margins.

We will also have a new view of access to home health this year. We're going to use CMS's new database on service area. We are going to be able to construct a map of the

service areas, self-identified by home health agencies. We'll also be able to overlay a map of the Medicare population to get a sense of the population in and outside of service areas.

Among the distributional issues, we will continue to examine urban and rural differences, and we'll also start to look at the need for refinements to the PPS. One refinement we'll consider is a change in the outlier policy for the home health PPS.

To enhance our understanding of quality, we actually have two questions. To answer the first question for March, we will assess the quality of home health before and after the implementation of PPS. Our work will lead to a single national quality score based on the clinical and functional improvement and stabilization of beneficiaries under the care of home health agencies.

For June, for the second question, we'll use the new Home Care Compare database and will begin research on the relationship of cost and quality for the home health setting.

Finally, to enhance our understanding of the recent decline in use and it's implications for access, we will add an investigation of the data from the national home and hospice care survey. Nancy Ray is here to discuss with you the initial

results of this research.

MS. RAY: So we pull data from the 1996, 1998 and 2000 survey. This is a survey done by the National Center for Health Statistics, part of the CDC.

We selected all patients, current and discharged, with Medicare as their primary payer for home health care and excluded anybody residing at any kind of hospital or inpatient health facility.

You have a table in your mailing materials that shows some preliminary results. Some of these results confirm what we found in our episode analysis that we publish in June of 2003. Increasing proportion of patients 85 and older, there no changes in the proportional of female patients. There were some new variables that we looked at using the survey, and that was one of the reasons why looked at data from this survey. More patients with a primary caregiver. We looked at the ADLs. Fewer patients had no ADLs in 2000, even though more than half reported no ADLs in 2000. But there was a decline between 1996 and 2000.

Other findings that we found, increased use of physical therapy services, a slight decline in skilled nursing services, decline in use of home health aides between 1996 and

2000, as well as an increase in the proportion of patients with arthritis as an admitting diagnosis.

Next steps. There's additional data in the database that we will be bringing to you at the December and January meetings. We can look at episode length for those folks who were discharged. And we'd like to compare home health care use of Medicare patients with and without Medicaid.

DR. KAPLAN: I'm going to go through the next steps on the long-term care hospital study very quickly. You've seen most of this data before. You've got it in your handouts. They are still growing like mushrooms, popping up all over. That led directly to our policy questions for this study, which are also in your handout.

The primary objective, and I want to emphasize this, because the primary objective of this study really is to come up with criteria that Medicare should use to define long-term care hospitals and to define patients that are appropriate for them. I want to emphasize that.

We're taking several approaches to this. We have several quantitative analyses. We're going to slice and dice and look at the long-term care hospitals more closely to see if they're all alike or whether there are differences by their

age, by their ownership status, et cetera, or whether they're hospitals within hospitals or freestanding.

We're also going to be doing multivariate analyses and looking at patients that have a high propensity to use long-term care hospitals, then see where those types of patients are treated in areas where there are no long-term care hospitals, and can then hopefully compare outcomes for those who use long-term care hospitals and clinically similar non-users.

We're going to have two qualitative analyses. One is structured interviews with physicians and others in areas with and without long-term care hospitals. Then we're doing site visits to long-term care hospitals.

Then the final step will be to develop policy recommendations.

This year will be our first opportunity to look at payment adequacy for inpatient rehabilitation facilities, which CMS calls IRFs. The PPS for these facilities started in January 2002. We are hopeful that we will be able to do this work but we are not certain because it will depend on how much cost report data is available for 2002 for these facilities.

Assuming that we can do the payment adequacy

assessment, we'll use the regular payment adequacy framework. We haven't talked about rehab in a while, so I just want to quickly tell you they specialize in providing intensive rehab services. Their primary mission is to assist individuals in regaining maximum functional independence and to be eligible for inpatient rehabilitation care patients have to be capable of sustaining three hours of therapy a day and benefitting from the care.

This is background on them. You'll be seeing these numbers again and again this fall. And the most frequent diagnoses we'll also talk about more in the fall. These steps I think you all know.

Let me just say that if we do get to a recommendation, we will, of course, look at cost differences.

Now onto hospice.

MS. THOMAS: We're going to look at the hospice benefit, use and payment issues this year. We didn't look at hospice last year, but we have looked at this benefit in the past.

The earlier analyses focused on end of life care and access to the benefit. In fact, the Commission has made recommendations that the Secretary evaluate the payment rate.

What's new this year is we have a couple of years of cost report data and we can begin to look at some of the payment issues.

I'm going to give a really quick overview of the benefit and eligibility for the hospice benefit. There's more detail on this in your mailing materials. I'll go over trends really quickly and talk about the proposed work plan.

The hospices must cover a broad array of palliative care including prescription drugs and counseling, which are not otherwise covered under Medicare. They are paid per day depending on the setting and the intensity of care. Most services are provided in the home, which includes nursing homes, although some inpatient care is also furnished.

Medicare has four rates. The rate for routine home care, which is the most common service, is $118 a day. And the highest rate, which is almost $700, is for continuous home care.

To qualify for hospice, beneficiaries must choose the benefit and they waive all rights for curative care for illness related to the terminal condition. Medicare continues to cover illnesses and injuries unrelated to the terminal condition.

Beneficiaries may opt out at any time and may change

hospices. They must be certified by physicians as terminally ill with less than six months to live if the disease follows its normal course.

Beneficiaries in M+C plans can also choose hospice. They can stay enrolled in the plan or not. If they stay in the plan, they continue to pay premiums to the plan and receive any additional benefits the play may offers, but generally receive all of their Medicare services through the fee-for-service program.

There were around 2,200 hospices in fiscal year 2001. As I said earlier, the hospice benefit is generally provided in the home. But like other providers, for example home health agencies, hospices may be freestanding or based in other providers. A few are in SNFs, some are in hospitals, and others are in home health agencies. The benefit is the same regardless of where the hospice is based.

The share of hospices that is freestanding has grown 10 percentage points from 50 percent to around 60 percent over the last 10 years.

Medicare hospice spending has grown rapidly over the past 10 years from less than $500 million in 1991 to $3.6 billion in 2001. Between the last two years on this chart

alone, spending grew 25 percent. CBO projects double-digit growth through 2005, leveling off at 7 or 8 percent thereafter.

One reason for this growth is rapid growth in the number of beneficiaries using the benefit. It's grown more than five times over this 10 year period from $108 million to $580 million in 2001.

But recent spending growth has been even faster than the number of beneficiaries using the benefit in large part because there's been an uptick in length of stay in hospice.

There was some concern of the pattern of decreasing length of stay over the 1990s, but it seems that there's been a change. I don't know about underlying patterns within the length of stay. There's been some concern over short lengths of stay in the past, so that's one thing we'll look at.

That brings me to the work plan. I'll be working with Cristina Boccuti on this. We'd like to use the newly available cost report data to look at differences in cost by type of provider, length of stay, census, and by types of cost. That is if the data allow.

We'd like to update data on the length of stay to 2002 and see what the change in the distribution of stay has been between short and long stays. Depending on data

available, we can also look at the use of the hospice benefit by M+C enrollees which over the past has been much higher.

We want to look at changes in the composition of the industry over time. And as we look at populations with high loss for disease management, as Joan and Nancy explained, we will consider hospice and how that array of benefits is provided for folks who are at the end of their life.

Finally, we'll report on the status of measuring quality of care in the setting.

MS. RAY: Everybody recalls that we created a post-acute care episode database. We published our first analysis in the June 2000 report. So the next step for this is to update the information in the database. We're going to include 2002 claims for the 5 percent file. That means we'll have data from 1996 to 2002. We're also going to include MDS and OASIS information into the database.

So I'm here to get your direction as to where you would like to take the analysis for the June 2004 report. As a first step, we do plan on updating some of the use and spending data tables that we put in the June 2004 report, but we'd like to take on additional work. And we can use the database to answer an number of questions.

We can look at outcomes of beneficiaries, pre/post-PPS. We can look at changes in Medicare spending for both post-acute as well as non-post-acute care before and after the implementation of the prospective payment systems.

And two other issues that we could use the database for, we can update MedPAC's analysis of factors influencing choice of post-acute care setting. This was Chris Hogan, a couple of years ago, used data from the Medicare Current Beneficiaries Survey 1993 to 1997. He pulled it. He looked at factors influencing post-acute care.

In particular, he found factors such as hospitals having a SNF unit, high supply of nursing facility beds, as important factors influencing whether or not a person uses SNF versus home health care.

The last analysis that would look at is changes in patterns of care over time between 1996 and 2002, look at how patterns of care changed, the number of post-acute care providers. Beneficiaries are seeing the patterns for where they're going and so forth.

We would like to hear from you any other possible direction you'd like to take the database.

MR. FEEZOR: Sally, I had the opportunity a week or

so ago to be in the audience for a chap who was peddling long-term care hospitals to other hospital administrators. And I just have to say that I was a little uncomfortable that there was a disproportionate amount of conversation on what it could do to the relative profitability by sending them your tired and your poor, as well as improving your hospital's mortality and some of its other ratings.

So I wonder, when you and Nick go on your road show, you may want to talk to one of the other, in addition to the referring physicians, maybe some of the hospital administrators or CFOs that refer an awful lot of business to them and sort of get an attitude, or at least some idea in terms of how they're being viewed.

DR. KAPLAN: The structured interviews that we're doing -- well actually, a contractor is doing with them for us, NORC and Georgetown are doing them for us, they actually are doing that. They have all of the hospitals that are referring to these hospitals in these matched market areas. They're looking at that.

MR. FEEZOR: I felt like I was in the old insurance market where you stratified your bad risk into a subsidiary and kept your good risk in a different company, so it was a little

uncomfortable.

DR. NEWHOUSE: Two comments. One is I think more the March report and one is more the June report.

On the SNF analysis, but more generally on our update framework, there's really something of a framing issue, I think. Here it's what's the right baseline?

The data that we presenting or showing on exit were post-'97, disproportionately for-profit hospital SNF. There was a huge entry before '97. My guess is of the same entities. So that maybe we've come back to where we were in the earlier '90s.

But I think at a minimum, we should show that. It more generally raises the question that if we're going to use entry and exit as an indicator of payment adequacy, we have at least an implicit judgment about what kind of capacity we want. And we haven't, I think, often made that explicit.

On the June report, this is something quite different but it goes both to the point of quality of care and accountability. And I don't think we've talked very much about the use of IT in the post-acute setting. That would both be capability and connectivity to the hospital and to the doctor. And particularly in the context of home care, electronic

charting, which is to say I think goes to both quality and accountability.

I don't have any great ideas about what the work plan there should look like, if any, but I think at a minimum it ought to be on our radar screen. I have the sense that it's fairly minimal now, but we could say something perhaps about to what degree it's used and what degree we think it could contribute.

DR. KAPLAN: Let me just briefly say we have had some conversations with some of the industries about IT and we will be bringing that to you when we move through our payment update.

DR. ROWE: A couple comments about hospice. While the expenses are impressive and the rate of rise is impressive, it would be interesting to see an analysis of the savings, if any, because the patients have to forego curative treatment. And presumably while they're enrolled in hospice, they're getting admitted to the hospital much less frequently and not developing those costs.

So it's really not fair to evaluate the hospice program by just looking at these expenses without looking at some of the trade-offs. I don't know if that's done or not or

it's available, Sarah.

MS. THOMAS: There have been a couple of studies that have actually looked at that, and actually found not great savings, in fact, a slight cost. Although the original evaluation of the hospice benefit found some savings, that was before this rapid rise in the use of the service.

I think the tricky thing is that those quick cross-sectional comparisons of costs really didn't control for a lot of matching of patients on their characteristics. And as time and data allow, we'd like to take a look at it in a more sophisticated way.

DR. ROWE: A couple of other comments. With respect to the length of stay, you've commented on this but it's just worth emphasizing, that we have to have a different mindset. When it comes to hospice, long length of stay is good. Shortly length of stay is bad. It's important to understand that the whole idea here is planning, getting people into the program early to prevent the hospitalizations that don't yield any benefit, to control their pain early on, to start to counsel them, to give bereavement counseling to the families, et cetera, et cetera. You can't do that in two weeks as effectively as you can do it in two months.

So long is good, short is bad. Since that's the opposite of the way we think about it in hospitals, et cetera, et cetera, in terms of length of stay.

Third is I think years ago there were very significant racial and ethnic disparities in utilization of the Medicare hospice benefit. African-Americans particularly didn't seem to have full access to the benefit, as I recall. I have a sense that that has gotten better but it would be interesting to refresh those data.

MS. THOMAS: There was a recent article in the Journal of the American Geriatric Society on just this subject. And I plan on pulling a lot of that information together.

DR. ROWE: That's great. If you could send me that, I should have that but I'm a little behind on some of my journals. Now the Wall Street Journal, but some of the others.

[Laughter.]

DR. ROWE: And then the last thing is I think that there is some ambiguity about what whether or not hospice, as Medicare defines it with this long list of benefits that you listed, is the same as palliative care. I think we should try to clarify that because I think that there's hospice just the place. Then there's hospice the benefit, which includes

hospice the place and a lot of other stuff. Then there's palliative care as it would be envisioned by JoAnn Lynn or Diane Meyer or the Robert Wood Johnson Foundation's Last Acts Initiative, which is a more comprehensive program.

I think we should be clear about how the Medicare benefit, at least, compares to hospice, just hospice the place, or palliative care in terms of comprehensive services.

Thank you.

MS. RAPHAEL: In regard to the nursing homes, I think the first study on trying to figure out a classification system that works is a far more important study, to my mind, than the study on what's happening with the hospital SNFS. Because we have spoken on numerable occasions about the inadequacy of the current classification system and the issue about refinement versus reinvention. So I consider that a particularly important study where I think we can make a contribution that's significant.

In terms of looking at hospital-based SNFs, I think we have to look overall at what's happening in occupancy rates in nursing homes. Because in order to see whether there are access problems we need to understand that, because there are issues here of substitutability with assisted living and your

IRFs and home health care, et cetera.

And I think it is instructive that the states, who have tried to change their policies and shift Medicaid dollars to home care, have had a very hard time doing it. So that about 73 percent of Medicaid spending on long-term care still goes to nursing homes despite all their efforts to try to move the system toward home and community-based care.

I don't know if this as at all possible and maybe this is something far in the distance, but I would be very interested in seeing whether it's possible to take a case like a stroke patient or a hip fracture patient and see what happens if that patient happens to land in a nursing homes or in home health care or in an IRF or in a long-term care hospital.

This is only my hypothesis. This is not at all proven but I believe there are patients who could land in any of those four places due to things that are not necessarily attached to their clinical characteristics or their care needs.

It would be interesting if down the road we could really compare the costs and the outcomes if it is at all possible to find a similar population. I know we have issues around people going into more than one post-acute care setting. I believe there were 18 percent who went to more than one. I

don't know if I have those numbers right. But anyway, that is something I'm particularly interested in taking a look at.

Another area that I would like know more about from your database is out-of-pocket spending. The last time I looked at it, and I don't know if my numbers are current, about one-third of long-term care spending in the nation was out-of-pocket. And it was quite high. I don't know if that's at all true today, but I think it's worth taking a look at what the out-of-pocket spending is in the long-term care area.

I was going to make Jack's point on palliative care because there is a movement now toward palliative care. I, myself, am not always sure exactly what that label means, but there are now more palliative care units in hospitals, there's more palliative care partnerships between hospitals and I know home care and hospice agencies.

So I'd like to see if we can try to capture some of what is happening here and is it at all significant for the Medicare program?

Lastly, while we say that a number of, for example, home health care is not capital intensive and it truly, in general, compared to nursing homes and long-term care hospitals, it is not.

I have seen much more of a movement toward using technology. It's far more widespread than I would have expected it to be, given that most home care agencies, in fact, are quite small.

So I think we should take a look at the systems, whether it's electronic charting or what's happening in terms of connectivity between physicians in home care agencies trying to transmit all these documents between hospitals and admitting offices and home care agencies. I think it's something we need to capture if we're going to do an adequate job on looking at update factors.

DR. WAKEFIELD: Sharon, I had a question about looking at access related to home health care. You talked in our materials about service area mapping, some data that you're going to be using from CMS. Could you tell me a little bit more about how they're getting at the county level data?

That is, are they looking at home health agencies that are certified to provide care in a county? But at least anecdotally I understand that just because they're licensed to do that, for example, they don't necessarily.

And is there a way that you'd be able to tease out, for example, a home health agency that services seven miles

into a county but they don't go 40 miles into a county? So how would that sort of a county look in this mapping? Would it be considered -- would one see that as services are provided, that county is covered because there's some penetration a few miles into the county? Or not?

Part of the reason why I'm asking you that question is because, at least in my region of the country, again anecdotally, there's been some movement toward defining a catchment area as say 25 miles out from the mothership. And that's it. So if that 25 miles takes you all the way across the county, great. Not really in the part of the country that I live in, because the counties are much larger.

But how will that be reflected in that mapping that CMS is doing?

MS. CHENG: I think that's going to be actually one of the strengths of this map. VEVAC and I are working on this map. It is going to be based on zip codes rather than counties. So we're going to be able to look at a granulation that's at least a fair bit finer than county.

It also is self-identified by the home health agency, so it is going to improve our ability to describe the service area because we're not going to just drop a random pin where

the address of the home health agency is and then draw lines from it.

CMS has asked home health agencies to identify those zip codes where they have or will serve patients. So that will reflect perhaps a home health agency whose nurses might live 50 miles from the agency and are willing to travel to that zip code.

So I think it's going to give us a pretty good picture of the service area. It will certainly raise questions about how many home health agencies serve that area? Maybe we'll be able to start to draw a picture of that.

The other reason we want to overlay population is to also get a sense, if we find a zip code that hasn't been identified as a service area what's the population of that zip, and then try to at least improve our description of it by adding that population covered.

I think it will be pretty good. I think it will be a good resource for us.

DR. MILLER: I just want to thank you guys. I'm really sorry that we railroaded you through this. And I appreciate the commissioners going along and being good sports about it.

I just would draw your attention just to two things in your packet, so that if you actually get some time to reflect on it, pages 23 through 25 have a good overview of the inpatient rehab, tells you the basic benefit, how many dollars, what the services are. Just if you want to familiarize yourself with that.

And then, of course, the hospice benefit, since we're kind of getting back into it, there's a lot of background in that section, starting on page 30.

Again, I appreciate this. I know that was tough to have to accelerate everything, but I really do appreciate it.

MR. HACKBARTH: Thank you.

Last for today is risk adjustment in managed care. And we are pretty close to back on schedule now.

DR. ZABINSKI: It looks like we're back on schedule again. Should I cut back any?

MR. HACKBARTH: That's not an excuse to be long-winded.

DR. ZABINSKI: You know I'm never long-winded. This with take like 12 minutes, is that okay?

To finish today's session I'm going to discuss risk adjustment issues in Medicare. Our motivation for presenting

this material is that MedPAC and ProPAC and PPRC, as well, have all made recommendations on risk adjustment. And we're at a point where CMS will soon begin using a new risk adjustment system that could substantially affect payments to Medicare+Choice plans. The Commission, thus, has an opportunity to evaluate the new system and make comments and recommendations.

My discussion today will actually cover two topics. One is the new risk adjustment system that CMS will begin using next year. And the other topic is the possibility of using prescription drug data to risk adjustment payments for comprehensive benefits provided by capitated plans in the Medicare program.

Before discussing either topic, though, I'd just like to quickly review what risk adjustment is intended to do. The purpose of risk adjustment is to adjustment the payments to plans for the expected relative costliness of their enrollees.

You cam see how this works in Medicare+Choice by examining the methods for calculating payments which is just the product of a county-based payment rate and an enrollee level risk score.

While risk score indicates an enrollee's expected

costliness relative to the national average, so it's job is essentially to adjust the base rate in each county up or down according to how much the enrollee is expected to cost.

The idea is that the risk score and the payment increase with an enrollees expected costliness. For example, risk scores below 1.0 indicate an enrollee is less costly than average, so payments for those enrollees are below the county base rate.

Conversely, risk scores above 1.0 indicate an enrollee is more costly than average, so payments for that enrollee are above the county base rate.

Now let's discuss the system that CMS will use to determine risk stores beginning January 1st, 2004. This system is a version of what's called the Hierarchical Condition Category or HCC model, and CMS has named their version the CMS-HCC.

This model uses enrollee's demographics and diagnoses from inpatient, outpatient, and physician encounters in a base year to determine an enrollee's expected costliness in the following year.

This is a more comprehensive model than the current risk adjuster which uses only demographics and principal

diagnoses from hospital inpatient stays.

While developing the CMS-HCC, CMS found that the costs of specific groups of beneficiaries differ so much that it was beneficial to develop different versions of the CMS-HCC for different populations. Therefore, there are four versions of the model, one each for the standard community dwelling population, one for the long-term institutionalized, one for ESRD beneficiaries, and one for frail beneficiaries participating in special programs such as PACE and Social HMO. In the next few slides we'll discuss these specific versions of the model.

First, the standard CMS-HCC. It is a slightly simplified version of the full HCC in the sense that the CMS-HCC collects beneficiaries' diagnoses into what they call 64 disease groups, whereas the full HCC has about 86 disease groups. Despite being a simpler model, the CMS-HCC does explain nearly as much variation in costliness as the full HCC, 10.8 percent versus 11.1 percent.

In general, for each disease group an enrollee falls into, CMS will make higher payments under the CMS-HCC.

In addition, CMS found that if a beneficiary has more than one condition, in some cases some combinations of diseases

cost more to treat together than to treat them individually. Therefore, the CMS-HCC also includes additional payments for the attractions of some conditions.

Ultimately, CMS will use the CMS-HCC to calculate an enrollee's expected costliness by summing their costs associated with the enrollee's demographics. There are disease groups that they fall into and the disease interactions that apply.

The CMS also developed a version of this model for the long-term institutionalized who are beneficiaries who have lived in institutions for at least 90 days. The long-term institutional version is not much different from the standard version as it includes the same 64 disease groups, the key difference between the models being that the costs associated with demographics and disease groups in the long-term institutional version were estimated with data from the long-term institutional beneficiaries.

A third version of the CMS-HCC was developed specifically for beneficiaries with ESRD. This version actually has three parts, one each for three ESRD subpopulations. Those who are on dialysis, those who have had a recent kidney transplant, defined as a transplant within the

last three months, and finally, those who have had a successful transplant, meaning a transplant that took place more than three months ago and the beneficiary has yet to return back to dialysis.

First of all, the part of the model for the dialysis patients includes the same 64 disease groups as the standard CMS-HCC, except that it doesn't exclude kidney diseases. The costs associated with disease groups in this model were estimated with data on dialysis patients.

Second, the part of the model for recent transplant patients is quite basic. It simply consists of making three equal monthly lump sum payments, one in each of the three-months following a transplant. These payments are simply adjustments upward in the dialysis-based payment rate for the higher costs to the transplant patients.

And finally, the part of the model for successful transplant patients uses the standard model, that is the standard CMS-HCC, with additional payments for the cost of immunosuppressive drugs and intensity of care.

The final version of a CMS-HCC is for frail community-dwelling beneficiaries enrolled in PACE and demonstrations including social HMO, the Minnesota Senior

Health Option, the Minnesota Disability Health Option and the Wisconsin Partnership Program. For institutionalized beneficiaries participating in these programs, CMS will actually use the long-term institutional version of the model I discussed two slides ago.

The idea of the frailty version of the CMS-HCC is to first determine an early risk score using the standard CMS-HCC model. Then an organization level frailty score will be added to the CMS-HCC score to produce a total risk score for each community-dwelling enrollee of these programs.

In this slide, I discuss the method for calculating the organizational level for frailty scores. First, CMS has decided to measure an enrollee's frailty with the number of difficulties and ADLs that the enrollee reports. Then CMS has used MCBS data in regression analysis to determine the relationship between the number of ADLs that a beneficiary has and the difference between their actual cost and their expected cost from the CMS-HCC. The idea of doing this is to measure how far off the CMS-HCC is in predicting costs for beneficiaries with different numbers of ADLs.

Using these results from the MCBS analysis, CMS has determined a frailty factor associated with number of ADLs

where the frailty factor is an indicator of the average percentage difference between the actual cost and the cost predicted by the CMS-HCC for each number of ADLs.

Ultimately CMS will survey community-dwelling enrollees of these programs to find out their number of ADLs. The agency will use these survey results to calculate a weighted average frailty score for each organization and this weighted average frailty factor is the organization's frailty score that is ultimately used to determine a beneficiary's total risk score.

In addition to developing several versions of the CMS-HCC, CMS also addressed a couple of issues related to risk adjustment. These include, first of all, that the CMS-HCC model will be phased in. In 2004, that means 30 percent of M+C payments will be based on the CMS-HCC but that percentage will increase annually until it reaches 100 percent in 2007.

Second, CMS will like two proportional adjustments to all payments to M+C plans in 2004. One adjustment is a dollar adjustment in payments for changes in providers coding of conditions over time. This change will decrease aggregate payments under the CMS-HCC in 2004 by about 1.5 percent.

The second adjustment is an increase to all payments

that were adjusted by the CMS-HCC, so that total payments in Medicare+Choice are constant in 2003 and 2004. With this budget neutrality adjustment, total payments in 2004 under the CMS-HCC will be 16 percent higher than they would be without the budget neutrality adjustment. But because only 30 percent of the payments will be adjusted by the CMS-HCC in 2004, the net effect is an increase in payments of about 5 percent.

Now I'd like to turn our attention to a different topic, that being the possibility of using prescription drug data to risk adjust payments to capitated plans and Medicare. This is not an entirely new idea. Some plans had approached CMS with the idea of being able to use drug data under the CMS-HCC.

Our motivation for discussing this topic was spurred by the reform bills that recently passed in the House and Senate. If the Congress ultimately passes reform that provides drug coverage in Medicare, interest in using drug data to risk adjust payments for comprehensive benefits may increase.

Now I'm not aware of any study that actually analyzes use of drug data to risk adjust payments in Medicare, but drug data and risk adjustment for non-Medicare populations has been excessively analyzed. This research suggests that prescription

drug data do perform fairly well. But because their results are not based on Medicare populations, I do emphasize that these results may or may not be indicative of how well they would perform in the Medicare program.

In any event, for the populations analyzed, these studies indicate that the drug data explain about as much variation in costs as what are called the ACG and ADG models, which are two widely used diagnosis-based models developed by researchers at Johns Hopkins.

However, two one models that use diagnosis data, one being the HCC model that we've already discussed and the second being the CDPS developed by Rick Kronick at UC-San Diego, explain more variation in costs than do drug-based models.

Now an important result from this research is that they found that the models that combine drug data and diagnosis data perform better than models that use either type of data alone. But I do caution that no study has analyzed the effect of adding prescription data to the CMS-HCC, so it is not clear how much adding prescription drug data to the CMS-HCC would improve that particular model.

As analysts and policymakers consider whether drug data are viable risk-adjusters, they should consider not only

the variation in costs explained, but other advantages and disadvantages of drug data relative to diagnosis data.

In the literature, the advantages of drug data cited include first that drug data often are more complete and higher quality. This is especially true for plans without encounter data such as those that pay providers subcapitated rates or on a salary basis.

Second, nearly all prescription drugs show up in pharmacy data, so using prescription data would not disadvantage plans that do not have encounter data.

And third, prescription drugs tend to be more timely. For example, it takes CMS about six months to collect enough diagnosis data to effectively determine risk scores but prescription data are often available soon after prescriptions are filled.

Disadvantages of drug data cited in the literature include that new drugs frequently are introduced and also use of drugs can change quickly. So models that use prescription data may have to be updated more frequently to account for these frequent changes than do diagnosis models.

And second, the use of prescription data may reward increased prescribing patterns which may not be a desirable

effect.

In closing, I would just like to say that we are seeking the Commission's comments and their views on risk-adjustment issues that they would like to pursue and perhaps make recommendations on.

DR. ROWE: I don't really see a value for us to go into deep considerations with respect to the pluses and the minuses and the potential theoretical values or disadvantages of adding the drug data. I think you should just get some drug data and add it to the Hierarchical CMS and see if it improves the proportion of the variance that's described. If it does, it's worth adding. And if it doesn't, it's not. Isn't that possible, rather than sort of a priori making some sort of hypothetical decision?

DR. REISCHAUER: Where are you going to get the drug data?

DR. ROWE: Are there not drug data available from plans in Medicare+Choice and that you can go and get the data? Don't all the Medicare+Choice plans have the drug data?

DR. REISCHAUER: They offer a million different coverage situations. Even if the Medicare prescription drug bill were to pass, I would have great reluctance about doing

this simply because the benefit that everybody has will not be the same. Some people will have a more generous benefit than others.

Unless you can make sure that that is not biasing the --

DR. ROWE: Do you think they're really that different?

DR. REISCHAUER: Across Medicare+Choice plans they're hugely different. Some don't provide any. Some provide only generics. Some have limitations of $500 a year.

DR. ROWE: I would recommend that you not do the pilot study on the ones that that don't provide any.

In other words, you could just go and pick a kind of middle of the road or fairly generous drug benefit and do the analysis. And if that doesn't improve the proportion of the variance that you can attribute, then it's not worrying about.

DR. REISCHAUER: But you're then than explaining the utilization of other services for people who have good drug benefits. And then you want to apply that to everybody else who might have deeply overpaid or over adjusted than everybody else.

DR. ROWE: No, it's okay the way it is.

I'm simply saying, and I think you're on the same -- but otherwise, you can go around the mulberry bush here forever, as to the pros and cons. It's a very pragmatic question.

DR. NEWHOUSE: There's also the issue of how do we get access to these data?

DR. ROWE: Alice will give you access to them.

[Laughter.]

DR. ROWE: CMS could pay a health to do the analysis on this data.

MS. DePARLE: Some of them wanted to.

DR. ROWE: Exactly. Maybe a health plan could just do the analysis and say this is what we found. I don't know, it seems to me easier than the hypothetical pros and cons.

DR. REISCHAUER: I think it probably doesn't improve at all. But I'm asking, so you find that out, it's an interesting article in a journal. But really, can you apply it given the structure of the program right now?

DR. ROWE: What you're saying is you wouldn't go there anyway, even if it improves?

DR. REISCHAUER: You couldn't go there is what I'm saying.

DR. NEWHOUSE: You couldn't go there without a drug benefit, is what you're saying?

MR. FEEZOR: Bob, you're saying because the drug benefits aren't equal, you couldn't apply whatever you learned from it then?

DR. REISCHAUER: We'd probably be better off applying it even with unequal, but it wouldn't be quite kosher, because some people have employer-sponsored coverage, some will have plan A, some will have plan B, some will on Medicaid.

DR. ROWE: See if this is logical. Since, as you say there are abrogados number of different benefits for health plan pharmacy benefits, then we wait until Congress decides what their benefit is going to be. And since there are so many obviously different variants out there, we pick the one in an M+C program which is just like the one that Congress picked. And we go and do the analysis on the data retrospectively to see whether it improves the variance. And then you know.

DR. REISCHAUER: What I was saying is under the current laws, Congress is not going to pick an benefit. The benefits could be quite different that are available to people.

DR. ROWE: We don't know what the law is going to be.

DR. REISCHAUER: No.

MS. ROSENBLATT: I was going to raise the data issue, too. I guess I'm less interested in the risk adjustment using prescription drug data. If does improve it, at least on the commercial population. I don't know what it does on the Medicare population. I think the health plans that are interested in using prescription drug data are those that either have capitated provider arrangements and don't get good underlying data and are looking at prescription drug data as being better than trying to get the underlying physician data. I think that's the whole issue there.

And a plan like Kaiser, I think, has been a big proponent of using prescription drug data, but I don't want to speak for Kaiser.

But the question I have, since I don't know all the bills that we were talking about at lunch very well, is there anyway to start collecting prescription drug data in this interim period, when the discount cards are being used or anything? So that at least there's data collection of some sort? No?

MS. DePARLE: Why not?

DR. REISCHAUER: No.

MS. DePARLE: Why not?

DR. REISCHAUER: You have prescription card A, and it covers certain medications. It doesn't cover others. You will buy some outside the card, some inside the card maybe. I mean, I don't know.

MS. DePARLE: That's a question about the quality of the data? Alice's question is can you collect it?

MS. ROSENBLATT: I mean, one of the things I see is let's suppose that a drug benefit does pass. And I think one of the concerns that everybody has is nobody knows what that is truly going to cost because we do not have data. So wouldn't it be nice to start collecting data now before something like that went in? Something is better than nothing.

MS. DePARLE: We have MCBS data.

DR. MILLER: The way a lot of this works, at least for estimation purposes, is you run it off of MCBS where you do have a more complete set of experience for the beneficiary. Of course, it's a small sample and there are issues there.

There was certainly contemplated in some conversations a while back that if you got the drug card off of the ground, it would give you some framework to begin to start doing this with the quality and incompleteness being the caveat to it.

When you say can't we just collect it right now, in Medicare, since there's no benefit, there's absolutely no vehicle. You would have to create the vehicle to do that.

MS. ROSENBLATT: I'm not saying now. I'm saying if the discount card does in, is there any provision there? I guess where I'm going is rather than us ending up with any sort of recommendation on risk adjustment connected with pharmacy, is it better for us to make a recommendation on data collection?

MR. FEEZOR: If I can just follow Alice, that's what I was trying to get at this morning, Mark, could we put something in our publications that talk about what a valuable resource this could be and to begin to at least contemplate that. Bob is right, it's going to be a very disparate number of benefits. But still, it is such -- based on our work at CalPERS, it's such an extraordinarily good modifier and purifier of the data.

And Dan, if you haven't seen it, actually Kronick did a lot of our work. But we did about a three-year study in terms of the availability of information and the best methodology for risk adjustment. We absolutely said we wanted

to use our pharmaceutical data as a modifier. That's about a three-year-old study.

DR. NEWHOUSE: I want to cross the chasm in the table and agree with both Jack and Bob. I agree with Jack that rather than debating whether the under-65 generalized to the over-65, we better get some data on some sample from the over-65, whether it's from the health plans or not, and find out what the increment in R-squared is in that.

But in the larger picture, I think I want to more agree with Bob because, my guess and I'd bet some money on it, from the under-65 data is that it's going to be a modest improvement.

Now what I'm worried about, let's suppose it is a modest improvement -- or even if it's more than a modest improvement -- rather one would want to use this as a risk adjuster, there will undoubtedly be drugs that kick a person into a disease category which is a very expensive disease category. And prescribing a relatively cheap drug will lead to a large increase in the reimbursement.

All of the studies that I'm aware of have to be in the context of not actually paying on the drug or not increasing the entities' revenue if you prescribe the drug.

Within Kaiser that would certainly be the case.

We already are worried about overmedication among a subset of the elderly, at least. And maybe there would be a demo or something, but we ought to have some knowledge of behavioral effects in addition to the just percentage of variance, in the absence of behavioral effects, that would go on here.

MR. HACKBARTH: Other comments? Okay.

That's it for today, except for the public comment period. Do we have any public comments?

MS. FISHER: I see I have a lot more time than normal.

[Laughter.]

MR. HACKBARTH: Karen, it just wouldn't be fair to the staff if we didn't treat you the same way.

MS. FISHER: Karen Fisher with the Association of American Medical Colleges.

I hope that you will indulge with me and bear with me for a second to talk about the cost to charge issue. I know it's dense, but it's also very important as we've learned from the outlier issue.

Jack accurately pointed out the impact of what can

happen with how costs and charge markups occur and can result in overpayments. But I'd like to point out the fact that it's important to recognize that it can also result in underpayments.

I'd like to use the outpatient system as an example because the outpatient system is done, the payments are based more on a service level, a lot less bundling than the inpatient side.

We have heard from a number of our members that in terms of markups that they will, for various reasons, oftentimes on the commercial side, will have a lower markup for high cost item than they will for a low-cost item. So they will have a sliding scale of a markup system because for a very high cost item they cannot mark it up 50 percent.

If that isn't the case, when you go to convert the charges of that high-cost item into cost, and you're using a cost-to-charge ratio that, for example, was based on the lower cost higher markups, let's say a 50 percent markup, where the high-cost item is really only marked up 10 percent, the result is you're going to obtain a cost for that item that is lower than that actually is.

The result is that if it goes into the system that

for some high-cost APCs, the APC payment rate, through no fault of the technical system of doing the payment rates, can be inadequately low because the costs you've derived are not the actual costs of the service. And I think that's important to recognize as you go in to do the study, the impacts of that.

That can also occur on the inpatient side.

Let me back up on the outpatient side. Do we really care about that? Not really if you're overpaying for the low cost items. In theory, if it was evenly set up, you have the overpayments and the underpayments offsetting each other. To be honest with you, I'm not sure how much I would care as a hospital.

The problem is if the underpayment is happening on the high-cost side, you need a fair amount of overpayment on the low-cost side to offset the underpayment.

So I think that's an issue that, as the staff does the analysis, it's important to look into.

On the inpatient side, it probably matters a little bit less because the payments are bundled. But I will say, and some of you will like the fact that I am going to circle around to IME on this, that if it does hold true, just hypothetically, and if you believe the teaching hospitals tend to have the

high-cost items which they may be marking up less, theoretically potentially the cost per case that you may have at a teaching hospital could be, on the books, lower than it actually is. We don't know that because the only data that's used is the Medicare cost report data and we're converting.

So when you look at a comparison of teaching hospital's cost per case to non-teaching hospital's cost per case, there could be a gap there that is less than it is in actuality.

The problem with all of this, I think it's a nice intellectual discussion, is it's very difficult to get at this. But I think with some of the work that's being done, GAO has been doing it, and some of the work the staff has been doing, I think we'll get at some of these items. But I thought it was useful to point out.

Thank you for your time.

MR. HUNTER: Mr. Chairman, I will try to be as quick as I can. Justin Hunter from Powers, Pyle, Sutter and Verbile. I am here today wearing two hats. My first hat is on behalf of Forsynius Medical Care, a supplier and provider of dialysis supplies and services.

Forsynius would respectfully urge the Commission to

take into account transparency and accuracy as part of any rate setting procedures that occur within the ESRD program as part of a new payment framework or structure. And in that regard, we would further urge you to consider examining some of what we believe are outdated cost reporting rules that oftentimes can have the arbitrary effect of denying service-related costs and treatment-related costs. Hopefully, as part of any new framework policy recommendations that you all devise, that will include an examination of these outdated cost reporting rules.

Ms. Ray, and I want to get to a second issue that Ms. Ray pointed out in her presentation of the ESRD issues, particularly the statement that on the non-composite rate side, or the drug reimbursement or separately reimbursable side, there is a phenomena of overpayment. I don't think anyone in the industry would deny that. That has been widely recognized by the industry. It's been widely recognized in the past by this commission.

I think it's very important to redirect your attention to the fact is that the reason for that is the underpayment on the composite rate side. Obviously, you all are going to be considering and examining HHS's recent report that took into account and formulated actually a market basket

index for the composite rate. That report is 60-some-odd pages and I would just cut right to the chase in terms of what we believe is one of its most important aspects.

A market basket index was formulated as part of that report. The data was backed up to 1996 and run through 2002. It indicated that the composite rate increase or the cost associated with the composite rate, excuse me, increased during that time period by over 20 percent. I believe it was 20.2 percent. It's been a while since I've looked at the numbers, but I believe that's it.

As Dr. Hakim indicated earlier today, during that same time period the 3.6 percent composite rate increase that he mentioned is what was experienced in the industry. Now I have not had an opportunity to look at what MedPAC's composite rate increase data showed during that time period, but I suspect that it would not vary much if at all.

And we would urge you all to seriously consider the data and the framework that is contained in that report as far as a composite rate, or market basket composite rate framework is concerned.

It is worth mentioning and should be underscored, in fact, that the composite rate for the ESRD program was the

first prospective payment system that was created under Medicare. And it remains the only prospective payment system in Medicare that does not have a market basket increase framework.

Consequently, the industry is forced to trudge to Capitol Hill increasingly single year and say give us a composite rate increase. It's not lost upon any of us that we look oftentimes to the work and recommendations of this commission in doing that. We believe that we should be treated like every other provider. And we appreciate the recommendations that you all have made in the past with respect to empowering CMS to provide a market basket index framework for an update.

I will change hats real quickly and go to an issue that concerns the Association of Freestanding Radiation Oncology Centers.

It struck me that during the course of the SNF discussion, with respect to access to services, that it might be worth mentioning an issue to you. It's a small one but since you're going to be looking at access, it's worth mentioning.

As part of the PPS for SNFs, when a nursing home

sends their patients to receive care off campus, outside of their facility, in an attempt to ensure that the SNF is not trying to get out of its obligation to provide care, there's a definition of resident for the SNF patient. And with respect to outpatient radiation oncology services, a SNF is permitted to send their patient to a hospital-based center to receive those services.

And in that circumstance, the hospital can bill Medicare separately under Part B and the SNF is off the hook. If the SNF wishes to send that same patient across the street, down the road, where have you, to a freestanding radiation oncology center, the SNF is on the hook for the services and the freestanding oncology center, the non-hospital-based oncology center, cannot bill Medicare separately for that. They have to get their payment from the SNF.

Our members from AFROC are very concerned about this. They're frankly having trouble serving SNF patients. So I point that out for your attention and consideration.

Thank you for your time.

MR. HACKBARTH: Anyone else?

Okay, we're adjourned for today. For the commissioners, we have a breakfast at 8:15. It will be

downstairs in the room where we had lunch.

The public session begins at 9:30 tomorrow.

[Whereupon, at 4:53 p.m., the meeting was recessed, to reconvene at 9:30 a.m., Friday, September 12, 2003.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 12, 2003
9:35 a.m.

COMMISSIONERS PRESENT:

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

AGENDA **PAGE**

P R O C E E D I N G S

MR. HACKBARTH: Good morning. We have three items on the agenda this morning. The first two relate to physician services and then the final one to a report on site visits on health insurance markets for Medicare beneficiaries.

Kevin, you'll lead the way on the first item. As I recall, there are two parts here. One is a review of the work plan and the second is an introduction to a report, a Congressionally mandated report, that we have to comment on is that right?

DR. HAYES: That is correct, and I will begin with the work plan which concerns our work on developing a payment update recommendation for physician services for the March report.

I should point out, by the way, that for our second topic we have with us today Melinda Beeuwkes Buntin from RAND and I'll be introducing her in just a moment.

So proceeding with the work plan topic, and I'll just move through this quickly, as in the case of other sectors, we are about to answer two particular questions with respect to physician services. First, whether the current level of payments is adequate or appropriate, whether the level of

payments is too high or too low.

The next question that we'll want to address, of course, is what do we expect in the way of changes in costs for the coming year.

With respect to the work we have in mind, they fall into two general categories. The first has to do with updating analyses that we included in this past March report, the March '03 report. And the analyses that we included there included entry and exit of providers, beneficiary access to care, changes in the volume of physician services. And then, in anticipation of what cost changes would be for the coming year, we addressed changes in input prices for physician services and the matter of productivity growth.

For the next report, we have a couple of additional analyses in mind to supplement what we did last time. In the area of physician willingness to provide services to Medicare beneficiaries we are hoping to have access to preliminary data from the National Ambulatory Medical Care Survey that is conducted by the National Center for Health Statistics. This would be preliminary data for 2003. The survey includes a question about whether physicians accept Medicare beneficiaries or not, so we thought that would be a good thing to look at.

We also intend to look at data on physician incomes. There are data available from a variety of sources on this including the American Medical Association, the Medical Group Management Association, the American Medical Group Association and others. So we'll look at all of that and see what that tells us about this issue of payment adequacy.

And finally, we want to introduce some new data this year on beneficiary access to care. You have been after us to come up with timely data and we have plans to sponsor what we're calling for now a quick turnaround survey of Medicare beneficiaries. I don't have the time right now to go into all of the details on this but we're hopeful this will provide us with very timely information on access to care and other issues as necessary.

So that's all I have on the work plan. If I can answer any questions that you might have about it, and otherwise we'll proceed with the AHRQ report.

MR. HACKBARTH: Kevin, could you explain a little bit more about the work on physician incomes and how it might fit logically into our framework? Let me pose a hypothesis as a way to stimulate your thinking. What if we were to find that the willingness to serve Medicare beneficiaries was constant,

or just for the sake of argument even increasing, yet physician total incomes were declining? What do we do with data about total -- I assume this is total physician income as opposed to just from Medicare?

DR. HAYES: That's correct. It would be total income from all sources. I guess we won't know what the data look like, of course, until we look at them and we're still in the mode of gathering the data from these different sources. But what I what would say, with respect to the particular scenario that you described, is that it's like everything else. It comes down to looking at a variety of different factors within the context of our update framework and to try and interpret as best we can what the data mean.

Beyond that, I can't say. It's just going to be a matter of going through this and seeing what we find.

MR. HACKBARTH: Although in other contexts, we have talked about the relevance of total margins versus Medicare margins, and I think where we've left that is our principal focus is on Medicare margins unless there is reason to believe that the total financial picture of a provider group is so severe that it will pose access problems for Medicare beneficiaries.

Hence the structure of my hypothetical where we have constant or improving access to Medicare beneficiaries, yet declining total physician income.

DR. HAYES: Just thinking out loud here, but based on what we saw when we worked with contractors on differences between Medicare's payment rates for physician services and those in the private sector, it's quite possible that we will see the kind of thing that you're talking about. Because recall that we saw some, in general, some not exactly -- we saw a narrowing of the gap between Medicare's payment rates and the private sector. And that was largely because of the shift from more well-paying private plans to lower paying private plans.

And so that would be a case where there might be an explanation for why physician incomes are moving the way they are and it would not necessarily have anything to do with what's going on with respect to the Medicare program. And so looking at the other measures in our framework, like the physician willingness to accept Medicare beneficiaries, would provide the perspective that we need, the balanced perspective that we would need.

DR. REISCHAUER: I guess I feel even more strongly than Glenn does about this issue. I'm interested in

physician's incomes just because I'm a nosy person. But I don't know what relevance it could really have to this, to the issues that are before us.

We should look at Medicare payments for services in comparison with the private sector and other government program payments and that makes sense. But if their incomes were going up tremendously you might find access going down because they could play more golf or something like that. The connections between the things we're interested in and income can go in many, many different channels and we'll be throwing out a lot of, in a sense, juicy information that could divert hard analysis of what the issues are that we should be focused on.

And as you know better than we, the fraction of total income for many physicians coming from Medicare is fairly small. For others it's fairly large.

I just am not sure this is worth devoting a lot of resources to.

DR. ROWE: Was this going to be done by specialty?

DR. HAYES: Yes, there are available by specialty and so we would look at those data, and also try to weight them, to come up with a kind of all-physician.

DR. HAYES: Recognizing my obvious bias here, but it

would be interesting to see the income for geriatricians because by definition they're not a group where a small portion of their income comes from Medicare services. And it is a group that we think can be helpful in the main toward the well-being of the beneficiaries.

And so that's a group that we don't want to strangle particularly. So that's one group.

DR. REISCHAUER: What we care about is entry and exit --

DR. ROWE: And quality.

DR. REISCHAUER: -- and quality, and those are caused by a lot of other things besides income. And what you would want to be looking at is income relative to other incomes in society, not just some sort of absolute level.

DR. ROWE: I think we're interested in intake and output and quality. And I agree with you, Bob, that there are things other than income that are important, but that's not a reason not to look at income. But it's not really compared to other things in society because it seems to me that if a physician, someone who has decided they're going to be a physician and has gone to medical school, is now deciding what specialty to go in, they're not looking at their income

potentially as a geriatrician versus if they become a lawyer or a plumber. It's versus becoming another kind of doctor.

And if this is a specialty that is particularly undercompensated, that doesn't seem to me to be in the best interest of the Medicare program. That's where I was going.

MR. FEEZOR: Kevin, in any of the relative income or relative payment levels between Medicare and the private sector, have there been any studies that go down below that to sort of the relative hassle factor, the relative promptness of payment, and the relative bad dept that evolves from the Medicare program versus that of commercial payers?

DR. HAYES: Yes. We sponsored a survey of physicians in 2002 where we asked about a number of those issues, particularly on the hassle factor question. I hesitate to report on the details because I'm not recalling them specifically, but we would be happy to update you on that at some future junction.

MR. FEEZOR: Actually, Kevin, I'm glad you couldn't because since the report was done in 2002, it was during my watch here and I didn't recall it either. So I'd love to see anything that we have on that.

DR. HAYES: Yes.

DR. MILLER: Is this a contractor's report?

DR. REISCHAUER: So we aren't supposed to remember?

DR. MILLER: We'll get it to you.

DR. NELSON: Kevin, I missed how much of the income data we would be developing ourselves, or how much we would just be citing other sources that are on the public record anyway. And whether or not the data that we cite are based on salaries rather than other evidence of what physician income really is.

And finally, apart from the difficulty in interpreting it in the context of what it is we are interested in, in terms of access to care for reasons that others have cited, there are so many confounding points with respect to geographic variations, inter-specialty variations, it seems to me that it would be very difficult for us to draw conclusions. Unless we can really make a contribution by providing additional information that isn't available otherwise, it seems to me that you may better spend your time someplace else.

DR. HAYES: To answer your questions, we don't have any intention of collecting our own data. On that physician survey that we conducted, we did ask for physician incomes and it was in some very general categories and it was just at a

point in time. So our intention was to work with available sources, secondary sources, entirely for this project.

With respect to salaries versus net income, the distinction here I think that you're talking about has to do with the difference between salaried physicians and those who are self-employed. And we have information from different sources and some of them address one and some address the other.

But you're right, there is an important distinction there and we would need to be cognizant of that when we interpreted the data.

With respect to the confounders, you are right. All the data that we have are indicators of national level estimates. And so would, in a lot of cases, most cases, perhaps all cases, it would not be possible to drill down to any specific geographic area and look at regional differences, let's say, in income patterns. The best we can do is an all-physician estimate or estimates by specialty.

MR. SMITH: I share Bob's reluctance to independently take a look of physician income. It seems to me, Kevin, that we ought to get there if other data, access data, entry/exit data, suggest that there's something that we ought to explain.

But Jack used the phrase undercompensated. Compensation might explain exit or it might explain entry but there isn't some absolute notion of undercompensation. And I'd be reluctant to try to think about that unless we had some Medicare issue, most importantly an access issue, which we were looking to explain that might then be corrected through the payment system.

But independently collecting data on physician income in order to explain something or in order to explain nothing doesn't seem like a very good use of time and, for prurient reasons, Bob's nosy reasons, would be as likely to be diversionary as useful it seems to me.

DR. ROWE: Let me try a line of reasoning and see if it's coherent, and it may not be. Or it may be coherent but not important, not reach our threshold for using our limited resources.

If we believe that improvements in the well-being in access in general of the beneficiary population can result from enhancing the cadre of people dedicated solely to their care and to research and to their problems, et cetera, and if estimates from other national organizations suggest that we have one-fifth as many of such people as we need to serve the

rapidly growing population when the baby boomers go to Golden Pond, et cetera, et cetera. The number of geriatricians in the country is actually falling and we've got this looming demographic wave.

Then is it reasonable to collect data with respect to the relative compensation of this group to see whether that's one of the factors that might be impeding development of the cadre. That's where I was going.

MR. SMITH: I think the answer in that case, Jack, is yes. But the predicate hasn't been established. We don't have, so far is we know, and we will continue to look at the data to see if one is emerging, we don't have an access problem. We don't have an entry and exit problem.

DR. ROWE: I would accept that. I'm thinking about 2010. We can't turn around and start producing them then, at that point. That's my point.

MR. SMITH: And we might well conclude that the country faces, and young baby boomers face, a potential access problem in 2010 or 2015 or whenever, and that we ought to do something about that access problem. And compensation might well be part of it.

But compensation for next year's providers is not a

useful part either of solving the 2010 problem or of understanding our access issues in the year for which we're trying to make a physician update.

MR. HACKBARTH: We're going to need to move on here because we do need to hear about the RAND report. I think Mark and Kevin have heard what we have to say on this.

Anything else, Kevin, before we move on to the Rand study?

DR. HAYES: No.

Moving on to the next topic of the AHRQ report, this report concerns increases in Medicare expenditures for physician services.

And just by way of background, let me say a few things about the purpose of the study, why it was conducted and so on. The Secretary of Health and Human Services, working through the Agency for Health Care Research and Quality, was required to conduct this study under the Balanced Budget Refinement Act of 1999. That act, among other things, addressed some technical issues that had emerged after the first few years of implementation of the Balanced Budget Act of 1997.

And one area that the BBRA focused on was the payment

update formula for physician services, what's known as the sustainable growth rate system.

One of the issues that had emerged with respect to the SGR had to do with the sustainable growth rate itself and whether it adequately accounted for advances in technology, improvements in medical capabilities, hat kind of thing. And so the Congress asked the Secretary to conduct this study and specified various factors to be addressed and they are listed on the slide here, the medical capabilities, technology, demography, and the geographic location where services are provided. And the Secretary was also given the opportunity to make any recommendations as appropriate.

And then the final provision in the law was that MedPAC was to review the study and provide the Congress with comments.

We had six months to do this. The Secretary's report was released April 15th, so the due date now for our comments is October 15th.

In the process of completing the study, AHRQ contracted with the RAND Evidence-based Practice Center for completion of work on the study. As I say, the report itself was released April 15th.

To help us understand more about what the Secretary's report says, we have with us today Melinda Beeuwkes Buntin from RAND. She's a health economist there and was the lead author on the report.

We'll ask her to go through their findings and then I will come back and give you a rough sketch of where we think the comments to the Congress might go.

DR. BUNTIN: I want to thank you for inviting me to speak about this study, and in particular thank Kevin Hayes and Joseph Newhouse, both of whom have actually given us comments on the study at at least two earlier stages of review. So thank you.

I'll give you a quick look at where I'm going. I'll first talk about our objectives, then outline our methodology, describe our findings for you, particularly our findings about the trends in the use of physician services by Medicare beneficiaries, describe those trends by health condition, and talk about the role of observable factors in explaining why there's been an increase in the use of physician services by Medicare beneficiaries. And finally, I'll tell you what I think our conclusions and the policy implications of those conclusions are.

To go quickly over the objectives, the objectives were, in short, to meet the Congressional mandate, as Kevin outlined it. But I should say that the objective of the study was not to evaluate the SGR or to figure out a way to fix the SGR. It was simply to look at the determinants of increases in expenditures for physician services.

In order to do that, we had to address a challenge that many people do in trying to figure out why health spending is rising. We needed to, in effect, decompose these changes in expenditures into different causes. The first step in doing that is to separate price changes from changes in quantity.

Luckily, in the case of physician services there is a very simple unit that captures the physician time, effort, knowledge, resources. In short, is an excellent measure of quantity of services delivered. And that's the relative value unit that forms the basis of the resource based relative value scale. This is, of course, the payment method used by Medicare for reimbursement for physician services. Prices are set by CMS when they establish the conversion factors.

So we were able to relatively easily decompose the change in expenditures for physician services into changes due to prices and changes in quantity.

I'm going to focus in his presentation on changes in quantity, so changes in numbers of RVUs delivered to Medicare beneficiaries.

When we were looking at those changes in RVUs we wanted to be decompose it into changes due to observable patient characteristics. But then, as in most studies of increases in medical expenditures, we were left with a large unexplained amount of residual change, so change that we couldn't attribute to discrete factors.

Many people would attribute this to technological change. In fact, I'm sure you'll hear more about that from the panelists who will follow me this morning.

So we had two methods of getting at what was going on in that residual that I'll tell you about as I go through our methodology. As I was explaining, the first thing that we did was examine changes in the RVUs delivered to a nationally representative sample of beneficiaries and we looked at the time period between 1993 and 1998.

We took the RVUs from the later time period, specifically from 1998, and we deflated them back to the 1993 baseline values. We did this for two reasons. One was to create comparable units across time so we could fix, let's say

reimbursement in practice patterns in 1993 and then look at if those practice patterns had held what would we expect to see in 1998 in terms of service use.

But we could also then decompose the increases in the use of physician services into those that were due to the use of new services versus an expansion in the use of services that were existing in 1993.

So we did that. We looked at RVU use per beneficiary per year. We attributed changes, as I said earlier, to measurable factors. And then we compared the predicted use we expected to see to the deflated use we would have seen if practice hadn't changed between '93 and '98. And then we looked at what actually happened in 1998.

After we had done that, we did find population groups where there was a larger or smaller than average increase or decrease in the use of physician services. So groups where this residual was large. And we gathered expert clinical opinion to try and explain why these residual changes were larger.

In addition, we also looked at the extent to which site of service changes and increases in managed care enrollment might have contributed to increases in RVU use among

the fee-for-service population.

Now I'll show you what are findings look like. We found that overall per capita RVU use increased by about 30 percent between 1993 and 1998. On this slide, the lower red line is what we predicted in terms of RVU use based on the observable characteristics of the population over time. This line actually slopes down slightly.

So while the average beneficiary in 1993 used about 38 RVUs, if we took all of their population characteristics and used those to project what would happen in 1998, we actually project that beneficiaries would use on average one fewer units of physician services. I'll tell you more about that later.

The yellow line is the deflated RVUs. So that represents the RVUs in terms of the 1993 fee schedule. The green line is the actual number of RVUs used.

If you break down these changes, you'll see that by 1998 there was a total 13 RVUs used -- a greater number of RVUs used in 1998 than we would have projected based on patterns in 1993. RVU use went up to actually about 50 RVUs per patient.

You can break this down into the majority of that use which was due to an increase in the use of existing services. So the difference between the red line and the yellow line of

7.5 RVUs was an increase in the use of services that were available and reimbursed for in 1993. And there were 5.5 RVUs increase on average due to services that were newly covered or newly added to the fee schedule, or services for which the number of RVUs was increased.

Since you might find it strange that we actually projected a slight decrease in the use of physician services, I thought I'd tell you why we saw that in brief. First, was that part of this is due to the changing age and gender composition of the Medicare population. Specifically, the number of disabled beneficiaries and the number of beneficiaries over the age of 85 increased. Those are two groups who actually have lower than average use of physician services. There was some change in the place of residence of beneficiaries. In particular, more than them lived outside of urban areas and moved to the West.

Finally, there was a change in the health status of beneficiaries. In particular, they were reporting fewer limitations in the activities of daily living and instrumental activities of daily living. And fewer of them reported a history of heart attacks. This is consistent with recent literature about advances in cardiac care and also in declines

in disability among the elderly.

So then we broke down these changes in the use of physician services by beneficiaries' conditions. This slide shows you, in the middle, the mean increase which remember was 13 RVUs per person.

There were some groups that had higher than average increases in the use of physician services and those are on the top of the slide. Those include decedents, patients with osteoporosis, patients with strokes or brain hemorrhages, and patients with heart conditions other than angina, CHD, or hypertension.

There were also some groups that had lower than average increases in the use of physician services, and that included patients who had broken their hips, or who didn't report any conditions, any health conditions.

We were able to break this down into the portion of these increases or decreases that was due to the use of services existing in 1993 versus those that were new. We're going to call them new services.

The yellow bars are the same as on the previous slide. The orange bars represent the increase or decrease in the use of services existing in 1993. And the blue bars

represent the increase in the use of services that were newly added to the fee schedule between '93 and '98.

You can see that, just as in the overall numbers, most of these increases in services are disproportionately due to an increase in the use of services existing in 1993.

We also broke this down by inpatient versus outpatient use. I won't go over this in detail, but you can see that there are a few categories where patients had greater or actually lesser growth in RVUs. Those included the heart condition patients again, colon cancer patients, Alzheimer's patients, and patients without any self-reported conditions. Interesting, the colon cancer patients and the Alzheimer's patients used fewer of the services that were existing in 1993 in outpatient settings in 1998. But they use services that were added to the fee schedule between '93 and '98.

DR. ROWE: What kind of services would those be?

DR. BUNTIN: The services that were existing or the services that were added?

DR. ROWE: [off microphone] It's counterintuitive. You would think that people were getting more colonoscopies so I'm not sure what other services you can be talking about. Have they had a diagnosis for colon cancer?

DR. BUNTIN: Yes, that's correct. These are people who say that in the past a doctor has told them that they have colon cancer. They may or may not have active colon cancer at the time we're looking at them.

The types of services that they might have, and this brings up an excellent point that I was going to get to later but I'll talk about now, which is that it's difficult to really pull apart what's going on within the new category and what's going on within the existing category. I'm labeling something existing if it was available in 1993.

However, an increase in the use of existing services could, in a sense, represent an expansion of medical knowledge or technological change and that we could be, for example, doing bypass surgery on someone who's older or sicker than we used to do it on. And that probably accounts for part of that increase in the use of existing services.

Now what's going on here is that colon cancer patients actually use fewer services. It may be, as was suggested, a substitution. So there may be a new service that they can get and that's why they're getting more new services that's replacing an old service.

There may be advances in technology that require

fewer follow-up visits after a procedure. There's a whole range of things. I can't specifically tell you what is going on within the colon cancer or Alzheimer's disease patient categories in the outpatient settings because those aren't conditions that we took to our clinical experts. But I can tell you what's going on with lung cancer patients who saw a decrease on the inpatient side in their use of physician services. I'll get to that in just a moment.

DR. ROWE: Thank you.

MS. DePARLE: Melinda, when you say existing, do you mean it was available at Brigham and Women's or that it was thought widely available and that Medicare covered it in all jurisdictions? Or did you go to the intermediary level to see how it was covered?

DR. BUNTIN: That's a good question. These were things that were reimbursed on the standard physician fee schedule in 1993, so there are some services that moved from special carrier codes onto the fee schedules and we're counting those in our category of new here. So they may have existed somewhere but if they weren't widely reimbursed, we're counting them as new.

So the picture looks again somewhat similar on the

inpatient side, although the mean increase in RVU use on the inpatient side was very small compared to the outpatient side. Decedents, osteoporosis patients, and strike and brain hemorrhage patients were again the categories that saw greater than average increases while lung cancer patients saw a significantly below average increase in the use of physician services. They actually saw a decrease in their use of physician services on the inpatient side.

Again, the decrease was due to a decrease in the use of the services existing in 1993.

By picking out these categories on these charts to show you who was greater or lesser than, I somewhat obscured one of our central findings which was that, in general, most patient categories did not see differences in the use of physician services that were differences from the average. So in fact, it was surprisingly uniform across conditions, the growth and the use of physician services.

So as I said, we picked out groups where the residuals were large or particularly small and we took those to our clinical experts. The conditions that we chose were osteoporosis, lung cancer, and stroke. When we took these to our physician panels, they actually came up with a very wide

variety of factors that could explain these increases or decreases in the use of physician services. I'll give you a few examples of them.

For stroke, one of the things that the physician experts put forward was improvements in the imaging of carotid arteries. They felt that this was part of a general increase, a recognition of the importance of preventing stroke recurrence, and that would explain the increase in the use of physician services by stroke patients.

For osteoporosis, there were new bone scans and also new pharmaceutical therapies that could explain their greater than average increase. For lung cancer, the physicians pointed to shifts in chemotherapy from inpatient to outpatient settings.

However in general, the factors that these physicians pointed to were not specific enough for us to break down those changes we saw and ascribe them to discrete causes. However, most of the sources of change that they pointed to are things that could be construed as constituting technological change.

There were couple of other factors that we examined that could affect the use of physician services. One was shifts in sites of service. As you may know, some services are

assigned fewer relative value units if they're performed outside of a physician's office. The reason is that they have to bear all of the practice expense of providing that service. We estimated, however, that the effect of this on the use of physician services or the change in the use of physician services was negligible.

There might also be an effect if unobservably healthier beneficiaries joined HMOs than the average RVU use in the fee-for-service population might rise. We estimated this effect. We found that a really upper bound estimate on the magnitude of this effect was a 6 percent increase. So it certainly wouldn't explain the majority of the increase that we saw.

To tell you about some of our challenges and limitations, one is that there may be factors that we can't observe that are driving variation or change in RVU use across beneficiaries. And there may be technological changes that are not captured by RVU updates or refinements. These are the things I alluded to before. If we're doing the same services but we're doing them for sicker or older populations than we used to. So we concluded that the increases that we're calling increases in the use of new codes are actually a lower bound on

the extent of technological change.

We also found that there were other factors such as prescription drugs which are not reimbursed by Medicare, in the case of outpatient prescription drugs, that can affect physician productivity or could affect use of physician services.

And finally, of course, we can't judge whether these increases in service use are appropriate.

So our conclusions were that case-mix actually explains very little of the 30 percent increase we saw in the some use of physician services. We found that increases in the use of physician services were surprisingly uniform across medical conditions. They took place across a wide variety of conditions, demographic groups, and types of services. The majority of the increase, however, was due to a greater use of services existing in 1993 as opposed to the increase in the use of new services. But some of these increases in use can't be ascribed to discrete causes.

The implications of this are that there's no really easy fix that we could find for the SGR. There was no evidence to recommend incorporating specific factors into the SGR to account for case-mix or location of service.

We also found that technological change was extremely diffuse and multifaceted, and would be very difficult to capture in a formula. We were concerned that there was a potential for access problems if demand for services continued to outpace the SGR limits. But most importantly, we concluded that it's really critical to understand the benefits of increased use of physician services in order for us to evaluate these changes we've seen.

MS. DePARLE: I had a couple of questions just drilling down into this. On your slide 14 you made the comment about your observation that managed care enrollment could affect your results here if healthier beneficiaries join HMOs than average RVU use in fee-for-service population rises. Can you?

DR. BUNTIN: Tell you how I did that?

MS. DePARLE: Yes.

DR. BUNTIN: In our modeling we accounted for all of the observable characteristics of beneficiaries. So we accounted for their age and their gender, whether they were disabled, their health conditions, things like that. So we were really accounting for a lot of things that might affect selection into HMOs. But we were concerned that there were

unobservable factors that might also -- unobservable selection into HMOs.

So what we did was we looked at patterns of spending for people in the period before they entered an HMO. So we took people who, on all the observable factors, looked the same. But one person had joined an HMO and the other person hadn't. And we took the differences between their costs and estimated that to be the selection difference. Should I back up and try that again?

MS. DePARLE: The one you looked at was fee-for-service Medicare; right?

DR. BUNTIN: That's correct. So we had fee-for-service Medicare. However, some of those beneficiaries joined HMOs.

MS. DePARLE: During the time period you studied?

MS. DePARLE: Yes. So for example, we had a beneficiary who might have joined an HMO midway through 1998. We said look at that beneficiary who joined an HMO. Let's match them, in essence, to a beneficiary who didn't join an HMO who, on all their other characteristics, looks like that one. What's their difference in costs?

And that's the difference that's due to those

unobservable factors that might make them healthier and more likely to join an HMO.

MS. DePARLE: What kind of difference in costs did you find? What, on average, was it?

DR. BUNTIN: We found a very large difference in costs. I believe it was on the order of 40 percent. So if you take these beneficiaries who have the same age, same gender, same reported health conditions and activity limitations, one joins and HMO and one doesn't, there's a 40 percent difference in costs.

And that's how we estimated the potential magnitude of that effect.

MS. BURKE: [off microphone] Is the difference that the fee-for-service use 40 percent more?

DR. BUNTIN: More.

MS. DePARLE: The other one, on page 15 I guess it is, you mentioned technological changes not captured by RVU updates. And you talked about factors such as prescription drugs that could affect physician productivity.

DR. BUNTIN: Yes.

MS. DePARLE: Can you tell us more what you mean by that?

DR. BUNTIN: Yes. The resource base relative value scale was developed to capture what's going on in a physician office and the work that's involved with delivering a typical service. It may not perfectly, however, reflective the fact that beneficiaries going in for a standard let's say intermediate office visit are now getting more prescriptions than they did in the past. Over time, with the five-year updates and things like that, we would expect the fee schedule to account for those things but it can't perfectly account for those things over time. And that's I was getting at.

DR. REISCHAUER: I think this is a fascinating study and provides a lot of insights, but I have a couple of questions and then some observations on you could cut it and look at this same problem a slightly different way.

One question is whether you made any sort of rough attempt to look at what was happening to RVU consumption by the non-elderly population versus the Medicare population.

The second one is whether you think there's any substitutability between the new and the old? In a sense, if there was no new technology, we might have gotten a whole lot more of the old technology being consumed.

This gets me to my sort of major observation, which

is there's lots of explanations for what's going on here that you that you didn't discuss and they might be in the longer paper. One is that this period was a period of very rapid income growth, particularly among the aged, and one would expect consumption of health to rise as incomes rise.

And secondly, one would want to look at the price to the individual of the product and if supplemental insurance was becoming more generous, cost-sharing was being reduced, one would expect abnormal increase beyond demography and other things in the consumption of the product. And it could be that barriers or access improved significantly over this period.

This is a period when providers are being ravaged by managed care companies and the relative attractiveness of Medicare improves because it's the last open range, so to speak, just to make Mary comfortable here, where doctors are free to practice without excessive intervention by bureaucrats. That was in quotes.

DR. ROWE: I know you disagree with what I said earlier but don't get carried away over there.

DR. REISCHAUER: So there are other ways of looking at this. I was wondering if you tried to go into this?

DR. BUNTIN: I'll take it from the top, which is did

we look at the use of RVUs by non-elderly?

No. We would very much have liked to, however we didn't have access to the data or resources to do so. It would have been very interesting.

We did compare some overall expenditure trends, and the trends were very similar. That's why in the detailed report you'll see that we have some conclusions saying that whatever is driving the use of physician services among Medicare beneficiaries, it looks like similar things could be driving the use of physician services by non-elderly, given the total dollar spent. But we couldn't break it down into RVUs.

On your second question about substitution, and I think actually what you were getting at there was are these old and new services substitutes? Are they sometimes complements?

I think both things could certainly be going on. You could easily imagine that a new imaging service could replace an old one, but it could also be that there are new imaging services that require the use of more office visits to follow up. So it's certainly possible that there are both substitutes and complements.

DR. REISCHAUER: What I'm getting at is when we do disaggregations like this and we all go out and say oh, it's

technology, technology is really driving this forward. If somehow I could freeze dry technology and just leave us constant, we might see 85 or 90 percent of what's going go on anyway, in terms of -- for the reasons that I then talked about, rising incomes, access, that kind of thing.

DR. BUNTIN: Yes. So in terms of what other factors might explain this, I think right actually rising incomes is one of my pet theories about why this is going on. I don't know a way to break this down and look at the effect of income change, but as I said it's one of my pet theories.

The price to the individual can also certainly change. If people are overall getting more services then not only due to changes in supplemental insurance but due to the fact that more people have already paid their deductible, we might see increases. There may also be feedbacks with the price changes that are changing volumes. So all these things could be going on.

I think that there is possibly more that could be done by drilling down lower than I was able to do within the constraints that I had in doing this study. More look at specific conditions to try to figure out what's going on and maybe get at some of those factors.

MR. MULLER: How did the RVU increase break out by in and outpatient utilization? Because managed care, in a sense, had less constraint on outpatient utilization at that time. So how did it break out between in and out?

DR. BUNTIN: On the inpatient side there was a very small increase. I believe it was two RVUs per person out of the total of 13 on average.

MR. MULLER: Also, the technology improvement, for example, CTs in '93 to '98 there was advances, and scopes and so forth. So a CT in 1998 was different than a CT in 1993, though in your categorization it would be an existing service; correct?

DR. BUNTIN: That's correct, although the extent to which the number of RVUs that were associated with reading a CT scan was changed, because of the advancements in CT scanning, I would be counting that as part of the new service.

MR. MULLER: Because I think based on some of the information we looked at last year, when we looked at the growth of the various outpatient facilities, especially in imaging and ambulatory surgery, the kind of increasing sophistication of doctors offices, all of that, it's not hard to see the major explosion being on the outpatient side because

the technology, by being more available on the outpatient side than it was in the prior period, made it possible to provide many more services to this population than before.

So it doesn't surprise me at all, the predominance of this. You said two of the 13 was inpatient, you said?

DR. BUNTIN: Right.

MR. MULLER: That's pretty consistent with the evidence we had last year.

MS. BURKE: Can I just follow up with a question, so that I'm certain that I understand how the data reads?

As Ralph suggested, there has been a change in the nature of services but also a clear movement out of inpatient settings to outpatient settings. To the extent, for example, that one sees an absolute move or there are things we can now do on an outpatient basis that we did on an inpatient basis, but they are not dissimilar, does that track as a new or an old?

And when you see a dramatic increase in the outpatient and a small increase on the inpatient, to what extent is the outpatient RVU use increase a reflection of those things have absolutely moved out of the inpatient setting?

DR. BUNTIN: I understand your question, but I can't

tell you the answer. I'm certain that some portion of that is due to things migrating from inpatient to outpatient, but I didn't break it down in terms of what things are -- were more predominantly performed on the inpatient setting in '93 and what percentage of them moved to the outpatient.

MS. BURKE: So the net effect is that we might see some of the increase in what is identified as new on the RVU side as the literal migration rather than actual move, or not?

MR. MULLER: A cardiac cath would still be existing in your classification, even if it's now done on an outpatient basis.

DR. BUNTIN: That's correct.

MS. BURKE: So it would be old, not new?

DR. BUNTIN: Yes, it would be old, not new. If the service was existing, regardless of where it was provided in '93.

MS. BURKE: So location wouldn't have had an impact on the definition of what is new?

DR. BUNTIN: Right, but it's yet another way in which the service itself, the technology may have changed to make it safe enough to perform in an outpatient setting.

DR. NEWHOUSE: That's why she's saying the new is a

lower bound.

MS. BURKE: Thank you.

MR. FEEZOR: Bob, I guess I was a little troubled by your assertion that maybe greater coverage might have been helpful, because I think in the mid to late '90s, and maybe Alice could bear me out, I don't think first off, the 10 categories of Medicare supplemental products didn't change in terms of any enhancement. The only thing that might have happened, in terms of product I think, would have been maybe some of those Med sup products may have gone to using PPO networks, but that probably wouldn't have changed the benefit structure. It probably would have simply been reflected in flatter price increases for a period of time.

MS. BURKE: Might you not have seen some change in financing? That is the availability of people to essentially purchase? You might not have seen a change in the product, but you might see an increase in the number of people because of their incomes.

MR. FEEZOR: I think income growth, which was the first assertion that I heard from Bob, I would totally agree.

MS. BURKE: But that could potentially track an increase in --

MR. FEEZOR: Greater access because there's less threshold because I'm richer. I can afford the product. Yes.

Melinda, fascinating study and I thought I was following along pretty well and then you threw me a bit of a curve. You made the difference, the significant difference of 40 percent in the Medicare enrollees that enroll in managed care versus the remaining fee-for-service. And in the summary, I had seen that basically the effects of managed care enrollment to be relatively small, something like less than 6 percent.

Help me understand those two figures.

DR. BUNTIN: Yes. So even though there's a large difference between those beneficiaries who enroll in managed care and those who don't, not very many beneficiaries --

MR. FEEZOR: So it doesn't matter.

DR. BUNTIN: When you look at the impact on the use of physician services as a whole, we said it only accounted for about 6 percent of the increase in expenditures. The reason is because of the small numbers of people migrating into HMOs.

DR. NEWHOUSE: Let me try to work down Bob's 85 to 90 percent is existing. First, on the income effect, the income elasticities in the literature are around .1 to .2, max .4. So

a 10 percent increase in income leads to a 2 percent increase in spending. And that would be real income change. So when we're looking at a 30 percent --

DR. REISCHAUER: [off microphone] Those aren't for the ultimate elderly.

DR. NEWHOUSE: Some of it may be. I'm sorry, on the income elasticities.

The issue, you're going to have a much bigger increase in income among the elderly than I think existed to try to account for an appreciable portion of 30 percent change.

Then, on the supplementary insurance side, two points. One is I thought it was actually on balance eroding.

And second, I'm sure post-'98 it's eroding. But the volume increases are continuing to occur, which seems to me to favorite the kind of interpretation Melinda gets to. And also, income growth is presumably slowing in the later period.

What do you mean by adverse selection, Allen?

MR. FEEZOR: [off microphone] Those who are --

DR. NEWHOUSE: That's right, so it might be a smaller change than you would otherwise expect, but the people that are -- still on balance there's a fall.

DR. REISCHAUER: But after 1997 it begins to fall.

MR. HACKBARTH: In fact, could you go to the slide actual per capita RVU use 30 percent higher than predicted? It's page six.

DR. NEWHOUSE: We wouldn't be going through these cuts in fees if the volume wasn't increase, right?

MR. HACKBARTH: I just need a bit of explanation on this. I didn't get the deflated RVUs, so if you could just explain that again to me. And then what you make of the change in the trend.

DR. BUNTIN: The change in the trend occurred right about the time of the five-year review, so that's when there's real divergence. That's when there's a wholesale change in the number of RVUs allocated to services. They took a comprehensive look at the fee schedule and made a large number of adjustments. And that's why they diverge in '96.

Let me go back to explain the deflated. There was a fee schedule that was implemented in 1992, the RBRVS. It assigned a certain number of RVUs to every service on that fee schedule.

Over time that fee schedule was changed based on recommendations of the AMA RUC panel to CMS. So for example, a standard office visit even got an increase in the number of

RVUs allocated to it during that five year review because they thought that it took more time and effort to see patients in that later time period.

So what I did was I took the services, I took the codes that were billed for in 1998, and I deflated them back to the number of RVUs that would've been assigned to them had the 1993 fee schedule been in place. So that's the deflated RVUs.

MR. HACKBARTH: Now go back to the first point again about the change in the trend and what you make of that?

DR. BUNTIN: You're looking at the fact that the yellow and the green lines on the slide are tracking together until we hit 1997, when they start to diverge.

MR. HACKBARTH: Just focus on the yellow or the green. Both are increasing steadily and then level off or turn down individually.

DR. BUNTIN: Yes. So the line that's diverging, the yellow line would be an increase in the use of existing services over time. So that yellow line is reflecting the fact that people are getting more and more office visits and bypass surgeries and things that existed in 1993.

MR. HACKBARTH: But it's closer to the predicted RVU use based on the demographic characteristics in 1998 than it

was in 1996?

DR. BUNTIN: Yes.

MR. HACKBARTH: As opposed to the preceding years where it was steadily diverging?

DR. BUNTIN: Yes. So why is it trending down there?

MR. HACKBARTH: Yes.

DR. BUNTIN: I think that part of the trending down is due to some substitution for these new services. But why exactly the green line is going down in the last year? I don't know the answer to that. There was some slight decrease in the use of physician services in 1998 as opposed to 1997.

MR. HACKBARTH: Any other questions or comments?

MR. MULLER: Could that have been the BBA effect?

DR. BUNTIN: Not that I can think of.

MR. MULLER: That was the first big hit.

DR. MILLER: This is unit you're looking at.

DR. NEWHOUSE: BBA on Part B was pretty generous in 1998. Those were the growth years.

MS. BURKE: Glenn, can I just ask one more clarifying question? I just wanted to go back to your explanation of why, under the prediction there was in fact a decline. And the discussion, at least it appears on the face of it to me to be

counterintuitive. One would have assumed as that age cohort got older that that line would, in fact, even on the prediction, have continued to increase rather than decrease. Why is that counterintuitive to me and no one else?

DR. REISCHAUER: [off microphone] -- younger.

MS. BURKE: But you have a large percentage who are the old.

DR. REISCHAUER: This is a standardized question.

DR. BUNTIN: This is the average beneficiary, so let me go over this one more time. Part of that decrease is, in fact, due to the age and gender. You would say yes, there are more of the oldest old.

The interesting thing is those 85-plus people actually use fewer physician services than the younger cohorts, than the younger old. And that's what we're seeing.

MS. BURKE: That seems counterintuitive to me.

MS. RAPHAEL: You also said that disabled people use less physician services, at least I thought I heard that.

DR. BUNTIN: Yes. This is holding other health conditions constant. So a disabled -- what does that mean?

MS. BURKE: I don't understand what that means. Holding constant other conditions if you're disabled?

DR. BUNTIN: So if you are a patient with a heart condition and you're younger than 85, you're actually going to get more care than if you're older than 85. That's what I mean by holding conditions constant.

MR. HACKBARTH: So they do less to the oldest patients?

MS. BURKE: For that condition. But overall, does this also suggest that the old old use fewer services?

DR. BUNTIN: Yes.

MS. BURKE: That seems counterintuitive to me.

DR. BUNTIN: It's consistent with the literature on less aggressive care towards the end of life for people who are older. So the same person dying of cancer at age 75 might get more aggressive care than an 80-year-old.

The decrease due to change in health status is consistent with some literature, for example, produced by Ken Mantin about declining disability among the elderly.

MS. BURKE: That's certainly true, that there is a decline. That I agree.

MS. RAPHAEL: So could these predict that as we have a larger percentage in the over-85 population, that we would have a decline in the use of physician services in the future?

DR. BUNTIN: I think that that would be extrapolating beyond the data for a whole host of reasons. And there's actually an interesting article that came out in the New England Journal yesterday which starts to look at some of these subjects.

It's an article by James Lubitz and he looked at persons at age 70, what their remaining life expectancy was and what they're remaining projected expenditures were over that life expectancy. And found that persons who were either sick or healthy at age 70 had approximately the same remaining expected health expenditures. So the people who are sick at age 70 were expected to live a shorter amount of time but spent about the same amount as those who were also expected to live longer.

MR. HACKBARTH: We're going to have to move ahead unfortunately. Kevin, what are our next steps on this, and when do they need to occur?

DR. HAYES: Our next steps on this are to submit a comment letter to the Congress by October 15th. And our rough sketch of that letter would include these points, that we've reviewed the study, that it shows some small effects of some factors on spending for physician services. Measuring other

effects is difficult, factors that would include technological change.

In general, we find that the results would complement the work that the Commission has done on growth and variation in use of physician services. It seems that all of this is in the mode of where we are answering some questions but more questions are coming up. And so clearly, we need to do some further work and we plan to do so in our June report.

That's kind of the key points that he would want to make in this letter. And if there are any others that you think we should include, we would be happy to do so.

MR. HACKBARTH: Thank you very much. Thanks, Melinda.

Now we turn to our panel on growth in volume of physician services. We have two guests. Kevin, you'll do the introductions?

DR. HAYES: I will.

So just to set this up, we view this panel discussion as a way of kicking off our work on a chapter for the June report on growth and variation in use of physician services. This would be a follow-on to a chapter we had in the June 2003 report. And you'll recall from that chapter that we considered

a couple of important issues.

One of the findings in that chapter was that we saw much variation geographically in use of physician services. And in interpreting those findings, we looked at the literature on the subject. In that literature, of course, we see some questions raised about whether that variation represents some unnecessary use of physician services and health care services in general in the health care system.

Another finding in the chapter was rapid growth in use of some services, such as imaging and tests. And there, when we tried to interpret those findings in terms of the literature, we quickly came upon this issue of technological change, the benefits of technological change, and how that has occurred with respect to a number of specific health care conditions.

And so putting those two findings together, and in trying to think about how Medicare payment policy might change, we see a dilemma here, a need to address what appears to be some waste in the health care system. And at the same time, if we're going to do something with payment policy, we need to do it in such a way as to protect and promote and so on the beneficial technological change that is obviously occurring.

We have with us today two panelists who have done research, much research, on these topics. They include first David Cutler, who was a professor of economics at Harvard University. And we also have Elliott Fisher, who is a professor of medicine and community and family medicine at Dartmouth Medical School and also a general internist at the VA Medical Center at White River Junction in Vermont.

And so, with that, I will turn this over to them. Elliott will go first. And what we're hoping is that we have presentations by the two speakers, questions and discussion to follow the two presentations.

MR. HACKBARTH: Welcome. We're familiar for me with your work and find it fascinating.

DR. FISHER: A pleasure to be here.

I'm a Mac person, so we may have to get David to drive over here.

I'm going to try to share some insights from our work on geographic variations to help us think more critically about the causes of what we saw in our prior work, that is that there are regions of the country where there are both high cost and poor quality at the same time. That's consistent with the work in your chapter looking at the variations at the state level in

quality and cost.

What I'm really going to try to do is very briefly go through our recent studies, share some data now based on analyses of national physician surveys done by the Robert Wood Johnson Foundation that are in a paper that we're preparing for submission. Anyone in the audience, don't cite it yet, please.

And then I'll think about how payment policy might help.

You're pretty familiar with our study. We don't need to go through it. We looked at about a million Medicare beneficiaries. We took advantage of the natural experiment that folks are living in different regions of the country which practice in different ways, in terms of the overall intensity of care in those regions.

This is a map of those regions. What you see is the red areas spend, in terms of the intensity of services and in terms of Medicare per capita spending, are about 60 percent higher in 1996 than the pale areas. This is exactly the same ratio that you see if you look at the data in terms of price adjusted spending, in terms of using RVUs and DRG weights as has been done in the previous speaker's talk.

The differences in spending are remarkably consistent

across time. That is by 2000 it's still essentially a 60 percent difference.

Those population that we studied were really very similar in terms of their health status across the five colored areas, the five levels of intensity, quintile one being the lowest spending, lowest practice regions. And quintile five being the highest.

This graphs the predicted one-year mortality based on the clinical data that we had for each of these cohorts. And you can see that it's basically flat.

Let me summarize the findings, and I think it's the findings in the content and process of care that I really would draw your attention to and will come back to in the last bit of the talk.

We classify, we being at Dartmouth, and I work with Jack and John Skinner and others. We find it useful to think about three categories of care. Effective care, that is those things that we know really work in medicine and that all patients of a specific clinical type ought to get. Aspirin in the setting of the heart attack would be a classic example. Or a flu shot for an elderly patient.

Effective care, when you compare the rates of

effective care in the highest compared to the lowest spending regions, you see that actually they're doing a worse job in the higher spending regions. That is on four of the six measures of cardiovascular quality of care drawn from the Cooperative Cardiovascular Project, care is slightly but significantly worse. And three of those four preventive measures that we have are worse in the higher spending regions.

Much to our surprise, the same is true for preference sensitive care. That is that it's basically flat across -- unrelated to differences in spending. Preference sensitive procedures are those which are discrete clinical interventions of well recognized benefit to patients where we argue because there are tradeoffs involved, that patients preferences are involved, and patients differ in their preferences for taking medication as opposed to the risks that may be associated percutaneous coronary interventions, that patient preferences should drive the decision.

Carotid endarterectomy would fall into that category. There's a risk of stroke at the time of the procedure. There's a choice that patients have to take aspirin or other platelet aggregation inhibitors. They ought to be presented a choice.

Remarkably, spending more, at least across geographic

regions in terms of Medicare, does not result in more of these specific kinds of services. So they're not getting more of these discrete clinical interventions.

What are they getting? They get what we call supply sensitive care. These are services, these are fuzzy sets we admit, but it's things like visits, hospital stays, time in the intensive care unit, which have long been recognized to be strongly associated with a level of that particular resource in the community where the patient is receiving their care.

This just summarizes some of the data. If you look at the differences in spending, office visits are 40 percent higher in the highest compared to the lowest spending region. Inpatient visits are 2.2 times higher. Initial specialist consultations 2.5 times higher. Again, 2.5 times higher in terms of the number of patients who are seeing 10 or more different physicians. I'll come back to that.

I think they're much happier in the high spending regions because there are many more psychotherapy visits there, which probably improves the quality of life.

The diagnostic cardiology procedures are done more frequently. Imaging tests are done more frequently. People get many more of the procedures that are done by specialists.

If you're having three times as many specialist consultations, you're more likely to get the procedures that a specialist would recommend because the specialist will want to understand and use the technology that they have at their disposal to try to work up the patient.

They spend more time in the hospital. And the overall intensity of care at the end of life is substantially greater. There are much higher rates of emergency resuscitation or the placement of vena cava filters, feeding tubes, and people spend about twice as much time in an ICU or a CCU before they die in a Philadelphia -- I don't know how many of you read the Wall Street Journal this morning -- as opposed to a Portland, Oregon.

This graph summarizes what I think is two important points. First, it reminds us, as you showed in your report in the spring, that most of the money is in evaluation and management services, imaging, diagnostic tests, and the minor procedures. Those are the upper four bars on the graphs.

The five groups of bars are the quintiles of Medicare spending. And what you see is there is a 5 percent difference, not shown on the slide, but the bottom blue bar which are major procedures, things like carotid endarterectomy, are only 5

percent higher in the highest spending regions of the United States than in the lowest.

The data is not shown there but the ratio for evaluation and management services is 71 percent higher. So there's substantially higher use of these imaging procedures, visits, diagnostic tests, and minor procedures.

Of course, the question is what does this lead to in terms of health outcomes and satisfaction? We actually looked. From the Medicare bene survey we had data on satisfaction. Folks in the higher spending regions are no more satisfied than those in the lower spending regions. There are no differences in the rate of functional decline in the Medicare population. And there's about a 2 to 5 percent higher risk of death in these chronic disease cohorts after adjusting for illness as best we could. But we had pretty good clinical adjusters in the higher spending regions.

So new data. What we see is higher spending in some regions of the country and worse quality.

Let me quickly go through the new data. I'm going to present a number of relatively disconnected observations and then try to put them together for you. As a clinician, trying

to understand what on earth could be going on that we ought to be thinking differently about. Why are costs higher and quality worse in some regions?

I'm from Dartmouth. We make a big deal about capacity. And it's pretty clear that there are more hospital beds and more physician in these higher spending regions. And at least in the data we've got so far, they're not great benefits that are being achieved from having more specialists, 65 percent more medical subspecialists, and 30 percent more hospital beds.

When we look at these two factors together, what you see is something interesting. This graph is complicated, but let me walk you through it. If you stratify the country, there is great diversity across the 306 regions that we have. And we can group regions according to the quintile of hospital bed supply within which they fall. That is, areas with the lowest number of beds per capita, that would be the front bar on the right, the front group of three bars. Those are all regions that are in the lowest quintile of hospital bed supply.

And if you go from the lowest to the highest quintile of medical specialist supply, you get about an 18 or 19 percent increase in the intensity of services provided. Measured using

DRG weights and RVUs.

If you are in the lowest quintile of medical specialist supply and give them more beds to work in, you get about an 18 percent increase in physician services.

At the back, though, if you're in regions that have the highest per capita supply of hospital beds in the country, and you increase the physician supply by just the same amount as when there are few beds available, here you get twice as much bang for your buck. Or twice as much buck for the bang, maybe is really what I meant to say.

That is, you spend 34 percent more with the same increase in physician supply if there are lots of beds around for us to work in.

I think, making up a story here, is it fits with what we've thought of as the role of the hospital as the physician's work place. In sociology certainly that's been well recognized.

It may make us much easier to work if we can do that work in the setting of a hospital where we can order more tests more easily, we can perform the procedures more quickly, we can order more consults more quickly.

Of course, to make it add up, you have to go around

the back. You get the same thing when there are lots of docs and you give them beds.

But the difference is exactly the difference we see in total per capita spending. If you look at these two factors alone, you get about 50 percent of the regional variation in per capita spending explained just on the basis of those supply factors. But that leaves 50 percent unexplained. So the glass is half full. It's an important factor. It's clearly not everything.

Here's some data from the physician survey of the community tracking study. And we compare the proportion of physicians in each quintile, we've assigned them based on their region of practice, to the same quintiles you saw before, so that we know that they're treating similar patients because the health status in the different quintiles has been shown to be similar.

And what you see is that a smaller proportion of them, 30 percent as opposed to 40 percent in the high spending regions, continue to offer primary care. It's a slight difference in the percent who are board certified or board eligible who are in practice.

There's a pretty remarkable difference, to my mind,

in the number who are international medical graduates in those bright red areas on the map, 11 percent to 36 percent. And the proportion who are in solo or two-physician practices is also substantially higher, about 50 percent versus 30 percent. All of these track along with spending.

There are a bunch of other things we looked at to try to understand with are the attributes of physicians in practice in these regions. You don't see differences in age or gender. They're paid in pretty much the same way. They report that productivity affects their compensation similarly.

Penetration of managed care is similar, revenue from Medicare and Medicare are relatively similar. There is a 5 percent absolute difference, 40 to 45 percent, in the proportion of docs who say they have some role as a gatekeeper, primary care docs who say they have some role as a gatekeeper.

Thankfully, the Robert Wood Johnson Foundation including vignettes to let us understand whether physicians really practiced differently in these different regions. And what we see is there are six vignettes. One of them was whether you would refer a 50-year-old man with two millimeters of ST depression on his exercise test to a cardiologist. And it's surprising that some people wouldn't refer everybody. But

everyone's close to 90 percent.

But there still is a trend toward slightly more propensity to refer in the higher spending regions.

But for every other one of the vignettes, the differences are pretty dramatic and significant and clinically important. At the bottom there, the notion that a monogamous woman who calls, who has had yeast infections in the past, and now reports a yeast infection and you say you need to see them in your office rather than tell them to go to the pharmacy and pick up the appropriate over-the-counter medication for at least a trial, it's 60 percent of docs. 57 percent of docs in the higher spending regions will suggest that they have an office visit, as opposed to 45 in the lower spending regions. Greater propensity to intervene, to refer.

There also are some information about their perceptions of practice. They were asked I can make clinical decisions in the best interests of my patients without the possibility of reducing my income. 74 percent in the lowest spending regions, but it was 69 percent significantly different when you look at the test to trend.

The complexity of patients I am expected to provide care for without referral is greater than I'd like, 19 percent

versus 31 percent.

A consequence, I think, of what we see is that the biggest difference in practice patterns that I believe we see is that it's about 17 percent of heart attack patients who see 10 different physicians in the first year after their heart attack in a lowest spending regions, but it's 31 percent in the highest spending regions. Who have 10 different physicians involved in their care.

Another consequence is they were asked about level of communication, whether it was adequate to support high quality care. The primary care physicians were much less likely to report that communication was adequate. Specialists were less likely to report that communication with primary care physicians was adequate. And they were less likely to say that it's possible to maintain the kind of continuing relationships with patients over time that promote the delivery of high quality care.

This is the one that David is going to have to explain to you. I'm not an economist, I'm a clinician. I'll make up a story about it and then David can help us think more clearly about it.

Physicians were asked could they obtain elective --

who thought they could obtain, when needed, elective hospitalizations, adequate length of inpatient stays, or high specialist referrals. Recalling that the highest spending regions have 30 percent more hospital beds per capita and that the populations have similar health status, they were much more likely to say they were having a hard time getting these services. They were having a hard time getting high quality specialist referrals, even though there are 65 percent more specialists.

Let me try to make up a story based on my clinical experience and how I look at this, to see if we can work our way out at least of the problem of why spending is higher and why quality may be worse in these regions. I think part of the story is obviously greater capacity. My explanation for why they perceive more difficulty getting inpatient stays is that there are more physicians, relatively, competing for -- yes, there are more beds. But there are relatively more physicians per capita in the higher regions than the compensatory increase in beds. So they're competing more for the available resource, because primarily there are more docs.

Fragmented care. It is pretty clear when you have 10 different physicians involved in a patient's care that it's

going to be tough to have communication work or to ensure that we're doing the right things. Physicians are in small groups. There is a higher propensity of specialist care. And there are incentives for fragmentation in these higher spending regions.

If you pay on the basis of visits, you're going to get more frequent visits. And I think it's possible that the reason we see physicians wanting to refer patients more frequently, feeling constrained that they are having to manage patients without referral is that gee, if you're having a hard keeping your income up, when a patient develops a new problem, the easiest his way to manage that is you continue to manage the high blood pressure but let's get the joint pain taken care of by the rheumatologist in an evaluation there.

If you're very busy in your office, one of the ways of getting out of it with frequent visits is to say I've got a five-minute visit, I don't have time to talk about that, let's have you see the specialist. So I think there are some incentives for fragmentation that are present throughout but that are easy to address in a high spending region than in a low spending region.

Clearly, there's inadequate infrastructure throughout health care. But in two pursue groups or a single person

practice, there's no way to communicate effectively with the other specialists that you're referring to other than typing a letter to them, which is really inefficient, even dictating a letter. Larger group practices are much more likely to have the information systems that support effective communication among physicians.

This is a whole literature on the coordination of care and how we improve quality in care, which is pretty well developed by showing that you need physician groups of a certain size in order to invest adequately in improving the information infrastructure.

And are incentives under the fee-for-service system, that most of these guys are operating under, reward quantity.

That suggests some general approaches. Reduce excess capacity, promote care coordination, improve infrastructure, and reward quality.

How can we help? How can payment policy help? We put out in the Health Affairs article last February the notion of comprehensive centers of medical excellence focusing an organizational accountability for costs and quality. I think it's quite possible, and we've got some data that now suggests this pretty well, that hospitals and their affiliated medical

staffs could form accountable units that could be held responsible for the cost and quality of care provided by that medical staff and to the patients who receive care there.

Most patients are highly loyal, especially once they develop serious chronic disease, are highly loyal to a hospital and to a care system. And then if that's true, we can measure the performance of these organizations on all of the key dimensions. We can reward patients for choosing them, reward were successful organizations.

Knowing what we know about capacity, the problem will be whether we in the United States can ever allow inefficient, low quality organizations to fail and close shop.

The fee-for-service system, a few suggestions, and these are just trying to think about what I saw, what we've seen in the data. I think to reduce excess capacity, CMS has some tools. It is remarkable that the red areas are where there are, in the country, the red spots, the hot spots are where there are a lot of residency programs. New York City trains lots of residents and I think they want to stay there.

So we need to think of some way of reforming graduate medical education to slow the growth, perhaps of the medical specialist work force. I'm not sure we need as many medical

specialists as we have. But especially to restrain the growth in areas that already have high physician supply and where care is already fragmented. GME payments might be used to do that.

I think we have a problem of lack of primary care coordination. In our medical school fewer and fewer students are going into primary care specialties because the income disparities are so great. It's something to think about.

And then I think you could conceivably use the payment system to reward consolidation and downsizing in the hospital industry.

How can we promote care coordination and reduce fragmentation? I think rewarding the development of integrated medical group practices is something that is feasible to consider adding to payment system. I'm not sure how you do it, but that's why we're all here, to think about how you might do it.

I think we should develop bundled payments for care coordination, creating a payment bundle to support primary care, additional incentives that fosters better communication among physicians, and between physicians and patients. For instance, by paying explicitly for shared decision-making, reward patients for working through their primary care

physicians somehow. The copayment structure could be different.

I think you have to create incentives for specialist generous collaboration rather than specialist/generalist fragmentation. Pay a specialist for initial evaluation only, not ongoing follow-up, but perhaps pay them to talk to the primary care physician.

And then improving the infrastructure and rewarding quality.

I'll stop there. Those are some of the ideas and I'm sure we'll have a chance to talk about them.

MR. HACKBARTH: I'd propose that we allow David to make his presentation and we can have our discussion. David, do you want to go ahead?

DR. CUTLER: Thank you very much for inviting me here. It's a pleasure to be here. I'm going to start off by disagreeing with most everything that Elliott said.

MR. HACKBARTH: That's what we're looking for.

DR. CUTLER: But actually the most bizarre thing is, at the end of the talk I'm actually going to wind up at the same place he did. So one of us is taking the high road and one of us is taking the low road, but I'm not sure which is

which.

So let me start off by just summarizing where I think Elliott left things. I actually don't disagree with any of the facts that he gave, that areas that spend more don't have materially better outcomes. That seems fairly clear. That there's direct observation not a lot of care is provided in settings where it's not needed or it's overprovided, that the total amount of overspending, according to estimates I think from Elliott and Jack Wennberg and John Skinner, perhaps 20 percent of Medicare spending. So the implication has been that payment policy should focus on restraining costs in high-cost areas, although that's not so much what Elliott focused on and that distinction is something that I want to come back to.

But I want to take a different road to get there is by saying, it's true that when you look at different areas over time, areas that spend more don't seem to get anything for it in terms of effective outcomes, health has improved immensely over time and medical care must have played some role in that. So I want to try and talk about that and to tell you what it is that I think we know from that and what we can conclude from that.

So I want to start off just by telling you a bit

about trends in health. Obviously the people here know this, if anything, better than me so I'm going to go through this fairly quickly, in two dimensions. Mortality is the easiest. With the exception of certain professor friends of mine, you can generally tell if someone is alive or not. Whereas quality of life -- please don't repeat that to anyone. Whereas, quality of life is a little bit harder, but I'll tell you about some of those measures.

So mortality has declined immensely. The average American at birth lives about eight years longer than he or she did in 1950. That continues a couple of centuries increase in life expectancy; truly dramatic changes. At the same time, and this came up during Melinda's talk this morning, on an age-adjusted basis this is the share of the elderly with substantial impairments in either personal or living functions. So these are things like they can't feed themselves, they can't do their own toileting or bathing, they can't manage their own housework, things like that. It's declined by about 1 percent to 1.5 percent a year. So it used to be one in four elderly people had these impairments and now it's about one in five. The only question is whether it's speeding up or whether it's just a relatively common decline.

So by essentially all measures, people seem to be in better health. The question is why.

To tell you a little bit about that I will pick one particular example, which is cardiovascular disease. As I age this becomes increasingly more relevant to me just from personal use. The other advantage of looking at cardiovascular disease is that there's been a very large reduction in mortality over time. The red line up at the top is cardiovascular disease mortality which has declined by about two-thirds in the past half-century. The green line just a little bit below that is cancer mortality. In early 1970s, by the way, was when we declared war of cancer, which did not have such a major impact on cancer mortality. Then you can see all the other causes way down at the bottom are things like AIDS. We may soon declare war on heart disease and God help us then.

So let me tell you about cardiovascular disease. Since there's clearly something going on, one wants to understand what it is. The first thing to do is to translate that number. The typical 45-year-old will live about 4.5 years longer now than in 1950 simply because cardiovascular disease mortality has declined. That's almost all of the improvement in longevity conditioned on reaching age 45 or so. Not that

that's the only thing that people die of, although it is the leading cause of death, but that's virtually the only one that has changed for people of that age.

At the same time, that person will spend a lot more. A fairly conservative estimate is that in present value added over the remaining life, the typical 45-year-old will spend about $30,000 more than he or she used to on care for cardiovascular disease. That includes the low-tech things that Elliott was telling you about. That includes various high-tech things. Averaged in there are the people who will die of cancer and not spend anything on cardiovascular disease. So there are a bunch of zeros in there mixed in with some people who will spend several hundred thousand dollars.

So what I want to basically do -- you know, I'm an economist and economists think about costs and they think about benefits. Occasionally they think about money, but more generally costs and benefits. So what I want to do is evaluate whether those costs and those benefits, how they play out.

The first thing I need to do is to tell you a little bit about that 4.5 years and what that came from. So there's some analysis that I've done. Let me just give you the bottom-line conclusion, which is that my guess is about two-thirds of

those 4.5 years are a result of medical intervention. I'll just give you, rather than going through gory details of analysis I will give you two examples.

Franklin Roosevelt died in the mid-1940s. He died of a stroke. The reason why he had a stroke is because his blood pressure was at levels that are completely unheard of today, somewhere well above 200 and somewhere around 160 or 170. If you ask why he wasn't treated, it's because there was nothing that could be done about it. The leading therapy at the time -- there were some drugs which you basically had to be hospitalized to take because you got injections several times a day and they had all sorts of side effects, or else they would cut the nerves to the blood vessels so that the blood vessels wouldn't contract so much. Or else they used fever, because it seemed like when you're focused on your fever you weren't so worried about your blood pressure. At least that's as best as I understand the theory.

So he basically died for

DR. ROWE: You went into the right -- you made the right decision about a career in medicine versus economics.

[Laughter.]

DR. CUTLER: My former dean at Harvard -- you'll know

why I'm thankful he's my former dean, once said that if you stacked all the economists in the world end to end, that would be a good thing. I imagine the typical patient feels the same way.

[Laughter.]

DR. CUTLER: So I think we could cure him for about 20 cents a day today.

Dwight Eisenhower had a heart attack in the mid-1950s. He was visiting Denver at the time. The standard medical therapy was to keep the patient flat on his back in bed for six weeks; literally in bed six weeks. Gingerly transport the patient home, where he would stay in bed for six months. He would essentially not do anything productive the rest of his life. They actually brought in the world's most famous cardiologist to consult on this, a fellow named Paul Dudley White, who was one of the founders of the American Heart Association, and he experimented with a novel therapy for President Eisenhower. He allowed him to sit up. But the patient did not respond well so they went back to the traditional therapy for him.

Now Dwight Eisenhower seemed to recover fairly well. If you want to know what would happen today were he to have a

heart attack, you should just ask Dick Cheney because he's had most of the things that you would do several times. The way that Dwight Eisenhower was treated would now be a malpractice suit. It actually turns out to be counterproductive therapy because you develop blood clots and things like that. So these are the sort of examples, the kind of intensive care both in the inpatient setting right after an acute event -- that's Dwight Eisenhower -- and the therapy outside of that, the Franklin Roosevelt care and the care for people with high cholesterol and other risk factors. Together that adds up to a lot of money, but a fair amount of the health improvements.

Then there's the remaining one-third which I attribute to various behavioral interventions. Not that those are independent of medical care, for example, doctors advising people about things and the Surgeon General advising people about things, but a somewhat different class of things.

So you get about three years out of that. Then the question is, are those three years worth about $30,000? Let me go fairly quickly through the answer to that. The example I want to give you is, are you willing to pay $300 for an airbag in a car? If you are, given the probability that an airbag saves your life, you value your life at about $3 million,

because about one in 10,000 people will be saved by airbag in their car. So if you're willing to pay $300 to save one in 10,000, that's like paying $3 million to save one person.

It's easier to think about in terms of years of life, so for a person with 40 years remaining, that would be somewhere about $75,000, or let me take as a rough benchmark, a year of life is worth about $100,000. These are the kinds of numbers that people put -- for example, EPA puts when it does what would be the value of clean air improvements. You don't see this so much in court cases but in a lot of situations where you say, how much do you have to pay people to work in very risky jobs compared to safer jobs? You have to pay them a wage premium because people don't want to be exposed to risk. How much does that premium turn out to be? It turns out to be something like on this order of magnitude, how much are people willing to pay for safety devices.

You can do it with or without the numbers. You can ask yourself whether $30,000 would be worth an additional three years or you can take my estimate of the value of if. But one way or another it seems fairly clear that all that stuff has been worth it.

I estimate a return of four to one. That is not a

return of 4 percent but a return of 300 percent. For those of you more comfortable with numbers than patients, that's a fairly high rate of return. All that's saying is that people are valuing their health quite a lot and when you develop ways that can improve health, people feel very happy about that.

I've done that for a bunch of different things. This is not all just me but a bunch of researchers. In all sorts of cases where you look you can see -- the cardiovascular disease example is the first row. I focused with Joe Newhouse on some of the heart attack stuff. In the second row there's some things on low birthweight babies. There's stuff about treating more people more aggressively who have depression; cataracts done earlier, at an earlier stage with increased visual acuity afterwards. Breast cancer and certain of the cancers are the only ones for which it's not obviously worth it, where we spend a lot more and it's not so clear we're getting much more. You can see that in the line that I showed you earlier.

But in the vast majority of cases we spend much more money than we used to. Why is that? It goes back to what Melinda was saying, because we do more stuff for people. It's not that we're actually spending more for the same thing, it's that we're doing more things for people and that stuff turns

out, on average, to be worth it. I emphasize the on average because that's a key part here.

But people are valuing their health highly, so when we develop new ways that people can improve their health they like to take advantage of that, especially when it's other people's money, but even, this suggests, when it's their own money.

So what about all the waste? Let me come back and link up to what Elliott was telling you about. Elliott was focusing on some of the overuse of care. I gave the CABG example, although he was pointing out several other cases with less intensive care that are substantially overused. There's also an enormous amount of care that's underused. If you take all the people with hypertension even today, more than 50 years, almost 60 years after Franklin Roosevelt died of hypertension, only one-third of people with hypertension are successfully controlled. Then there are all sorts of medication errors which generally fall in the category of misuse of care. That is frequently the misuse of care. That is stuff that should be done but not on that patient, or in the wrong setting or something like that.

Here's how I want to propose thinking about it, which

is that traditionally the waste and value have gone together because of the way that we have reimbursed things. So I want to come into the payment policy, where you couldn't get rid of one without getting rid of the other. So I want to make a distinction here between the intensity of services and the value of services. The intensity is how much medical stuff is in it, ranging from the stuff that I could almost do, to the stuff that Jack Rowe wouldn't be caught dead having me do for him. Then the value of services being the things that's are really quite worth it, on the right, and the things that have relatively low worth on the left.

I wanted to think about different types of therapy. So the first one which is up here is things like health promotion, followup and monitoring dealing with patients who need referrals, or who need something very routine that even I could do. Relatively low intensity, frequently very high value because people have such difficulty using the system. That's one of the themes that comes out of Elliott and others' work.

A little bit further down are things like chronic disease management, figuring out what sorts of medications people with high blood pressure should have, what sort of screening tests, making sure that mammograms are read

regularly. These are more intensive than Jack would want me doing, but not intensive enough to really need too much of Elliott's time.

Then down at the bottom are the various types of fancy things. So there's episodic acute and chronic care dealing with, let's say, surgery for people with severe coronary artery disease, or various kinds of heroic interventions that Elliott was telling you about. Those things are very, very intensive and they're sometimes valuable, sometimes not. Traditionally the regional disparities literature has focused down there, although it's increasingly starting to focus on some of the other things.

Now let me talk a bit about how payment policy fits into that. The traditional reimbursement system was basically a box like the green box that highlighted the stuff towards the bottom half of this figure. It said, look, if something is very intensive we'll pay more for it. It gets a higher RVU. The doctors will get a lot of money for doing it. And if something is less intensive, we either pay for it only very poorly or not at all. For example, having the nurse call the patient to check up on something is actually not an RVU code at all. You cannot get reimbursed for it.

I asked a bunch of doctors why they don't e-mail their patients and the most common answer is because I don't get paid for doing that. Not that it's technologically difficult. In fact I know one insurance company that wanted to -- one HMO that wanted to set up e-mail communication between the doctors and the patients and the only thing they couldn't figure out was how do you get the e-mail to work so that only those companies that are willing to pay extra get to e-mail, their patients get to e-mail the doctors and you keep the other ones from being to do it because they weren't going to get paid for those other ones. So it's all an issue of money there.

If you think about that green box, that corresponds remarkably well to what was done. So down at the bottom right you have the very high intensity stuff that's worth it. That's the development of the surgeries for the heart attack patients, the development of the new pharmaceuticals to prevent risk factors and so on.

Down at the bottom left you have the things that Elliott was telling you about, the high-tech stuff that's wasted. Those are the ICU days and people who don't need it, the intensive interventions at the end of life for people who really would rather die quietly at home, the various other

kinds of things. Those all count the same, or as I think about it, there are only two industries in the economy where you get paid for what you do, not how well you do it. One is health care and the other is primary and secondary education. It's no coincidence that those are the two parts of the economy where we worry the most about the quality of the services that we're getting.

A little bit up you had the disease management things which were reimbursed sort of okay. Seeing a doctor was generally reimbursed okay so you got to see a doctor. But the stuff above that reimbursed horribly so you didn't get very much about that at all. And the kinds of care coordination or lack of care coordination that Elliott was talking about fall in that upper category, and if you just look at the green box it's no surprise about that.

The thing that strikes me the most as an economist looking at health care is how important green boxes are for what's done, instead of -- in addition, perhaps, to medical textbooks. So the first we tried to do to change this is we decided to move the green box up a little bit. We'd make it a bit tougher to get reimbursed for the fancy stuff in managed care plans and we'd create a few more incentives to see the

doctor in primary care settings by reducing the copayment rates, although we wouldn't actually give the doctor any time to see you. So it wasn't quite such an effective incentive.

We got basically what the shift would tell you, which is doctors tell you it's a little bit harder to do the fancy stuff, and they'd like to do a bit more and their patients would like to see a bit more of the other stuff, but fundamentally not enormously big changes. That's exactly what this kind of shift would suggest. As long as all we do is focus on moving the green box up and down that's all that's going to happen is we're going to add and cut out more valuable and unvaluable services. We're going to have them go together because that's fundamentally what the incentives are doing.

I think what we need to do is not actually shift that box up and down but to rotate it, and to think about a payment system that's not independent of the quality of the services but that's very much dependent upon the quality of the services. So trying to distinguish amongst all that fancy stuff and amongst all the disease management stuff and say, look, those things that are contributing the most to improve health will get reimbursed more.

This is picking up where Elliott came out, which is

rather than just saying -- and I think to great credit of him and his colleagues, rather than just saying, look, we know that services are overused in Miami, let's just take money away from Miami. They said, we know that there's high-quality stuff. Let's figure out how to pay more for the quality stuff. That's the implication that comes out here too.

There are various sorts of measures here. There are process measures, which might be appropriate for a particular physician such as screening, testing, use of effective services. There are actual outputs which may be at a somewhat more aggregated level. One would want to think of groups of doctors or potentially hospitals, or insurance plans as a whole. There are measures of patient satisfaction. I don't have a worked-out scheme here, but it's the concept that I think is the most important here, which is trying to introduce at least some payment based on that. Some of these things look actually quite familiar to what Elliott said, which I take as a good, not a bad thing. That is whenever an economist can agree with a doctor I think the world is probably happier, at lease the economist is happier.

So if I were doing something in the Medicare payment policy realm it would be to think less about the intensity of a

particular RVU setting and more about the distinguishing sum -- taking a vertical slice rather than a horizontal slice and thinking some about what do we know about the quality of the services provided and how do we reimburse at a higher rate potentially through some kind of bonuses the higher quality care.

So as I said, it's a different road actually winding up at a fairly similar location. I'll stop here.

MR. HACKBARTH: Okay, let's open it up for discussion. David and Elliott, feel free to leap in at any point. Don't wait for somebody to direct a question to you. We're here to hopefully share in your expertise, so at any point.

DR. ROWE: First of all, thank you both. This is extraordinarily high protein content and really a pleasure for us, and in addition, very relevant to what we're doing here, so wonderful to have you guys. I have just a couple questions.

Elliott, I wondered a couple of things, and I've spoke with Jack about this in the past but I don't recall exactly where it came out -- whether or not you had data with respect to physician extenders? Because it seemed like the bigger doctor groups were in the lower cost, higher quality

areas, and the more onesies and twosies were in the others. The way I interpreted that is they were more likely to have the advanced practice nurses who were in fact going to handle that phone call from that woman with that fungal infection and tell her to go to the pharmacy rather than -- because the larger practices have a little infrastructure and what have you.

So I wondered if you had data with respect to -- I just have three questions for you. One is data on physician extenders. Then I have one question for David.

The second is whether you have data on capitation. California is the last area where physicians are really willing to take capitation these days and California didn't look like a particularly pale state on your map. That might tell you something, or not tell you something about funding mechanism and the surge -- puts the surge in and you might expect it to be a relatively low-cost area and it doesn't seem to be.

The third question is whether you had data for the VA? Since the VA is a national program, you work at the White River Junction VA with John Lawson and others, it's a national system but the funding is kind of uniform. The physicians don't have those economic incentives. Do you really have in the same areas that you have deep red, do those VAs have more

cardiologists and more referrals, et cetera, or do those VAs behave differently? Because that would be -- I thought that would just be intuitively an interesting observation. So those are my questions.

DR. FISHER: Great questions. We don't have data on physician extenders I'm afraid. The Robert Wood Johnson survey does not, I don't believe it has questions about it, but it's an important question. Clearly, one of the advantages of the larger physician groups are exactly there are more people around to answer phone calls, they're much more likely to have electronic medical records, they're more likely to have chronic disease management systems in place. Tony Cassolino's work has shown pretty well that those are factors -- physician group size is associated with those factors.

So, no, we don't have that data but I would not be surprised if some of the reasons that the areas are able to maintain their low cost and perhaps higher quality is that there's little bit more invested in those factors. Although we do have from the survey, now as I think about it, measures of the relative preponderance of those quality measures such as electronic medical records, physician reminders, chronic disease management. Those are pretty similar across areas in

terms of the proportion of physicians reporting having them.

The second question was about California managed care capitation. It is interesting to look at California. Northern California is a pale area and Southern California is a bright red area. The proportion of physicians in the RWJ data who report receiving some payments via capitation is relatively similar across regions of different intensity, different practice intensity.

The third question is about the VA, which is really very interesting. There was a paper by Carol Ashton and Melda Ray looking at regional variations in VA hospitalization rates for patients with chronic disease and they found, not surprisingly, the VA system has variations in the service use across the regions, the 23 service regions of the networks that are currently in place. Those differences are pretty similar to the differences you see in the Medicare population.

There are two competing explanations for the similarity. One which they put forward was that doctors are taught a practice style by their residency programs and this is what's going on. The other is that it also happens that, by and large within the VA health care system, the areas that have lots of VA hospital beds and staff are in the old industrial

Northeast where the population of veterans has declined. So Jack Wennberg's response in the editorial about the Ashton piece was, yes, but supply is important.

I think we'll end up discovering -- and this is conjecture, no evidence yet -- that the culture that evolves in a community is driven both by the numbers of docs and how they learn to practice, and then by the training effective coming into that system.

DR. ROWE: One question I had for David, kind of a high-level question. You look at cardiovascular disease, myocardial infarction, low birth weight babies, and you look at these improvements in disability and the cost and you say it was worth it, and it's hard to argue with that. But implicit in that is it's worth doing it again. That is, we made the investment, we had all these improvements, look what we got. We got 400 percent return. Therefore, you make the same investment again you're going to get another 400 percent return.

It seems to me that there is a limit to life expectancy. That there is a limit below which you're not going to go in disability. There is a limit in low birth weight infant mortality below which you're not going to go. Therefore

we shouldn't necessarily assume that we can replicate this very exciting experience that we've had in mortality and morbidity over the last 30 or 40 years. Maybe we can. I just want to know whether or not we're making the assumption that we can as we address the questions that you're raising.

DR. CUTLER: That's a very good question. We sometimes think the future will be too much like the past and one can get in trouble there. Another way of phrasing the question is, what do we know about the technology of medical discovery and do we have any basis to believe that, for example, we've picked all the low-hanging fruit and now the remaining fruit on the tree are harder to get to. Everyone can have their own guess about that.

My own personal sense is that we probably haven't because the nature by which we discover new things is changing fundamentally. That's relative to the trial and error way of discovering things in the best it's a more scientific way and it will be with things like the genome and stuff. So that the things we're going to develop in the future have the potential to be just as consequential as the things that have come along in the past. Just as expensive and, at least I think, the potential to be just as consequential.

So I don't know that it's moving down a curve where first you undertake the high rate of return investment and then the remaining, but the whole schedule by which we, the whole means by which we discover things is changing.

DR. ROWE: You might be able to able to take some subsets like certain kinds of disabilities or certain kinds of neonatal things and actually analyze them and parse them into refractory kinds of things potential. Then you might actually be able to generate some --

DR. CUTLER: Yes. It's very clever for some things, like the infant mortality. In fact we continue to make improvements in low birth weight infant mortality, but because the mortality rate is so close to zero those aren't translating into as big changes in life expectancy. So what it will really have to be is partly other sorts of things like, for example, new types of cancer therapies and stuff that we haven't been successful at in the past. I'm not quite the person who would know for sure whether if you looked at it those have the promise to be as fundamental as the things that have gone on before, but my rough reading suggests that there's reason to believe it might be.

There was an issue of JAMA early in 200, 2001, I

think it was February of one of those years, on the prospects for medical innovation in the coming 25, 50 years or something, that went through field after field and tried to lay out what they thought was possible. Nobody went and added those up and said, okay, if you took half of this what would you get in terms of outcomes for anybody? But that would be the kind of exercise that you're suggesting. That would be very important here.

DR. MILLER: Can I just make one point on that? The way I was thinking about this is less the notion of, where are we on the curve as, if you agree with four to one, and if I follow the notion of turning the box on the side, the question that might be more achievable is, why isn't it six to one? Could you get the same result with fewer resources?

DR. CUTLER: The answer is, absolutely, we could have gotten the same result with fewer resources. Or if you account for the services that are not provided to people, for example, the hypertension therapies, the care for depression and so on, that would have cut into that. I have no idea whether if we got rid of the overused care and we provided the underused care we would spend more or less. I suspect we'd spend a little bit more, maybe half as much as Elliott thinks we'd save in getting

rid of the overuse we'd spend in reducing the underuse. But the net impact would have been much, much higher. That's the sense in which we're really far inside what we could be doing. We're far below what we could be doing.

The statement that it was worth it on average is not a statement that everything that we did was worth it.

MR. FEEZOR: Just to follow a question that Jack raised. I found some interest in California on your chart per capita spending being particularly heavy in L.A. because that is an area that at least in terms of the CalPERS under-65 population there is significant less spending there. In fact by about 18 percent. Even when you correct for the demographics it's still in the neighborhood of 11 or 12 percent. So I guess I was a little surprised at that -- literally, it is almost reversed and in fact my expenditure pattern in the Bay Area where you do have it slightly darkened, is that way, and certainly Sacramento in the red speaks for itself. That's fairly famous and that's reflected there. I don't know why but I'd like to look at that a little bit more at some point.

DR. FISHER: One hypothesis would be that if there are real constraints on what the physicians can do in the

under-65 population, that the relatively unfettered fee-for-service Medicare population is how one balances one's books.

MR. FEEZOR: That's got to be it because it is the Southern California basic that my large medical groups were most willing to be very competitive in dealing with my third-party payers; very, very competitive.

DR. NEWHOUSE: Let me echo Jack's comment about the presentations. I guess another way to put David's response to Jack was the quote from our report of 1945 that there were no diminishing returns to knowledge generation.

I had a second order response to Elliott. Since David didn't rise to the bait about explaining the elective hospital admissions, I will. Although I wondered -- I believe, am I not right, that the community tracking survey responses by the physicians are not Medicare specific? So this is a speculation now about what could explain it, that managed care is much more prevalent in the high-spending areas than the low-spending areas, probably for causal reasons, and that what you're seeing in those responses is a backlash to managed care. That they were saying they were having trouble, or more of them were saying they were having trouble getting admissions in, getting length of stay, getting referrals and so forth. So

that's a thought.

The other remark I wanted to make -- two other remarks actually. Elliott and David's policy conclusions, while there was certainly some overlap, didn't fully agree. That is, Elliott emphasized controlling growth of specialists and decreasing hospital beds in the high-spending areas. Emphasized may be overstated, but he brought them up.

I would have said I don't really quarrel with the across space variation point but the real issue, which is almost an impossible issue I think is, what do we need 20 years out in the way of specialists? The reason it's impossible is that we don't know what the technologies are going to be. If we put ourselves back in 1970 and ask what we would have projected as the need for interventional cardiologists we'd have probably blown it. Similarly, in the 1950s projecting nephrologists, we'd have blown that one too.

My concern would be that we not put something in place that goes at this that somehow gets in the way of a response that we will need over the lifetime of the physicians and the hospitals looking to the future.

I guess I was going to make some remarks about paying for quality but we've covered that in the June report and I'm

sure it will come up in the future, so in the interest of time I'll stop.

MR. HACKBARTH: Any response?

DR. FISHER: A couple of points. One is that the analysis for physician perception control for any of the managed care penetration variables that we have on the physician, so I don't think it's just managed care penetration. Actually, the only variable in managed care penetration that is really even moderately different is the proportion who say that they're captitated, and that's a small relative change in controlling for it. It leaves the effect still in place.

I think the second point about physicians and the numbers of physicians and hospital beds really speaks more to the quality problem than to the cost problem. I believe that they contribute to higher cost, but as I look at the information we have I'm much more worries about their impact on quality. What we know about, at least from some analyses I've seen done by one of my colleagues, David Goodman, who worries a lot about the physician workforce, is you have to add four physicians to every one of the high physician areas before one moves to Iowa. So simply allowing the current system to remain is likely to exacerbate the disparities in specialist supply

that we see.

I don't see evidence that the greater specialist supply is leading to better care. I think there's some good evidence that specialists, working together with primary care physicians, do contribute to improved quality, and for heart attacks is where the evidence is best. But those studies don't look at whether having 10 docs involved in your care is better for you than having four, and that's the major consequence.

So I think we need to at least consider, both for the sake of costs and for the sake of improving quality, where do we want our specialists and how many do we want. Whether the policy response to the unpredictability of where we need physicians is to either constrain or expand in an unlimited way the physician supply, I think neither of those are the right answer. The right answer is a way of retraining physicians in specialties where they're needed rather than leaving them there doing things which are outdated and not necessarily beneficial.

DR. NEWHOUSE: If you constrain the total number of specialists actually they'll fall out of the low-rate areas first.

DR. FISHER: I agree there are some risks and we have to think about how to do it right.

MR. MULLER: I too share the sense of how well this work is done. One of the ways in which I think the two may have come together that I'd ask you to comment on in terms of policy implications is to -- you brought up the notion in your article on accountable units. As one thinks about enhancing quality, both in terms of quality control, cost control, specialization control and so forth, could you comment a little bit more about what kind of a accountable -- obviously one is a hospital. That's the classic one in the American setting, big, large group practices and so forth. But both what kind of accountable units do you see that we'd want to encourage, and secondly, what kind of incentives would you want to give those accountable units?

DR. FISHER: I think that there's a fair bit of data on the challenges of measuring individual physician performance, both in terms of case mix adjustment and in terms of just adequate numbers of patients to be able to up with stable estimates of quality. That may not be true for satisfaction because a physician will have enough patients in their panel to measure the satisfaction of those patients. But the real rationale that I see for fostering the growth of integrated delivery systems or physician groups that are

affiliated with hospitals, is that I believe that that's the right size where you can learn what's going on in the process of care that leads to better outcomes and improves the quality of care. That they'll be big enough to justify the investment.

So I think it was Mark's early work in the late '80s or early '90s about medical staff, whether the medical staff of a hospital isn't one way to think about paying for inpatient services. But I think since we're, in the absence of managed competition a la Alain Enthoven where everybody signs up for lovely, fully integrated systems, that measuring the performance of specific hospitals and their medical staffs and reporting both their efficiency, which varies dramatically across institutions, and on their quality, would provide additional information that might allow you to both encourage those hospitals to improve both efficiency and quality and be big enough to evaluate, be big enough to look at outcomes.

AMI, heart attacks, judging the quality of heart attack care is all about how do the physicians and hospital system work together to ensure that the patient when they get to the emergency room gets their aspirin and gets to the cath lab quickly if they've got one, or transferred to the hospital that has one if they don't have one. So that's my accountable

care unit, accountable care organization.

DR. CUTLER: I think there are different sorts of measures that can be used at different levels. It's obviously easiest when one thinks about a bigger unit. Beyond a hospital there would be a health plan, for example, either in the private sector or as Medicare pays HMOs or something.

But I think one could even think about it in physician payment, to link it to the previous discussion. I occasionally muse over, let's say if you just took the Medicare beneficiaries -- Nancy-Ann may know the answer to this. If you said, of all the Medicare beneficiaries who go to a typical physician, what share of those beneficiaries is there some measurable process that the physician should have taken that we can see, did the physician do it and count that positively or negatively towards, let's say a score for the physician? My guess, it may be half, one out of every two patients, one out of every three, one out of every two patients there's something that the physician should have done. Not that it's always the same. Not that you're going to develop one measure, because you're not going to have enough patients with any particular thing, but if you aggregate it across things.

So it may be that there's actually a large enough

sample at the individual physician level to say, even if one is Medicare we can come up with a measure of how well that physician is doing at a process level. I don't think at a particular physician level you could do outcomes. As you get bigger one could think about doing that for groups of physicians.

DR. ROWE: Did the recent research show 55 percent?

MS. DePARLE: Yes, Melinda's colleagues at RAND. That was Medicare data.

DR. ROWE: So about 55 percent of the patients receive the whole evidence based thing.

DR. REISCHAUER: Thank you both for coming. This is very interesting. I have a small methodological question for Elliott. I might have asked this before to you. When you were dividing the HRRs by per capita beds and per capita physicians, was the per capita total population?

DR. FISHER: Yes.

DR. REISCHAUER: So that captures some of the questions that you --

MR. FEEZOR: Total Medicare population?

DR. REISCHAUER: No, total population.

My question for you, David, is whether in a fee-for-

service world there's really a practical way of twisting the box and moving it to the right. To use your technical language, there's some stuff that is ineffectual for everyone, and clearly getting rid of that is an obvious way to save money. But my understanding is the problem is that most stuff is effective for some and not effective for others, and ex ante, it's often difficult to decide for whom it will be effective. In a world like Medicare, you can't really use averages. If there's any even modest group, if for 5 percent of the people it's effective, politically it's very hard to deny it to the other 95 who believe for them it might be effective.

Do we have any kind of work that is trying to see for various procedures, particularly the fancy stuff that is expensive and on average has low value but for a very tiny fraction has high value, whether we can ex ante identify those people?

DR. CUTLER: Let me give two answers. I'm not sure you'll like either but let me give two strategies. The first one is -- the first simpler one would be, rather than having just one RVU which is the same for everything, but add another layer which is based on, in essence, the diagnosis of the

patient. So think about introducing a DRG-type adjustment into it.

What it would do is that, let's say you'd you would count an RVU higher if it was done in a situation where it was clearly appropriate. So let me think if I can do a specific example.

If a patient has diabetes and you order every three months the HBA1C or the retinopathy, you do the pulsar testing in the feet and other extremities, that would be a higher RVU than if that were done but not for a diabetic patient, or if it were not done. So the RVU would depend upon the diagnosis of the patient and whether that was clinically indicated or not, or whether based on guidelines we judge that to be appropriate. So that would be the individual for that encounter, the payment for that encounter differed.

The second way to do it -- by the way, at the hospital level what you think about is something like introducing into the DRG payment something about either the quality in terms of the -- there you'd really have to do the process. So for example, if there was the evidence that a beta blocker was prescribed or aspirin was prescribed, then the DRG payment would be higher. So just as distinguish them now

between surgical and non-surgical and complications versus not, you'd add a little bit of payment there based on the process measures of what's done.

The other way to do it is to think about an annual bonus system with everything that's done contributing to points during the year. So at the hospital level it would be, every time the heart attack patient got the beta blocker and the aspirin that contributes a certain amount of points. Every time that the physician did the cholesterol screen and prescribed a medication which was appropriate you get a certain amount of points. Then at the end of the year you'd take the points, normalized somehow based on how many you should have earned or whatever, and you'd allocate some additional payment based on that. So if you hit 100 percent of the possible points, maybe that would be a 10 or 15 percent bonus for Medicare. If you got half that, maybe it would be half of that set of points. That would not be on the individual patient level.

There you could think about doing some explicit outcome-based payment. It would be easier in the hospital setting, like for example, with the AMI patients. New York State has a long history of CABG reporting so you could

actually use those kind of risk-adjusted measures in the payment for the hospital overall for that year. Rather than just measuring it and putting it out, you'd actually have some of the payment conditional on that. But you couldn't do that for any particular patient. You'd have to do that based on the characteristics as a whole.

DR. FISHER: I'd like to put my two cents in. I think rewarding quality to the extent we can define it clearly is an excellent idea and I think one of the challenges is that even as NCQA struggles to develop good, precise measures of high quality of care is, or RAND, there are not that many things that are going to be easily identified and tracked that we should reward. We should try to do it, but we shouldn't count on it to fix the problem of difficult decisions and the gray areas about the use of this advanced technology.

I think there are two issues that I think should be distinguish that may point both to the same answer. That is there's the question of what's the right decision for that particular patient. There are certain risks -- take implantable cardiac defibrillators, for example. Expensive technology. Our vice president has one. We all might want them sooner or later. But making the decisions about who

should get one and who really stands to benefit as opposed to who is going to have their life prolonged with end-stage heart failure and die of suffocation as opposed to die of an arrhythmia, which the arrhythmia is the preferred way to go if I'm given a choice. So the decision-making is difficult.

We ought to try to ensure that when it's these expensive high-stakes decisions, bypass surgery would be a good one, elective angioplasty would be a good one, that we pay real attention to helping make sure that patients are involved in the decision so that they understand the choices and there's informed patient choice and we ought to pay for it. It's not going to be that hard but we ought to make sure that physicians are rewarded for adopting nationally-validated protocols that ensure that patients get balanced information on the risks and benefits of these procedures. I believe there's tremendous overuse, and Brooks has shown it to be 40 percent or greater depending on how you define it, in the use of these major procedures. Those are people who if well-informed might very well choose differently. The randomized trials on shared decision-making protocols suggest that patients choose more conservatively than their doctors recommend generally.

Second related challenge is the problem of patient

safety. That is, I'm not sure that we know quite well, as David pointed out, volume makes a big difference, but volume is only one of the predictors of poor outcomes and doesn't explain variations in cardiovascular mortality following bypass surgery.

There are things about the quality of the organizations. While it may not be particularly easy, but the model of centers of excellence where we will pay for the procedure in a center of excellence but not in a place that does 20, or in Reading, or in the new cardiac hospitals that are expanding, we ought to think carefully because that would do two things. That could allow us to improve the decision-making because those would be places that would be making wiser decisions and those would be places where you could be sure that the outcomes were better so the patient has a chance to benefit.

The data on many of these procedures is that if they're done in a place that is not high-quality with good outcomes, the benefits were flipped so that it's on average harmful. The carotid endarterectomy data is quite clear. So those are two suggestions that at least -- thinking about centers of excellence is a strategy for helping improve

decision-making and outcomes I think might be a useful tool.

MR. HACKBARTH: Unfortunately, we're running out of time. And I have two commissioners remaining on my list, Alan Nelson, Nancy-Ann and then we'll have to close it.

DR. NELSON: Add my thanks. Two questions, Elliott. One, there are some areas that are conspicuous in the low per capita spending areas that have relatively high specialist population ratios, Portland, Salt Lake City, Denver, for example. Any explanation there?

The second question is, is there any correlation between per capita spending and the degree of penetration of for-profit providers, hospitals, nursing homes, home care and so forth?

DR. FISHER: Thank you for the questions. There are certainly areas that have lots of specialists per capita. The Portland area is -- one of the important things to recognize is that places like Iowa and Portland I believe may have high concentrations of specialists within the particular area. Iowa I know better than Portland. But they do a much better job of distributing the specialist services across the population of other surrounding hospital referral regions. Our measures of specialist supply are not allocated. They're within those

areas. So that if a region does a good job within, as in Seattle and Portland, a good job of allocating the specialist's time across the entire region they may look high in specialist supply but low on per capita spending on the residents of that specific region.

Now the second question, for-profit. John Skinner, Elaine Silverman and I did a study of for-profit hospitals and both the absolute levels of spending in the areas that have for-profit hospitals and the growth in spending were higher. We published that in the New England Journal three years ago I think.

MS. DePARLE: I note you agree on centers of excellence, both you and David agree that that's a good idea. That's two votes, and I think more than it's ever gotten at the other end of Pennsylvania Avenue, so on that hopeful note --

DR. CUTLER: Didn't we do that with heart transplants?

MS. DePARLE: I was going to say, I think it's a great idea and we have had some success. We did a demonstration. It's been discussed here a number of times. But also you could analogize, with some caveats probably, to the transplant program as well, with some success. One could

argue about whether we did a very good job of the criteria in the beginning, but at least we've said this is important, it should have happen, but it should only happen at places that have shown they can do it effectively. I think it's worked pretty well. I'm only sorry that that model is not more widely accepted.

Elliott, I've heard you talk about this twice now in the Washington policy halls, but I am curious as to the reaction you get. Have you done this talk on the Upper East Side, or Boca Raton, or places where there's high utilization?

DR. FISHER: I have given the talk on East Long Island which another little red spot on the map, but I frame the talk around, it's all about quality. There are good theoretical reasons to think that more medical care can be harmful, and Gil Welch and I wrote a piece summarizing the mechanisms of harm from too much medical care. I think physicians get it.

My experience there was many of them felt constrained by the way the payment system worked to keep doing what they're doing rather than take the time to think, talk to patients long enough to be able to persuade them that they didn't need the specific intervention that was advertised on television.

That's why I focused in my suggestions on at least thinking about the care coordination and management part more explicitly so that patients have someone who can really provide them good information about whether they should listen to that ad.

MR. HACKBARTH: Nancy-Ann, do you think it makes a political difference if things are constrained at the front end as opposed to after they've diffused everywhere?

MS. DePARLE: Definitely.

MR. HACKBARTH: So if you tie the limitation to the initial coverage decision, say we're only going to pay for this at certain places, you may have a somewhat different dynamic than if everybody is invested in the service and then you say, we're only going to pay for it at a few places.

MS. DePARLE: Everybody has invested, and by the way, it's the highest DRG. Yes, I think that makes a difference. I don't have the history. Sheila and Senator Durenberger may, and Mark you may. But with transplants, it was a number of years before Medicare covered them and then when it did cover them it launched this program and I guess that was in the law. But, yes, I think that's a good model.

DR. CUTLER: I think the example that Nancy-Ann brought up, and the more general of the difficulty of

regulation I think highlights why the payment structure may be useful. That is, it's very hard to tell a hospital that's not doing well that you're going to deny payment there. But it's easier just to say, on the basis of outcomes you don't get any bonus and if you can't meet your cost that's tough. You just should stop providing this. That's your decision to do, and it's not my decision to take it away from you. The other hospital down the street that's doing it much better is going to get more money for it, but that's just the way that it is.

So I think even broader than just Medicare, all the certificate of need stuff largely failed because we didn't have the willpower to tell anyone to do anything. But when it gets to be financially appropriate or inappropriate then we really see more action. That's partly why I focused more on the payment side than on the regulatory side.

MR. HACKBARTH: I'm afraid that we're going to have to bring it to a close. Thank you very much. It was very, very helpful.

Our last session in this month's meeting is on health insurance markets for Medicare beneficiaries, a report on some site visits that the staff has conducted.

Who's leading the way?

MS. LOWERY: MedPAC has been examining beneficiaries Medicare supplementation because we know that get beneficiaries rarely have only the basic Medicare package. To further extend our initial analysis of national surveys and administrative data which suggested that there is great variation in the supplemental insurance options both available to beneficiaries and that which beneficiaries choose, MedPAC staff working with Mathematica Policy Research experts conducted site visits in five markets, Long Island, New York, the state of Nebraska, San Diego, California, Atlanta, Georgia, and Minneapolis-St. Paul, Minnesota. Several commissioners actually helped us identify appropriate individuals with whom to speak, and in particular we would like to think Senator Durenberger and Sheila Moroney at the National Institute for Health Policy for all of their help on our site visit to Minnesota.

Altogether we spoke with 155 people, primarily in person but also via telephone in some instances. The site visits have helped us to identify factors that contribute to or pose barriers to the effective functioning of markets for different sorts of insurance products for different beneficiary populations.

A snapshot view of these markets can be seen in this

table. In the left-hand column you can see the population of an area, the number of Medicare beneficiaries, the percent of the aged population that is poor, the percent of workers under collective bargaining agreements which can be used as a rough indicator of how prevalent and/or generous their retiree health coverage may be, and Medicare+Choice penetration.

We chose Atlanta because it appeared to have a relatively high percentage of beneficiaries in Medicare fee-for-service only and relatively low percentages of Medigap, Medicare managed care, and employer-sponsored retiree coverage. We selected Long Island because it appeared to have a high percentage of employer-sponsored supplemental coverage and New York State has guaranteed issue and community rating requirements for Medigap plans.

Minnesota is a Medigap waiver state, meaning it has products other than the standard A through J plans, and the Twin Cities have high Medicare managed care penetration much of which is in cost plans. San Diego has a very high M+C enrollment and a high concentration of military retirees who have recently gained access to a new generous supplemental insurance program, the TriCare for Life program. Nebraska is a rural state and has very high Medigap penetration.

Now I'll turn it over to Scott who will provide more details on Medicare supplemental insurance options in the sites.

DR. HARRISON: I'm going to describe some of the salient features of the first three of the five markets that we visited and I'm going to try to abbreviate this because I know that we're running late.

Long Island, which we've defined here as Nassau and Suffolk Counties has experience a steep decline in the number of M+C options available over the last several years. There are now two plans serving the area down from eight, and the penetration has dropped from 20 percent in 2000 down to 12 percent now. Plans that have pulled out of Long Island, we think primarily have pulled out because of lower M+C payment rates on the island compared with neighboring New York City. Medicare fee-for-service spending on the island is similar to most parts of the city after you take out the GME, but the payment rates are $70 to $240 per month lower than those in the five boroughs. Nassau and Suffolk rates do appear to be about $30 per month under the fee-for-service spending in this counties.

Those plans that still serve Long Island charge

premiums of over $100 per month and offer generic-only drug benefits while there are zero premium plans with better benefits in the city. To make this problem more uncomfortable, beneficiaries on Long Island see all of the New York City TV ads where the managed care companies in the city are advertising all the great benefits that they can get, then they call up and find out, sorry, not for you.

For other kinds of coverage, the New York metropolitan area is heavily unionized and there's quite a difference in retiree coverage among the public unions and those people who work for private companies.

In the Medigap market, insurers are required to community rate for the disabled as well as the elderly and open enrollment is required. Offerors appear to have adapted to these requirements and view them as creating a level playing field. However, when these requirements first came in they were not pleased.

However, there aren't limited Medigap offerings on Long Island. There are 11 companies offering the most basic Medigap plan. Premiums start at about $80 per month and there's only three insurers that offer a drug plan and none of them offer a Plan J. Some New Yorkers can get drug coverage in

another way. The state operates the very popular Elderly Pharmaceutical Insurance Coverage or EPIC program. Medicare beneficiaries are eligible if their incomes are $35,000 or less. There's premiums on a sliding scale and fixed copays for drugs.

As far as the general provider structure on Long Island, hospitals generally have consolidated into -- not generally, they really have almost totally consolidated into two systems and each contracts as a group. Physicians typically practice individually or in small groups. Provider risk-sharing is limited. The plans they no trouble creating networks of physicians but they have trouble getting hospital discounts.

Let's move to Nebraska. Since 1999 there's been only one M+C plan in Nebraska run by United and it serves only the Omaha area. United has recently also added a non-demonstration PPO in Omaha. Both of those, the HMO and the PPO are zero premium products with no drug coverage. The HMO also has a high option available and that does include generic drug coverage and the premium there is $71 per month.

Outside of Omaha, Nebraska beneficiaries can enroll in two private fee-for-service plans. The premiums there go

from $9 to $88. Neither of those plans offers a drug benefit. They haven't been much of a factor. The two plans together have enrolled fewer than 150 beneficiaries in the state.

Medigap is by far the most common source of supplemental coverage in Nebraska. Over half of Medicare beneficiaries in the state have supplemental coverage through a Medigap plan. Thirty-five Medigap insurers offer products, although only four offer any of the prescription drug plans. The plans start around $50 a month at age 65 and only two Plan J's are available and they start at around $200. There's no guaranteed issue for the under-65 disabled in Nebraska, and there's only one plan listed on the CMS -- by the way, all the Medigap data and number of insurers I'm getting off the CMS web site. There's only one listed that provides products to the disabled and it offers only a Plan A or B.

As far as employer coverage in the area, it's very low due to the lack of large businesses and unions in the state. The state government itself does not offer retiree health coverage to Medicare-eligible retirees. Those individuals with employer-sponsored coverage have had to fund more of that coverage out-of-pocket. Employer contributions have decreased. The take-up rates have stayed fairly high, and

primarily because these plans are sometimes the only way for retirees to get reasonably priced drug coverage.

MR. HACKBARTH: Scott, can I just intervene for a second? I'm worried that we're going to lose the remaining commissioners, so if I could, I'd ask you to take a little bit different tack here and focus on the cross-cutting gains that as I look at your presentation, are page 10 and there after, as opposed to the individual market detail.

DR. HARRISON: That's fine. I'll turn it over to Jill then to do that.

DR. BERNSTEIN: Our contractor, Mathematica Policy Research is currently drafting a report covering all of the site visits. We're working with them and we've identified a number of themes and those are what we wanted to talk about for the most part today anyhow.

First, even though everything that we've read suggested there was a problem with employer-sponsored retiree coverage, we were not ready for what we saw on the site visits. Small and midsize employers simply were not offering coverage, and even some of the large employers are moving toward plans in which retirees pay the full premium. That is, employers will arrange for group plans for people but they're not contributing

for retirees after they hit the age of 65 in many of the places we visited including a couple of states. Nebraska and Minnesota state employees don't have any contribution made toward their retiree health coverage. University systems are moving away from it, and hospital systems are not offering any retiree health coverage.

There are certain exceptions in certain industries and some of the public sector places, including the state of Georgia. But we think we need to spend more time doing additional work to understand the implications of cutbacks in retiree health coverage for Medicare, for beneficiaries and for other insurance products.

Second, a lot of what's happening across all the supplemental types of insurance, Medigap, M+C, employer-sponsored, and Medicaid is driven by the cost of prescription drugs. One of the factors shaping the group market and employers willingness to organize group products even when they don't contribute to the premiums is the ability to craft drug programs for employees that are not available in the individual market.

So we want to look more closely at how existing drug coverage works or doesn't work and different kinds of insurance

arrangements, M+C, M+C group contracts, Medigap options under select plans, under generic-only options like the ones we found being marketed in California and some other states under the H, I, J plans, and under waiver systems like Minnesota which offers a different kind of drug benefit and is picked up by a much larger proportion of people than the Medigap options in the states under the NAIC rules.

Third, even though Medigap and M+C options operate under federal rules, state regulators and state oversight remain important. We want to focus more attention on the implications of things like guaranteed issue and open enrollment as they affect the current playing field, and what sorts of federal preemption issues might come into play if new insurance products become available either through incremental changes or through broader policy changes.

A related theme also came up. From the perspective of many of the people we talked to, some of what has involved, some of what states and organizations have worked hard to put into place seems to be working pretty well. Notable examples are the EPIC program in New York, the popular Integrated Care System serving beneficiaries in Minnesota as well as the state's Medigap system, or the managed care system in San

Diego. People there are worried that changes in policy could undo what they've put in place and replace it with something that might not work as well.

Three more quick issues. In previous reports we raised some issues regarding meeting beneficiaries' needs with different kinds of insurance and bolstering beneficiaries' ability to make good choices in a complicated set of choices. Site visits provided additional food for thought. These markets offered different kinds of choices at different prices. One constant, however, was the cost of supplementation can be very high and it's out of reach for some beneficiaries. In some markets, insurers and plans have responded with new lower-cost products, often with high deductibles.

Advocates raise some serious questions about the extent to which beneficiaries understand the increasingly complicated choices that they have, and in particular whether they understand the low-cost options that are being marketed. We also heard a lot from providers, plans and beneficiary advocates about perceived with the way Medicare and other payers pay for care. There's a lot of variation in M+C payment rates across these areas which affects benefits and premiums. There's variation in the payment rates to providers under fee-

for-service which affects Medigap rates, and there's variation in the ways that these rates compare to each other across these areas.

As you know, in some places we visited the M+C rates are significantly lower than they are in other area of the country which plans and beneficiaries see as unfair. In two markets where we visited people, in San Diego and Minneapolis, providers and plans believe that managed care penetration was a major factor shaping the health-care delivery patterns resulting in lower utilization and therefore lower M+C rates. But it's also important to note that in some of the other places we went, Long Island is an exception but it's generally true in the other sites, M+C rates are actually higher and in some places significantly higher than they would be if the plans were paid at the fee-for-service level in those areas.

The site visits weren't designed to provide nationally representative data on payment policy and these issues probably should be input for other follow-up work that we will do and collaborate with our colleagues on. But we think it's important as context that virtually everyone we talked to is convinced that some aspect of Medicare payment is unfair, although the reasoning varies from place to place. I

think that's a very important context.

Finally, the way that provider organizations are structured, the extent to which different groups of providers can or have incentives to create networks or negotiate rates clearly affects the market for supplemental insurance products. This work has helped us to identify as kind of a typology to help us to explain how different insurance products have evolved or will likely evolve in the future. This could help us identify how policy changes when they're overlaid on these different kinds of markets might play out.

So where we're going is we're going to get you a draft report to talk about at the next meeting. We're going to have a final report by the end of the year, hopefully sooner. And other aspects of this work will be integrated into work that we plan to do for the March report, in particular looking at what's going on in M+C PPOs in particular. And in the June report we want to focus more heavily on what's going on with employer-sponsored retiree health benefits.

With that, we will take your input.

MS. BURKE: I think these are exactly the right questions to ask. It obviously doesn't need to be said that the passage of a drug bill will presumably throw a great deal

of this into -- in terms of understanding what the impact is. I don't know how you plan to accommodate that, but I guess what I wouldn't want to have is us appear to have produced something with no sense of what's going on in the rest of the world. But I'm assuming as you go forward and as we look at this, some suggestion as to what the impact might be of a broader benefit would at least be noted in reference in terms of the analysis that would have to be done.

MR. HACKBARTH: Any others?

DR. WAKEFIELD: I stepped out, so my apologies, I probably missed this. On your follow-on work, leading up to why this follow-on work as it's listed here, any reason why Medigap is not up there?

DR. BERNSTEIN: No, Medigap will be covered.

DR. WAKEFIELD: In one of those two reports.

DR. BERNSTEIN: It will definitely be covered in the main report.

MR. HACKBARTH: Okay, thank you. I apologize for the limited amount of time and the rush we put you through.

We'll have a very brief public comment period.

MS. McELRATH: Unlike Karen, I won't say it looks like I have a lot of time.

I just want to point out that the volume number, the 30 percent is double what the trustees report would have for the same period, and it's also greater than -- there were some numbers that PPRC did. So it's always hard to tease apart what's volume and what's cost, so I'd just point out it's different.

Then the other question I think is, so what conclusion would you come to? Maybe one conclusion that you come to from the fact that you can't tell exactly what it is that's driving the volume is that you should get rid of the SGR, which is where the Commission is, and where we would prefer to stay. If in fact, however, Congress is going to keep an SGR, does that mean that you shouldn't do any of the other things that the Commission had recommended prior to going to the position of having no SGR? Does that mean you shouldn't have a 2 percent add-on, or that you shouldn't count a 6-percent change that's due to demographic change?

We would say a 2002 pay cut of 5.4 percent would have been offset by that 6 percent so you shouldn't just ignore it.

MR. HACKBARTH: Okay, thank you very much. See you in October.

[Whereupon, at 12:21 p.m., the meeting was

adjourned.]