

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

**Thursday, October 9, 2003**  
**10:11 a.m.\***

COMMISSIONERS PRESENT:

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MR. HACKBARTH: Let's get started.

MS. RAY: Good morning. As you recall, at the September meeting Joan and I presented a workplan on how we were planning to examine disease management, the use of disease management in the fee-for-service traditional Medicare program. During our discussion you raised some questions and issues that we will have to consider as we proceed with this analysis, including questions regarding typology, how do you measure, how do you evaluate effectiveness, how do you target different population group.

We thought as a next step that we would present a panel of experts and they would give you--talk about disease management from different perspectives. So I'm going to be very brief in my introduction. Their bios are in your mailing family materials. Our first two speakers are researchers. Glen Mays is going to open the discussion. Glen is a senior health researcher from the Center for Studying Health Systems Change. Following Glen will be Dave Knutson. Dave is a director of health systems study from the Park Nicollet Institute for Research and Education. Then Jeffrey Simms will follow. He has actually implemented

1 a disease management program. He's with North Carolina  
2 Medicaid and he's the assistant director from the division  
3 of medical assistance. Gentlemen.

4 MR. HACKBARTH: Welcome to you all. We appreciate  
5 your willingness to share your expertise on this very timely  
6 topic. Glen?

7 MR. MAYS: Thank you very much. Employers across  
8 the country are now into their fourth consecutive year of  
9 double-digit annual increases in health insurance premiums,  
10 with 2003 being the largest increase since 1990. In  
11 response, a number of employers and health plans are now  
12 embracing disease management and related care coordination  
13 strategies as a way to potentially rein in those costs, and  
14 really in response to facing few other alternatives for cost  
15 containment and quality improvement.

16 Today I'm going to share with you some findings  
17 from the most recent round of the community tracking study  
18 conducted by the Center for Studying Health System Change to  
19 offer insight into the experiences of health plans and  
20 employers across the country are having with disease  
21 management in health care and what lessons might be drawn  
22 for Medicare. And I do want to acknowledge my co-authors

1 Ashley Short and Jessica Mittler in this research.

2 I want to just by way of background just briefly  
3 give you an overview of the community tracking study. This  
4 is a study that is designed around 12 randomly selected  
5 communities across the country that are studied on a rolling  
6 basis every two years. So we've been tracking these markets  
7 longitudinally since 1996. These markets were selected  
8 randomly so that they are nationally representative of  
9 health care markets across the country, and in particular  
10 markets with a population of at least 100,000.

11 In each round of the study we conduct interviews  
12 with a wide range of health care stakeholders, 70 to 100  
13 interviews in each of those markets, speaking with  
14 representatives from health plant, employers, providers at  
15 the physician and hospital levels as well as policymakers to  
16 get a broad and balanced view of trends in health care and  
17 health care delivery. That allows us to triangulate results  
18 and to develop a balanced perspective of how these markets  
19 are evolving over time. The findings I'll be talking about  
20 today relate specifically to the most recent round of  
21 research, that's the round four site visits that were  
22 conducted between September 2002 and May 2003.

1           The community tracking study sites, as you can see  
2 here on this map, a broad geographic representation here.  
3 Again, these are all markets with at least 100,000  
4 population.

5           It's clear from this round of the research that  
6 employer and insurer interest in disease management has  
7 clearly grown substantially over the past two years in  
8 response to a number of factors. Clearly, as we have seen  
9 over the past three to four years, other cost containment  
10 tools that health plans have attempted to use, and those  
11 tools specifically associated with managed care, have  
12 largely faded from use in many markets in response to  
13 consumer and provider dissatisfaction with some of the more  
14 stringent approaches to health care management. In  
15 particular, strategies such as prior authorization and  
16 primary care gatekeeping have been de-emphasized by health  
17 plans in many markets in response to these dynamics.

18           At the same time, as we mentioned earlier, health  
19 plans and employers have continued to confront double-digit  
20 increases in health care costs and in health insurance  
21 premiums so there's still a need to find other approaches  
22 for managing costs that are perhaps more acceptable to

1 consumers and providers. Along with that there's been a  
2 growing awareness of gaps in health care quality and the  
3 fact that we have an enormous gap really in many areas in  
4 terms of the evidence that we know about health care  
5 strategies that can work to improve health and the types of  
6 health care that patients actually receive in real world  
7 health care settings.

8           So a growing concern among health plans and  
9 employers in finding strategies for closing that gape  
10 between evidence and practice. As a result there's a lot of  
11 optimism about the role that disease management and related  
12 care coordination strategies can play in closing that gap.  
13 In addition, we found a real desire among employers to find  
14 strategies that move beyond simply reducing benefits or  
15 increasing cost sharing on consumers as a way to rein in  
16 health care costs. That's really why, a major reason for  
17 the growing enthusiasm in disease management.

18           Health plans and employers are pursuing two  
19 related approaches in this area. One is the traditional  
20 disease management concept which encompasses programs that  
21 target defined populations of members that have specific  
22 health care conditions and applying standardized protocols,

1 treatment protocols and interventions to address those  
2 conditions. So it's really a population-based strategy for  
3 affecting health care delivery.

4           A second related strategy, often termed case  
5 management, intensive case management or high-cost case  
6 management is really a much more customized approach. It  
7 targets individual patients that are deemed to be at high  
8 risk of health care complications and high health care  
9 costs. Often these patients have multiple conditions  
10 they're facing, so it's not a disease-specific approach but  
11 it's really highly customized to the individual patient  
12 needs. Therefore, the interventions that are used to  
13 coordinate care are highly customized and often go beyond  
14 medical care services to include social supports.

15           Increasing we're finding that health plans and  
16 employers are viewing these two strategies as really being  
17 interrelated efforts for reducing cost and improving quality  
18 of health care. So we're seeing in many cases a blurring of  
19 the distinction between these two approached in private  
20 health insurance markets.

21           Who offers these kind of programs and how are they  
22 purchased? Clearly, most employers purchase disease



1 management programs from their health insurers still in the  
2 markets that we studied. Health plans in turn, some health  
3 plans develop their disease management programs internally  
4 while others contract with specialty disease management  
5 vendors to offer these programs.

6 More recently we found in a few markets some of  
7 the larger self-funded employers have begun to contract  
8 directly with the specialty disease management vendors for  
9 these programs rather than purchasing them through their  
10 health plans. One rationale for that that some employers  
11 cite is the ability to cover all of their employees with a  
12 single set of disease management programs, even though they  
13 may offer multiple health plan choices. So that all  
14 employees can be covered on a single set of programs, they  
15 can realize perhaps by some economies of scale in providing  
16 those disease management programs while still offering their  
17 employees a choice of different health plans and benefit  
18 designs.

19 Also in some markets medical groups and hospitals  
20 are actively involved in developing and offering disease  
21 management programs. We've seen that particularly to be the  
22 case in markets where you still see a lot of risk

1 contracting between health plans and providers. So when  
2 providers are actually bearing the financial risk for health  
3 care services you see substantial involvement of hospitals  
4 and medical groups in directly developing and offering these  
5 disease management programs. And necessarily in those  
6 markets, health plans find it--are less engaged directly in  
7 delivering these disease management interventions because  
8 it's really that responsibility has been delegated down to  
9 the provider level.

10 Over the past two years we have seen evidence in  
11 most of the 12 markets that we study of expansions in  
12 disease management offerings by both insurers and employers.  
13 Employers in most of these markets are pressing health plans  
14 to offer more programs that more targeted to the specific  
15 health care needs in their workforces. Historically we've  
16 seen a lot of activity among health plans in offering  
17 disease management interventions in some of the most  
18 prevalent disease areas such as diabetes and asthma and  
19 chronic health--congestive heart failure. Many employers  
20 have begun pressing health plans to offer an expanded array  
21 of interventions that are perceived to more directly address  
22 the health care needs in their employee populations.

1           Employers, for example, that have predominantly  
2 younger workforces are often dissatisfied with the limited  
3 range of programs that may be offered by the health plan  
4 because they don't perceive their workforce as having  
5 intense needs in the chronic disease areas. They'd like to  
6 see more programs targeted to health conditions affecting  
7 younger populations. So in response to that we have seen  
8 health plans over the past two years undertaking a variety  
9 of efforts to add new programs. So moving beyond those  
10 traditional areas in diabetes and asthma to look at things  
11 like low back pain, osteoarthritis conditions, orthopedic  
12 injuries, obesity. So a broader range of health conditions  
13 that would be of interest to employers.

14           A second important trend that we've seen health  
15 plans adopt is beginning to migrate their disease management  
16 programs from the HMO product, which has historically been  
17 where many of these disease programs have been developed and  
18 rolled out, into other types of health insurance products.  
19 Particularly, finding ways to adapt these programs to fit  
20 PPO products, given the fact that in many markets we have  
21 seen a rapid growth in enrollment in the PPO products and  
22 really a stagnation or even a declining enrollment in HMO

1 products. So there's been, in several markets, a lot of  
2 work by health plans to adapt these programs for the PPO  
3 products and for less restrictive managed care products.

4           Additionally, health plans have been investing  
5 intensely in activities to boost participation in these  
6 programs by members. So they're looking at ways to engage  
7 consumers, to provide outreach to consumers, educate them  
8 about the programs, and encourage their participation. This  
9 has really been in response to problems that health plans  
10 have historically had with low rates of participation in  
11 many of these programs. Along with that, plans in a number  
12 of the markets have been making considerable investments in  
13 information systems designed to support their disease  
14 management programs. So systems that would both provide  
15 information to consumers about their disease states and  
16 about self-care strategies and also systems that can provide  
17 information to providers to help empower providers to  
18 support member participation in these programs.

19           In Seattle, for example, several large health  
20 plans were developing systems that would be able to provide  
21 information to providers about the specific patients in  
22 their panel that would be eligible for specific disease

1 management and case management interventions so that a  
2 provider could begin to play a role in encouraging  
3 participation in the programs.

4           Another major finding from the last two years of  
5 experience in the private health insurance markets that  
6 we're studying is that health plans and employers have begun  
7 a new focus on intensive case management over the past two  
8 years. So as I mentioned previously, this involves  
9 targeting smaller subgroups of members that are really  
10 perceived to be high risk or high cost members. So it's not  
11 necessarily a disease-specific strategy but across the  
12 patient population to identify the subgroups that are at  
13 higher risk of health care complications and health care  
14 costs. A number of plans are now experimenting with  
15 predictive modeling applications as methodologies for  
16 identifying those high risk cases prospectively. So the  
17 interest is in identifying patients before they have  
18 incurred catastrophic health care costs and help to  
19 coordinate their care so that some of those costs can be  
20 avoided.

21           The focus of these intensive case management  
22 programs really varies across plans and across markets.

1 Some of them are focused pretty tightly on reducing  
2 hospitalizations among at-risk populations. Others look at  
3 lowering total health care costs, so their predictive models  
4 are really developed at trying to project total cost for  
5 their members and targeting those high cost cases.

6 Then other plans have developed these case  
7 management programs around addressing care management for  
8 non-compliant patients. Often those approaches really rely  
9 heavily on providers for identifying patients that are  
10 having trouble complying with recommended treatment  
11 regimens, and then enrolling those patients into the  
12 program.

13 Interestingly, in a number of cases we found that  
14 the reason in particular for large self-insured employers  
15 being interested in intensive case management programs were  
16 requirements from stop-loss insurers that employers who are-  
17 -as a condition of obtaining stop-loss insurance employers  
18 need to have these case management programs in place for  
19 managing high cost cases. In some cases it's a requirement.  
20 In other cases employers can obtain lower premiums for their  
21 stop-loss coverage if they have these programs in place.

22 Health plans and employers are taking a variety of

1 different strategies for integrating the intensive case  
2 management programs along with other disease management  
3 programs. In some cases, in a number of markets health  
4 plans are actually introducing these case management  
5 programs alongside their traditional disease management  
6 programs. Here the plans really view the case management  
7 programs as filling in the gaps that are not addressed by  
8 disease-specific disease management programs.

9           Other plans have actually adopted intensive case  
10 management programs as a wholesale replacement for their  
11 disease management programs. In one case in Seattle, a  
12 large insurer that had been investing pretty heavily in  
13 disease management over the past four years has really made  
14 an about-face over the past two years and discontinued all  
15 but one of its disease management programs and replaced that  
16 with intensive case management. The rationale there was  
17 that, the health plan reported that the disease management  
18 programs were spending a lot of resources identifying the  
19 full population of patients with disease but only a very  
20 small percentage of those patients with a particular disease  
21 such as diabetes were actually not managing their disease  
22 effectively and really needed the intense support. So by

1 moving to an intensive case management approach the plan  
2 thought it would be a more efficient use of resources by  
3 targeting the case management resources only on the very  
4 high-risk and high-cost patients.

5           Additionally, a few plans actually are offering  
6 employers a choice of different types or levels of  
7 management that include both disease management and  
8 intensive case management approaches, often with the  
9 different programs targeted at different levels of risk for  
10 patients. So they would really profile patients based on  
11 their level of risk and then assign them--map them into  
12 disease management or intensive case management programs  
13 depending on their health care needs and level of risk and  
14 conditions identified.

15           I next wanted to turn to issues around perceptions  
16 of program effectiveness, which is clearly an area of  
17 enormous interest for payers and health plans in this arena.  
18 In general, the hard evidence of effectiveness in return on  
19 investment is fairly limited for disease management programs  
20 and case management programs. We have good evidence, solid  
21 evidence for an array of specific programs where there's  
22 been strong controlled clinical studies that look at these



1 issues. But where the gap exists I think is in how these  
2 programs are actually operating in practice, and the cost-  
3 effectiveness and return on investment in these programs  
4 once they are implemented in different health care settings.

5           Certainly, we've seen--there's a lot of variation  
6 in how these programs are rolled out by individual employers  
7 and health plans in different markets. As a consequence we  
8 found that perceptions of the effectiveness of these  
9 programs varied pretty widely, both across markets as well  
10 as within markets. In fact most of the health plans and  
11 employers that we spoke with in this round of interviews  
12 actually indicated they did not have enough experience  
13 and/or not enough enrollment in these programs to be able to  
14 yet assess the effects on cost or quality at this stage.

15           Just by way of example, to give you a sense of the  
16 variation in perspectives of program effectiveness, in  
17 Seattle one case that I mentioned already, and insurer  
18 discontinued virtually all of its disease management  
19 programs over the past two years because of the high cost of  
20 administering those programs, fairly low rates of  
21 participation, and also the perception that the members who  
22 were participating were not--a very small fraction were

1 actually benefitting by the program because a very small  
2 fraction were actually not complying with the disease  
3 management protocols and recommended guidelines already. So  
4 that insurer actually discontinued four of its five disease  
5 management programs and moved to an intensive case  
6 management approach. The one program it retained was a  
7 program that focused on high risk pregnancy and that was the  
8 one where it did have some fairly solid evidence of return  
9 on investment over a fairly short period of time.

10 In contrast, we found several insurers who did  
11 report significant findings in terms of the effectiveness of  
12 their programs. A large insurer in Boston, for example,  
13 reported that a program it had in place for congestive heart  
14 failure resulted in a 33 percent reduction in hospital  
15 admissions for the patients participating in that program  
16 and a 5 percent drop in total cost for patients  
17 participating in that program. Similarly, a large employer  
18 in New Jersey that had started an intensive case management  
19 program for high-cost conditions in its workforce reported a  
20 \$2 return on its investment for every \$1 spent on that case  
21 management program.

22 But the fact is that many other insurers and

1 employers in the markets that we studied indicated they did  
2 not have clear evidence, particularly on the issue of cost  
3 savings or return on investment. A number of health plans  
4 were able to report some significant findings with respect  
5 to improved adherence to recommended protocols and  
6 guidelines, improved screening, improved patient compliance  
7 with self-management strategies. But many of them indicated  
8 that they were not able yet to assess actual economic  
9 outcomes and cost savings from these programs.

10           A few of the challenges to program effectiveness  
11 that health plans and employers noted. Clearly, limited  
12 member awareness and participation is a major challenge.  
13 Along with that, challenge of engaging providers in disease  
14 management and enlisting their support in getting patients  
15 involved in the programs. Health plans, the commercial  
16 health plans face a large problem with membership turnover,  
17 the fact that their members frequently switch health plans  
18 and they often don't have many members long enough in their  
19 programs to realize the benefits from their programs, and  
20 particularly to realize a return on investment.

21           Then also difficulties that health plans face in  
22 measuring and demonstrating their program effects, being

1 able to look long enough into the horizon to measure program  
2 effects. And also issues around different perspectives  
3 between insurers and employers and what the important  
4 outcomes of interest are.

5           To address some of those challenges we have seen  
6 some experimentation with ways to enhance both member and  
7 provider engagement in disease management programs as a way  
8 to improve the effectiveness. Health plans in several  
9 communities, for example, have begun to offer members lower  
10 copayments in exchange for participation in disease  
11 management programs. We saw that in markets such as Miami  
12 and in Syracuse. Several other health plans, as a way to  
13 target providers and engage them in the programs have  
14 started to offer exemptions from prior authorization  
15 requirements for providers that are participating in disease  
16 management programs and that are compliant with the practice  
17 guidelines associated with those programs.

18           Then additionally, health plans in Boston and  
19 Orange County, for example, have started to experiment with  
20 using financial incentives targeted to providers, again,  
21 tied to physician compliance with disease management  
22 protocols. So these are some of the strategies that are

1 beginning to be tested as a way to improve program  
2 effectiveness.

3           Finally, just in conclusion I wanted to summarize  
4 our findings here. I think it's fairly clear in looking  
5 across markets and the experience of private health plans  
6 and employers that clearly plans and employers are investing  
7 more in disease management despite relatively limited  
8 evidence of effectiveness of these programs. Plans are  
9 increasing the number of programs they are offering.  
10 They're also increasing--they're offering these programs in  
11 a broader array of health insurance products, and  
12 particularly focusing in on ways to offer these programs in  
13 PPO products which have really become the predominant model  
14 of health insurance delivery in most markets.

15           At the same time, employers are pushing for  
16 programs that are more tailored to the health care needs of  
17 their workforces, and also pushing for more evidence about  
18 program effectiveness. I think the bottom line here is that  
19 while there is a lot of enthusiasm for these programs and a  
20 lot of experimentation, a lot of innovation in private  
21 health insurance markets, there's still strong demand for  
22 more evidence of the effectiveness of these programs.

1 I'll stop there.

2 MR. HACKBARTH: What I'd suggest we do, as opposed  
3 to having questions for each presenter, why don't we get all  
4 of the presentations out on the table and then have a  
5 broader conversation. David?

6 MR. KNUTSON: Thank you very much. Disease  
7 management is a growing industry, as we just heard. The  
8 phenomenon is a child of many parents, many trends in health  
9 care, and is now seen as a way to improve quality and  
10 efficiency of care, primarily for individuals with a  
11 dominant single chronic disease. Disease management and  
12 chronic illness management are nearly synonymous when one  
13 considers the problems that are addressed and the approaches  
14 that are encompassed.

15 So what are these characteristics of a disease  
16 management program? There are so many resources we could  
17 use to identify these, the Disease Management Association of  
18 America, Ed Wagner's group and others, a project that John  
19 Christianson at the University of Minnesota and I conducted  
20 in the mid-'90s with a national expert panel reached these  
21 conclusions, that a chronic illness care program--and I  
22 would submit a disease management program--includes the

1 following key characteristics. Clinical and referral  
2 guidelines, a team approach with care coordination. This  
3 requires a restructuring of care and all the relationships  
4 among members of the team, nurses and physicians  
5 particularly. This came through loud and clear, no program-  
6 -it has to be an organizational level approach. It can't be  
7 based on a primary care office visit, for example. None of  
8 these can be based on office visits. Therefore, even if  
9 it's a provider-implemented program it can't be embedded in  
10 a visit. Patient self-management programs are needed,  
11 patient registries and reminders, an ongoing performance  
12 measurement and feedback.

13           When one looks at these they distill down to some  
14 key features. One is, of course, the guidelines, and the  
15 fact that guidelines have really become much more accepted.  
16 You're less likely to hear physicians say, this is cookbook  
17 medicine. The idea of evidence-based medicine is now  
18 commonplace.

19           Then we look at the clinical IT. This is  
20 happening; the Holy Grail. It's been a long time but it  
21 seems to be happening where the kind of IT capacity is  
22 becoming available so that one can do the things you need to

1 do to track, monitor, and respond to changes for people with  
2 chronic illnesses and for anyone in a disease management  
3 program. We also need to consider the patient and we have  
4 to find new ways to engage the patient, not only with  
5 education but skills for self-management.

6 Then finally, the restructuring. This is the most  
7 difficult part of the whole thing, and provider  
8 organizations have not been good at change management. But  
9 I submit that the restructuring will occur when a number of  
10 other ingredients are in place.

11 I'm going to skip ahead. We heard about the first  
12 stage of disease management, the independent, direct-to-  
13 patient disease management programs that are prominent  
14 today. They're less difficult to administer because you can  
15 avoid dealing with the network. They're a useful start but  
16 they probably are of limited potential. I submit that  
17 increased benefit may be obtained through a more difficult  
18 integration of disease management within the provider  
19 setting. This is certainly something that managed care  
20 organizations are attempting to do, and insurers, but often  
21 it's been a more direct route to go directly to the  
22 employee/beneficiary/patient through a vendor.



1           But I also would submit that the optimal design  
2 for a disease management program would more explicitly focus  
3 on the provider-patient relationship, and I'll talk about  
4 that later.

5           But before that, what do we know about the  
6 effectiveness of disease management? There are a few, not  
7 many, meta-analyses and critical reviews of the literature  
8 available. I again look back to the team I'm on led by John  
9 Christianson. We reviewed 399 articles evaluating managed  
10 care organization sponsored programs. The vast majority of  
11 those evaluations were poor quality. Either the patient  
12 characteristics were poorly specified, the intervention was  
13 poorly specified, or the outcome poorly specified. We ended  
14 up with only about 35 to 50, based on how rigorous we wanted  
15 to be, articles that seemed to be good enough so we could  
16 understand something about where they might generalize.

17           But through all that we found evidence that  
18 disease management programs do improve care. But we also  
19 found evidence that they had poorly diffused into routine  
20 care. In other words, everyone had a pilot and everyone  
21 focused on one disease, and everyone had a true believer  
22 site, artificial funding, work-around systems, and they were

1 doing something, but very little had happened to diffuse it  
2 into usual care.

3           Another more recent meta-analysis published in BMJ  
4 by Weingarten and group conducted a meta-analysis of 102  
5 articles meeting criteria. His keyword search started out  
6 with 16,000-plus articles, so one of his conclusions was  
7 that the field is littered with poor quality studies. But  
8 what he did then is break down these different interventions  
9 into the types of strategies the program used. They were  
10 either strategies directed at changing provider behavior or  
11 at changing patient behavior and informing patients. So  
12 programs used either patient education, feedback, and  
13 reminders and/or they used provider education, feedback, and  
14 reminders. The one additional strategy that they found was  
15 patient financial incentives for participation.

16           The programs that use any of these strategies  
17 produce modest to moderate but significant statistical  
18 improvement. But as Weingarten says in his conclusion,  
19 little is really known about the relative effectiveness and  
20 cost, therefore cost effectiveness associated with these  
21 different strategies.

22           So let's go back to the providers. What is the

1 extent of diffusion of disease management practices in the  
2 U.S. physician organization let's say? I would like to  
3 first turn to a recent article in JAMA published by Larry  
4 Casalino at the University of Chicago and his former group  
5 at Berkeley, Steve Scharitel and others based on a national  
6 survey of all the physician organizations in the country  
7 with 20 or more physicians. I won't go into the details of  
8 the methods. I wanted to point out that the primary focus  
9 of the study was to try to identify their use of what he  
10 calls organized care management processes. Now if you look  
11 at these, this list on the slide is the list of so-called  
12 CMPs, case management, self-management registries and  
13 reminders, guidelines and physician feedback; the usual  
14 suspects. They asked whether these processes were used for  
15 the following diseases; also the usual suspects, diabetes,  
16 asthma, CHF and depression.

17           The findings and the number of--he had a 70  
18 percent response rate, 1,104 groups responded. The findings  
19 were that 15 percent of these groups use no CMPs, 18 percent  
20 use some for all four diseases, 49 percent use some CMPs for  
21 at least one disease--that's diabetes--and 9 percent use all  
22 CMPs for all four diseases.

1           Looking at diabetes, which was the disease for  
2           which there was the most effort, case management 43 percent,  
3           self-management programs, 57 percent. Now for those of you  
4           who are really paying attention you'll know that this does  
5           not jive with the previous slide. It is what was reported  
6           in JAMA, and I think the issue there is that they asked  
7           about self-management which is patient education  
8           generically. They didn't ask it about a specific disease,  
9           those four types, so it's very likely that most groups are  
10          going to say they have patient education programs. I'm  
11          surprised that it's only 57 percent, but that's the  
12          disconnect between the figures on the previous slide.  
13          Registries 40 percent, guidelines and reminders 38 percent,  
14          physician feedback 48 percent.

15                 He also looked at factors related to CMP use.  
16          First is the availability of external quality incentives.  
17          He asked the medical groups whether they in fact were paid,  
18          or whether they were experiencing any of these incentives,  
19          some were financial, some were not financial like public  
20          reporting. 74 percent said they had at least one of seven  
21          types of external incentives, 17 percent four or more, and  
22          33 percent no incentives. Again, these are the numbers

1 reported. I went back to find the nuance that would  
2 indicate what the denominator was but I couldn't find it at  
3 this moment, but these are the numbers reported.

4           With regard to clinical IT capacity, they asked a  
5 series of questions that tried to probe the stage of  
6 development of the use of clinical IT for the management of  
7 these four diseases. Fifty percent reported that they had  
8 none of these six clinical IT functions available and 76  
9 percent reported two or fewer. In the study the analysis  
10 showed that both external quality incentives and clinical IT  
11 capacity independently were significantly associated with an  
12 increased use of CMPs. So this is providing some high  
13 level, but some evidence that some of these tools and  
14 pressures or incentives seem to play a part. There could be  
15 many other factors that do, but at least this is some  
16 indication that there's an association here.

17           If we look particularly at providers and how they  
18 are reacting to the need to integrate disease management  
19 programs in their practice they would identify a number of  
20 barriers. The first is financial constraints, of course.  
21 The second is provider time burden. Again as I mentioned,  
22 it cannot be visit-based so it really does need to be a

1 separate program. Many of them lack clinical IT capacity.  
2 In some cases they have the capacity but they haven't  
3 developed the disease management application yet.

4           On another study that we've just started where I'm  
5 involved in an organizational economic evaluation of the  
6 implementation of a diabetes program in 11 medical groups in  
7 the country it is very interesting that some have  
8 implemented EMRs but have not yet developed the registry  
9 capacity. In other words, it's been a little bit of an  
10 afterthought. For others it's been, of course, the first  
11 thing we want to do is do this. But what I've observed in  
12 many groups is that when the EMR is in place it's an  
13 explosion of opportunity perceived by even the rank and file  
14 physicians, and it's an amazing thing to behold. So I've  
15 come to the conclusion that clinical IT by itself will be a  
16 milestone and a breakthrough in allowing for what we call  
17 disease management to be successfully implemented in medical  
18 groups.

19           I do think also thought that the incentives need  
20 to support this. In another project that I've just become  
21 involved with funded by HRQ, we're looking at how incentives  
22 are translated to and within provider groups in Minnesota

1 and Colorado. We are trying to understand the new pay for  
2 performance phenomenon and try to understand it from the  
3 provider's prospective. Some of these demonstrations are  
4 also good starts, just like targeted disease management, a  
5 good start but possibly self-limited. Targeted pay for  
6 performance is a good start, probably self-limited because  
7 they have some Pavlovian idea of a response to incentives  
8 and don't typically--haven't tried to understand the  
9 incentives in the environment of a medical group. But we're  
10 going to try to address some of these and we're going to  
11 build on the work of Casalino, Schartel, Wagner, and others.

12           The wild card in all this though, I think, is the  
13 poor mechanism for patient involvement. I think that's  
14 something where we really don't yet know how do that well.  
15 I'll explain what I mean in a second. I've got very limited  
16 time so I'll move much faster.

17           Judy Hibbard, who some of you know as--I guess you  
18 could call her a guru on the consumer behavior, and others,  
19 have made a number of observations recently. Hers in a very  
20 good overview article that was just published. She  
21 identifies three types of roles for patients,  
22 consumer/beneficiaries. One, of course, is the informed

1 choice role we've all been pushing. She says, as I and  
2 others have found in our own research, that consumers still  
3 show little use of the kind of information we're providing  
4 in report cards and seem not to be switching as often as we  
5 think they should in a rational consumer-driven market.  
6 It's happening but not to the extent that anyone has hoped.

7 She also talks about the evaluated role where the  
8 consumer's perspective, primarily through satisfaction  
9 surveys, are included as a quality measure. But she talks  
10 more now about the co-producer role; the patient as a  
11 collaborator with the physician in this case, and the values  
12 of that. Underneath all that would be the concept you're  
13 familiar with self-management, shared decisionmaking, and  
14 collaborative care. I could go into details but maybe  
15 during the Q&A.

16 I think one of the observations though that they  
17 all make and that we've made is that the provider-patient  
18 relationship remains a dominant force. Not matter what we  
19 try to do produce a consumer choice market we can't deny  
20 this force. Even when you talk to someone like David Lansky  
21 at FAACT and they produce physician-specific quality  
22 information for patients, the patients instead of saying,



1 this bothers me, I'm going to switch doctors. They bring it  
2 to their physician and say, maybe I can work with my  
3 physician to improve his care or her care. That's a  
4 different world than was contemplated I think.

5 We all know that patients more successfully  
6 participate in disease management programs when physicians  
7 recommend or refer. That's a common experience. If their  
8 physician says, I think you should do this, they will go to  
9 it, they'll stick with it much better. As you heard, some  
10 of the independent stand-alone programs aren't getting good,  
11 what they call compliance. I think it's the concept of  
12 compliance that is fundamentally the problem.

13 One of the things we haven't done is try to  
14 understand this provider-patient relationship from a lot of  
15 perspectives. I think providers will be able to administer  
16 disease management when EMR is implemented. I think maybe  
17 some small providers need help but I think that by itself  
18 will do a lot. Programs must be operated at a physician  
19 organization level. They can't be physician based. We know  
20 that, but a lot of medical groups are aware of that. New  
21 incentives must be developed but they have to get beyond  
22 just targeted pay for performance. Therefore we need really

1 a broad conceptual model of the economics of the whole  
2 thing. In that model I think needs to be focus on the  
3 patient-doctor relationship.

4 I don't think we have enough explicit attention,  
5 as we try to push choice, in the role of agency. I think  
6 that we assume the primary care physician is a trusted agent  
7 for the patient, but we don't know, especially when  
8 consumers are paying more and there's more cost-sharing for  
9 choice in treatment, how the patient's perspective is being  
10 enlisted in the decisionmaking process. We know the primary  
11 care physicians aren't trained well to do this; some of the  
12 good ones do. But I think if we build the incentives, build  
13 the information around optimizing on that relationship then  
14 I think we have a better chance of producing cost-effective  
15 care in general, let alone disease management.

16 Thanks.

17 DR. REISCHAUER: Thank you. Jeff?

18 MR. SIMMS: Good morning and thanks for the  
19 opportunity to tell you about North Carolina's experience  
20 with our Medicaid program with disease management, but also  
21 with our primary care case management program.

22 We have a program that's called Community Care of

1 North Carolina. Over the last couple years its name has  
2 changed a couple of time but it's referred to as ACCESS II  
3 and III. But it's built upon a program that's a statewide  
4 primary care case management program called Carolina Access  
5 where we have more than 75 percent of the Medicaid  
6 population in the state linked with a primary care provider,  
7 so the basic fundamental or foundational step is there where  
8 we've been able to link the Medicaid patients with the  
9 primary care provider. While building upon that foundation  
10 we implemented or we began implementing in 1998 the  
11 Community Care of North Carolina program which joins  
12 together all of the community providers, all the  
13 stakeholders at the local level, which are the hospitals,  
14 the health departments, the departments of social services,  
15 along with the providers because we realize that it's a  
16 multifaceted approach this needed to really serve the  
17 Medicaid population across the state. It creates community  
18 networks that assume responsibility for managing recipient  
19 care.

20 The program focuses on improved quality,  
21 utilization and cost-effectiveness. Now ideally, when we  
22 started the program some five years ago we really wanted to

1 have the opportunity to focus in on quality improvement  
2 initiatives, but that was also about the time the states  
3 began seeing major problems in their budget deficits so we  
4 began having to quickly shift and figure out ways--because  
5 we all agree that quality improvement initiatives will  
6 result in cost-effective care, but it's not going to give  
7 you an immediate cost effectiveness that we were needing and  
8 that the legislature was requiring of us during that time.  
9 So improving quality, utilization, and cost effectiveness.

10           So what we began doing was building upon the  
11 Carolina Access program which had all the contracts with  
12 primary care providers across the state, and we began  
13 developing networks with 2,000 or more--currently we have 13  
14 networks with 2,000 or more physicians participating and  
15 more than 417,000 enrollees enrolled in the Community Care  
16 of North Carolina program.

17           As you can see, this is a map of the state which  
18 gives you the different 13 sites. It's probably difficult  
19 to see on the black-and-white printout but we're covering  
20 the state. We've got urban versus rural areas. We're  
21 really trying to get the providers to network together and  
22 the communities to network together as opposed to setting up

1 new sites. We really want to begin just building and  
2 expanding upon what we currently have in place across the  
3 state now.

4           The Community Care networks are set up as  
5 nonprofit organizations, or some of them, the public  
6 providers end up serving as the administrative entity for  
7 the Community Care networks. In a number of the sites the  
8 federally qualified community health center is the  
9 administrative entity. It's comprised of the safety net  
10 providers, of course, those who have traditionally continued  
11 to serve the Medicaid population. They have to establish  
12 steering committees, medical management committees. They  
13 received \$2.50 per member per month care management fee.  
14 It's important to understand, like I said earlier, this is  
15 still based upon the fee-for-service reimbursement. So they  
16 still receive their regular Medicaid reimbursement on a fee-  
17 for-service basis, but on top of that they receive an  
18 additional \$2.50 per member per month. Then with that money  
19 they're able to hire care managers and medical management  
20 staff to do the care coordination and care management for  
21 the patient population.

22           The networks assume responsibility for the

1 Medicaid patients. They really come in and as the providers  
2 have their patients linked with them--we systematically link  
3 the patients with the provider and then that provider and  
4 the network becomes responsible for the services provided to  
5 the patient population that's linked with them. We identify  
6 the costly patients and the costly services, or we allow the  
7 networks to do that and we want them to figure out ways to  
8 do that intensive care management that my colleagues were  
9 talking about earlier. They develop and implement plans to  
10 manage utilization and costs, and they create the systems to  
11 improve the care.

12           Some of the key program areas in managing clinical  
13 care for Community Care of North Carolina is that you've got  
14 to implement the quality improvement strategies or the best  
15 practice processes. Disease management happens to be a very  
16 integral part of our program in North Carolina. We're  
17 managing the high risk patients. We're managing the high  
18 cost services, and we're building accountability through  
19 monitoring and reporting.

20           One of the things that must happen and that we  
21 have continued to have is having strong provider support.  
22 But in having the strong provider support and buy-in, you've

1 got to provide them usable material in a timely manner where  
2 they can know what's happening. A lot of times just peer  
3 pressure alone ends up resulting in the providers wanting to  
4 change their behavior. But you've got to be able to provide  
5 them the information as quickly as possible, and that has  
6 continued to be a challenge for the North Carolina Medicaid  
7 program. But most Medicaid programs across the country face  
8 that challenge of having the information system to be able  
9 to give that information in a timely manner. Most of them  
10 don't have the information systems built to provide that  
11 sort of information so they're having to go back and change  
12 it be building data warehouses and those sorts of things.

13 This is just a schematic of the managing of  
14 clinical care. This shows you how we handle it at the state  
15 level. We have a clinical directors group which is  
16 represented by a medical director from each of our sites  
17 coming together on a consistent basis to identify targeted  
18 disease management or care management processes. Then at  
19 the local level each of the sites have a local medical  
20 management committee that implements the initiatives that  
21 were led down to them by the state clinical directors group.  
22 But then they can also take on local initiatives. There are

1 some sites that are participating in grants that they've  
2 received to do things with child development, developmental  
3 services, with ADHD, those sorts of things. Then it goes  
4 down to the practice level where each practice usually has a  
5 physician champion or a clinical champion who makes sure the  
6 practice implements the protocols and the processes as well.

7           With implementing the best practices, it's  
8 evidence-based guidelines, it's improvement specialists.  
9 Like I said, there are practice champions. There are the  
10 establishment of the improvement processes. And there's  
11 benchmarking and goal-setting. Again, that brings in the  
12 accountability and the pieces that we've got to have in  
13 place where they can see targets that they need to be  
14 striving for. So really is getting the providers bought in  
15 and sold on the approach.

16           We have implemented disease management strategies  
17 specific to asthma and diabetes. The clinical directors  
18 have really worked to set the performance standards. For  
19 example, with asthma we're just using the national  
20 guidelines for that. Then the local provider buy-in is  
21 obtained.

22           The standardized physician toolkits. There is a



1 need to standardize your processes and the approaches. When  
2 we first started out the program in '98 we really wanted to  
3 take this as an opportunity for the local communities to not  
4 feel that the state was coming down and driving them as to  
5 how things should be done. So in our pilot sites we had  
6 different strategies being done. But what we realized over  
7 the years is that there's got to be a way where we pull in  
8 some consistency and some standardized measures and  
9 approaches to it. But we still at the state level are  
10 allowing the local sites to do it. We give the local--we  
11 provide assistance with the local infrastructure and the  
12 consistency. But we just provide technical assistance and  
13 tell them, ask them how you can get it done at your local  
14 level. I think that has gotten us a lot of support from the  
15 local communities. And then the practice level quality  
16 improvement system processes.

17           The accountability is there, again as I was  
18 stating. The chart audits, the practice profiles, the care  
19 management reports which identify the high risk, high cost  
20 patients, the PAL which is our pharmacy advantage list  
21 scorecard, and the progress toward the goals and the  
22 benchmarks. We have been able to really provide some data

1 that allows the providers to become better advocates for you  
2 and really identifying some of the patients that they need  
3 to understand may be frequent fliers, and they work very  
4 closely with those patients. Those are the sorts of  
5 information and material that we provide to them.

6           Again, some of the programs; asthma, diabetes.  
7 We've also had to do some things with targeted emergency  
8 department management, pharmacy, and therapies. The  
9 pharmacy is one that we had to be tapping into because of  
10 the immediate cost savings that we can see result from the  
11 initiatives that we put in place, because the others are not  
12 going to give us the immediate cost savings or give us the  
13 greatest bang for our buck. So we have the opportunity with  
14 the infrastructure that we have in place to look at things  
15 related to pharmacy and there's some information later in  
16 the presentation regarding that.

17           Our asthma initiative, we have pretty much, like I  
18 said, implemented the asthma guidelines for the national  
19 benchmarks and guidelines. You can see that some of the  
20 process measures which include the number of asthmatics with  
21 documented staging in the charts, the number of staged  
22 asthmatics with inhaled corticosteroids, the number of

1 staged who have an asthma action plan. All those sorts of  
2 things based upon the chart audits and the process measures  
3 that we're doing, we're seeing improvements in those areas  
4 and we're hoping to continue to see that.

5           But as we add on more practices--and now we're  
6 moving beyond the practices that were excited about coming  
7 onto the program and we're now beginning to expand and  
8 having to bring in providers who were not necessarily the  
9 champions but what we're saying to them is, this is the way  
10 we want to see Medicaid provided across the state of North  
11 Carolina so we really need you to come on board. So as  
12 we're seeing that, we're having to change a lot of behavior  
13 with some of our providers.

14           As you can see, this is some outdated data here  
15 but we're trying to get the more recent data. But you can  
16 see just by the case management and care management that  
17 we're doing with asthma, the episode cost in comparison to  
18 those patients under the age of 18 who are not linked with  
19 ACCESS II or III provider is a lot less.

20           Our diabetes initiative, again, these are the  
21 chart audits where you can look at the different sorts of  
22 process measures in relation to diabetes. We're seeing

1 improvements in that area as well.

2 ED utilization, the same thing. For patients who  
3 are not linked with a primary care provider who is in ACCESS  
4 II and III we're seeing their ED rates are higher than those  
5 providers who are with an ACCESS II or III network. Most of  
6 the Medicaid programs across the country have really felt  
7 that our hands have been tied in a number of areas in  
8 relation to emergency room cost containment because of the  
9 changes with IMTAL and prudent layperson, but we're trying  
10 to work as best we can with some of the care management and  
11 case management with these patient populations. We identify  
12 the frequent fliers, we do the follow-up calls with them.  
13 We have letters that go out to them. We try to do as much  
14 education as possible with them to contain that cost.

15 Then as I was stating earlier, we felt that we  
16 needed to pull in some things in relation to pharmacy,  
17 because we knew that we could see an immediate cost savings  
18 with that. So that's why we began doing things like our  
19 prescription advantage list, the nursing home polypharmacy  
20 project, and the ambulatory polypharmacy project as well.  
21 If you'll notice with this, in most primary care case  
22 management programs across the country the nursing home

1 population is not included in that sort of a system, and the  
2 same thing in North Carolina. But we have the  
3 infrastructure in place that allowed us to build upon it and  
4 look at populations who would not traditionally be included  
5 in the PCCM models.

6           The PAL pharmacy--we've developed a pharmacy  
7 committee through the clinical directors, the statewide  
8 clinical directors committee. The pharmacy committee  
9 defines the drug classes and unit doses. Medicaid  
10 calculates the relative drug cost and the ranking. We then  
11 inform the Community Care of North Carolina physicians and  
12 then we measure the changes in prescribing patterns.

13           This is just an example of what is actually sent  
14 out to the providers. It's important to understand, this is  
15 a voluntary program. It's not something that the state has  
16 mandated. The providers are taking this on as their  
17 initiative. We were required by--we went into our budget  
18 session two years ago and immediately began telling them  
19 about the things we were doing in Community Care of North  
20 Carolina and they immediately cut our budget by \$29 million  
21 and we had to come up with some ways to--strategies to make  
22 sure that we would see that materialize, and the physicians

1 felt the need to begin dealing with pharmacy. So they began  
2 voluntarily expanding the PAL list and they have continued  
3 to do that statewide as well.

4 The preliminary findings show that we are seeing  
5 somewhere, about 22 percent lower expenditures compared to  
6 the pre-rollout; post-rollout as compared to the pre-  
7 rollout. So that actual savings for that period of time was  
8 about \$640,000. But we're seeing it continue to grow.

9 We are now in the process beginning November 1  
10 we're taking it statewide. Again we're asking the providers  
11 to voluntarily participate in it. We're working with the  
12 local medical societies, we're working with specialty  
13 societies as well and telling them, this is the only way  
14 that we can really begin working together and really  
15 creating a way to save dollars for the Medicaid program.  
16 The providers are excited and working with us to get it  
17 done. The hospital association is helping us as well,  
18 because this is expanding beyond just the primary care  
19 providers. But again, one of the benefits to Community Care  
20 of North Carolina is it has established the infrastructure  
21 for us to build upon it to take on other initiatives.

22 The nursing home polypharmacy initiative, we've

1 got it in place where we've got pharmacists and physician  
2 teams working together. They review the drug profiles, the  
3 medical records of Medicaid patients in nursing homes. They  
4 determine if there's a drug therapy problem, recommend a  
5 change and perform follow-up to determine if the change was  
6 made.

7           The screening criteria is that the nursing home  
8 residents wither greater than 18 drugs used in a 90-day  
9 period--and the numbers show that we had about 9,208  
10 residents who met this criteria. Our database, the Medicaid  
11 database is used to flag the charts according to the  
12 following criteria: inappropriate drugs for the elderly, the  
13 Beers drugs, the drugs used beyond usual time limit, the  
14 warnings and precautions. We still tag it or attach it to  
15 the PAL list. And also the potential therapeutic  
16 duplication.

17           Preliminary findings, we've had the 9,208 patients  
18 reviewed. As you can see, the recommendations made on  
19 8,559, unnecessary therapies 19 percent, more cost effective  
20 drug 56 percent, wrong dose 7 percent, potential adverse  
21 reaction 9 percent, needs additional therapy 3 percent,  
22 other 6 percent. As you can see, the ones that we

1 implemented, about 74 percent.

2           Based upon these findings, the teams are cutting  
3 cost. This is an opportunity again. Community Care of  
4 North Carolina has given us the opportunity to do some of  
5 these more intensive care management things, and  
6 specifically with the nursing home polypharmacy. As you can  
7 see, the evaluation is being conducted by the UNC School of  
8 Pharmacy.

9           Other initiatives that are under development is  
10 the continued statewide expansion, the dually eligible--  
11 expanding it to dually eligible population, and figuring out  
12 some ways to really work with that population; most of the  
13 time some of our most costly patients in the Medicaid  
14 program. But again, it's an issue of where some of the  
15 federal regs prevent you from being able to mandatorily link  
16 them with providers and to deal with them in our  
17 environment, but we're figuring out ways to do it.

18           We're also realizing, like my colleagues were  
19 stating earlier, we've gotten the providers who have been  
20 the volunteers and the ones who want to do this and now  
21 we've got to figure out how do we sustain this down the  
22 road, so incentive programs that got to be put in place.



1 Our secretary for the department of health and human  
2 services is very committed to looking at health disparities,  
3 so Community Care of North Carolina gives us the opportunity  
4 and the infrastructure to look at things like disparities.

5 Improved collaboration with public providers,  
6 which is where--we're in the process of revamping our mental  
7 health system and that's another provider and stakeholder  
8 that we're having to tap into. Looking at in-home care and  
9 targeted disease management, continuing to do that as much  
10 as possible and building upon it. The infrastructure is  
11 there for us to be able to build upon that.

12 The lessons that we've learned? The top-down  
13 approach where we come from the state level and say, it's  
14 got to be done this way, doesn't work in North Carolina, and  
15 the providers will fight the system. So we decided, let's  
16 come together and figure out how we can make it work. I  
17 would say that we've been successful with that in North  
18 Carolina. We've also had a very supportive legislature in  
19 regards to provider reimbursement as well. They have been  
20 very supportive of the Medicaid program with our  
21 reimbursement rates for our primary care providers, so that  
22 has helped us as well.

1           The community ownership and working with the local  
2 communities, that just reinforces the concept that we can't  
3 do this alone. We must partner together. The incentives  
4 must be aligned. In North Carolina, the major incentive and  
5 the push for getting Community Care of North Carolina up and  
6 running and the disease management strategies was that the  
7 providers in North Carolina have not been strong supporters  
8 for the MCO model for the Medicaid population. We have a  
9 very limited MCO option in North Carolina. It's only in  
10 Charlotte and Mecklenburg County, and we only have about  
11 10,000 Medicaid patients who are linked with an HMO in that  
12 community. So the providers have really felt vested and had  
13 a vested interest in seeing this sort of model run.

14           We must develop systems that change behavior, and  
15 we must be able to measure the change. Change takes time  
16 and reinforcement, and that's what we continue to have to  
17 battle with our legislature to let them know. We're trying  
18 to do as much as we can to get it implemented and to see the  
19 immediate cost savings, but it takes time.

20           Thank you.

21           MR. HACKBARTH: Thank you. Ralph?

22           MR. MULLER: Thank you to the three of you for

1 that very helpful overview. I have two questions that are  
2 interrelated. One is that from the point of view of the  
3 Medicare program, especially with the elderly part of that,  
4 what do we know about how effective disease management is  
5 given that, obviously, many years have already passed by  
6 before they become Medicare eligible? A number of you  
7 pointed out that the evidence on disease management isn't  
8 that conclusive yet, but what do we know about the Medicare  
9 part of that in terms of effective investment is for  
10 Medicare given that perhaps a lot of it should have been  
11 done, as you pointed out, in the Medicaid population a lot  
12 earlier?

13           Secondly, you point out that there is a lot of at  
14 least preliminary evidence that case management, especially  
15 around high cost, high risk cases may be a more cost  
16 effective way to go. Can you speak a little bit to the  
17 interrelationship of disease management and case management,  
18 especially if you think that disease management may be a way  
19 of, if it is a good marker for which cases you may want to  
20 case manage. I understand that it may not be cost effective  
21 to do disease management across a whole population of  
22 diabetics, asthmatics, et cetera, but is that a good marker

1 for the cases that may be case managed or are we better off-  
2 -are there other markers of which cases one may want to case  
3 manage if that's where the most cost effective interventions  
4 can be? I know those questions may interrelate, but any of  
5 you want to take those two on?

6 MR. MAYS: I'll start with the first question. I  
7 think in terms of how effective we think these programs can  
8 be for the Medicare population, I think there are clearly  
9 some unique opportunities in Medicare for implementing these  
10 programs and it may bode well for their effectiveness in the  
11 long run. One certainly is the relatively high prevalence  
12 of chronic disease which many of these programs target. The  
13 other being a relatively stable membership in the Medicare  
14 program. So Medicare is not going to confront these  
15 problems of membership turnover that's really confounded a  
16 lot of the efforts in private health insurance.

17 Thirdly, you have the ability to take advantage of  
18 population data systems as a way to begin to prospectively  
19 identify what patients might benefit from disease management  
20 and case management. I think there are also potentially  
21 some unique challenges that Medicare faces as well, one  
22 being the fact that the population often has multiple

1 chronic diseases and may be at later stages of disease that  
2 may be less amenable to intervention and cost savings.

3           Additionally, the importance of a pharmacy benefit  
4 for many of the disease management programs, managing  
5 pharmaceutical therapy is an important component of many  
6 disease management programs that are out there in the  
7 private sector. The fact that not having that benefit in  
8 place in Medicare and not being able to take advantage of  
9 pharmacy claims data in the process of managing disease is a  
10 challenge that Medicare is going to face. So I think those  
11 are elements that are going to play into implementing these  
12 programs in Medicare.

13           Certainly in the markets that we examined, the  
14 health plans in several markets that had the most experience  
15 with disease management and were making the most investments  
16 in disease management were plans that had a history of  
17 participation in Medicare HMOs in the Medicare program. So  
18 I think there are certainly in markets that have had more  
19 experience with Medicare managed care, there are health  
20 plans that have particular experience in using disease  
21 management for Medicare populations and some of them are  
22 able to report significant results with their programs,

1 particularly on the side of quality improvement.

2 MR. KNUTSON: As a researcher it's probably not  
3 appropriate for me to say we need more research, but for  
4 congestive heart failure it's close to a no-brainer in terms  
5 of disease management intervention as you can get, and then  
6 moving out from there it becomes murkier. I think the  
7 question for us is, the first observation about Medicare is  
8 that a whole lot more of what should go on is probably  
9 embedded in good primary care because of the complexity,  
10 especially as we move to caring for people with complex  
11 medical conditions or the frail elderly.

12 I don't think we know yet, or at least I don't,  
13 how one would on the margin figure out where to put energy.  
14 For example, do you really go after, beyond CHF, the most  
15 severe end of the spectrum for this condition and then move  
16 on to--I don't think we know that. We don't know the  
17 relative cost effectiveness of any of this, or cost benefit  
18 I should say in this case. So I think that kind of research  
19 is needed.

20 I think it's promising the new demonstration  
21 projects that CMS has been initiating. I think this story  
22 from North Carolina is promising in the sense that you can

1 start working in the fee-for-service world and maybe build  
2 from that some capacity to introduce what we call good  
3 managed care. But I don't think we know enough to know  
4 where to start, and where to go next, and where to go after  
5 that; at least, as I say, I don't.

6 MR. SIMMS: I would say just with your second  
7 question dealing with how do you tie in the intensive case  
8 management with the disease management, what we've done with  
9 the North Carolina experience is it ends up being more of a  
10 care coordination thing.

11 Specifically with the children that we serve in  
12 our program, like for example the children who end up being  
13 asthmatic children, we figure out ways to really do care  
14 coordination for them by tapping into other case managers  
15 that are currently coordinating service for those children,  
16 like the child service coordination. That's why it's so  
17 important to have all of the stakeholders bought into it at  
18 the local level because what we end up identifying and  
19 finding is that, you're right, there are a lot of other case  
20 management programs going on with some of the patient  
21 population but what we're able to do through Community Care  
22 of North Carolina is really try to develop a system of care

1 for that particular population. So I think there is a need  
2 for the coordination with the intensive case management in  
3 addition to what's being done on just the disease management  
4 side as well.

5 MR. MULLER: Jeffrey, especially you point out  
6 that when budget crises come all of a sudden there's not as  
7 much investment in these kind of programs. I think one  
8 could certainly see, given the complexity of the American  
9 health care system why one would for qualitative reasons  
10 want to invest a lot in care coordination and care  
11 management. But given the kind of budget crunch where we  
12 talk about budgets for Medicare, Medicaid and so on, my  
13 guess is the bigger thrust will come on cost savings rather  
14 than quality improvement because that's what people I think  
15 are more likely to put their dollar behind is where you can  
16 get the big cost savings.

17 I could see where in disease--if you could have a  
18 low cost disease management program from identifies--I'm  
19 talking about this now from the point of view of cost  
20 savings rather than from quality improvements, a low cost  
21 disease management program that then helps you target where  
22 the costly interventions perhaps can be avoided. Because I



1 know there's evidence, for example, in using prenatal care  
2 as a way of avoiding infant mortality and premature birth  
3 and so forth where you can obviously save some big dollars.  
4 More in the Medicaid program, obviously, than the Medicare  
5 program, by getting people to prenatal care and then trying  
6 to avoid obviously the very costly consequences in dollars  
7 as well as obviously in the quality of life of prematurity.  
8 So in that sense, if one can use low cost interventions like  
9 just monitoring a person during pregnancy as a way of  
10 avoiding that one--what I'm searching for is, are there  
11 lower cost disease management programs that then led to big  
12 cost savings, because I think that's--insofar as we are  
13 looking at disease not for quality of care but also as cost  
14 dampening strategies, my guess is that's where the real  
15 appetite is going to be for those kind of cost savings.

16 MR. KNUTSON: If I could make one more comment.  
17 One of the areas that might be promising and I assume you  
18 probably thought through this a bit, is monitoring the  
19 introduction of palliative care benefits by some insurers.  
20 Even though it's a little early it seems to be promising  
21 from a lot of perspectives. It would be one of those areas  
22 where we start with the assumption that the individual--

1 nobody wants the care that's being provided, and which just  
2 haven't figured out how to get the right decisionmaking  
3 environment. I mentioned this agency problem before.  
4 Palliative care is a great example where you're continuing  
5 treatment but you're adding this thing and it looks like  
6 it's producing some savings or least breaking even.

7           But again it's early. There's been some Robert  
8 Wood Johnson-funded studies that are worth looking at, and  
9 maybe more that I'm unaware of, but I certainly would think  
10 that would be a good start and a way to try to figure out  
11 how to get a new perspective on decisionmaking or on  
12 treatments that really nobody wants, including the patient.

13           MR. FEEZOR: Thank you. I'd like to thank all  
14 three of you for an excellent presentation. I feel a  
15 little bit like it's old home week. In my previous  
16 existence out at CalPERS I was always a part of the health  
17 system changes survey; looked forward to that exchange and  
18 see some of the information coming back. And actually  
19 before leaving for California I worked with Jeff to set up  
20 one of those community care programs and it's good to see a  
21 report and see you again, Jeff.

22           A couple of observations. David, first I'm struck

1 by your comment that we have not spent enough time looking  
2 at how important that patient-provider decisionmaking role  
3 is. I'll take your bid for additional research. Probably  
4 need to look more in terms of variation of how disease  
5 management, various disease management programs engage the  
6 providers or bypass them, and perhaps trying to get some  
7 better analysis around the kind of consumer, whether it's as  
8 Judy would say, one of the more engaged consumers or not, to  
9 really begin to tool up our effectiveness. I think that  
10 would be ripe for research.

11 Glen, one question for you and then--let met start  
12 with a comment on Jeff's comments that will follow up a  
13 little bit on yours, Ralph. I think one of the important  
14 things that made the community care programs begin to really  
15 take off was the feedback of information. Jeff mentioned  
16 that in his presentation. This went to providers or to  
17 those committees, and it is analogous with what I think Glen  
18 was talking about, that most employers now are pushing very  
19 hard from, whether it's certain disease management vendors  
20 or their claims-payers, for the kinds of information to  
21 begin to target that.

22 I think to underscore another component that came

1 out though in Jeff's comment is that that \$2.50 or the  
2 monies that go back, don't necessarily go back to be spent  
3 for clinical decisions. His comment about having the health  
4 department, social services sitting at the table, that many  
5 instances those monies will get allocated for something  
6 else, which I think is something that is an interesting  
7 juxtaposition if you start thinking about how do you apply  
8 this to an older population.

9           Having said that, I think a key difference in the  
10 community care programs in most of the communities, areas  
11 that I'm familiar with that Jeff's presentation referenced,  
12 you have a smaller subcomponent of the physician and  
13 provider leadership there, and a group that probably works  
14 together even though they're not in any sort of large group  
15 practices for the most part, but probably work together in  
16 more of a community spirit that you may not have that same  
17 dynamic to broader providers who in fact are dealing with  
18 the Medicare population.

19           Then the obvious or the final thing is that  
20 obviously the Medicaid population tends to be less hospital  
21 and more outpatient, so it's in the individual physician's  
22 own interest I think to participate more actively in some of

1 that and I think that has been the success of the program.

2 Glen, one question for you. In looking at those  
3 employers or employment-based coverages that are beginning  
4 to do what you call high risk identification on the front  
5 end, any discussions or problems noted with respect to  
6 privacy issues or ADA implications?

7 MR. MAYS: I think those are definitely concerns  
8 for employers that are trying to move in this direction. We  
9 didn't hear of any employers actually encountering barriers  
10 or not being able to proceed because of those issues, but  
11 they're certainly issues that they have to work out in  
12 moving those programs forward. Particularly we heard of  
13 some employers who are looking at ways to bring together  
14 their health care claims data together with their  
15 information on their experience in their workers  
16 compensation to better target these interventions and also  
17 to better monitor effects on the back end. In doing that  
18 those same issues also come up and integrate in those  
19 databases.

20 But again we didn't hear--certainly those are  
21 issues that employers are confronting in moving this  
22 forward, and to be sure there's not a lot of employers out

1 there doing this at this stage. It tended to be very few,  
2 large employers in the markets that we studied. They're  
3 addressing those issues but they don't appear to be game-  
4 stoppers in terms of...

5 DR. NEWHOUSE: I'd like to echo the thanks to you  
6 for taking the time and effort to come and sharing your  
7 information with us. I'd also like to go along the lines  
8 that Ralph and Allen started, how do we take this over and  
9 apply it in the Medicare context? My first question is  
10 actually just something for my own information. I struggle,  
11 like everybody else is with, how is this organized within  
12 the context of traditional Medicare?

13 So my question is, if traditional Medicare is  
14 having demonstrations of disease management, which I thought  
15 I heard somebody say, who is running these demonstrations?  
16 Not CMS, but how is it getting implemented on the ground?  
17 What is the entity that is actually out there is managing  
18 disease and how does it integrate with traditional Medicare?  
19 Can anybody enlighten me on that?

20 MR. HACKBARTH: Can any of the panelists answer  
21 that? If not, I think one the staff probably--

22 MR. KNUTSON: I can make a start. I think maybe a

1 staff person would know more. There are five or so demos  
2 that one could, if you look inside of them see some, for  
3 example, quality incentive or it's a disease management  
4 demo, per se. There's the capitated disease management demo  
5 where possibly 30 sites are soon to be announced, between 20  
6 and 30, and those will be typically provider-sponsored  
7 organizations. They can be M+C plans but the preference is  
8 not. If it is an M+C plan selected, they have to enrollee  
9 two from fee-for-service for every one that they rollover  
10 from their M+C product.

11 There are others. There's a demo that is a  
12 straight disease management demo where a case management  
13 fee, I believe, is paid to a disease management organization  
14 and then they need to show savings.

15 There's a physician group practice demonstration  
16 project which--

17 DR. NEWHOUSE: That second one, how are the  
18 beneficiaries identified?

19 MR. KNUTSON: I know there are two or three sites  
20 and from what I understand, and I'm going to be right out on  
21 the edge of the limb here, they're doing actually a  
22 randomized controlled study. They're actually finding

1 people eligible and then randomizing in or out of that  
2 program.

3 DR. NEWHOUSE: But as Glen said, we don't have a  
4 drug benefit so we can't identify that way.

5 MR. KNUTSON: The idea was that they would include  
6 that and still show a savings. They might include a drug  
7 benefit.

8 DR. NEWHOUSE: But you have to have some prior  
9 knowledge about the drugs that are being used to--I don't  
10 want to put you further on the spot but I'd suggest then  
11 maybe this is an area we should find out something about.  
12 Maybe staff could follow up.

13 AUDIENCE SPEAKER: I'm actually a CMS staff person  
14 and I work in the demonstration group. What you've said so  
15 far is pretty much dead on. I also wanted to let you know  
16 that a week from now my director will be briefing MedPAC on  
17 the demonstrations, specifically the disease management  
18 demonstrations. So if you have any further questions she  
19 might be able to answer that.

20 DR. NEWHOUSE: I'm just still struggling with  
21 beneficiaries with multiple problems, dealing with multiple  
22 providers, many of whom are in very small groups or even



1 solo practice, with no drug benefit, which affects both the  
2 targeting side and the compliance side, how this even starts  
3 rolling down the runway, let alone gets in air. But I'd be  
4 delighted to be shown how it does.

5           There's one just point of information I wanted to  
6 make which was some data I saw the other day that I found  
7 interesting and I thought cast the enthusiasm for disease  
8 management is a somewhat different light, although not  
9 entirely, which is I think the enthusiasm at least as I hear  
10 it stems from the observation that--pick a number--5 percent  
11 of the beneficiaries account for half the dollars, and  
12 following Sutton's law, go where the dollars are. These  
13 people are largely people with chronic disease, et cetera.

14           The data I saw divided the distribution of people  
15 by spending into thirds, so it looked at the bottom third,  
16 the middle third, and the top third of spenders. Then it  
17 looked at the rate of increase in each of those thirds over  
18 time. Lo and behold, they were almost the same, the rates  
19 of increase, which is consistent with the notion that the  
20 general shape of this distribution doesn't change. That is,  
21 for many years it's been the case that 5 percent of the  
22 people account for half, plus or minus, of the dollars,

1 which suggests that disease management may be fine, although  
2 as David and others said, the jury is even out on that. But  
3 it's presumably not doing much about the two bottom thirds  
4 of the people which are some substantial share of the  
5 spending. So this suggests it may be an answer but it's not  
6 the magic bullet.

7 DR. NELSON: I also have an observation and a  
8 question. To some degree my observation follows what Joe  
9 was pointing toward. It has to do with my suspicion that  
10 the cost benefit calculation for an employed group may not  
11 be transferable to a Medicare population because there is a  
12 time window. It's to the benefit of the employer or the  
13 insurer to manage the diabetes, defer the renal failure and  
14 the other complications until a person retires. But the  
15 Medicare patients may not necessarily avoid that expensive  
16 crash; it just comes later. And when it comes it may even  
17 be more expensive if it involves Alzheimer's disease or  
18 cancer instead of a nice clean quick coronary at home. So  
19 not being Kervorkian in this, I still think that we have to  
20 be cautious lest Congress jump to some leaps in scoring this  
21 in overall program savings.

22 The question that I had for Dr. Knutson drills

1 down a little further on your statement that these programs  
2 shouldn't be physician visit based. What is the most  
3 sensible basis for reimbursing these activities? Is it with  
4 the team being reimbursed? Or is it capitation plus visits?  
5 Or is it just capitation? Or is there some other  
6 arrangement that seems to make sense, particularly with  
7 respect to the Medicare population?

8 MR. KNUTSON: Some of the so-called pay for  
9 performance methods used now include paying explicitly for  
10 education. Medicare already does that for diabetes for  
11 recognized providers, but other purchasers are thinking of  
12 doing the same thing. Some are measuring a number of  
13 quality indicators and then offering a bonus over the top,  
14 regardless of how they were paid. If it was fee-for-service  
15 or capitation, there's some additional amount that's over  
16 and above your regular revenue flow.

17 I think those are, as I said, good starts in that  
18 any targeted approach like that engages, it gets us focused,  
19 it indicates a new interest, but ultimately a design needs  
20 to be something a little more global and in the fabric of  
21 the financing system. I personally think that we're working  
22 our way toward--let me give you an example. Even with risk

1 adjustment, which is something I spent a lot of time on,  
2 you're basically coming up with your risk scores by finding  
3 the average cost, usual care usually, and it may be  
4 inconsistent with your desire to improve or increase the  
5 short-term expenditures for a particular--for disease  
6 management, per se. We haven't figure out how to build  
7 these models on some sort of--not just what is but what  
8 ought to happen, and figure out who to stage it.

9           One of the interesting things going on in Southern  
10 California, Robert Wood Johnson funded the Rewarding Results  
11 program, a group of health plans and providers are  
12 demonstrating a pay for performance approach. One of the  
13 things they've done, and this is a theme that I've jumped on  
14 is they will pay a bonus for hemoglobin A1C control. But  
15 they'll also pay a bonus for a clear improvement in your  
16 clinical IT application, which is an interesting thing.  
17 They actually have a trajectory and every year they go back  
18 and say, can you do this now? Can you do this now?

19           If they show progress they get a reward for that,  
20 and it's because they believe they need to support capacity  
21 building. The capacity building then helps prepare them for  
22 a time when we're going to run out of specific diseases with

1 enough prevalence, evidence, money, all that, like diabetes  
2 that we can get these good starts based on, and have more of  
3 something that's cross disease and built into the fabric of  
4 care.

5           How to finance that in the long run, I've been a  
6 fan of mixing fee-for-service with some budgeted amount  
7 based on some--instead of what-is, some oughts in there too.  
8 So it's a little bit of a nuanced partial cap idea I think  
9 in the long run. But the whole world is grappling with that  
10 right now. I don't think we really know yet. I certainly  
11 don't think that 5 percent based on your hemoglobin A1C  
12 controls going to be the long run solution but it's a good  
13 start.

14           MR. SMITH: Thank you, all. This was very useful.

15           David, a conundrum embedded in your presentation I  
16 just want to raise and ask you to reflect on and then a  
17 question. You say that disease management can't be visit-  
18 based and for obvious reason that makes sense. On the other  
19 hand, you report that beneficiary or patient compliance goes  
20 up dramatically when this comes from the physician. I  
21 suspect that there's more to that relationship and something  
22 that would suggest that the visit, or at least the

1 supervision of the visit, or the place of the visit probably  
2 continues to play an important role. I suspect you've  
3 thought about that and wonder if you could must on it for a  
4 bit.

5 Second question, you talked about the wild card  
6 importance of the patient role and I wondered if there had  
7 been any experience with financial incentives for patients  
8 or financial incentives that shared savings between the  
9 provider and the patient.

10 Jeff, a question for you. The nursing home  
11 pharmacy compliance rate was staggering it seemed to me,  
12 that 74 percent of the recommendations were implemented. I  
13 couldn't figure out, and if you could talk a little bit  
14 about it, who paid for those? Did you pay for them  
15 independently? And then, who is responsible for  
16 implementing them and why did they? Why would they? What  
17 was the incentive that worked? Did you have either a  
18 participation incentive or a financial incentive? Did you  
19 share the savings? How did you get that extraordinary  
20 compliance?

21 MR. KNUTSON: Regarding the visit-based approach,  
22 that statement is based upon the current, the typical visit,

1 and the 15 minutes and the time spent, even with good  
2 rooming, preparation and other things it's still not  
3 adequate and therefore a program is needed, one at the  
4 organizational level. Now I think there's a broader trend  
5 that is also a wild card and that is how many different  
6 access points will emerged with Internet and telephone and  
7 other sources that will be optimal in terms of the right  
8 access point at the right time to get the appropriate care?  
9 When one thinks like that, then the visit probably will  
10 change itself.

11 In other words, a lot of visits are simply, in  
12 that context, unnecessary and time could be better spent in  
13 counseling, coaching, in serving as the good agent if you  
14 will, meaning understanding the values, the preferences of  
15 the patient, especially when the patient has more economic  
16 responsibility for treatment choices. How that all is  
17 organized I think is potentially an efficient way to go. So  
18 the visit could be the core of the whole thing ultimately.  
19 I don't know. But right now, the way the treadmill works  
20 you just can't build a chronic disease or a disease  
21 management program on it.

22 The second question?

1           MR. SMITH: Asking whether you had any experience  
2 thought about--your point about the importance of the  
3 patient role, and I wondered whether you had experience with  
4 financial incentives either directly to beneficiaries or  
5 patients or shared incentives with providers.

6           MR. KNUTSON: The Weingarten meta-analysis  
7 actually--and I didn't cover this--included in it some  
8 programs that did provide a direct financial incentive for  
9 so-called compliance with disease management programs and  
10 those actually produced some of the more significant  
11 improvements really. So that is an option. There are other  
12 kinds of incentives for patients that include--that are more  
13 in the choice environment where you have somehow lower  
14 coinsurance, for example, or a lower out-of-paycheck  
15 deduction if you choose a higher quality provider,  
16 ostensibly a provider who's doing all these good things that  
17 can be measured and that's going on.

18           But anyway, I think that's been a limited amount  
19 of direct payment. Where it's been done according to  
20 Weingarten's study it looks like it's effective.

21           MR. SIMMS: To answer your question about the  
22 nursing home polypharmacy, the major incentive was the \$29



1 million reduction in our budget that we needed to get  
2 something in place to really begin seeing--then on the  
3 provider side it was a fear of reduction in the rates. So  
4 what it ended up being was that partnership again where we  
5 got the nursing home long term care pharmacy association to  
6 work with the community care providers to implement these  
7 strategies. The funding for it was actually taken out of  
8 the \$2.50 PM/PM. They then invested that money into getting  
9 the pharmacist to work along with the provider to implement  
10 the program.

11 DR. WOLTER: Allen and David essentially asked my  
12 questions, but just a couple things that have occurred to me  
13 through all this. I think there's a bit of a tension in  
14 this conversation around the intensive case management  
15 versus the more population approach to disease management,  
16 and that's normal I suppose. But if you think about the  
17 world of quality as it's unfolding, much of what's being  
18 discussed is what patients don't get when they should get  
19 it, and that in many cases drives outcomes over a long  
20 period of time that aren't as successful as they could be.  
21 That investment doesn't get you the shorter term cost  
22 savings but it may create improved health outcomes and save

1 you cost in the long run. So that's just something we have  
2 to wrestle with.

3           Also, I could not agree more, I don't think the  
4 current model of care which is based around an episodic  
5 visit adapts itself very well either to some of the new  
6 system approaches that we need for quality or to intensive  
7 case management for that example. So to move from what we  
8 have now to something else probably would require some type  
9 of an investment since we don't have good data right now  
10 about how well those things will work, and which models will  
11 work the best, and how much money can be saved. If you  
12 looked at it in a non-governmental or non-health care model,  
13 it would be some investment in research and development is  
14 probably going to be necessary to find some models that can  
15 create some success.

16           Personally, I think there's a lot here in terms of  
17 where we could go in terms of how health care delivery  
18 system could change to attack these problems better. I  
19 think the problem we have is we look at adding incentives to  
20 the current way that health care is delivered rather than  
21 maybe create incentives around newer models of care. I  
22 think that slows the whole process down and I think Joe was

1 essentially making that point earlier.

2 MR. HACKBARTH: There is a lot that's very  
3 appealing to me as a layman in the basic concepts here, but  
4 I think that Glen in his presentation is right in saying  
5 that a very basic strategic choice for Medicare is, do you  
6 try to accomplish these things through the traditional fee-  
7 for-service program or through private options that are made  
8 available to Medicare beneficiaries? As I understand the  
9 research and what I've heard from clinicians, former  
10 colleagues deeply involved in these activities is that what  
11 we're talking about is changing behavior of both clinicians  
12 and patients at a very fine level of detail.

13 The traditional Medicare program that's free  
14 choice and episodic payment has many strengths, but changing  
15 behavior of patients and clinicians at that level is not  
16 among them. So you're talking about a major, major  
17 adaptation of the traditional program to make it even have a  
18 fighting chance of doing these things. Once you do that,  
19 you don't have the traditional fee-for-service Medicare  
20 program any longer. You've so altered its fundamental  
21 characteristics that you're going to have something  
22 different. Whereas, in private plans, the nature of the

1 interactions between clinicians and patients and payers, at  
2 least on the face of it would seem to have greater potential  
3 for being melded in ways that can accomplish these goals.

4 So that came out a little bit more definitive than  
5 I meant. There's a question mark at the end of it, but  
6 that's my instinct on the question that Glen raised.

7 DR. REISCHAUER: I thought the presentations were  
8 very good, and along with the others, thank you for coming  
9 and sharing your wisdom.

10 I want to build on Glenn's remark but in a  
11 slightly different way. I think the research suggests that  
12 physicians and groups don't practice different kinds of  
13 medicine for different payers in a sense. I'm wondering if  
14 this does spread, become more common among employer-  
15 sponsored plans, wouldn't maybe a lot of the benefit from  
16 it, without any action by CMS or Congress, spill over  
17 possibly? Some of this involves changes in the behavior of  
18 physicians. Some of it involves the development of  
19 capacities, different kinds of people, different IT systems  
20 within the offices of group practices or others. In a  
21 sense, some of it is a fixed cost in a way and once you've  
22 done it for one group there are economies of scale, and then

1 there's a small amount that is a variable cost.

2           If this proves to be a trend that will improve  
3 outcomes or reduce costs I think Medicare should move  
4 forward in a proactive way, but I'm wondering, if it doesn't  
5 whether at least some of the benefit is going to accrue to  
6 Medicare anyway.

7           MR. HACKBARTH: Sometimes he asks these rhetorical  
8 questions.

9           DR. REISCHAUER: I was thinking also, within North  
10 Carolina, how many of the folks in the Medicaid system  
11 really are involved in this effort? As you said, the dual  
12 eligibles are under a different set of rules that constrain  
13 you. I didn't know if everybody else in the system was  
14 participating in one way or another. You said it was those  
15 groups, those physician groups that volunteered and came  
16 into this, implying that there maybe are a number of people  
17 out there who aren't, and we're dealing with 50 percent, 25  
18 percent, 90 percent, I don't know of the non-dual eligible  
19 population. Did this spill over to other people?

20           MR. SIMMS: Let me answer the North Carolina piece  
21 real quick. In the statewide Carolina Access program, which  
22 is the one that I was saying is the foundational program, we

1 have probably about 4,000 primary care providers contracted  
2 to participate in that program. So far in the Community  
3 Care of North Carolina program with the 13 networks we have  
4 over 2,000 providers participating in that. So it's the  
5 remaining 1,500 or 1,700 that we're still having to  
6 transition into the Community Care of North Carolina. Some  
7 of those will be providers who have smaller numbers of  
8 Medicaid, so therefore, their investment in this will not be  
9 as great of some of the other providers. But the bulk of  
10 the safety net providers are already in the program and now  
11 it's a matter of going and dealing with the provider who has  
12 100, 250, 300 Medicare patients.

13 On the patient side, the bulk of the patients are  
14 going to be the women and children who are eligible for  
15 Medicaid. Now we have some of the elderly population who  
16 may be straight Medicaid that we do have enrolled, but the  
17 bulk of them are going to be the women and children.

18 MR. KNUTSON: I think it's true that in my own  
19 studies and in others that there's a mode of practice and  
20 it's typically common across payers. The question is when  
21 did a medical group tip into capitated behavior, this sort  
22 of thing. That's actually the theme, or one of the

1 questions we're asking in Minnesota and Colorado with this  
2 HRQ project that I'm co-leading, and that is can we bring  
3 purchasers together to so-call align incentives so that it  
4 produces not only a coherent signal but the magnitude that  
5 can get the attention of a provider group?

6           One of my favorite mechanisms of financing was the  
7 buyers health care action group product and I, along with a  
8 lot of others of us in the Twin Cities have studied it and  
9 written about it. But it's dying. One of the reasons it's  
10 dying, even though these care system, provider care systems  
11 have loved it, is that it didn't generate more than a few  
12 percent of revenue for any of them.

13           This was a problem for them to such a degree that  
14 they actually invited three years ago CMS in to talk about  
15 whether Medicare would be willing to purchase directly from  
16 them using the same mechanism. The belief then was, and I  
17 think it's still there, that employers can innovate.  
18 They're rarely stick with a game plan. These can't. It's  
19 just not in the cards. There is progress. Things happen.  
20 NCQA comes along. But frankly, they can't stick with a game  
21 plan. They can innovate. We watch what they do, but until  
22 Medicare does it, it's not institutionalized in this

1 country. We're working in Colorado and Minnesota on just  
2 getting Medicaid and commercial purchasers together with the  
3 hope that maybe somewhere down the road we can bring  
4 Medicare into the same financing scheme.

5 So I think you're right, but I think the question  
6 is a critical mass of everything.

7 MR. MULLER: If we're thinking of disease  
8 management, case management as a way of trying to dampen  
9 those curves on all three thirds of the population, in other  
10 words, the whole population that Joe referred to earlier,  
11 then I think there's some things going on along the lines  
12 you suggest in provider systems and so forth that tries to,  
13 for the reasons that Nick mentioned, where people are trying  
14 to look at quality efforts that reduce variations in care  
15 along the lines that panel, Elliott and others mentioned  
16 last month. So there may be some transference from what's  
17 going on in the non-Medicare population to the Medicare  
18 population.

19 But if one is looking at trying to reduce the  
20 number of high cost cases that occur--I understand in a  
21 distribution there's always 20 percent or 30 percent high  
22 cost, but if part of this is really an effort to reduce the



1 number of cases that become high cost cases then I think the  
2 evidence is not, as I said today, is not that clear that  
3 disease management is making a big difference in causing  
4 that to occur. I think one of the questions we have in  
5 front of us is that what the people who are trying to  
6 control cost in the Medicare program and trying to  
7 ultimately target here is to reduce that number of cases  
8 that evolve to high cost, and whether it's having palliative  
9 care rather than high cost ICU care at the end of life? I  
10 think that's one of the questions for us to consider, where  
11 the evidence is on what causes those high cost cases to not  
12 occur.

13 DR. WAKEFIELD: Mr. Simms, just a quick question  
14 for you. When you rolled your program out did you see any  
15 sort of differential successes or challenges in rural versus  
16 urban communities with regard to your disease management?  
17 Did it play differently? Was it easier to do in rural  
18 communities in engaging and developing networks? More  
19 difficult? Any sort of differential impact when it was  
20 rolled out?

21 MR. SIMMS: Allen may be able to respond to this.  
22 He was in one of the rural communities when we--I guess it

1 would be considered a rural community. What we were able  
2 to--definitely more of the providers there served the  
3 Medicaid program or Medicaid population. Where you get into  
4 the urban areas, the options are there for them and many of  
5 them will have limited enrollment in the Medicaid program.

6           So I guess that really is the major thing, is that  
7 when you begin dealing in more of the urban areas we have  
8 the community health centers who were the larger providers  
9 and a lot of the outpatient centers were the larger  
10 providers, and they're the ones who end up being the safety  
11 net providers in those communities. So when you really  
12 begin moving outside of that and start tapping into some of  
13 the private providers, that's where you really have fewer or  
14 limited enrollment, whereas in the rural communities pretty  
15 much every provider there serves Medicaid and they serve  
16 Medicaid in a large number. So that really is one of the  
17 major things that we've seen.

18           MS. DePARLE: I wanted to follow up on the point  
19 that you made earlier, Glenn, about the difficulty that  
20 Medicare has in doing some of these things. I tend to agree  
21 with you and have certainly had that experience, and it's  
22 one of the reasons I've made the argument that private plans

1 have an important role in Medicare. But I actually heard  
2 something today here that I think gives me a slightly  
3 different takeaway, and it's from Mr. Simms' experience in  
4 North Carolina, because as I understand it that is fee-for-  
5 service. You're not talking about managed care plans doing  
6 this. So I think in a way I take away from this the  
7 argument that many of us have made is that traditional  
8 Medicare--fee-for-service is really a misnomer, but  
9 traditional Medicare needs more tools to be able to be more  
10 effective. We didn't get that granular on exactly how did  
11 they do this and whether Medicare could ever do that, but I  
12 found this to be somewhat hopeful in that sense that at  
13 least in a state they've been able to do some of those  
14 things.

15 MR. HACKBARTH: Jeffrey, my understanding was that  
16 in North Carolina that we're talking about a limited network  
17 of providers. This is not everybody that serves Medicaid  
18 recipients. We're talking about a select group of  
19 providers, the so-called safety net community health  
20 centers?

21 MR. SIMMS: No, actually pretty much we have--it's  
22 all the providers that we contract with, primary care

1 providers in North Carolina that serve Medicaid. Now the  
2 safety net providers end up being part of the networks, but  
3 we're talking about private providers as well that we have  
4 contracted with through our primary care case management  
5 program which is a fee-for-service program that allows you  
6 to link Medicaid patients with a primary care doctors. So  
7 it is statewide as far as the number of contracts we have  
8 with the doctors. So it's not limited to just safety net  
9 providers. These are private providers, family practice,  
10 internal medicine, pediatric practices across the state.

11 MS. DePARLE: Do you have an estimate of what  
12 percentage of the total providers in the state you're  
13 dealing with?

14 MR. SIMMS: Actually I would say--let's do it by  
15 specialty. Pediatrics, I would say it's pretty much 100  
16 percent. Family practice I would probably say 98 percent of  
17 the family practice docs. Internal medicine is where it  
18 gets a little iffy because you're going to bring in some of  
19 the specialists and stuff as well, but I would say in that  
20 arena we're probably dealing with 75, 80 percent of the  
21 providers across the state. Pretty much the way the program  
22 is established is that if you're going to serve Medicaid in

1 North Carolina on a primary care provider side, that most of  
2 the providers are going to be in the Access program,  
3 Community Care of North Carolina, because they realize this  
4 is the way to do it, because the program also gives them an  
5 opportunity to have some control over how they serve, manage  
6 the population, because of the linkage with them they then  
7 have control over the referral system and stuff for the  
8 patient population.

9 DR. MILLER: I just wanted to get in on this  
10 because it hit one question that I had written down, because  
11 I also thought some of the things that I heard in North  
12 Carolina were a new twist on this that I hadn't heard in  
13 lots of other discussions that I've been involved in,  
14 particularly the ED, the pharmacy, and the nursing home.  
15 You also mentioned therapies quickly.

16 I think the question goes like this, can you help  
17 us to parse out how what goes on there is different than the  
18 standard prior authorization types of activities and how  
19 it's more like disease management or case management? Or  
20 how would you characterize what's going on in those  
21 settings? Because I think it does get to how it works  
22 within the fee-for-service environment.

1           MR. SIMMS: I think it goes back to what I was  
2 saying is the fundamental or the foundation that we've been  
3 able to establish in North Carolina. That is, first of all,  
4 having a strong enough provider network system across the  
5 state willing to serve the Medicaid population, and we did  
6 that through the ACCESS program. Then what we were able to  
7 do is then link the Medicaid recipients through--originally  
8 we started out as a 1915(b) waiver program that gives you  
9 the ability to mandatorily link certain eligible populations  
10 with a primary care provider that you've contracted with  
11 that will say, I'll provide 24 hours, seven-day-a-week  
12 coverage. I'll refer to specialists. I'll serve as the  
13 gatekeeper of the health care services.

14           Those are really the fundamental things that we  
15 did ten years ago that we're now building upon through  
16 Community Care of North Carolina with things like disease  
17 management, the care coordination, the pharmacy advantage  
18 list as well. So really the fundamental thing that had to  
19 happen was the linkage of the Medicaid recipient with the  
20 primary care provider and having adequate providers and an  
21 adequate provider network to serve them.

22           MR. HACKBARTH: I'm sure we could go on for quite

1     awhile. Carol, I'm going to give you the last word here.

2             MS. RAPHAEL: I'm just struggling with how to  
3     think about the fee-for-service system because as I look at  
4     this four key things have to happen. You have to move to a  
5     science of medicine. You have to have clinical guidelines  
6     that are widely accepted and diffused. I think, Glen, you  
7     said that you saw some sense of more adoption of this.

8             Then you have to have a notion of individual  
9     responsibility for your own health, that it's no longer just  
10    vested in the profession but that you as an individual have  
11    some clear responsibility. So that's another major change  
12    that has to occur, potentially cost-saving change if we  
13    shift some of the responsibility off to individuals.

14            Then you have to think differently about the unit  
15    that provides the service. I'm not entirely sure, except  
16    that we think it has to be a team. Again, maybe we can do  
17    some labor savings here if we move from higher cost  
18    professions to lower cost professions.

19            Then you have to think differently about the time  
20    dimension because you aren't only measuring short term  
21    outcomes here. You have to really look at longer term  
22    outcomes, which led you to think that Medicare had more

1 opportunity because we have a more stable population and  
2 would ostensibly have more incentive to invest.

3           So what I'm struggling with is where Glenn was,  
4 how would you put all of these major changes together in the  
5 fee-for-service system, and what are the mechanisms that we  
6 have that could effectuate these kinds of changes? I was  
7 just wondering if any of our panelists had any thoughts  
8 about that.

9           MR. KNUTSON: All I would say is I think you're on  
10 a couple of important tracks right now. I think North  
11 Carolina's experiences is very informative. I think there  
12 are some other states who in their Medicaid programs are  
13 going to move down a similar path with their PCCM program.  
14 Colorado, for example, went from eight or nine HMOs down to  
15 one and I think it's stopped enrollment right now. So the  
16 question is, what can they do to not go back to traditional  
17 fee-for-service and yet build care management into their  
18 fee-for-service system? There are, from what I understand,  
19 a number of states, maybe a handful, looking at the same  
20 thing. I would figure out who they are and monitor their  
21 progress and follow North Carolina.

22           The second is, the CMS demonstration projects when



1 you really get into them are quite interesting, particularly  
2 the capitated disease management program. It sounds like  
3 you're going to hear about it, but some of those look really  
4 promising to me to be informative about what Medicare can  
5 do.

6 DR. NEWHOUSE: This is a suggestion for our  
7 chapter actually and it builds on the notion of Alan Nelson  
8 talking about employers deferring cost, and Nick talking  
9 about underuse and upfront costs in the hopes of later  
10 savings, and Carol talking about the longer run view. Jim  
11 Lubitz about a month ago published an article in the New  
12 England Journal in which he tried to assess the effect of  
13 the decline in disability on longer run Medicare costs, and  
14 the answer was it was about a wash. That suggests to me  
15 that disease management and case management, probably both,  
16 ought to be framed on the research side of having very great  
17 importance on better health outcomes and quantifying those.  
18 That that's where the value is. That probably the costs may  
19 be about a wash.

20 Moreover, it may be a very long time before we  
21 actually find out the answer on cost, but first of all that  
22 the longer run framework or the lifetime framework is the

1 right framework to have and that it's very important to get  
2 some kind of assessment of health outcomes in these the  
3 programs even in the shorter run.

4 MS. BURKE: The target group may not necessarily  
5 be the top third. Part of this issue is that it really may  
6 not be about costs and about the drivers for the top third,  
7 which are acute short-term episodes at the end, but rather a  
8 long-term investment in better outcomes that may affect it  
9 but in a different scenario. So I think we have to think  
10 about it differently.

11 MR. HACKBARTH: Thank you very much. It was very  
12 informative and I'm sure we could have continued through the  
13 afternoon but other things beckon. Thank you.

14 We will have a very brief public comment period  
15 before breaking for lunch, if in fact there are public  
16 comments.

17 MR. ROYWELL: My name Bob Roywell. I'm with the  
18 Visiting Nurse Associations of America, and as someone  
19 recently introduced me, I'm a recovering CMS employee. In  
20 any event, it would be hard to add anything to the  
21 discussion we had today but I'd like to just make--if I had  
22 a slide up there with five points on it that I would like to

1 emphasize, the first is that although I think it was said in  
2 a different way, is that disease doesn't develop into  
3 chronicity in a physician's office or in a hospital. It  
4 develops in the home and community, and I think that's where  
5 the solution to this problem lies.

6           Secondly, we really need to have a model that  
7 integrates physician and perhaps nurse practitioners into  
8 the homes in a home care plan if we're going to solve this  
9 problem, particularly the people that we deal with. We're  
10 not privileged to be funded very often for prevention. We  
11 receive the lion's share of our funding for people who, as  
12 someone put it, have crashed and burned, often with multiple  
13 chronic conditions. If we're successful in rehabilitating  
14 them to the point in 30, 60 or 90 days where they're  
15 somewhat ambulatory and somewhat more able, then Medicare  
16 funding ends and they're left at the tender mercies of what  
17 comes next.

18           So I think my next slide would be continuity. It  
19 is a tragedy to see people leave home care only to return  
20 six months or six weeks later because there has not been  
21 continuity, whether that continuity is through private  
22 insurance or through a Medicaid system which doesn't

1 integrate terribly well in long term care when people leave  
2 Medicare onto Medicaid, not to mention the delicate dance  
3 between Medicare and Medicaid cost shifting, which would be  
4 amusing if it didn't hurt so many people and didn't exhaust  
5 limited resources.

6 Fourth, I think we have to realize we have to  
7 integrate some of the disease management principles into  
8 what we have talked about in terms of aggressive or  
9 intensive care management. I think one without the other is  
10 not going to be successful.

11 Lastly, I think to be successful this has to reach  
12 the fee-for-service population. Unless the system changes  
13 more dramatically than it's changed in the last 20 years,  
14 for the foreseeable future we're going to be dealing with  
15 primarily Medicare in a fee-for-service system. So we have  
16 to be able to reach that population and I think the people  
17 that reach that population have to be incentivized to enter  
18 into these programs, and they also have to know that they  
19 deal with people with whom they have some community  
20 connection and some confidence.

21 Thank you.

22 MR. HACKBARTH: Okay, we will reconvene at 1:00.

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

MR. HACKBARTH: Before we begin this afternoon's presentations I wanted to just yield to Mark for a second for an announcement for the public audience, and then just one follow-up point about our discussion this morning.

DR. MILLER: Because I think there were some people asking in the public audience, Sarah Thomas has been promoted to the deputy executive director. We're going to put a notice out on either Friday afternoon or Monday. It was just the meetings caught up with us and we weren't able to get it out. So if you're wondering why she's sitting up there, it's not because she's done anything wrong. It's because she did something right.

Then in two seconds or less, at lunch there was--I just want to say something about the disease management conversation that was driven by some conversation at lunch. I think it is still an open question on how the physician, the role the physician play, there's the notion at one extreme that the physician is providing the disease management and paid to provide the disease management. But another role is, you involve the physician at the front end, get all your protocols straight and your strategies but that

1    caring of the disease management is more by social workers,  
2    nurses, that kind of thing, and that there's still a  
3    continuum there for analysts to explore as we think through  
4    how this works.

5                   Then one final statement on fee-for-service versus  
6    private plans. I think that, which venue it works in is  
7    also still an open question. It's not that it has to be one  
8    or the other. I think there's discussion still open on  
9    that. From the lunch conversation, I don't think it was  
10   entirely clear on that so I just wanted to make that point.

11                   MR. HACKBARTH: Okay, let's turn to our agenda for  
12   this afternoon. The first issue is physician payment and  
13   specifically bundled payment options. Kevin?

14                   DR. HAYES: Good afternoon. Our plans for the  
15   June report include a chapter on use of physician services,  
16   and one topic we could consider as part of that chapter is  
17   bundled payment for physician services. So we're here today  
18   to provide you with an overview as to why the Commission  
19   might want to see that topic addressed in the June report  
20   and how we would address questions on the topic for a  
21   chapter in the report.

22                   When they say bundling, we're referring to the

1 size of the unit of payment. For physician services the  
2 unit of payment is small. It's one of 7,000 discrete  
3 services for which there are payment rates in Medicare's  
4 physician fee schedule. The question is whether that unit  
5 of payment should be expanded in some way.

6           There are two general approaches to doing  
7 something like this. The first would be to group related  
8 services that are provided to patients over a span of time.  
9 An example of this comes from the current somewhat limited  
10 bundling that is in the fee schedule already and that would  
11 be for surgical services where we see a single payment rate  
12 for pre-op visits, the surgical procedure itself, and post-  
13 op visits.

14           Another approach to bundling is to group services  
15 that are provided together at a point in time. An example  
16 of that would come from the way Medicare pays rural health  
17 clinics. There is a single per-visit rate that is paid and  
18 it covers the visit itself as well as related ancillary  
19 services such as lab work.

20           So we're ready to move on to the topics at hand.  
21 Before I do so just let me point out that in the paper that  
22 we sent you for this meeting you saw that we made use of



1 some software that groups claims into episodes of care.  
2 Vivek ran the software and he's here with me today so if you  
3 have any questions about that you can address them to him.

4           So as we look more closely at this topic we know  
5 that there is some bundling of payments already in the fee  
6 schedule. I cited the surgical services example. Another  
7 example is the monthly capitation rate that physicians  
8 receive for the services they provide in the way of  
9 evaluation and management of dialysis patients. What are  
10 the other possibilities? At this point it's hard to say  
11 where we would end up, but what's left is non-surgical  
12 services as well as surgical services and associated non-  
13 surgical services provided during the same episode of care  
14 but not currently part of the surgical bundle at present.

15           Reasons to consider further bundling, we've listed  
16 three here. The first is that it would broaden the scope of  
17 financial incentives for efficiency. Second, it seems that  
18 from an administrative feasibility standpoint it's a bit  
19 more feasible now to do more bundling than it was in the  
20 1980s when bundling was last considered as an issue. And  
21 the third possibility is that it would seem, just on the  
22 surface anyway, that it would be easier to link payment to

1 measures of quality of care. This is a topic that you  
2 addressed in this past June's report. So what we'll do now  
3 is just go through these reasons here one by one.

4           Focusing first on bundling and financial  
5 incentives, recall that the Commission over the years has  
6 spent a fair amount of time considering the major design  
7 elements of payment systems and one of those is the unit of  
8 payment. With a large unit of payment, the scope of  
9 financial incentives includes both the mix and quantity of  
10 services and the inputs used to provide services. In the  
11 case of a small unit of payment like that in the physician  
12 fee schedule, the scope of the incentives is more narrow.  
13 It just applies to the inputs used in delivery of services.

14           So the question here is whether it's time to  
15 revisit the fee schedule, the physician fee schedule's unit  
16 of payment? One reason to do that follows up on the  
17 discussion you had last month. We had a panel made up of  
18 Elliott Fisher and David Cutler and there was some  
19 discussion there about overuse of services. So  
20 reconsidering the unit of payment in the fee schedule might  
21 be one way to address that problem.

22           A disadvantage of bundling, however, is that it

1 does increase the risk of stinting. So the question then  
2 would be, in any consideration of this, whether it's  
3 possible to minimize that risk as part of any expanded  
4 bundling policy.

5           Moving on to the next item here which would be the  
6 question about whether it's administratively feasible to do  
7 this. Here, just as I said, it seems like it's a bit more  
8 feasible from an administrative standpoint to do bundling  
9 now than it was previously. To bundle services two things  
10 need to happen. One is it's necessary to decide what  
11 services are in the bundle and when they're bundled. In  
12 other words, how the bundles are defined. The other  
13 consideration is just that it's necessary to identify these  
14 bundles during claims processing.

15           Looking at these two points separately we can see  
16 on the issue of just defining the bundles we have seen the  
17 emergence of the availability over the past ten years or so  
18 of the software to bundle claims into episodes of care. So  
19 that would be one tool that could be used to help figure out  
20 how to define bundles.

21           The other is that there is precedent now for  
22 clinical involvement in matters of this sort. CMS and its

1 contractors currently use coding edits to review the billing  
2 codes that are reported on claims for payment. As part of  
3 that process there is input from a group known as the  
4 correct coding policy committee which is made up of  
5 physicians and other health care professionals. So a  
6 question here would be whether that process for working on  
7 the coding edits could be adapted to consider the bundling  
8 of the type that we're discussing here today.

9           On this issue, I mentioned the coding edits, it  
10 would seem like a tool of that sort would be an integral  
11 part of implementing any expanded bundling policy. Those  
12 edits are in place now used by CMS's contractors who process  
13 the claims. It would be a matter of invoking those edits  
14 and making payments accordingly.

15           A third reason to consider bundling has to do with  
16 this idea of linking quality measures and payment.  
17 Currently the payments for physician services are for  
18 services, for discrete services. By contrast, when we  
19 consider the research that's going on on development of  
20 quality measures, the focus there is somewhat on services  
21 but it's primarily on conditions. You could see that this  
22 morning in the discussion about disease management, that

1 that seems to be a hot bed of activity. But on development  
2 of quality measures, thereto, it seems like the focus is on  
3 conditions.

4           When we take, for example, the work of the Agency  
5 for Healthcare Research and Quality, they have set up these  
6 evidence-based practice centers to prepare reports, conduct  
7 technology assessments and so on on care for Medicare and  
8 Medicaid beneficiaries. If you look at the topics that  
9 those centers are working on it's either overall care for  
10 patients with certain conditions or it's services but  
11 services always in the context of conditions.

12           So connecting all this idea to bundling, with  
13 bundling, there again we're talking about payments for  
14 services, but like AHRQ's work it's in the context of  
15 conditions. So if that's the case it would seem that it  
16 would be possible to link quality measures to bundles  
17 according to the conditions that are used to defined them.

18           So what would we do on this topic for the June  
19 report? If we think about bundling and the related concept  
20 of episodes of care and where the innovation is these days,  
21 some of it is in the private sector in the areas of disease  
22 management, provider profiling, and payment. So one thing

1 we would do is to consult with private sector experts who  
2 have experience in these areas and develop an understanding  
3 of the strengths and weaknesses of bundling. We would also  
4 review the experience with bundling in Medicare. CMS staff  
5 have been thinking about this topic for a long time and we  
6 would meet with them and get their thoughts on what might  
7 work. We'd also review the experience with the centers of  
8 excellence demonstrations for lessons learned.

9           The next issue we would need to address would be  
10 identifying alternative criteria for defining the payment  
11 bundles. An example of such a criterion would be something  
12 having to do with the number of physicians involved and  
13 whether it would be necessary to define bundles in terms of  
14 just the services that are typically provided by just one  
15 physician or whether it needs to be something perhaps  
16 larger.

17           Another issue concerns determining payment amounts  
18 for bundles. This ground was covered when decisions were  
19 made about the bundled payments for surgical services, so we  
20 would review that experience and we would also draw on any  
21 relevant experience in the private sector.

22           Another topic to consider here has that to do with

1 those coding edits and the extent to which they could be  
2 used in an expanded bundling policy. There we would consult  
3 with CMS staff and the claims processing contractors that  
4 they use. We would also talk to representatives of the  
5 AMA's correct coding policy committee.

6           With respect to quality measures that might be  
7 relevant here, we would conduct a literature review and  
8 identify evidence-based measures of quality that are  
9 relevant to different types of episodes of care and  
10 therefore to different payment bundles.

11           Finally, we would assess options for minimizing  
12 the risk of stinting.

13           So that's about all we wanted to cover here.  
14 We're anxious to get your feedback on how to proceed on this  
15 topic, and happy to answer any questions that you have.

16           DR. NEWHOUSE: Kevin, it was hard for me to get my  
17 hands around this at this level of generality but I think if  
18 we can talk about specific cases where it might be useful  
19 we'll be ahead. But let me say I'm generally kind of  
20 skeptical about how much gold is in the ore here. We know  
21 we have a problem of overuse and underuse. You actually  
22 allude to that. At first blush, as you say, this reduces

1 overuse but at the price potentially of increasing underuse.  
2 You talk about a couple of things that I wanted to ask you  
3 about in that context.

4           One is, as I understood it, you were going to make  
5 the fee dependent on certain things happening. This was the  
6 tie to quality-based payment. It wasn't clear to me that we  
7 needed to bundle to do that, if we were going to do that.  
8 And if we were going to do that, whether or not it's in the  
9 context of bundling there's a lot of issues to be addressed  
10 like how do you update this. This sounds a little like the  
11 FASB updating accounting standards to me. And how do you  
12 audited if this was actually done. If it's on the outcome  
13 side then we get into the whole risk adjustment issue.

14           Then the episode issue almost surely would often  
15 involve multiple physicians. Then I'm not clear who gets  
16 the bundled payment. We don't even, for a lot of reasons  
17 don't bundle, for example, surgeons and anesthesiologists  
18 payment which clearly would be one of the most obvious  
19 things to bundle if you were going to go this route. So I'm  
20 not sure what you have in mind when you say, bundle an  
21 episode unless it's entirely within the purview of one  
22 physician.



1 DR. HAYES: Let me take a stab at those. With  
2 respect to the link between payment and quality, I could see  
3 an evaluation, so to speak, of policy in this area where we  
4 start out just identifying payment bundles based on criteria  
5 that we've alluded to in the general way in this. Whatever  
6 those payment bundles are, fine. Then in keeping with the  
7 Commission's recommendation about using incentives to reward  
8 quality, I could see where on a parallel track, whatever the  
9 case might be, that there would be a move also to try and  
10 link measures of quality with the payments.

11 One of the things that we would want to do is to  
12 do some research to identify the extent to which there are  
13 evidence-based measures of quality that could be used for  
14 this purpose. At this point we don't do what the state of  
15 play is in that area. I'm optimistic that there are going  
16 to be some evidence-based measures of quality that would be  
17 useful for this purpose. But in any case, I see some  
18 linkage here between a bundling policy and linking quality  
19 measures to the bundled payments, but there are some timing  
20 issues that would have to be sorted out and it could be that  
21 one would happen before the other.

22 On the other business about multiple physicians,

1 you're exactly right. It all turns on this question of how  
2 the bundles are defined, and to what extent we can identify  
3 bundles that are typically provided by one physician. Let's  
4 say that there's a decision made that we want to focus only  
5 on bundles where usually services are provided by one  
6 physician. Then we would look at the claims data and see to  
7 what extent it's possible to identify bundles of that sort,  
8 how meaningful they would be in the grand scheme of things  
9 in terms of spending, to what extent they respond to other  
10 criteria that might be relevant.

11           There could be, I could imagine, a branching here  
12 where you say, okay, we're going to focus on episodes that  
13 are typically provided by one physician but we need to have  
14 some provision in this policy that allows for cases where  
15 multiple physicians happen to be involved. That is true  
16 with respect to the current bundling for surgical services  
17 where it is possible for physicians to provide within a  
18 surgical bundle just the pre-op visits, just the post-op  
19 visit, and a different physician provides a surgical  
20 procedures itself. So in the claims processing there are  
21 these payment modifiers that are identified on claims that  
22 flag such claims.

1           So that's the kind of thing that would get sorted  
2 out as we work through this, and I see some do-ability here  
3 but without going further we don't know exactly what things  
4 would look like.

5           MR. HACKBARTH: Let me just say a word about the  
6 context for this discussion, at least as I see it. This  
7 presentation is part of a series now that goes back over  
8 quite some period of time. We have looked at physician  
9 payment issues. We're on record as being unhappy with the  
10 SGR as a way of dealing with, if not the actual increase in  
11 volume and intensity, the risk that the rate of increase in  
12 volume and intensity will grow over time. Medicare more  
13 recently has been in a period where the growth in volume and  
14 intensity has been relatively low, though in the last year,  
15 18 months there's been now again some uptick in the rate of  
16 increase.

17           I have found myself in the position, in dealing  
18 with people on the Hill, of being asked the question, if you  
19 don't like SGR, what do you like? We could respond to that  
20 by saying, we are simply not concerned about what's  
21 happening in volume and intensity, or we can look for  
22 alternative approaches that we think would be for compatible

1 with--

2 DR. NEWHOUSE: I thought we said we'd like  
3 something similar to what institutional providers, the  
4 process for setting their update, as opposed to a mechanical  
5 formula.

6 MR. HACKBARTH: In fact we did. What we said was  
7 that the initial baseline was to use a measure of input  
8 price increase with a productivity adjustment, but then  
9 there's also a discretionary factor. But even there you  
10 would be manipulating a price to deal with the volume issue  
11 and there are other ways that you can go, including bundling  
12 to create incentives for controlling volume.

13 So the implicit premise of this presentation, I  
14 think, is that there is some concern, if not about the  
15 current growth in volume and intensity, the potential that  
16 it will accelerate and pose significant budgetary problems  
17 for the program. Maybe before running down that path we  
18 need to have some explicit discussion among the  
19 commissioners about how concerned we are about that, whether  
20 we believe that we need to come up with a proposal to deal  
21 with volume and intensity, or alternatively, we think that  
22 for the most part the growth in volume and intensity is a

1 good thing. It's better care for Medicare beneficiaries.

2 MS. BURKE: Glenn, it seems to me that the other  
3 issue that's there but unsaid and is picked up a little bit  
4 in the document but I think needs to be brought out as well, is  
5 the extent to which the payment system moves towards a  
6 system where there is a check on quality, where there is a  
7 presumption that we can move towards a series of decisions  
8 that encourage certain kinds of care. One of the questions in  
9 bundling that I found here but not here is this question,  
10 because there's a presumption that you can't link metrics to  
11 individual services but only into bundles and I'm not  
12 entirely sure I agree with that, which was Joe's point as  
13 well.

14 But it seems to me that in addition to your  
15 question of, do we believe there's a concern about intensity  
16 and about volume is also the implicit question about whether  
17 or not what we're seeing is in fact linked to quality, and  
18 whether in fact it is down result in outcomes that are what  
19 they ought to be. So I think as we engage that question we  
20 need to look at it in the broader context as well. That it  
21 ought to be, to what extent can you build a system that  
22 presumes to have some linkage to an outcome that is

1 measurable and is related to quality ought to be part of  
2 that fundamental question as well.

3 DR. NEWHOUSE: Glenn, can I respond to you? The  
4 evidence on overuse, and underuse for that matter, is in the  
5 cross-section. It's the Miami's of the world. That's a  
6 very different issue than the growth over time which is  
7 going on everywhere and which may well relate to what  
8 beneficiaries ought to be getting. It seems to me very hard  
9 to use payment policy that's going to address an overuse and  
10 not potentially also affect underuse. But that's all in the  
11 cross-section. I just see the issue of the SGR and control  
12 on volume growth over time as a very different issue than  
13 the issue of overuse and underuse at a point in time.

14 DR. NELSON: We know that there are variations,  
15 but we don't know where within that variation the optimal  
16 lies. One of the problems that I had with the tone of this  
17 paper in talking about incentives to reduce overuse was the  
18 fact that it seems to me that if we decide to look at  
19 bundling it ought to be to try and link payment with the  
20 appropriate use, and that if there are all of these  
21 unrecognized or undertreated hypertensives wandering around  
22 out there, we've said that preventive services aren't being

1 offered at the rate that they should, we say that diabetes  
2 is not being managed to the degree that it really should be,  
3 that indeed there may be a greater potential for--that is,  
4 the underuse problem may be a bigger problem than the  
5 overuse problem. It may turn out to be a wash.

6           What we want to aim for, if bundling has any  
7 capacity to do, and I doubt that it does, if we're talking  
8 by and large about E&M services, and that's mostly what  
9 we're talking about here, it might be possible to bundle  
10 EKGs into office visits or something like that, but trying  
11 to bundle E&M services in a way to rationalize usage it  
12 seems to me is a tough call because we don't know where the  
13 optimal lies. We know there are big differences in how  
14 often people with chronic conditions see doctors, but we  
15 don't know how often they should.

16           DR. NEWHOUSE: And even if we had the right rate,  
17 you've got to get it to the right people. You could have  
18 exactly the right rate and if the wrong people get it, you  
19 haven't accomplish anything.

20           DR. ROWE: A couple points. I agree with much of  
21 what's been said. First, you've talked in the paper and  
22 your comments about consulting the AMA's correct coding

1 policy committee and I think that's a good thing. The AMA  
2 has a view about correct coding and it's not necessarily the  
3 only view out there.

4           You also mentioned consulting with some of the  
5 software vendors that CMS has begun to deal with and I'd  
6 just point out that this is an issue that health plans have  
7 been dealing with for 15 years. This is a very high volume  
8 issue for us. My company handles about 800,000 claims a day  
9 and we have a vast experience with the question of bundling,  
10 in courtrooms as well as out of courtrooms. I think you  
11 might consider talking with some health plans, private  
12 sector experts, and you might get a group of them that have  
13 particularly done some M+C work so that they have some  
14 understanding about Medicare as well and get an intersection  
15 there.

16           Secondly, I'm concerned about some of the adverse  
17 effects of bundling, unintended adverse effects.  
18 Clinically, I think the issue of reducing the use of  
19 preventive services is a very, very significant concern. We  
20 have to make sure that preventive services are not further  
21 reduce in their utilization. We just need, to whatever  
22 extent there needs to be some juice in the payment system to



1 make sure that preventive services are made available to  
2 every Medicare beneficiary, we need not to--make sure that  
3 we remove that or dilute in some way. I think that's a  
4 significant concern.

5 I think it would be helpful to frame this as it's  
6 not just about the money. The discussion is about overuse  
7 and cost-effectiveness, but the facts are that if a patient  
8 goes into a doctor and has an interaction with a physician  
9 that generate five claims, that's five claims that have to  
10 be sent in, and five claims that have to be adjudicated, and  
11 five checks that have to get sent. It's a very costly  
12 experience for the doctor's office and for whoever is  
13 cutting the check. Even if the total amount of money was  
14 exactly the same that the doctor was getting.

15 Bundling isn't necessarily just about--it's about  
16 making the system much more efficient rather than having  
17 necessarily any effect on what the doctor does. The  
18 implication of the way it's written is that doctors are  
19 doing things they don't need to do because they're getting  
20 paid for all of them. My point is, if they were just doing  
21 exactly what they should do, which many do, sending one  
22 bill rather than five bills makes a lot of sense. So I

1 would like to see some language about that.

2           Let me give you a couple examples of unintended  
3 consequences of bundling that you have to be careful about.  
4 One is a disaggregation of the bundle in time, so that the  
5 patient, instead of going in, explaining to the patient  
6 what's going to happen, signing the consent form and having  
7 the procedure is you come in on day one, you have the  
8 explanation, you sign it, you go home, you think about it  
9 overnight, you come back the second day and you have the  
10 procedure, so you have two visits. Because if you did it  
11 all at once it would be one visit and you'd only get paid  
12 for the procedure and you don't get paid for any of the  
13 extra time that it takes, et cetera. So that's not an  
14 efficient system that works that way.

15           A second is a disaggregation of the services not  
16 in time but by person. You wind up involving more providers  
17 than you need to provide because if one provider did it all  
18 it would be one bundle, one bill. But if I do X and he does  
19 Y, then there's two bills. So there are these unintended  
20 consequences sometimes that we have a lot of experience with  
21 and you can think about how to get things done efficiently.

22           The last point has to do with disease management.

1 Somebody mentioned disease management. I think I want to  
2 mention that particularly because I put it in the same  
3 category as preventive services, although sometimes it's not  
4 considered preventive services but it really is, like eye  
5 exams for diabetics, or screening for urine protein and  
6 stuff like that. These are really important things and they  
7 should get paid for, and if we don't pay for them they're  
8 not going to get done as often as they are if we do pay for  
9 them. They've been shown to be cost-effective things to do.  
10 So if in bundling we wind up removing payments for things  
11 which are in fact cost-effective things to do, it's  
12 counterintuitive. So we have to take all these things into  
13 consideration as we formulate the bundling.

14           The last is, I would emphasize a little more the  
15 really long term excellent experience we've had with surgery  
16 and with comprehensive care in patients on dialysis, because  
17 this is not new to Medicare. This has been going on for a  
18 very long period of time and it works, I think, for the  
19 patients and for the providers. It's mentioned in your  
20 paper but I think I'd talk a little more about the duration  
21 that we've been doing this and how well it's gone. Thank  
22 you.

1 DR. MILLER: Can I just try and get one  
2 clarification in your comments? You preface your comments  
3 by saying that you agreed with a lot of what was said, but  
4 some of what you were saying seemed to imply that there was  
5 bundling that went on among the programs that you deal with.  
6 I think even your last comment--

7 DR. ROWE: Sure.

8 DR. MILLER: So can you talk, if there's this much  
9 concern about it and all of these concerns have been raised,  
10 how does it work and what problems or what successes did you  
11 have with it?

12 DR. ROWE: The major problem I think we had as an  
13 industry which varied across plans was that in the eyes of  
14 many physicians bundling became synonymous with the concept  
15 of automatic downcoding, so that it was just seen as a way  
16 of paying less. The views of plans early on was that this  
17 unbundling--I remember when I was in academics we used to  
18 talk about the concept of the least publishable unit.  
19 Instead of having some big paper with a lot of data in it,  
20 there were 10 papers that were published. As soon as you  
21 got enough data to send this one off to the journal, then  
22 you get the next one. The health plan had a view that this

1 was the least billable unit.

2           So to give an extreme example, instead of a  
3 physical it was examination of the left hand, of the left  
4 arm, of the left leg, of the left foot, of the back, stuff  
5 like that. That is an absurd example but that's the  
6 theoretical objection.

7           I think we've come a long way from there and I  
8 think we have a lot of experience with physicians and with  
9 health plans in figuring out what kind of bundling makes  
10 sense clinically and what kind doesn't make sense  
11 clinically. I in general feel that the efficiencies that  
12 are raised out it are more important than the fraud and  
13 abuse aspect of it. I think we're overemphasizing the fraud  
14 and abuse aspect of it in the conversation and not  
15 emphasizing the efficiency aspect of it. That's my general  
16 feeling about it.

17           MS. DePARLE: So Jack, to Mark's question, do you  
18 now pay physicians for office visits in a bundled way as  
19 opposed to paying them for individual.

20           DR. ROWE: I think it varies for what kinds of  
21 services there are, what kind of specialties there are, what  
22 kinds of diagnosis there are. I'm not an expert on all of

1 these things but there has been worked out approaches to  
2 doing it.

3 MS. BURKE: But Jack, it would seem to me that the  
4 obvious place to begin that is with chronic conditions where  
5 there's a certain predictability about the things that need  
6 to be done over a timeframe. Harder to understand--it's  
7 improved by the movement to hospitalists which we're  
8 beginning to see where you do have these segmentations where  
9 they go in the door and they stop. You have the stuff that  
10 happens before, the stuff that happens, and the stuff that  
11 happens after in fairly predictable pieces, a surgical piece  
12 being the obvious.

13 But on the non-surgical piece, to what extent have  
14 you in fact been able to construct a model that allows you  
15 to predict and pay on the basis of things that should occur  
16 over the long term in the treatment of someone who--I mean,  
17 on the episodic, I walk in the door, I have an acute  
18 condition and I move out; different issue. But in the  
19 obvious question of the chronically ill which is what you'd  
20 likely see in Medicare, beyond the diabetics, the  
21 hypertensives, how far have you been able to go in that kind  
22 of predictive financing, in structuring those kinds of

1 models?

2 DR. ROWE: My sense of it is that there's a lot of  
3 variability in the industry in how far we've been able to  
4 go, and I can't give you exact information on this, Sheila,  
5 unfortunately, though when we next meet I'll be prepared to  
6 do that and I'd be happy to get my staff in touch with you.  
7 But my sense of it is that working with professional groups  
8 such as the American College of Obstetrics and Gynecology  
9 we've been able to--I'm not familiar with the gynecological  
10 oncologist, for instance. They came to us with a proposal  
11 for what they thought was a good bundle, because they said,  
12 it doesn't make sense the way you're paying, and it doesn't  
13 make sense the way some people are practicing. So by the  
14 way we, the gynecological oncologists, believe that this is  
15 the correct bundle that should get done for everybody who  
16 has X or Y. So it's a disease-specific thing but it's done  
17 with the medical professionals obviously.

18 MS. BURKE: I hear what you're saying. That is a  
19 good example of a specific diagnosis that is somewhat  
20 predictable in the treatment. You have a certain presenting  
21 diagnosis. There are certain things that one does that are--  
22 -

1 DR. ROWE: They're going to have a biopsy, and  
2 they're going to have this treatment, they're going to have  
3 that, and let's just pay for the management of this patient  
4 with this problem.

5 MS. BURKE: Which again suggests defined units  
6 lend themselves to this, or specific chronic conditions  
7 might lend themselves to this, or other things--it is closer  
8 to surgery in that sense. It's fairly definable, beginning,  
9 middle, and an end, or a long term.

10 DR. MILLER: I think that somehow we've gotten--I  
11 think it's fair--this is the kind of stuff that we're  
12 talking about. When we said non-surgical, maybe it wasn't  
13 clear that non-surgery can mean a non-surgical admission;  
14 might have a clear path of visits that follows it, to follow  
15 up on that. So that might be--like a surgical stay in a  
16 hospital has a follow-up bundle of visits, you could move  
17 that concept to non-surgery. Not non-surgery in the sense  
18 of everything on the planet. I think it's more of the  
19 notion of a non-surgical admission, and then precisely the  
20 exchange between you two on the notion of a bundled payment  
21 for ESRD physicians happens now, or for dialysis happens  
22 now. But you could expand that concept to other chronic



1 conditions. This is the kind of stuff--it's not coming  
2 across. This is the kind of stuff that was in our mind.

3 DR. NELSON: The classic example, the one that's  
4 talked about in medicine is treatment of a myocardial  
5 infarction, where there are a certain number of procedures,  
6 there's a protocol that should be followed, and if it's  
7 uncomplicated, fairly stereotype length of stay. But there  
8 are others that--that stands out because it's one that is so  
9 well defined.

10 But it would really be helpful if--we may not be  
11 able to, not having a November meeting, but it would really  
12 be helpful to have the kind of panel that we had this  
13 morning for disease management with private sector models  
14 and programs so we could really drill down on that.

15 DR. ROWE: We already bundle, the other place we  
16 bundle, Mark, that's worth mentioning maybe is in hospital  
17 payments. We don't get a bill from the hospital that says,  
18 seen by the nurse at 7:30 in the morning; given breakfast.  
19 Seen by the physical therapist; transported to X. We get a  
20 bill per diem or something, or we pay based on a DRG or  
21 something. That's a bundled payment, right?

22 MS. BURKE: But Jack, we did, in the old days when

1 we moved from 223 limits to--when we made this progression  
2 into a DRG system, the work that went into creating those  
3 structured episodes, the DRGs, arguably what we're  
4 suggesting here is a comparable kind of analysis on the  
5 physician side. The difficulty has always been, I think, is  
6 that to the extent that things happen in a building they are  
7 more easily defined. That's been our long term problem is,  
8 how do you define things that occur outside and all of the  
9 players that get involved. The episode in a hospital is a  
10 somewhat easily, record kept kind of. But the doc piece has  
11 never really been there. The doc piece is arguably a  
12 somewhat separate piece.

13           But I don't disagree with you that's where you'd  
14 want to go, but once you move beyond certain predictable,  
15 myocardial infarct, certain predictable kinds of things, it  
16 does get more complicated. You can imagine for diabetes the  
17 things that ought to happen in the treatment of a diabetic  
18 patient, how often they ought to be brought in, what are the  
19 tests that ought to be done on a routine basis, whether they  
20 get their eye exams, whether they get their feet examined,  
21 those kinds of things. But my guess is there is a limit to  
22 those kinds of things, although maybe as we look at the

1 pattern of use in Medicare they will be a fairly defined set  
2 that drive a lot of it that would be worth looking at.

3 DR. REISCHAUER: You also have to ask whether  
4 they're more likely to occur if you bill them separately or  
5 if you bundle them.

6 DR. ROWE: That's the point.

7 DR. REISCHAUER: And if you bundle them without  
8 any kind of qualitative oversight on this--

9 DR. ROWE: I'm worried about that too, but you  
10 have to trust the doctors at some point. I think that while  
11 there may be some stinting of services, I guess one of my  
12 points is, when we do the analysis we should also include in  
13 the analysis the savings associated with reducing the number  
14 of claims that are submitted.

15 DR. REISCHAUER: That's why I asked to butt in  
16 because I thought you gave both sides of the argument here,  
17 because I was with you when I read this the other day on,  
18 save a lot of administrative costs because you don't have to  
19 send in a whole lot of bills. But at the same time you have  
20 to remember that each of the services that we bundle  
21 together almost assuredly would be also separately billable  
22 under other kinds of conditions. You raise the possibility

1 that rather than have the lab test done by the doctor he'd  
2 say, go to my brother down the hall who's running Joe's lab,  
3 or something like that. So you'd have to have a whole lot  
4 of checks to make sure that you weren't being ripped off in  
5 some sense and there would be a back and forth. So the doc  
6 would only have to send in one rather than five bills, but  
7 he'd get four letters saying, are you sure this isn't part  
8 of the episode, did you order this test, or something like  
9 that. That might be more onerous in fact.

10 DR. ROWE: We have all this experience so you can  
11 walk around and talk with some folks and they can tell you  
12 what specialties and what diseases are most amenable, what  
13 conditions, to an approach. You don't have to do  
14 everything. We could add a couple to the dialysis and see  
15 how it went.

16 MR. HACKBARTH: We have a number of people who  
17 have been waiting patiently.

18 MS. DePARLE: I just had a small point. I think,  
19 like most people have said, the idea of determining an  
20 episode of care is very appealing and it certainly has  
21 worked well in some other context. But my question mainly  
22 had to do with your suggestion that this was

1 administratively feasible. I think the way you said it was,  
2 should be more administratively feasible than it was 20  
3 years ago. One would hope so, and yet when you bring up the  
4 correct coding initiative, about which I know quite a bit,  
5 I'm a little bit surprised or curious that that would be  
6 seen as a building block for this, because it's a pretty  
7 primitive tool. To go back to Jack's vernacular, it was  
8 Medicare's attempt to make sure that if someone said they  
9 did surgery on your hand, they didn't also bill for  
10 amputating your hand. It's pretty basic stuff. It was just  
11 coding edits.

12           And the reason there's an AMA committee is because  
13 the AMA didn't like what they thought was black box  
14 medicine. They wanted to know what the coding edit were.  
15 But CMS, then HCFA, couldn't give them the coding edits  
16 because we had, at the strong urging of Congress, purchased  
17 some off-the-shelf software to do the edits and that company  
18 said they were proprietary so we couldn't give them to the  
19 AMA. So that's why all that happened. I'm sure it's a very  
20 good group of about clinicians who would be helpful in this  
21 process, but I don't think the correct coding initiative,  
22 unless it's really become a lot more ambitious than it was a

1 couple years ago is a place to say that we have a building  
2 block here.

3 DR. STOWERS: I just wanted to get back to what  
4 Glenn said a minute ago about what we're trying to of  
5 accomplish here. I agree with the comments on the tone  
6 about stemming or looking at the growth in physician  
7 services. But I think when we go back to our chapter on  
8 growth in physician services, it's not in E&M, and it's not  
9 in following diabetic patients, and it's not in all of the  
10 examples that we've been using. It's in the high tech, and  
11 all of these kind of things, and yet we're trying to create  
12 this tremendously complicated system of bundling in an area  
13 that's even had some negative growth in a lot of cases. It  
14 may be 1 or 2 percent. So I'm really wondering where we're  
15 headed here with that.

16 And most of those areas that we're talking about,  
17 it's more of an underuse problem, if we're going to focus  
18 this on quality, instead of an overuse. If we get into  
19 looking at these high-end services, then we really get into  
20 somebody in the emergency room has ordered the MRI and now  
21 how are you going to penalize that physician for ordering an  
22 MRI that's going to increase--

1           So I just really think we're headed up the wrong  
2 tree here if we're looking at growth in physician services,  
3 or at the very least we link our examples in the bundles  
4 that we're looking to to the areas where there are rapid  
5 growth in physician services. That even gets back to the  
6 drug issue that is penned into that growth rate. So are we  
7 going to bundle medications in there too, because that's a  
8 huge part of it. So I'm really worried more about the  
9 underuse problem than I am the other.

10           Then I just had another question. I've never read  
11 anything that the bundling with surgery, after all of this  
12 20 years of experience, has slowed growth in spending. I  
13 think if we're going to--

14           DR. ROWE: We don't know what it would have been  
15 without it.

16           DR. STOWERS: But the only thing, there again, to  
17 be limited was essentially the number of E&M visits that  
18 were connected to the surgery to be sure that we didn't have  
19 five post-op visits instead of the four. Again, E&M is not  
20 the problem. I'm like you, Jack, I've watched the pre-  
21 consult to get them ready for surgery, be sure that it  
22 happens X number of days ahead of the surgery, so what

1 normally could have been, arrive that day, get it done kind  
2 of thing ends up in a \$200 consult three days before  
3 surgery. I think it's increased cost and I don't think it's  
4 done a thing for the volume of the number of surgeries being  
5 done.

6           So again, I think we really need to connect it to  
7 where the growth is, and number two, show that what we've  
8 had as a trial over all this period of time has made a  
9 difference. So anyway, I'm just a little concerned about  
10 where we're headed with E&M visits.

11           MR. SMITH: Most of what I wanted to raise has  
12 been raised several times so I'll try to be brief.

13           I was struck it looking at the product of the  
14 software that you used that it would be easier to link  
15 quality measures to the payment system in and unbundled  
16 system than a bundled system, and that making sure we  
17 understand how we use the quality data, quality information  
18 that is now becoming more available, as you point out in  
19 here. In an unbundled system it's harder to tell whether it  
20 happened or not. So if we want to use the payment system  
21 and link it up with quality, I'm not sure why bundling  
22 helps.



1 DR. ROWE: That assumes a fidelity between the  
2 billing and what happened. You're assuming that everything  
3 that is billed for--

4 MR. SMITH: That is presented for payment actually  
5 happened; right. But that's a different kind of problem.  
6 The information and the construction of the episode that the  
7 software allows you to do, does allow you to tell whether or  
8 not a request for payment was presented for something that  
9 should have been done. In a bundled world that's a harder  
10 to do.

11 DR. ROWE: There's a difference between quality of  
12 care and quality of billing.

13 MR. SMITH: I understand.

14 My second set of questions, Kevin, I'll try to  
15 reference them, really had to do with the link between this  
16 morning's conversation and this one. It struck me that what  
17 was missing from here was an effort to inquire as to whether  
18 or not bundling might help us address exactly the questions  
19 Jack raised a few minutes ago. That an episode of care  
20 bundle or a bundle that incorporated examination, evaluation  
21 and preventive services might not be an important addition  
22 to the payment system, and how could we think about that

1 bundle?

2 I think as several of my colleagues have said, the  
3 focus here is on bundling as a way to get docs to do less.  
4 As a proposition, I'm not at all sure that that's the one we  
5 ought to be embracing. I do think there's a way to think  
6 about bundling as getting docs to do more of the right  
7 thing. But that's a larger modification of the payment  
8 system than a bundle that is aimed at somehow responding to  
9 a perception that docs are doing too much, which I think in  
10 some cases may be true but I'm not sure a bundle is the  
11 right way at it.

12 MR. MULLER: My comment builds on both Ray's and  
13 Dave's, which is what are we trying to bundle? It goes back  
14 to the larger unit question, what's the larger unit you want  
15 to bundle? We all know that the driver, in many ways, of  
16 health care costs, medical costs, is physician initiation.  
17 But the actual things we pay for tend not to be the  
18 physician services. It's hospitals, it's imaging, et  
19 cetera, and so forth, whether it's facilities or devices and  
20 so on.

21 So the question I would raise is, the bundle that  
22 one wants if one is looking at both utilization and cost, is

1 the bundle in that interaction between the physician  
2 judgment and the device or the facility used. So whether  
3 that's an extension of the APC thinking and so forth--so my  
4 question and my comment is, do we want to bundle them more  
5 in that way, that gives us an incentive to have the  
6 physician use the right technology, the right facility, the  
7 right drug, the right device and so forth? The discussion  
8 so far has been very much on how one thinks about putting  
9 together discrete physician services so that you have three  
10 visits, or four, or five. But I would say it's the  
11 interaction of the doctor with the physical thing that Pete  
12 likes so much that we have to think about in terms of the  
13 facilities, the drugs, devices, and so forth. That's the  
14 larger unit that I would suggest we look at.

15 DR. NEWHOUSE: This all leads me to wonder how  
16 much effort should go into this for the June report. If we  
17 come down to we're trying to find instances where it's  
18 sensible to bundle that are confined to within single-doctor  
19 services, I'm not persuaded that there's a lot of value  
20 there, but I could be wrong. I certainly don't think  
21 there's enough value that it responds to the concerns, as  
22 Glenn framed it, that are raised around the SGR that more

1 bundling somehow relieves the pressure on physician  
2 spending.

3           I want to close with a couple comments on the  
4 stinting issue. One is just an example of how pervasive I  
5 think it is. In effect, coordination and counseling are  
6 bundled with the visit fee in the sense that there's no  
7 separate payment for them. I think we all think that those  
8 are probably under-provided, and certainly when you talk to  
9 physicians they will tell you they don't take the time to  
10 tell smokers to stop because they don't get paid for that,  
11 and they don't get paid for coordinating the care to any  
12 greater degree, and in effect that's a bundled payment.

13           Now I agree with the comments about the ESRD  
14 system but in the ESRD system we have gradually moved so  
15 where we have, compared to much of the rest of the system,  
16 some reasonable outcome indicators. We have things like KT  
17 over V that we monitor and act upon, I think, if they're  
18 unsatisfactory. Again, given the concerns about potential  
19 underprovision, it's not clear to me we want to go the route  
20 of more bundling without something analogous to that, which  
21 I think for much of what we're talking about we're not  
22 likely to have.

1           So again I would be happy to be proved wrong but  
2 I'm not sure we're the group, or the staff is the group that  
3 ought to work on bundling. People have been thinking about  
4 coding for a long time in terms of what CPT codes makes  
5 sense to be put together. Are we going to really add to do?  
6 Maybe we are, but I think that's where we're at.

7           DR. NELSON: What's KT over V?

8           DR. NEWHOUSE: We should ask the nephrologist.

9           DR. ROWE: It's a measure of dialysis  
10 effectiveness. It's essentially a clearance rate kind of  
11 measure. It's a blood test.

12           DR. MILLER: Glenn and I were talking and he  
13 wanted me to wrap up and summarize what we're heard. I  
14 think all that went really well.

15           [Laughter.].

16           DR. MILLER: Actually, I've heard a couple of  
17 things to perhaps run to ground, and also to give Kevin  
18 credit where credit is due. Kevin has been saying that he  
19 wants to bring a panel in in December to talk about how this  
20 works and I told him that I wouldn't promise him that  
21 because I didn't know how much work we would have to grind  
22 through in the December meeting. So credit where credit is

1 due, he had that idea and has been pushing me to make sure  
2 that it happens in December and I just wasn't sure we would  
3 have the time to do it. The certainly will look for that  
4 time a lot more aggressively now.

5 I also heard two things that are hard to  
6 reconcile. Remember, we did talk about technology and  
7 growth and some of this flowed from the last conversation we  
8 had where some things were taken off of the table and it  
9 was, see how far you could get on this. Notionally, if you  
10 listen to Jack and some other comments, the notion of  
11 bundling for limited circumstances, perhaps for efficiency--  
12 and we really weren't trying to convey the tone of fraud and  
13 abuse--but efficiency and administrative savings that might  
14 be a path, although fully acknowledging that it's not going  
15 to capture large blocks of dollars. I don't think we  
16 thought that this was going to capture large blocks of  
17 dollars either.

18 A little more complicated is the other comment,  
19 drawing together Ralph and Ray's comment, the notion of can  
20 you put something together with the physician and the piece  
21 of technology that gives an incentive to use the right piece  
22 of technology, if I'm following those comments. The notion

1 of trying to focus, Ray, your comment, on where the growth  
2 is occurring; high tech imaging and those kinds, and then I  
3 think it was Ralph's point on putting together something  
4 with the physician and the technology, if I followed your  
5 point. We could try and look at that a little bit.

6 I think those would be the three blocks of things  
7 from this I could hear that we could take another look at  
8 based on what I heard. I guess the thing I would just draw  
9 your attention back to, and maybe this is what the panel  
10 would be about, this does go on. People do do this. It's  
11 just, I think, a question of what its intent is and what its  
12 purpose is. I really think it does create the building  
13 blocks to move towards a quality measurement. I think it  
14 is, and I must be crazy but I think it is difficult to track  
15 it service by service. It's true that in ESRD you do have  
16 all of those measures, but you also have an event that you  
17 can track and look at quality relative--

18 DR. REISCHAUER: No, just the opposite.

19 DR. MILLER: Like I said, I must be crazy.

20 MR. HACKBARTH: What I hear Mark saying is, it's  
21 not just the bundling in and of itself. It's a way of  
22 thinking about the care that needs to be provided. It's not

1 discrete visits. So the idea is, you bundle these things  
2 together and say, for this particular condition you need  
3 kind of a course of treatment. It's not enough that you pay  
4 on that basis alone. You also have to have the quality  
5 measures and assess what happens.

6 DR. REISCHAUER: But you have at least the claim  
7 that the service was delivered when you keep things  
8 unbundled.

9 DR. NEWHOUSE: Under penalty of law.

10 DR. REISCHAUER: So why is this an advance?

11 MS. DePARLE: You could say the same thing with  
12 hospitals though, with DRGs, the services may or may not  
13 have all been delivered, and we don't do anything about that  
14 right now.

15 MS. BURKE: But the point is that it was easier  
16 when you bundled and I think my reaction is it isn't  
17 necessarily easier, which is not to suggest that bundling  
18 doesn't make sense for certain things, and that you will  
19 have to have a check on the system to ensure that in fact  
20 that predictive group of things occurred. But it does not a  
21 priori suggest that it is better or easier to do it by  
22 bundling, because it is not. It's easier to track it per



1 unit because then either you did it or you didn't, you  
2 billed for it or you didn't, presuming the bill reflects  
3 what actually happened.

4 But I don't think one's easier than the other. I  
5 think bundling is more complicated but it doesn't mean it's  
6 a bad thing to do.

7 MS. DePARLE: Can I just make a suggestion too?  
8 If we pursue discussion of this, I think it helps--there is  
9 a table, Table 1, that talks about frequent episodes of  
10 care. If we could have this be a little more concrete as to  
11 what we'd be talking about. When I think of it as  
12 hypertension your points, Mark, make more sense to me and I  
13 can see why you would say that a bundle helps. When I'm  
14 just thinking about physicians, I'm thinking E&M visits, the  
15 way Ray was, so I have a hard time understanding how we  
16 would actually do this.

17 So if we bring in a panel or whatever, it would be  
18 helpful to be pretty concrete about what exactly they did  
19 and how they did it. Maybe like these 10 episodes of care,  
20 that's 31 percent, that's a lot. If you really think you  
21 could that, that might be worth doing.

22 MR. MULLER: I would say based on what I'm hearing

1 here and perhaps what I think I heard Joe say is, I think  
2 it's a very important topic but not quite ripe in terms of  
3 where we are, because I think there's quite a different set  
4 of views around the table as to what we're bundling, and  
5 what the virtues of bundling and unbundling are, and the  
6 effects on quality and so forth. So I'm also thinking about  
7 all the things we have to do in December without the  
8 November session, so we've got a lot of big topics there.  
9 So whether we could take three hours--this is more--  
10 scheduling thing is whether we could take three hours on  
11 this when we're not quite ready on this.

12 MR. DeBUSK: Should we even be pursuing this?

13 DR. STOWERS: I think the very least we need to do  
14 in the chapter is, if we're going to link bundling to  
15 quality is that we need to make the point, in most cases the  
16 more we bundle whether it be in an HMO model or whether it  
17 be in a DRG, whatever, brought on the great necessity of  
18 greater monitoring to make sure that the quality or no  
19 stinting was occurring. So really when you come to quality,  
20 the more you bundle, the less you usually assure quality.

21 A good example of that is bundling the E&M  
22 service. When I see a patient I'm responsible for the

1 patient until the next visit all for that one E&M service.  
2 That's managing the home health care, that's managing  
3 getting therapy, that's managing--and yet what we're talking  
4 about is those things are not occurring. So when the  
5 management services came out of the AMA process to go, we're  
6 not paying and separating out a payment for management. I  
7 think we'd have been a lot better off unbundling the E&M to  
8 include some of the management things in between so the we  
9 were getting this quality, coordination of care, that kind  
10 of thing. So I think we at least need to look at the flip  
11 side of that in the chapter.

12 MR. HACKBARTH: Okay, we need to move on to the  
13 next item, so thanks, Kevin.

14 Next up is Medicare supplemental markets.

15 DR. BERNSTEIN: Good afternoon. I'm going to  
16 briefly walk through the summary document that we sent you  
17 about the site visits that we did over the summer with the  
18 help of Mathematica Policy Research. Bob Hurley from  
19 Virginia Commonwealth University who worked on that project  
20 is also here and if you have any questions later about  
21 specifics on the site visits any of us has an equal chance  
22 of being able to answer them.

1           The objective of the site visits was to help us  
2 understand the factors that shape the different markets for  
3 supplemental insurance that we have seen across the country.  
4 We were looking for the sources of variation in order to  
5 understand what the implications of the variation in these  
6 different markets might be for Medicare beneficiaries and  
7 for Medicare policy now and in the near future. The sites  
8 that we went to were Atlanta, Long Island, Minneapolis-St.  
9 Paul area, the entire state of in Nebraska, and San Diego.  
10 These areas have approximately the same number of  
11 beneficiaries although their size varies considerably, and  
12 the distribution of different kinds of supplemental coverage  
13 also varies tremendously across these three areas.

14           Although Medicare is a national program with  
15 standard benefits, the array of products that beneficiaries  
16 use to supplement Medicare are shaped in large measure by  
17 local factors. For the purposes of summarizing what we  
18 learned on the site visits we have divided these into four  
19 sets of issues which I'll talk about briefly. One is state  
20 regulation and oversight. Second is the organization and  
21 history of the local systems. We also looked at the nature  
22 and concentration of employer-sponsored retiree health

1 benefits in each of these areas. Finally, we looked at the  
2 interaction of privately-funded supplemental products with  
3 publicly-funded products, particularly for low income  
4 beneficiaries.

5           We discussed the issues of state and local  
6 regulation with a variety of people in each of these sites,  
7 and I'm going to move from specific issues up to more  
8 general issues. A major topic that comes up, particularly  
9 in states that have not made changes in excess of the  
10 National Association of Insurance Commissioners model  
11 regulations is access to supplemental insurance for disabled  
12 beneficiaries under the age of 65. To of the states we  
13 visited don't have any special provisions for extra open  
14 enrollment or guaranteed issue. Three of them do.

15           This is an issue which is still in play.  
16 California only increased protections for beneficiaries  
17 under 65 a couple years ago. They had a special open  
18 enrollment period and they're going to have another one  
19 starting in January because evidently no one was aware of  
20 the first one. They were kind of concerned about that.

21           As it turns out, the Medicare+Choice program is  
22 what brought this issue into special light in a number of

1 these states. There was some hope on the part of the  
2 beneficiary advocate community that M+C programs would  
3 provide an option for people who couldn't get supplemental  
4 insurance. This turned out not to work out very well. In  
5 the two states that didn't have special provisions the M+C  
6 market never really developed all that much and there was  
7 never a great deal of enrollment for people under 65. Now  
8 that the availability of M+C programs in both Nebraska and  
9 the Atlanta area is quite limited impact, we're back to the  
10 same position we were at before which is an issue of some  
11 concern for the beneficiary community.

12           Moving to the next area, there are really basic  
13 differences in the way Medigap insurance in particular looks  
14 in states. Minnesota is a waiver state and its products are  
15 actually quite different from the national products in some  
16 substantive ways. In particular, the structure of the drug  
17 benefit that's available in Minnesota Medigap is a little  
18 bit more generous than anything that's available under H, I,  
19 and J. It's expensive, but there are also differences in  
20 the way Minnesota Medigap is structured in terms of the  
21 select policies so that there are options available to  
22 beneficiaries in Minnesota for coverage which includes drug

1 coverage that are more accessible, evidently, than they are  
2 nationally. Twice as many people who buy Medigap in  
3 Minnesota get a drug coverage version than is true for the  
4 benefit in the other states.

5 DR. REISCHAUER: But isn't that because it's one  
6 of the three states that was excluded from the requirements-  
7 -

8 DR. BERNSTEIN: Right.

9 DR. REISCHAUER: --and they have to keep the plans  
10 that were defined as of the early 1990s?

11 DR. BERNSTEIN: They made the reforms right before  
12 the OBRA reforms and they basically went through the same  
13 process, they just came up with a slightly--they believe  
14 that their structure was superior to what NAIC came up with  
15 so they didn't switch to the NAIC option. Their actuaries  
16 have some very interesting insights into what they think  
17 they did, although they're not taking credit for it being  
18 entirely on purpose but it seemed to have worked out pretty  
19 well.

20 Medigap is the basic form of coverage in  
21 Minnesota. The M+C rate is not that high and there's very  
22 little employer coverage there compared to some other urban

1 areas that would be comparable to Minneapolis. So it is a  
2 big deal there.

3 New York is also a heavily regulated state under  
4 the regular system but New York has pure community rating  
5 and open enrollment and guaranteed issue. There are less  
6 policies sold in New York, and they're not cheap but we  
7 didn't hear any complaints when we were there about the  
8 availability of Medigap from beneficiaries or from  
9 regulators.

10 We also saw differences in the regulatory climate  
11 that affects supplemental products. Some states are very  
12 happy with the existing set of standardized policies and  
13 don't want any changes to it and are very resistant to the  
14 introduction of innovative benefits. Other states are much  
15 more laissez faire and believe that the basic rules cover  
16 the options and if it's okay with the national system, it's  
17 okay with them. California is the prime example there.  
18 There are a lot of different things going on in California  
19 and I'll come back--but the insurance options in California  
20 are more diverse than they are in other standardized states.

21 In the broadest level, some of the state  
22 regulations actually affect who can participate in the M+C



1 market and what insurers can do. In Minnesota for-profit  
2 organizations can't find health plans, PPOs or M+C or any  
3 kind of managed care plan, so there are contracting  
4 arrangements with commercial vendors that have established  
5 contracting intricacies there that have affected the way  
6 they go forth with things like PPOs.

7           New York has a rule about insurers not doing out-  
8 of-state business which would be an issue, and California's  
9 prohibition of corporate practice of medicine has had an  
10 effect on the way physician groups have organized themselves  
11 there, which in turn has an effect on who participates and  
12 what kind of managed care arrangement or insurance  
13 arrangement.

14           Moving to the local delivery systems. It's kind  
15 of obvious to say that managed care and M+C options look  
16 different in markets where integrated care and HMOs are a  
17 way of life versus markets where they're not, but they're  
18 more fine-tuned differences that stem from that kind of  
19 basic difference across the places that we went to. The  
20 four metro areas that we visited are about the same size in  
21 Medicare population but they have very different kinds of  
22 health care provider organizations, physician groups,

1 relationships with hospitals, et cetera. M+C options fit in  
2 some of them and they don't fit very well in some of these  
3 other places.

4 Both Minneapolis and San Diego have strong managed  
5 care organizations and have had high penetration rates in  
6 managed care in the commercial market for decades. In  
7 Minneapolis, pretty much everyone we talked to told us about  
8 the region's strong commitment to integrated care and to  
9 quality initiatives and to strong relationships between  
10 providers and health plans and so forth. In San Diego, the  
11 physician groups are clearly committed to contracting with  
12 health plans and capitated arrangements still actually work  
13 there, and there are a lot of people who are committed to  
14 sustaining those relationships. Beneficiaries also are very  
15 loyal to managed care in San Diego even though the quality  
16 of the M+C benefits has deteriorated somewhat over time.

17 Some of the points that are listed in the sub-  
18 bullets there are--contrary to popular opinion, rules of  
19 thumb don't always apply because of these differences in  
20 local delivery systems. As I said, in San Diego some  
21 provider organizations really like capitated arrangements.  
22 In Minnesota we talked to plans who said they had put

1 together rural networks and they planned to put together  
2 more rural networks in adjoining states. In other urban  
3 areas it seemed to be virtually impossible to put together  
4 networks that could participate in PPOS or in MedicareSelect  
5 plans. Atlanta was one example and Long Island is another.

6 Finally, history and cultural or whatever you want  
7 to call it, makes a difference in some of these areas.  
8 Beneficiaries in some of these markets were very happy about  
9 the coming of managed care, M+C programs, and very unhappy  
10 when things didn't work out the way they wanted them to and  
11 the plans, particularly in Atlanta, just disappeared. It's  
12 almost personal. People are very skeptical, including the  
13 people who work in the counseling organizations about  
14 managed care and its ability to ever serve these people's  
15 needs so they're going to be skeptical when anything new  
16 comes along.

17 The issue of employer-sponsored insurance came up  
18 a couple times this morning. Again, despite the fact that  
19 it is clearly true that there's a decline in retiree  
20 benefits, it's still important in some of these markets, in  
21 Long Island in particular, there are big variations across  
22 the industry groups and the public versus private sector

1 with regard to these benefits, but across all of them we  
2 heard very mixed views about how--on the one hand these  
3 things remain important. They're important to the  
4 beneficiaries. They're important to the employers. All of  
5 them are concerned about cost. All of them are concerned  
6 about, in particular, prescription drug benefits and the  
7 cost of those plans.

8           One thing that we heard about that's important is  
9 the extent to which, in an effort to reduce costs or  
10 liability in employee benefits in general, employers in both  
11 the public and private sector can move retirees into their  
12 own risk pool, which reduces the increase in cost for the  
13 working population but leads to fairly steep premium  
14 increases for the retirees and may cause them to drop  
15 coverage.

16           So we have to be very skeptical now when you look  
17 at the offer--percentage of employers who say they're  
18 offering coverage to retirees masks the fact that, first of  
19 all, some of the retiree premiums are very, very high in  
20 some of these programs, and in some of these programs  
21 employers are no longer able to contribute at all to the  
22 retiree population. They offer the plans because they're

1 group plans and group plans have distinct advantages, mainly  
2 in terms of being able to craft benefits more flexibly than  
3 you can in the individual market. In many cases, the  
4 retiree plans are the only--provide a way of offering a much  
5 better drug benefit than you can buy through H, I, or J and  
6 there isn't much else out there except for some generic-only  
7 plans.

8           Finally, employer-sponsored insurance still has a  
9 big effect in some areas on local health plans. In some  
10 markets contract plans for M+C through employers constitute  
11 one-third or more of the business that some of the M+C plans  
12 are involved with.

13           Another unique example is the TriCare for Life  
14 program which is an employer-sponsored plan from the  
15 Department of Defense which covers supplemental benefits and  
16 offers an optional free--it doesn't cost anything to join  
17 it--drug program for military retirees. When that came  
18 online a little over two years ago in San Diego it affected  
19 about 14 percent of the Medicare beneficiaries living there.  
20 Thousands of people left their existing plans, dropped  
21 either M+C coverage or Medigap coverage. A major insurer in  
22 Atlanta also told us 10,000 of their members dropped Medigap

1 when TriCare for Life came online. So these organizations  
2 do affect each other.

3 On a sadder note, in Minnesota--it doesn't affect  
4 Minneapolis as much as the state as a whole, large declines  
5 in coverage for iron and steelworkers as a result of plant  
6 closings has led to really interesting competition among  
7 Medigap and M+C plans in that state as well.

8 We also talked about some of these low income  
9 programs this morning so I'll just go over this really  
10 quickly. The supplemental coverage offered through the full  
11 Medicaid program varies substantially across states; has a  
12 big impact on beneficiary access to coverage. The income  
13 limits in Georgia are less than half of the income limits in  
14 Minnesota, which has the highest. Asset levels vary  
15 considerably across these states as well.

16 For the Medicare savings programs, that would be  
17 QMB and SLIMB, QI1 program, the income is set nationally so  
18 those are the same but again the state asset requirements  
19 come into play. There's even more variability when it comes  
20 to the prescription drug benefits available for low income  
21 beneficiaries. Georgia has a program which basically helps  
22 people get private sector drug assistance, whereas Nebraska

1 has no program at all; New York has a very popular program  
2 called EPIC which many of you know about, which provides  
3 coverage to people of low and moderate income levels. It's  
4 a very large program, and given the support that it has in  
5 the state and the commitment that the state has made to us,  
6 we heard a lot of people there say that they were actually  
7 concerned that changes in national policy could be  
8 detrimental to the people of New York because it could leave  
9 them with something worse than what they have now.

10           The last thing I'll mention even more briefly is  
11 that the dual eligible issue is clearly important in all of  
12 these areas. In most of the states, dual eligibles are not  
13 generally in managed care because it's optional and it's  
14 very difficult to coordinate benefits, particularly drug  
15 benefits. However, the MSHO program, Minnesota Senior  
16 Health Options in Minnesota is a fully integrated waiver  
17 program that combines Medicare and Medicaid benefits into a  
18 single funding stream, and a lot of folks there are actually  
19 in managed care. The plans that are participating in that  
20 think there's a tremendous potential for better care and  
21 more coordinated care and efficiencies, and later this year  
22 other staff will be getting back to you on some of the

1 issues regarding dual eligibles and some of what's going on  
2 with them.

3           Looking to the future. One common theme that we  
4 heard and what we emphasized in the report is that generally  
5 across all the five sites we went to, as different they  
6 were, the Medigap market is seen as a stable thing. The  
7 insurance regulators, the insurance companies and  
8 beneficiaries know what the rules are. They generally  
9 understand them. They had very few complaints about  
10 regulation, and it was striking to us that this is just as  
11 true in New York or in Minnesota as it was in places where  
12 there was very little regulation in comparison. Knowing  
13 what the rules are with these products is very important to  
14 people.

15           There's a growing tension, however, as some of the  
16 forms of Medigap and different sorts of Medicare+Choice  
17 products evolve, as benefits have eroded and cost-sharing  
18 has increased Medicare+Choice plans begin to look a little  
19 bit more like Medigap products. Medigap providers for their  
20 part, particularly in places where they're being more  
21 innovative or trying to come up with ways of addressing the  
22 prescription drug needs of their clients and also trying to



1 deal with cost by using high deductible plans.

2           They're also adding benefits like homeopathic  
3 medicine or the prevention programs or exercise programs  
4 that attract different groups of beneficiaries so that in  
5 some places like California it's really hard to figure out  
6 what these products are, whether they're Medigap or whether  
7 they're Medicare+Choice. Those differences are important  
8 because they're regulated differently. The open enrollment  
9 season issues are different, and the community rating  
10 provisions are different, and the re-entry into the market  
11 are affected by different federal and state protections.

12           A number of the beneficiary folks we talked to in  
13 California were really beginning to have trouble trying to  
14 figure out what to tell their clients. In terms of Medigap  
15 alone, the SHIP was unable to provide price information on  
16 alternative Medigap products because the system is so  
17 complicated, there's so many different options and they're  
18 so hard to compare to each other that they had basically  
19 lost the ability to help the people that called them to get  
20 that kind of information. It's also not available on the  
21 state insurance department web site, the pricing  
22 information, because they can't keep track of it either.

1           I just want to go through one really quick example  
2 of how some of this plays out by using an example that was  
3 raised with us a number of times in different states and  
4 that has to do with the regulation of private fee-for-  
5 service plans, which are very, very much like other  
6 Medicare+Choice plans with a couple of unique distinctions.  
7 Like Medicare plans, you can't deny people entry based on  
8 any kind of personal--age or health or whatever. No  
9 difference for smokers or nonsmokers like there can be in  
10 other insurance. They have the same open enrollment,  
11 guaranteed renewal rules as other M+C plans. They are M+C  
12 plans. They have benefits similar to other M+C plans. To  
13 the extent that they have--you can set up a different  
14 systems of copayments. They cover some non-Medicare  
15 services. They offer some kinds of discounts for things  
16 like sometimes hearing aids, sometimes prescription drugs,  
17 out-of-area coverage. They look a lot like other M+C plans.  
18 They also look a lot like some of the Medigap plans that are  
19 available out there.

20           Currently none of them have networks, which does  
21 make them different from other M+C plans. But the other  
22 difference that has insurance regulators concerned is that

1 nobody reviews their rates. CMS by law doesn't review the  
2 rates of private fee-for-service plans, and states are  
3 preempted by federal law from reviewing the rates that are  
4 offered by these plans.

5           The concern of the regulators is that these are  
6 insurance products that are licensed to do business in their  
7 state, beneficiaries buy them the way they would any other  
8 Medicare product but it looks more like they're buying  
9 Medigap than M+C. But if the plans raise their rates  
10 substantially over time but don't leave the area, then the  
11 beneficiary might be in a difficult situation because they  
12 don't have--if the plan still exists they don't have the  
13 same rights as they would if the plan just disappeared and  
14 they would have automatic reinstatement rights for Medigap  
15 under federal law--I mean, M+C under federal law.

16           If an M+C plan disappears and there are no other  
17 M+C options, a person has certain rights to reenter the  
18 Medigap market, which is true of these plans. But if the  
19 plan is still there but offering a very high rate, this puts  
20 them in a different position. In a state like Minnesota  
21 where they are very careful about regulating everything,  
22 this is causing a great deal of consternation.

1 DR. ROWE: Can you say that again? I got a little  
2 confused.

3 DR. BERNSTEIN: I think I said it wrong. If  
4 you're in an M+C plan and it disappears, it withdraws from  
5 your area, there are federal protections for reentering the  
6 Medigap market. You're allowed within certain number, a 60-  
7 day window or something, you're allowed to reenter the  
8 market and buy certain of the Medigap plans without  
9 underwriting. Since private fee-for-service is an M+C plan  
10 it counts in there, so in many rural counties of Minnesota  
11 it's the only M+C option--actually Minnesota is a bad  
12 example. They have M+C everywhere. In many areas of many  
13 rural states it's the only option that's there. So if one  
14 private fee-for-service plan comes in and it's charging \$70  
15 a month for a benefit and then it leaves--

16 DR. ROWE: You can't afford that so you drop that  
17 but you don't have this reentry eligibility.

18 DR. BERNSTEIN: Right, because there's still an  
19 M+C plan. You can go back to regular Medicare but you can't  
20 get Medigap.

21 DR. ROWE: Why can't you buy Medigap? Is there a  
22 law against it?

1 DR. BERNSTEIN: It depends on the state rules.

2 After the 60--

3 DR. ROWE: You can never buy back in?

4 DR. BERNSTEIN: No, you can buy it but there are  
5 different rules in every state. You don't get guaranteed  
6 issue. In New York it doesn't make any difference because  
7 it's community rated and open enrollment, but other states  
8 you can't.

9 DR. ROWE: Tell me about the exceptions.

10 DR. BERNSTEIN: This is complicated, but the  
11 bottom line is, private fee-for-service looks like M+C but  
12 you don't have the same--nobody is reviewing the rates.  
13 That's what gets people upset and that could have an impact  
14 on beneficiaries if that's all that's available.

15 DR. ROWE: I don't understand. It seems to me  
16 that you are implicitly suggesting--you're kind of a born  
17 regulator. You're implicitly suggesting that what you  
18 should do is have some people review these rates. Why don't  
19 you solve the problem the other way and put in a regulation  
20 that gives these people the right to access Medigap at those  
21 rates, rather than create another bureaucracy reviewing all  
22 these rates? Wouldn't that fix the problem a little easier?

1

2 DR. BERNSTEIN: I'm not sure that the states want-  
3 -I'm not proposing or was not building to a recommendation  
4 that they review the rates. I'm saying that the regulators  
5 don't know what to do with these products that look sort of  
6 like Medigap and sort of not like Medigap, and kind of like  
7 M+C but not exactly like M+C. They have a lot of questions.

8 DR. ROWE: And they want to review the rates.  
9 You're saying, why can't we review the rates for these  
10 policies in this state that people are buying? I'm just  
11 saying there's another solution to the problem that would be  
12 much simpler and less bureaucratic.

13 DR. BERNSTEIN: I don't think the regulators in  
14 other states will want to review them. I think Minnesota  
15 like to review things. In fact they review things they're  
16 not even allowed to review.

17 MS. BURKE: Jill, can I just ask one further  
18 question on the structure of these plans? You indicate that  
19 there's no rate review. Are there similar to the normal  
20 insurance structure in most states as to reserve  
21 requirements or any of those kinds of issues?

22 DR. BERNSTEIN: They have to be licensed by the

1 states so it depends on the state's rules.

2 MS. BURKE: So it's just a function of that. So  
3 it may or may not.

4 DR. BERNSTEIN: Right.

5 MR. FEEZOR: Indirectly it may.

6 MR. SMITH: Purveyors are subject to normal  
7 insurance department regulations. What they're selling  
8 isn't but the sellers are.

9 MR. HACKBARTH: So the finances of this particular  
10 plan, is the premium appropriate for the costs, are not  
11 subject to state review but the overall financial stability  
12 of  
13 XYZ health insurer is because it's a state-licensed entity.  
14 That's a threshold requirement for participating in Medicare  
15 is that they're a state-licensed--

16 DR. BERNSTEIN: Right, they have to qualify to be  
17 a Medicare contractor, so they have to meet those  
18 requirements.

19 So as we develop--we're going to give you a final  
20 report on the site visits and we're going to look at some of  
21 these other issues further, so I just basically have two  
22 questions for you. One is whether there are particular

1 topics that were raised in the material we sent, or  
2 elsewhere, that you think we should be pursuing? And  
3 secondly, whether you would be interested in us looking at  
4 potential policy changes that might improve beneficiaries'  
5 ability to meet their supplemental needs.

6 MR. SMITH: Jill, thank you. I found this  
7 fascinating at the last meeting when we looked at the site  
8 visits and the mailing materials. I found it fascinating  
9 but not very satisfying, in that the question, so what,  
10 never got raised in any useful way. Does the structure of  
11 the supplemental market end up costing beneficiaries  
12 differentially out-of-pocket? Does it affect utilization?  
13 Does the structure of the market affect health outcomes to  
14 the extent that we know?

15 It's interesting that Minnesota and New York  
16 continue to be heavy-handed regulators and Jack would prefer  
17 to be in Nevada, but so what? Is the experience of one of  
18 Jack's policyholders in New York significantly better,  
19 significantly worse, significantly more expensive? Do they  
20 buy less supplemental health care than folks in a difficult  
21 market? It's hard to even begin to think about answers to  
22 the questions you raise at the end without knowing whether



1 or not this stuff matters.

2 DR. BERNSTEIN: One of the reasons that we did  
3 this is because when we did the national overview it was  
4 clear that it did matter. There a lot more people in some  
5 of these states that don't have any supplemental coverage  
6 than in others. In previous work we've tried to look at  
7 whether having different kinds of supplemental insurance  
8 makes a difference in terms of the way people use services.  
9 We haven't done that again recently, but that was going to  
10 be part of what we'd like to do in the future.

11 We're particularly interested in looking at what  
12 the decline in employer-sponsored benefits actually means,  
13 and where do these people go, and what are their options,  
14 but haven't yet figured out a good way of getting the data  
15 to track some of that. So those are all really important  
16 issues that we'd like--and that's one of the reasons that we  
17 wanted to talk to you today is to get some ideas about what  
18 particular directions you'd like us to go in.

19 MR. SMITH: In general I'd be more interested in  
20 what kind of services do they consume and how much do they  
21 have to pay for them, rather than what the architecture of  
22 their supplemental choice is.

1 DR. BERNSTEIN: Every year in the context chapter  
2 do an analysis of out-of-pocket spending and we do that by  
3 different type of supplemental coverage.

4 MR. SMITH: Incorporating some of that in here  
5 would be--

6 DR. BERNSTEIN: We did that last year and we're  
7 doing that again for the context chapter this year. We're  
8 also developing a chapter for the June report looking  
9 specifically at beneficiary resources and liabilities,  
10 basically looking at what they're spending for health care,  
11 and how they're paying for it, and how that's changed over  
12 time.

13 MR. SMITH: Looking that in terms of the  
14 differences in supplemental marketplaces?

15 DR. BERNSTEIN: That will be one of the things  
16 that's in there.

17 MR. HACKBARTH: Whether the different regulatory  
18 regimes are good or bad depends in part on who you are as a  
19 beneficiary and what you're expected expenditures are, what  
20 your health status is.

21 DR. BERNSTEIN: Actually, one of the things that  
22 will be in the report that we haven't had a change to talk

1 about is the natural experiment in San Diego when almost  
2 50,000 people went from having just military retiree  
3 coverage, which wasn't very good, to having TriCare for Life  
4 coverage, which is very good and has a very good drug  
5 benefit. We have yet to figure out how to get hard data on  
6 this, but there was a lot of anecdotal evidence that their  
7 use of services has changed dramatically as a result of  
8 having different kinds of supplemental. They're using a lot  
9 more services.

10           So it is an issue. Again, on Long Island more  
11 than 60 percent of the people, according to CPS, have  
12 supplemental coverage through their employer. Utilization  
13 patterns there are very difficult than they are in San Diego  
14 or Minneapolis.

15           MR. HACKBARTH: One of the interesting things that  
16 I read on this subject, I think it was Kaiser Foundation  
17 report that looked at different markets and looked at the  
18 options available to certain hypothetical beneficiaries with  
19 different conditions and associated health care costs, and  
20 said, what are the total health care costs for this  
21 hypothetical 80-year-old frail female, or a 65-year-old  
22 healthy male in different markets, when you take into

1 account the premiums plus the out-of-pocket expenditures?

2 It was very interesting and enlightening. Huge differences;  
3 huge differences.

4 MR. FEEZOR: Glenn, I think you and Dave probably  
5 at your last question framed what really we should be  
6 focusing more on in our analysis of this. I bear some  
7 responsibility because Jill and Scott had asked my opinion  
8 from my days 15 years ago as a regulator about what were the  
9 right market and some of the nuances.

10 In retrospect, I am concerned about two or three  
11 things about our work thus far. Out of the five sites we  
12 picked, three are in notoriously unique states in the terms  
13 of the regulatory environment. That is Minnesota, that is  
14 New York, that is California. Two, I think three of those  
15 are out of the four or five who maintained a duality of  
16 regulatory oversight for a long time. Basically said that  
17 HMOs were not in the insurance business and that sort of  
18 thing. So in retrospect I worry about that.

19 Also in retrospect as I look--we looked largely at  
20 urban markets, with the exception of all of Nebraska, and we  
21 got all of Nebraska in order to get equal numbers I guess,  
22 or equal size markets.

1 DR. BERNSTEIN: No, we wanted to go to a state  
2 that was rural; someplace that was rural.

3 MR. FEEZOR: In retrospect, even that one I worry  
4 a little bit about the presence of Mutual of Omaha being so  
5 very, very strong early in the supplemental market, though  
6 they may not be anymore. So you may want to just touch base  
7 or do a couple of quick and dirty conversations with some  
8 other less urban states to see if there's some--to verify  
9 what you found in Nebraska.

10 By the way, parenthetical, I think what will be  
11 interesting, Jill's point on the evolution of a lot of the  
12 Medicare+Choice products to look more like Medigap and  
13 Medigap to mimic some aspects of some of the Medicare+Choice  
14 products despite different regulatory--Jack may bear it out  
15 and I'm sorry Alice isn't here, but an awful lot of the--  
16 because of what seems to be the intransigence of the  
17 division of managed health care in California almost every  
18 HMO that I know is in fact filing dual license. They in  
19 fact are filing HMO look-alike products under a department  
20 of insurance license in order to have greater flexibility in  
21 their benefit design and so forth.

22 Then just one other observation. Because it is

1 probably a more static market now maybe this is not as  
2 important, but I think it's hard to look at what happens in  
3 the Medicare supplemental market generally without looking  
4 and giving some credence--and it's very tough thing to do  
5 market by market--by looking a little more carefully at the  
6 distribution mechanism by which those products are sold,  
7 looking at the compensation or the reimbursement, whether  
8 it's a captive sales force, independent agent, does that  
9 commission pan out over two years? Even though some of the  
10 Medigap reform efforts limited some of that variation, I  
11 think that's important. Then ultimately, and the point was  
12 made in this paper, how the regulatory construct fits with  
13 where there are some regional or local payment and physician  
14 network practices and attitudes are awfully important.

15           Two other just quick points. There was a new  
16 study that's just been released. I haven't had a chance to  
17 see it on public entity retiree.

18           DR. BERNSTEIN: I've got it.

19           MR. FEEZOR: Okay, just wanted to make sure you'd  
20 seen that.

21           Then finally, I don't know who's doing the  
22 actuarial work for TriCare for Life, but the future cost of

1 that--I see a lot of snickers. I may be stepping into it,  
2 but it won't be the first time nor the last. But the  
3 unfunded liabilities, not only--Jill's point on the number  
4 just in San Diego, but even within the CalPERS program when  
5 people began to say, when we move to just a 10 or--in fact  
6 most of our retirees in the CalPERS program pay very little;  
7 certainly the state retirees. But even when we start  
8 talking about a pay increase out-of-pocket on premiums for  
9 the retirees, I had a significant number, hundreds that  
10 actually bolted from an almost free retiree coverage in  
11 CalPERS to TriCare for Life. If I could have been a little  
12 more selective about which ones left me that wouldn't have  
13 been all bad from my perspective, but I really do worry  
14 about who's tracking that from the federal government  
15 standpoint.

16 DR. REISCHAUER: By the time the bill comes in  
17 Arnold will be president and he'll handle that issue.

18 [Laughter.]

19 DR. BERNSTEIN: I just wanted to mention that the  
20 full report has a lot of the detail that we haven't been  
21 able to talk about including the agents. There's much more  
22 richness but it was hard to--we'll get a lot of that stuff

1 to you.

2 DR. WAKEFIELD: I take the point that some of  
3 these examples might be little bit on extreme ends or  
4 atypical examples, but frankly, I liked that read. I agree,  
5 if you can, to deal some maybe more run-of-the-mill markets  
6 or circumstances into the mix might be helpful. But I  
7 thought this was pretty illuminating. The variation was  
8 striking to me, and I found that to be helpful. I did have  
9 the same reaction and why I asked to be called on was  
10 because I wanted to raise David's point, which he already  
11 raised and that was, I had some difficulty connecting this  
12 to the beneficiary at the end of the day. But you answered  
13 that. If we can deal that content back in here, I really  
14 interested in, recognizing all of this then, what's the link  
15 to out-of-pocket expenses, for example, to beneficiaries?  
16 How are they impacted by these kinds of variations? Because  
17 I actually found this quite helpful, but that was the piece  
18 I was still missing. And I heard your answer, you're coming  
19 back and that's going to be dealt back in again. So  
20 basically that question was already raised.

21 I do have a different question though on--I also  
22 had a second question on private fee-for-service. Is it



1 still the case, Jill, that these tend to be primarily in  
2 rural areas? At least the first one out of the box was. Is  
3 that still the case or are we seeing them equally  
4 distributed in urban and rural areas? Just out of  
5 curiosity.

6 DR. HARRISON: Next presentation will have a table  
7 that will show you that.

8 DR. REISCHAUER: When we do whatever we do in this  
9 area I hope we don't lose sight of what I think should be  
10 the message of MedPAC, and that is because employment  
11 conditions and health markets and the regulatory framework  
12 and Medicaid policy vary tremendously from area to area or  
13 state to state, the availability of supplemental insurance  
14 will be unequal and it will be inequitable with respect to  
15 cost, availability, structure, generosity, everything.

16 The right way or only way to solve this problem is  
17 to expand the basic Medicare package so that it constitutes  
18 a package that the vast majority of the elderly and disabled  
19 regard as adequate and they don't need two health insurance  
20 policies. We two years ago wrote something about that,  
21 about how one could do that. But we'll be here 50 years  
22 from now talking about the strangeness and the inequities

1 that exist and how you might tinker around the edges and  
2 make some of it, the repercussions a little better than they  
3 otherwise would be, but you'll come nowhere near to solving  
4 the basic problem unless you expand the coverage of the  
5 basic Medicare benefit.

6 DR. HARRISON: The one thing that we really found  
7 was the search for drugs was very important in all of the  
8 markets. People stay in retiree plans where they have to  
9 contribute lots of money only because they're going to get  
10 drugs out of it that they can't get elsewhere.

11 DR. REISCHAUER: But as soon as we cover drugs  
12 we're going to worry about catastrophic.

13 DR. HARRISON: Right. I'm just saying, an example  
14 of what we found from the case studies is that drugs are  
15 swinging a lot of the decisions that are going on here. I  
16 don't know that we have a lot else that we saw.

17 DR. ROWE: Just three quick points. One is, I  
18 thought the stuff at the end of the chapter on how the  
19 Medigap policies seemed to be turning into M+C and M+C  
20 seemed to be turning into Medigap and it was getting to be a  
21 blur of the distinction yet they were regulated very  
22 differently was interesting. One of your questions is, are

1 there particular topics, and you didn't talk about that much  
2 in the presentation but I thought that was interesting.  
3 Maybe if there was some sort of a table or something that  
4 showed the direction that each product was going and how  
5 they were trying to get--they seemed to be converging, I  
6 thought that was interesting.

7           Second is, I think you should say something to  
8 distinguish corporations that are putting in policies that  
9 individuals who are not yet hired or who may be hired but  
10 not yet retired will lose certain benefits versus actually  
11 reducing the benefits of currently retired people, because  
12 they're two very different things. There are a lot of  
13 companies that are saying, no more X for retirees after next  
14 year or something like that, or two or five years from now  
15 or a sliding scale, because they don't want people to rush  
16 out and retire. But that's not influencing the market now  
17 because that company's retirees still have benefits. That's  
18 one subset.

19           Then there are the subset of people who actually  
20 are having their benefits reduced in retirement while  
21 they're retired and I think it's not obvious from what you  
22 presented about that.

1           The third is just a quick question. When you were  
2 in Minnesota, whether the proximity to Canada had any effect  
3 on the search for drugs. We hear a lot about people going  
4 to Canada get drugs, and I just wondered if you had heard  
5 anything about that or saw anything in the market up there  
6 that was different than in North Carolina or something like  
7 that.

8           DR. BERNSTEIN: Yes. There's a very large program  
9 run by a nonprofit consumer group there that has a very  
10 large drug importation business going on. I think they're  
11 having a little bit of legal--

12           DR. ROWE: Are they licensed--

13           DR. BERNSTEIN: A little bit of legal issues going  
14 on there now, but it's a very big program. They sort of  
15 invented--they've one of the driving factors behind the  
16 entire national movement. It's a huge organization.

17           MS. DePARLE: When you say very large, Jill, what  
18 do you mean?

19           DR. BERNSTEIN: It's the Minnesota Senior  
20 Federation and has like 80,000 people who belong to it in  
21 Minnesota plus others. They have a professional full-time  
22 staff and it's a real place.

1 DR. ROWE: I was hoping that wasn't going to be  
2 the answer, but given that it is then I think Minnesota is  
3 particularly inappropriate for us to draw any conclusions  
4 from with respect to--while we're comparing, we're picking  
5 three different markets or four different markets and we're  
6 trying to see what's going on. Here we've got this one  
7 market with this huge drug importation--

8 DR. WAKEFIELD: I think more states are doing  
9 that. There's probably at least three or four states.

10 DR. ROWE: Three or four out of 50.

11 DR. WAKEFIELD: Ralph's saying 16 or 17 states.

12 MR. HACKBARTH: We need to keep moving here, I'm  
13 afraid. Carol has the last comment and then we need to move  
14 on.

15 MS. RAPHAEL: This is something I'd like to have  
16 you focus on. It's on the road to tinkering, to make this  
17 better in the interim. That's the young disabled, because  
18 we know they're growing in the Medicare population. We know  
19 there are real issues about access to Medigap. I think you  
20 highlighted last year or the year before. You make some  
21 very brief reference to it, but I'd like to really  
22 understand the Medigap market for the young disabled under

1 65.

2 DR. BERNSTEIN: I didn't do it this time because  
3 we had talked about it in some earlier sessions. There's  
4 data--we've been looking at it and it will be discussed in  
5 the report.

6 Actually, if I can make a really brief comment  
7 about the site visits and where we went. Site visits are  
8 really--you can't generalize from them but they're really  
9 good at looking at things that are different. I think the  
10 methodological advantage we had here is, in a sense looking  
11 at extremes to get a sense of how things could play out. We  
12 will be very careful in trying any conclusions from these  
13 five weird places about national--we need national data to  
14 do that. We can't do that from these five places, but you  
15 can see some really interesting nuances that can play out in  
16 very different ways which we thought would be helpful.

17 MR. HACKBARTH: Thank you.

18 Next up is Medicare+Choice. Scott and Tim.

19 MS. DePARLE: While we're changing tables I just  
20 want to say, I think that it's commendable that the staff  
21 went to the effort to make these site visits, because I know  
22 do with the limited staff how much extra effort and energy

1 it takes to go out there. But as we're seeing more and more  
2 how different markets are I think that's an important  
3 perspective that we need to have so I want to thank them for  
4 doing that.

5 DR. HARRISON: In this session we're going to  
6 focus on payment rates and plan availability in the M+C plan  
7 for next year. In its May announcement of the M+C rate  
8 increases for 2004, CMS announced that expected fee-for-  
9 service growth in Medicare for beneficiary will be 3.7  
10 percent in 2004. The payment formulas feed off this number,  
11 and running that through the formulas we get the following  
12 updates.

13 Payment rates in floor counties will rise by  
14 approximately 5 percent. Rates in non-floor counties will  
15 increase by the legislatively set guaranteed minimum of 2  
16 percent, plus 0.2 percent to account for increased coverage  
17 responsibilities from national coverage determinations, so  
18 the total increase there is 2.2 percent. Combining the  
19 effects of these rate changes, the average base payment rate  
20 for M+C plans will rise by 3.2 percent for next year. On  
21 top of these increases CMS is raising all county rates by  
22 4.89 percent as part of the introduction of the new risk

1 adjustment system in 2004. I'll get into this in just a  
2 couple minutes.

3 As you may remember, there are two absolute floors  
4 that vary with the characteristics of a county. One floor  
5 applies to counties in large urban areas, defined as  
6 metropolitan statistical areas containing more than 250,000  
7 residents. The other floor applies to all other counties.  
8 The large urban floor was introduced in BIPA, and BIPA also  
9 set the floors at \$525 per month for the large urban areas  
10 and \$475 in the other areas. The rates are growing at the  
11 rate of per beneficiary fee-for-service spending growth, and  
12 the floor rates for 2004 are \$592 per month in the large  
13 urban areas and \$536 per month in the other areas.

14 Now note that as the floor rates increase at rates  
15 higher than the 2 percent minimum guaranteed increase more  
16 counties will have their rates raised by the floor. For  
17 2004, about 7 percent of Medicare beneficiaries live in the  
18 counties that will be newly affected by the floors in 2004.  
19 In other words, they were not affected by the floors in  
20 2003. These are some big counties; Montgomery County,  
21 Maryland and Denver, Colorado, for example.

22 Approximately 63 percent of Medicare beneficiaries



1 and 40 percent of the M+C enrollees will live in floor  
2 counties in 2004. Back in 1998 when there was one national  
3 floor only 15 percent of beneficiaries lived in floor  
4 counties, and as recently as 2001 when the second floor was  
5 influenced 49 percent of Medicare beneficiaries lived in  
6 floor counties, and now we're up to 63 percent.

7           As a greater share of M+C payments are determined  
8 by the floor rates, payment policy moves farther from the  
9 Commission's stated objective of Medicare paying the plans  
10 equivalent to spending that would occur on those enrollees  
11 under the traditional program.

12           So how are M+C payments related to Medicare fee-  
13 for-service spending now? While the increases in M+C rates  
14 have been below growth in spending in the fee-for-service  
15 Medicare program over the last several years, we estimate  
16 that for 2004 M+C plans will still be paid on average at  
17 rates higher than per capita spending in the traditional  
18 fee-for-service program. For 2004 we estimate that across  
19 all counties Medicare is paying Medicare+Choice plans an  
20 average of 103 percent of what it would cost to cover the  
21 current mix of M+C enrollees under the traditional fee-for-  
22 service program.

1 Medicare pays 110 percent of fee-for-service for  
2 enrollees in floor counties in the large urban areas and 113  
3 percent of fee-for-service in other floor areas. By  
4 contrast, in non-floor counties Medicare pays 100 percent of  
5 average fee-for-service spending which just happens to match  
6 Commission preferences.

7 All these estimates though assume that the average  
8 health risk of M+C and traditional enrollees are the same,  
9 other than differences accounted for by the demographic  
10 characteristics. However, CMS has found that M+C plans  
11 enroll a less costly population than would be accounted for  
12 by demographics and, therefore, on average Medicare is  
13 paying M+C plans more than 103 percent of Medicare spending  
14 under fee-for-service.

15 Let's get into the effects of the risk differences  
16 between the two parts of the program.

17 CMS has estimated that plans enroll beneficiaries  
18 that are, on average, 16.3 percent less costly than  
19 demographically similar beneficiaries in the traditional  
20 program. The new risk adjustment system was designed to  
21 correct for this risk difference. I really should say that  
22 this 16.3 percent figure is based on simulations of plan

1 data that was submitted--the diagnoses that were submitted  
2 by plans specifically for these simulation purposes. If  
3 plans were not successful in collecting all the diagnostic  
4 data then the difference will not turn out to be that large,  
5 but we don't know yet.

6 In 2004, plans will be paid a blended rate based  
7 30 percent on the new risk adjustment system and 70 percent  
8 on the old demographic system. However, CMS has decided to  
9 compensate plans so that total payments under the new system  
10 in 2004 will be the same as if all payments were made under  
11 the old demographic system. CMS has chosen to accomplish  
12 this version of budget neutrality by increasing all county  
13 rates in 2004 by 30 percent of the total 16.3 percent, or  
14 4.89 percent for 2004.

15 MR. HACKBARTH: Scott, can we go back to the first  
16 bullet because I saw a couple puzzled looks on what that  
17 meant? Let me see if I understood you correctly. So what  
18 CMS did was, based on data submitted by plans, compared to  
19 riskiness, if you will, of the current enrollees--

20 DR. HARRISON: Expected cost.

21 MR. HACKBARTH: The expected cost of the current  
22 enrollees with the fee-for-service population. Using this

1 risk adjustment system they said that there's 16.3 percent  
2 less risky, or lower expected cost than the fee-for-service.  
3 However, this may overstate the difference. To the extent  
4 that the plans do not have all of the information properly  
5 coded, the patients may be sicker, if you will, than what  
6 this information suggests so the gap could narrow somewhat  
7 as coding improves. Is that correct?

8 MR. FEEZOR: Narrow or increase.

9 DR. HARRISON: I think it's unlikely to increase.  
10 It would probably narrow if we thought that the plans didn't  
11 have all the data in from their different providers. I  
12 guess it would be unlikely to think that they had more data,  
13 more diagnoses than--

14 MR. HACKBARTH: When they're not paid to code  
15 correctly they tend to undercode and there's less complete  
16 information, which leads the patients to look healthier.

17 DR. HARRISON: Correct.

18 MS. DePARLE: Although you said this was a  
19 specific sample that the plans submitted for this purpose,  
20 right?

21 DR. HARRISON: Yes.

22 MS. DePARLE: So we assume they had every

1 incentive to code properly.

2 DR. HARRISON: It only gave them an example of  
3 what the impact would be. Payments are still based on a  
4 model completely calibrated by the fee-for-service data.

5 MR. HACKBARTH: I guess the other important point  
6 is that even if Scott is directionally correct; namely, that  
7 the difference would tend to narrow, it's hard to say how  
8 much it would narrow. It probably doesn't account with the  
9 full 16.3 percent.

10 DR. HARRISON: Probably not.

11 MR. SMITH: Glenn, if I could just stick with this  
12 for a minute to make sure I have my arithmetic right. Would  
13 it be right to say that the effect of the CMS decision to  
14 rates by 4.89 percent is the same thing as having put off  
15 the blended rate?

16 DR. HARRISON: Not doing anything for risk  
17 adjustment, right..

18 MR. SMITH: The math is the same.

19 DR. HARRISON: Right.

20 What they did was they didn't touch the 70  
21 percent, and they did touch the 30 percent but then they  
22 gave it back. The point is that this treatment of risk

1 adjustment would most likely push M+C rates further from the  
2 fee-for-service level at which the Commission had  
3 recommended the M+C rates be set.

4           Now I do want to note that these higher payments  
5 based on risk differences between the plan enrollees and  
6 fee-for-service beneficiaries is not a new problem, however,  
7 we didn't have a number to pin this to before. Also, the  
8 4.89 percent portion has now been made explicit. That  
9 portion will grow if the adjustments continue to be made as  
10 risk adjustment is phased in fully. I should also note that  
11 CMS has not committed to paying the budget neutrality factor  
12 to plans after 2004, and if they do not then payments will  
13 get closer to fee-for-service levels.

14           MS. BURKE: Scott, can I ask a question? I just  
15 want to be sure that I understand what the impact of the  
16 neutrality provisions are. In making the adjustment, the  
17 4.89 in order to--essentially to recover the amount that  
18 would be lost as a result of the blending, the impact will  
19 vary by plan. So that it's not absolute neutrality by plan,  
20 it's neutrality against the system.

21           DR. HARRISON: That's correct.

22           MS. BURKE: So you may still have, presumably,

1 variances and there may be plans in fact who do less well as  
2 a result of the transition.

3 DR. HARRISON: Yes.

4 MS. BURKE: In which case, what are the  
5 expectations that we're going to end up with a series of  
6 appeals to be more specific in the neutrality adjustment?  
7 You're going to have winners and losers.

8 DR. HARRISON: They vary by plan.

9 MS. BURKE: That's my point. So having had to set  
10 floors and do a variety of other things to protect people,  
11 one could only assume--

12 MR. HACKBARTH: So 4.89 percent is the right  
13 increment for the plan that has a selection of risk that  
14 matches traditional Medicare, normal selection of risk?

15 DR. REISCHAUER: No, it's average for all  
16 Medicare+Choice plans.

17 MS. BURKE: It's the average, so there will be big  
18 winners and losers potentially.

19 DR. HARRISON: Yes.

20 MS. BURKE: So one could only imagine that there  
21 may well be attempts to further correct for this temporary  
22 period, correct? If history repeats itself, one could

1 imagine that we're going to be asked to go in and save  
2 somebody.

3 MR. HACKBARTH: If everybody is interpreting  
4 budget neutrality as budget neutrality for me.

5 MS. BURKE: Theirs; correct.

6 DR. REISCHAUER: These guys have been playing  
7 around with this for a couple of years now. They all know  
8 this was coming and we haven't heard, I don't think, any big  
9 screams about it.

10 Let me ask you if I'm right here. This 103  
11 percent wouldn't change at all if we completely phased in  
12 risk adjustment and gave another 11 percent increase, right?  
13 It offsets.

14 DR. HARRISON: No.

15 DR. REISCHAUER: The 16 is--beyond the 4.89. Two  
16 more slugs of 4.89, but then we reduce the payment because  
17 we put in risk adjustment fully, so that would lower  
18 everything. Then that we lower it back up. If we do the  
19 calculation it would still come out to 103.

20 DR. HARRISON: That's my next point, if that were  
21 the case you'd end up paying about 120 percent on average  
22 because you'd be paying the 103 just for the base rate



1 differences and on top of that you would have given back  
2 16.3. We have 103 percent that we talked about before, and  
3 that's just the base rate differences. That assumed that  
4 everybody was--

5 MS. BURKE: That's the floor.

6 DR. HARRISON: That's right. Now on top of that--

7 DR. REISCHAUER: But then if you did not do budget  
8 neutral risk adjustment it would lower it down. You'd lower  
9 it down and with the extra money you bring it back up.

10 MR. SMITH: You'd end up at 103.

11 DR. HARRISON: -- but that's adding the 4.89, and  
12 twice more.

13 DR. REISCHAUER: What I'm saying is, we're at 103  
14 and we're at 30 percent risk neutrality, we go from 30 to  
15 100 percent risk neutrality which lowers the payment so  
16 we're way down below 103. Then we add the money back up and  
17 we're at 103, not 120.

18 DR. HARRISON: We'd be at 103 but for different  
19 populations then, because the M+C population would be less  
20 costly. The 103 ignores any risk differences. Now if these  
21 risk differences really are there, then you would be paying  
22 16 percent above the 103.

1 DR. ROWE: I'd like to point out that I believe  
2 the discussion has an implicit assumption in it, or at least  
3 the material does as you read it, when we make all these  
4 comparisons as to what the health plans are getting paid  
5 versus what CMS is paying in the traditional plan. It's  
6 103, it's 105, it's 120, it's 130, et cetera. The implicit  
7 assumption is that the health plans' cost are the same as  
8 Medicare's cost and therefore this is profit or they're  
9 being overpaid or something. It might be worth having a  
10 sentence in the chapter that says, that the health plans are  
11 paying--

12 DR. REISCHAUER: So less efficient--

13 DR. ROWE: --are paying 130 percent of Medicare to  
14 the hospitals and 108 percent of Medicare to physicians  
15 nationwide, or something like that that at least give a  
16 little sense of fairness, because otherwise the whole  
17 conversation goes on without any reference to these higher  
18 costs.

19 MR. HACKBARTH: I think it ought to be explicit in  
20 saying that the private plans cost more than traditional  
21 Medicare.

22 DR. ROWE: I think that would be fair, because of

1 contracts with the providers.

2 MR. HACKBARTH: They pay providers more.

3 DR. ROWE: We pay the rural hospitals more, we pay  
4 the physicians more.

5 MR. HACKBARTH: Even after you adjust for the  
6 difference in benefit package they cost more.

7 DR. ROWE: But there's nothing in the chapter that  
8 I saw about benefit package differences or contracts with  
9 providers. I think it's the other side of the coin.

10 MR. HACKBARTH: I agree with that. I think  
11 different people will interpret that differently and draw  
12 different significance from it. Plans, we're being  
13 underpaid; it's not covering our costs, and proponents of  
14 traditional Medicare will say--

15 DR. ROWE: That's not our problem.

16 MR. HACKBARTH: Right. They can't do it as  
17 efficiently.

18 DR. ROWE: I understand that. I just think it  
19 would provide a little balance.

20 MR. HACKBARTH: That is the bottom line.

21 DR. ROWE: Could I make another comment which you  
22 may or may not want to include? I might want to quit at the

1 point that I got something in.

2           If you're going to talk about why people didn't  
3 pull out, which in the main they didn't. I think Wellpoint  
4 pulled out Atlanta and otherwise basically nobody pulled  
5 out.

6           DR. HARRISON: Right. That's coming.

7           DR. ROWE: That's basically what happened this  
8 year. Why did that happen? I think one of the answers is  
9 that health plans are waiting to see what's going to happen  
10 in Congress with the Medicare bill, and if the new Medicare  
11 proposal, the administration's third pathway proposal  
12 doesn't get passed or that people think that people might go  
13 back and put some more money into Medicare+Choice because  
14 they want to continue to preserve the option. And that as a  
15 consolation prize or whatever there may be--but no one was  
16 interested in putting that extra money in now because they  
17 didn't want to distract people from this new proposal that  
18 they wanted to draw attention to and support.

19           So many of the health plans, looking at what was  
20 going on said, we really have to wait another year to see  
21 what's going to happen to the Medicare+Choice funding, so it  
22 would be premature to pull out, but we don't want to go into

1 more counties either because we're not sure. So I think  
2 that's an explanation, one man in the street explanation for  
3 what may have been going on in people's minds as they were  
4 looking at this.

5 MR. HACKBARTH: Just the average man on the  
6 street.

7 DR. REISCHAUER: Is that Wall Street, Jack  
8 [Laughter.]

9 MR. HACKBARTH: We need to press ahead, so Scott,  
10 lead the way.

11 DR. HARRISON: Jack got a little ahead of me, but  
12 how are plans responding and how will they be participating  
13 under these rates for 2004? As far as plan participation  
14 goes, I guess the interpretation is up to the individual.  
15 The M+C program has stabilized. Less than 1 percent of  
16 current Medicare+Choice enrollees will be affected by plan  
17 withdrawals this year. Of those enrollees who will lose  
18 their coordinated care plan, only about 1,000 live in areas  
19 not served by another Medicare+Choice coordinated care plan.

20 Also since the start of the year new plans have  
21 entered the program and expanded their service areas.  
22 Currently CMS lists four plans with pending applications

1 into the program and another 15 non-demonstration plans  
2 seeking service area expansions. Beneficiary participation  
3 in the program has been flat over the last year and,  
4 unfortunately, we don't yet know how benefits and premiums  
5 will change for 2004 and, thus, we can't suggest how those  
6 changes may affect beneficiary enrollment for 2004.

7           Here's a chart on the availability. The chart  
8 includes the effects of pullouts for 2004, but we do not  
9 have any information on how new plans may affect  
10 availability. But at least 63 percent of Medicare  
11 beneficiaries will have a coordinated care plan available in  
12 2004, up from 61 percent at the beginning of this year.  
13 Although a new private fee-for-service plan joined the M+C  
14 program this year, Sterling, which is the largest fee-for-  
15 service plan is reducing it's service area by withdrawing  
16 from over 500 counties. As a result, only 32 percent of  
17 beneficiaries will have access to a private fee-for-service  
18 plan compared with 34 percent earlier this year. However,  
19 CMS does list two plans as having new M+C private fee-for-  
20 service applications pending, so we could have some more  
21 next year.

22           So for 2004, 77 percent of beneficiaries will have

1 an M+C choice available, down from 78 percent at the  
2 beginning of 2003. Beneficiaries living in floor counties  
3 are much less likely to have a coordinated care plan  
4 available than those beneficiaries living in non-floor  
5 counties, although they are more likely to have access to a  
6 private fee-for-service plan available. Those differences  
7 have narrowed, although a good portion of the changes are  
8 really attributable to counties shifting from non-floor to  
9 floor state.

10           Despite the overall increase in coordinated care  
11 plan availability, rural areas continue to lag with only 16  
12 percent of rural beneficiaries having a plan available.  
13 Also virtually all of the loss in the private fee-for-  
14 service availability occurred in rural areas.

15           Some of the other work that we plan to complete  
16 includes examining the benefit packages and premiums of the  
17 M+C plans and then examination of the enrollment in the PPO  
18 demonstration plans to see how those plans are affecting the  
19 overall M+C program. Of course, we will report on any  
20 legislation that comes along that would affect the program.

21           MR. FEEZOR: Scott, good work, and despite how  
22 hard we tend to make your job around here. I wondered, just

1 reading this excerpt itself, I had a little problem drawing  
2 the conclusion looking at the same facts that you did that  
3 the plan has stabilized. It's sort of like saying that  
4 you've got plans that are making application--that's sort of  
5 like intentions. Execution is different. I guess I'd bit a  
6 little more cautious. I think we need to do two things.  
7 Either we need to be a little more cautious in our judgment,  
8 as perhaps rather than stabilized that it's in a period of  
9 uncertainty, particularly when you give the fact that there  
10 seems to be a rather flat enrollee choice. That, after all,  
11 is the most important measure, I would argue.

12           Otherwise we might want to, in some of our charts,  
13 show a longer period of history which does show that there  
14 has been a significant decline for a lot of understandable  
15 reasons that we've opined on and analyzed in the past. This  
16 does seem to be a leveling out. But to say that it has  
17 stabilized on the evidence that we've presented, I have  
18 little trouble with that language and I think we need to  
19 soften it a little bit. I would argue that probably just by  
20 what Jack said, there really is, because of some other  
21 potential policy changes, there's a lot of uncertainty  
22 around it, both from enrollee and from probably the insurer



1 side.

2 DR. ROWE: I think, Allen, one point relevant to  
3 what you said is, one way to look at the lack of increase in  
4 enrollees is that there isn't any marketing out there. That  
5 if people are really going sideways and it's a wait and see,  
6 then this is not the time when you're going to be expending  
7 a lot of resources on marketing because you may be getting  
8 out of--you're waiting and seeing. So you wouldn't have  
9 marketing, and when you don't have marketing you don't have  
10 as much enrollment. So I think it's consistent with what I  
11 was saying.

12 MR. SMITH: Picking upon Allen's point and  
13 offering at least a competing explanation, Jack, is it's not  
14 the same product, and it's more expensive. So we're not  
15 comparing the same thing that people were selling in 1999 to  
16 what's being sold today, and talking about stabilization  
17 it's important to make that point as well.

18 DR. STOWERS: Scott, I had a question if you just  
19 had a concept of this. It may be silly. But if we were to  
20 take the areas where Medicare+Choice is not available and we  
21 added on the benefits that are additional in  
22 Medicare+Choice, primarily the drug benefit, what would the

1 plus be? Would it be a plus three to add on those benefits  
2 in traditional Medicare or would it get up to a plus 20?

3 DR. HARRISON: You mean the actuarial of an M+C  
4 plan?

5 DR. STOWERS: Right, and adding it onto base fee-  
6 for-service. In other words, I think there's where you'd  
7 start seeing the efficiency of the delivery systems. Just  
8 curious. In other words, we've got this package that's out  
9 there in certain areas where Medicare+Choice is available  
10 and then we have the fee-for-service areas where it's not  
11 available so there's a difference in the benefit package  
12 essentially in Medicare+Choice and in traditional because  
13 there's no--how much would it take to add on to the  
14 traditional Medicare fee-for-service payments to get the  
15 rest of the population up to the same benefits?

16 DR. HARRISON: In other words, how much would you  
17 have to raise rates by in some of the rural areas to get  
18 plans to come in?

19 DR. STOWERS: Yes, rural or urban. Just areas  
20 where there's not the Medicare+Choice plan available. How  
21 much more would we have pay in fee-for-service to get that  
22 benefit out there?

1 DR. HARRISON: I think there was a study--

2 DR. NEWHOUSE: Yes, there's an old ProPAC study.

3 DR. HARRISON: There was a simulation done a  
4 couple years ago that suggested you're talking lots and lots  
5 of money.

6 DR. REISCHAUER: But I don't think that's relevant  
7 now because the Medicare+Choice drug offerings have shrunk  
8 very, very significantly and virtually all of them or a very  
9 high percentage are charging premiums now. What you want is  
10 the net benefit of the actuarial cost of the drug benefit  
11 minus the premiums that people are paying that's over and  
12 above. I don't think it would come out to be much money.  
13 But it wouldn't offer much protection either.

14 DR. NEWHOUSE: You'd have to also add in the value  
15 of copay reduction.

16 DR. ROWE: It wouldn't offer protection for a  
17 population but it might for individuals, right? It might be  
18 a net--

19 DR. REISCHAUER: An awful lot of these things now  
20 have limits that are relatively low, \$1,000 or less, and  
21 they're broken down by quarters so you don't get more than  
22 \$250 a quarter something like that, so you really aren't

1 offering people with large drug expenditures the  
2 catastrophic protection that they would expect.

3 MS. BURKE: Scott, in terms of your plans going  
4 forward and the things that you anticipate doing what's not  
5 noted is looking at the implementation of and the impact of  
6 the payment change; essentially the phasing in of the risk  
7 adjuster and shoring up for a short period of time and how  
8 that differentially impacts. Is that something you would  
9 imagine doing? Again it's the question of neutrality will  
10 hit people differently. In some places it won't in fact be  
11 neutrality. So is that something that you anticipate coming  
12 back and telling us how that works since they're only  
13 proposing to do it for a year, presumably it's something of  
14 a predictor in terms of who's going to be--

15 DR. HARRISON: I believe CMS has at least done the  
16 simulations. I don't know whether I've seen any results of  
17 what the distribution would be in terms of plans. We can  
18 ask and find out.

19 MS. BURKE: The reason I ask the question is at  
20 least historically when there were--literally when we were  
21 going county by county and determining what rates were going  
22 to look like it became the focus of a lot of activity,

1 depending on where geographically they happened to be  
2 located. So it might be of interest to us to have  
3 anticipated where you're going to see big shifts, if you  
4 are. Maybe the impact won't be great but it will be  
5 instructive, I believe. One might want to look going  
6 forward at what that has looked like, because if they're  
7 only proposing to do neutrality for a year, I assume they've  
8 also done the rollout in terms of what those numbers, what  
9 the allocation and the impact is going to be in the outyears  
10 of fully phased in--

11 DR. NEWHOUSE: If they have a sample they probably  
12 don't have enough to do--

13 DR. HARRISON: I assume they have the full impact  
14 analysis.

15 MS. BURKE: My guess is they do.

16 DR. HARRISON: But it's not clear whether they're  
17 going to do it past 2004. We're in this gray area. There's  
18 been differences of opinion about what the law says about  
19 whether they're supposed to be doing this, how the budget  
20 neutrality is supposed to work.

21 MS. BURKE: But I could lay odds, if Mark hasn't  
22 already heard, that we will begin to hear the patter of

1 little feet around issues of the predictions of what those  
2 allocations are going to look like and what the impact is  
3 going to be geographically.

4 DR. REISCHAUER: The law says that they have to  
5 phase the risk adjustment in in two more steps, right?

6 DR. HARRISON: Yes.

7 DR. REISCHAUER: But the question of whether they  
8 make the positive 4.9 judgment is still up in the air. The  
9 patter of little feet probably won't be to the Hill, it will  
10 be to the executive branch which made this decision before.

11 MS. BURKE: Perhaps. But it could also be to the  
12 Hill.

13 DR. REISCHAUER: But also these plans have had a  
14 pretty good idea of how their payments weren't going to be  
15 affected I think for the last six months and my guess is  
16 when they submitted their rate increases for 2004 they built  
17 in what they had to charge to compensate, if they were hurt  
18 or if they were benefitted. If they didn't, they'll be out  
19 of business and they probably should be.

20 MS. BURKE: I don't doubt that, but I think just  
21 for instructive purposes it will be interesting to look at  
22 what those shifts are going to be like and the phase in.

1 DR. HARRISON: I will request that from CMS. I  
2 don't know whether they'll give us stuff we can break down  
3 geographically.

4 MS. BURKE: That's fine. Because we used to  
5 literally get it by county. I could have told you exactly  
6 who was going to get what in what county for what plan.

7 DR. NEWHOUSE: This would also change sometime as  
8 enrollment changes.

9 MS. BURKE: Absolutely. It will change for a  
10 variety of reasons but it will be a base against which you  
11 can anticipated if Florida is differentially, or Iowa would  
12 strike me as being of interest.

13 MS. DePARLE: Just as a point of information,  
14 Scott, you referred to the dispute about budget neutrality  
15 in this which I remember quite well, but I thought Congress  
16 in the end in a law--I guess it would have had to have been  
17 BIPA--instructed CMS to not make it budget neutral. I  
18 thought--or to make it budget neutral. CMS when I was there  
19 our position was--

20 DR. HARRISON: I believe the language resides in a  
21 conference report somewhere.

22 MS. DePARLE: Okay. But when I was there our

1 position was that it was not intended to be budget neutral.  
2 Then I thought after that there was some congressional  
3 mandate--intervention.

4 DR. HARRISON: Right, and the intervention was not  
5 in statute. I believe it was in the form of conference  
6 language or something.

7 MS. DePARLE: So that's why they're saying that  
8 they may not do it in the future, or they have not opined--

9 DR. HARRISON: I think they haven't decided  
10 whether it cost them budget money or not.

11 MS. DePARLE: It depends on what you use as the  
12 baseline, which I would think it probably does.

13 Are we going to make recommendations on this?

14 MR. HACKBARTH: We actually took this question up  
15 in the abstract, I guess it was: how do you do the budget  
16 neutrality? How do you phase in the new risk adjustment?  
17 The position that we took was that you should not make this  
18 sort of budget neutrality adjustment. What we're striving  
19 for is to have our payments to health plans be equal to  
20 traditional Medicare after risk adjustment. So you  
21 shouldn't be throwing in new money to offset the fact that  
22 they have lower payments due to healthier enrollees. I think



1 that was two years ago that we took that position, and I  
2 personally think it was still the right policy.

3 DR. REISCHAUER: And you can see what an impact it  
4 had.

5 MR. HACKBARTH: We've got to move on. Thank you.  
6 Next up is long-term care hospitals. Sally.

7 DR. KAPLAN: The purpose of this presentation is  
8 to bring you the latest results from our research on long-  
9 term care hospitals. In June 2003, we reported that  
10 patients in market areas with long-term care hospitals had  
11 similar acute hospital lengths of stay whether they used  
12 long-term care hospitals or not. Long-term care hospital  
13 patients were three to five times less likely to use SNFs,  
14 suggesting that long-term care hospitals and SNFs are  
15 substitutes. LTCH patients had higher rates of mortality  
16 and Medicare paid more for their episode of care. Higher  
17 mortality might have indicated unmeasured severity of  
18 illness.

19 Today I'm presenting results from analyses  
20 designed to answer the three research questions on the  
21 screen and in your handout. The first analysis is to answer  
22 the question, what is the effect of certificate of need on

1 long-term care hospital beds? We investigated whether the  
2 presence of a certificate of need, or CON program, for  
3 hospitals reduce the number of LTCH beds in a state.  
4 Twenty-six states and the District of Columbia have a CON  
5 requirement. The other 24 states do not.

6 As you can see from the table on the screen and in  
7 your handouts, half of the eight states without any long-  
8 term care hospital beds are CON states, half are not. Half  
9 of the eight states with 100 or more beds per 100,000  
10 beneficiaries are CON states, half are not. States without  
11 a CON requirement have 11 percent more long-term care  
12 hospital beds per 100,000 beneficiaries compared for CON  
13 states.

14 We can conclude that having a certificate of need  
15 requirement for hospitals has little effect on long-term  
16 care hospital beds. Since CON programs can vary in their  
17 strength, we plan to look at this issue further by examining  
18 the relationship of long-term care hospitals and the  
19 strength of the certificate of need.

20 Now we turn to the question of how long-term care  
21 hospitals differ by age, ownership, freestanding versus  
22 hospital-within-hospital. To answer these questions we

1 analyzed the same 11 DRGs used for the June report. Old  
2 long-term care hospitals were established before October  
3 1983, new hospitals were established in or after October  
4 1993, and middle long-term care hospitals were established  
5 in the decade between.

6           The volume of cases is very different. For  
7 example, new long-term care hospitals account for 66 percent  
8 of cases in the 11 DRGs, middle long-term care hospitals  
9 account for 22 percent, and old LTCHs account for 12  
10 percent. For-profit long-term care hospitals account for 60  
11 percent of cases, non-profits account for 34, and government  
12 long-term care hospitals account for 6 percent. There's a  
13 lot of overlap between new and for-profit long-term care  
14 hospitals.

15           When we looked at differences in case mix we found  
16 mostly similarities with about a 12 percent difference among  
17 long-term care hospitals by age group and a 5 percent  
18 difference by ownership. When we went inside the 11 DRGs  
19 and examined acute hospital length of stay, use of SNFs,  
20 mortality, and total episode payment, controlling for DRG  
21 and severity level, the only substantial difference was that  
22 total episode payments were less for old long-term care

1 hospitals. This appears to reflect the TEFRA payment system  
2 that was in effect before PPS. Remember that this data is  
3 2001 and the PPS did not start until October 1 2002. Under  
4 TEFRA old long-term care hospitals were paid more than new  
5 ones.

6           To answer the question, what factors predict  
7 beneficiary use of long-term care hospitals we used  
8 multivariate analyses. The unit of analysis for the  
9 multivariate regressions is the beneficiary's episode of  
10 care. Beneficiaries discharged from an acute hospital alive  
11 in the first six months of 2001 were the universe studied;  
12 5.3 million observations. Episodes began with acute  
13 hospital use and ended with death, readmission to an acute  
14 hospital, or no post-acute care services for 61 days.

15           The first regressions were to try to predict first  
16 post-acute care setting after discharge from the acute  
17 hospital. We used clinical and demographic factors, acute  
18 hospital characteristics, and beneficiaries' proximity to a  
19 long-term care hospital. We used Dartmouth Atlas hospital  
20 referral regions and hospital service areas as proxies for a  
21 beneficiary's proximity to an LTCH. An HRR without a long-  
22 term care hospital was the furthest away, an HRR with a

1 long-term care hospital is closer, and a hospital service  
2 with an LTCH is closer still. Being admitted to an acute  
3 hospital that has a hospital-within-hospital is the closest.

4 Our preliminary results are, a diagnosis of  
5 tracheostomy is the strongest predictor of long-term care  
6 hospital use. Some other diagnoses predict LTCH use, such  
7 as respiratory system diagnoses with ventilator support,  
8 acute and subacute endocarditis, amputation, skin graft and  
9 wound debridement, and osteomyelitis. Severity level four  
10 quadruples the probability of long-term care hospital use  
11 regardless of diagnoses.

12 As proximity to an LTCH increases, the probability  
13 of LTCH use increases. For example, a beneficiary living in  
14 an HRR with a long-term care hospital has twice the  
15 probability of using a long-term care hospital compared with  
16 a beneficiary living in an HRR without one of these  
17 facilities. A beneficiary living in a hospital service area  
18 with an LTCH has four times the probability of using an LTCH  
19 compared with a beneficiary living in an HRR without such a  
20 facility. Being admitted to an acute hospital with a  
21 hospital-within-hospital quadruples the probability that a  
22 beneficiary will use a long-term care hospital.

1           To predict post-acute care setting we divided  
2 beneficiaries into four clinical groups using a clinical  
3 complexity model that predicted probability of long-term  
4 care hospital use. The four clinical groups ranged from  
5 very low to very high. We then compared regression  
6 coefficients by proximity to an LTCH and clinical complexity  
7 group.

8           First we found that the clinical model we used  
9 worked to predict discharge destination. The other results  
10 we found are the probability of beneficiaries using LTCHs  
11 increases as clinical complexity increases in each  
12 geographic group or proximity to LTCH group. The  
13 probability of using LTCHs increases as clinical complexity  
14 and proximity to LTCH increase. For example, the  
15 probability of using LTCHs is 10 times greater for  
16 beneficiaries in the very high clinical group if they live  
17 in a hospital service area with an LTCH rather than HRR  
18 without an LTCH.

19           Two other findings from putting the beneficiaries  
20 into four clinical complexity groups are that, first, the  
21 probability of using an inpatient rehabilitation facility  
22 increases as clinical complexity increases and proximity to

1 an LTCH increases. Second, the probability of SNF use  
2 increases as clinical complexity increases and decreases  
3 with proximity to an LTCH. For beneficiaries in the very  
4 high clinical complexity group, the greatest probability of  
5 SNF use is in areas without long-term care hospitals.

6 In our continuing research on long-term care  
7 hospitals our next step will be to focus the quantitative  
8 work on answering the question about where patients  
9 clinically similar to those using long-term care hospitals  
10 are treated in areas without these facilities. This will be  
11 a multivariate regression analysis. On the qualitative side  
12 we have two studies. First, we have a contractor conducting  
13 structured interviews in market areas with and without long-  
14 term care hospitals. Second, we are making site visits to  
15 long-term care hospitals.

16 DR. NEWHOUSE: Sally, thanks for all this  
17 analysis. This has been a difficult area for a long time.

18 On this last step of where are patients treated,  
19 what we'd really like to know is something about costs and  
20 outcomes. It strikes me that we're going to wind up in the  
21 position we're in, that knowing Miami costs more than  
22 Minneapolis, but while people are prepared--some people are

1 prepared to make judgments about that, ultimately we don't  
2 have a lot--I mean, the recent Fisher stuff helps there.  
3 But do you have any plans to do anything on the outcomes  
4 side?

5 DR. KAPLAN: Yes, we do.

6 DR. NEWHOUSE: Do you want to say anything about  
7 that?

8 DR. KAPLAN: We do plan on looking at outcomes.  
9 We are including in outcomes--is that what you want to know,  
10 Joe, what kind of outcomes we're looking at?

11 DR. NEWHOUSE: What kind of outcomes.

12 DR. KAPLAN: We're looking at total episode cost.  
13 We're looking at total episode length of stay. We're  
14 looking at mortality at different periods. In other words,  
15 mortality at 30 days post-admission to the acute hospital,  
16 60 days post, 90 days post, 120 days post, as well as death  
17 in the year 2001. These folks were admitted to the acute  
18 hospital in the first half of 2001.

19 We also are going to be looking at readmissions to  
20 the acute care hospitals as well.

21 DR. REISCHAUER: Sally, I think this is all very  
22 interesting but I'd like to have a little more context.



1 Maybe you provided this context in previous material that  
2 you've given us, but I was just wondering, for people with  
3 these diagnoses what fraction of them end up in a long-term  
4 care hospital? Is it 80 percent of the level four  
5 tracheostomies, or 10 percent?

6 DR. KAPLAN: I actually can give you a general  
7 ballpark figure out that. The probability of being admitted  
8 to a long-term care hospital never exceeds more than 3  
9 percent.

10 DR. REISCHAUER: You mean even very high  
11 probability?

12 DR. KAPLAN: I'm sorry, I need to go back and  
13 check on this then and get back to you with this, because a  
14 tracheostomy is really high up there. So, yes, you're  
15 right.

16 MR. HACKBARTH: When you say never more than 3  
17 percent, you're talking about in an area where there is one.

18 DR. KAPLAN: Yes, I'm talking about in a hospital  
19 service area with a long-term care hospital.

20 MR. HACKBARTH: So even with tracheostomy it's --

21 DR. KAPLAN: No, I don't think with--no, that's  
22 for the very high clinical group but I'm not specifically

1 talking about any particular diagnosis. I'm talking about  
2 very high clinical complexity group, the odds are never  
3 greater than 3 percent.

4 DR. REISCHAUER: So for the threes and fours  
5 across this average of DRGs it would really be that low.  
6 Then I think the questions that Joe asked are very  
7 important.

8 DR. KAPLAN: Exactly.

9 DR. ROWE: I think if you try to get the quality  
10 of care or outcomes it's going to be very difficult using  
11 the measures you suggested, Sally, because these are fatal  
12 diseases in many of these cases and everybody is going to  
13 die. If these are patients with amyelotropic lateral  
14 sclerosis or some other, you know. It doesn't mean it was  
15 bad care if the patients don't survive. You're going to  
16 have to find some other measures, and lengths of stay is--  
17 which is good, short or long? If we're talking about  
18 hospice, if this were care at the end of life, long length  
19 of stay is good. It's not bad.

20 So I think it would be nice to try to find some  
21 other measures like infection rates or nutritional status or  
22 family satisfaction. I don't know enough about what the

1 case mix is here, but I'm just a little concerned that  
2 people might jump to conclusions about some of these  
3 outcomes that really don't reflect the underlying nature of  
4 the clinical situation. Nick used to run ICUs. You  
5 populated places like this with some of your patients. Do  
6 you have some sense of what kind of outcomes would be worth  
7 looking at?

8 DR. WOLTER: In our part of the world they don't  
9 exist so we take care of these patients either in the acute  
10 care setting, in a SNF, or in some other way.

11 DR. NELSON: The people that are there to get six  
12 weeks of IV antibiotics for endocarditis or osteomyelitis,  
13 they'd have a pretty good outcome, a lot of them.

14 DR. NEWHOUSE: Also these long-term care hospitals  
15 are very heterogeneous on the whole, so who gets cared for  
16 where is actually very important here. They're much more  
17 heterogeneous than acute care hospitals.

18 DR. MILLER: I think what we would be trying to do  
19 is take a look at these outcomes--and I realize that they're  
20 crude. One of the problems is, unlike some of the other  
21 post-acute care areas, there's no assessment instrument  
22 going on here, so there's something to grab onto. One of

1 the places that we might want to go to as we look at this,  
2 because as you think about it these outcomes are very crude.  
3 You look across relative areas, SNF, hospital, whatever the  
4 case may be, then start asking yourself, are there certain  
5 diagnoses and severity levels that do well here? And then,  
6 would you want to be thinking about an assessment instrument  
7 to try and get inside a little bit to see pre, post, and how  
8 patients do here? That's kind of the direction we're trying  
9 to push in. Not kind of. That is the direction we're  
10 trying to push in.

11 MR. FEEZOR: Sally, I sent you running after this  
12 certificate of need thing and I owe you a piece of document  
13 in follow up, but just in talking to a couple of folks in  
14 the CON world I don't even think this has hit their Richter  
15 scale. It's been just below the radar. And in one other  
16 instance I spoke with a lot of the excess beds that have  
17 been authorized that have been taken out of service by some  
18 of the merger mania in the late-'90s now seem to be being  
19 brought back online in this form, so again it is probably is  
20 flying just below the radar screen.

21 MR. DeBUSK: Let me ask you, Sally, how do you  
22 define the acuity level here with these sick, sick patients?

1 DR. KAPLAN: We have 400 APR-DRGs, which are the  
2 400 most frequent, severity level, risk of death, or risk of  
3 mortality, ICU use, which basically is ICU or CCC days. We  
4 have hospitalization in the 90 days prior to this particular  
5 acute hospital admission. That's it.

6 MR. HACKBARTH: Okay. Thank you, Sally.

7 DR. KAPLAN: Are you ready for the next one?

8 MR. HACKBARTH: Yes. Inpatient rehab.

9 DR. KAPLAN: The prospective payment system for  
10 inpatient rehabilitation facilities, better known as IRFs,  
11 at least by some people, began on January 1, 2002. The  
12 research I'm presenting today begins our examination of IRFs  
13 and the PPS. At the end of the presentation I'll talk  
14 about some questions we plan to research and I'll ask you  
15 for significant issues you'd like addressed in the June  
16 chapter.

17 IRFs are generally characterized as specializing  
18 in intensive rehab; physical therapy, occupational therapy,  
19 and speech therapy. To be eligible for this care in the  
20 Medicare program, beneficiaries have to be capable of  
21 sustaining three hours of therapy per day.

22 Inpatient rehab facilities are defined as distinct

1 from acute hospitals by a series of requirements. The most  
2 important requirement is that 75 percent of an inpatient  
3 rehab facility's cases have to be in 10 diagnoses that are  
4 believed to require intensive rehab. One of the 10  
5 diagnoses, polyarthrititis, has become very controversial. It  
6 is the condition by which patients with major joint  
7 replacements have been counted in the 75 percent for IRFs.  
8 When major joint replacement cases are not counted, few of  
9 the IRFs are in compliance with the rule. As you'll see in  
10 a moment, major joint replacement is the most frequent  
11 diagnosis treated in IRFs. CMS's new proposed 75 percent  
12 rule make it difficult for IRFs to admit beneficiaries with  
13 joint disease or major joint replacement.

14           Before I talk about what changed between 1999 to  
15 2002 I'd like to explain why I'm talking about 1999. Most  
16 of the information you'll see today is from RAND's research.  
17 They designed the payment system using 1999 data. Although  
18 we cannot say that these changes between '99 and 2002 were  
19 caused by the PPS, some of the changes are consistent with  
20 changes we saw in response to the acute hospital prospective  
21 payment system.

22           In addition, in 1999 the BBRA mandated a per-

1 discharge payment system for IRFs so these facilities were  
2 aware of the type of PPS they would have and may have  
3 changed behavior in preparation for the PPS.

4           The number of Medicare cases increased 6 percent  
5 per year between 1999 and 2002. Other changes include the  
6 distribution of diagnoses, the inpatient rehab facility  
7 length of stay decreased, the case-mix index increased, and  
8 the acute hospital length of stay decreased for patients  
9 discharged to an IRF.

10           Now let's look a little closer at most of these  
11 changes. As you can see on this chart, the largest changes  
12 in distribution of cases by RIC, or rehabilitation  
13 impairment category, are in stroke and major joint  
14 replacements; the two biggest RICs in 1999 and 2002. The  
15 other changes were small. In some RICs the share of cases  
16 didn't change and I've not shown them. Between 1999 and  
17 2002 stroke and major joint replacement changed places as  
18 far as number one and number two.

19           In the acute hospital in these years there also  
20 was a big change in these two groups of patients. For  
21 example, stroke cases decreased by 28 percent over the three  
22 years and major joint replacement cases increased 17 percent

1 from '99 to 2002.

2           It is also possible that payment policy may have  
3 driven the changes in distribution. Although the payment  
4 rate was the same for the lowest level of impairment and no  
5 comorbidities for the two diagnoses, the rate increases  
6 faster as comorbidities increase for major joint replacement  
7 cases.

8           On average, the decrease in IRF length of stay was  
9 about 5 percent per year. Decreases in length of stay are  
10 consistent with a per-discharge prospective payment system.  
11 This decrease is similar to the 4 percent decrease in length  
12 of stay we saw in the first year after the hospital PPS was  
13 implemented.

14           Changes to the case-mix index may include reach  
15 changes in case mix in addition to improvement in coding and  
16 upcoding. The national IRF case-mix index increased about 1  
17 percent per year from '99 to 2002. To compare, the acute  
18 hospital case-mix index increased 4.4 percent in the first  
19 year of PPS alone. Earlier transfers from acute hospitals  
20 probably would result in real case-mix index change.  
21 Because comorbidities increase payments, IRFs are more  
22 likely to code comorbidities under the PPS. This would



1 result in coding improvement.

2           Almost 90 percent of IRF patients are transferred  
3 from acute hospitals. It is surprising that the acute  
4 hospital length of stay and the IRF length of stay both  
5 would decrease at the same time. Unfortunately, we'll be  
6 unable to directly assess the effect of these length of stay  
7 decreases on patient's outcomes because the measurement of  
8 functional status and cognitive status in IRFs changed from  
9 '99 to 2002. We will be able to examine whether discharge  
10 destinations changed pre and post-PPS. In the future, if  
11 length of stay continues to drop we will be able to assess  
12 the effect of the drop because we will have more than one  
13 year of data.

14           As you remember, in the June 2003 report we  
15 recommended that CMS conduct a demonstration on payment for  
16 quality and we pointed out that IRFs were a good place to  
17 start because they have a data collection system that is  
18 robust, well accepted, and standardized. Payment for  
19 quality might reduce decreases in length of stay that  
20 implicate quality.

21           There are many things that we could examine in our  
22 research on IRFs and the PPS. Some of them are on the

1 screen now. The question for you is, are there other  
2 significant issues you'd like addressed for the June 2004  
3 report?

4 DR. ROWE: Sally, just a comment about the change  
5 in the proportion of cases, the stroke and major joint that  
6 you commented on. First of all, I think this is fabulous.  
7 This is the best news I've heard. I've been sitting here  
8 five years. A 28 percent reduction in acute hospitalization  
9 for stroke between 1998 and 2002 is fabulous. If that  
10 reflects better anti-coagulation of people with atrial  
11 fibrillation or more rapid intervention in patients with  
12 evolving stroke, which I think it may, I think it's great.

13 In fact the 28 percent reduction is so high that  
14 it would explain this whole thing. It's almost not worth  
15 going into the payment issues. You do mention this could be  
16 due to the fact that there are 28 percent fewer strokes, and  
17 then you go into all this stuff about how the payment  
18 mechanism might be causing it, when in fact you may have  
19 already explained it. But that's because this is MedPAC and  
20 we're into payment. If this were the American Society of  
21 Neurologists we wouldn't go to that second level.

22 But in the first level I think perhaps even more

1 important than the number of strokes in hospitals is the  
2 severity of the strokes, which you don't comment on. If  
3 we're getting more effective in treating stroke and treating  
4 it more rapidly, then for any given group of patients  
5 admitted to the hospital with stroke there will be fewer  
6 very severe strokes, and those are the ones that are likely  
7 to go to the inpatient rehabilitation facility. And there  
8 will be more people with less severe strokes, and they're  
9 more likely to go home or get home care or visiting nurse  
10 care or something else as they get rehab.

11           So I would mention something about the severity,  
12 and I would see if there are any data with respect to  
13 severity within the population of stroke patients because it  
14 may be that in fact there's been a shift, in addition to the  
15 number of patients.

16           DR. REISCHAUER: Sally, you were talking about the  
17 decline in the length of stay, and then noting that it was  
18 surprising that the length of stay in acute care hospitals  
19 declined at the same time as the IRF length of stay. The  
20 explanation may be, if you look at your Table 2, over those  
21 two years or three years there was a 58 percent increase in  
22 the number of people going to IRFs. What might have

1 happened is those that would have been discharged somewhere  
2 else who were the less severe cases ended up going to the  
3 IRF, and that would have lowered both of these length of  
4 stay at the same time. Just the existence of more beds and  
5 more facilities in effect produces a result that on the  
6 surface looks like good news but in fact it could be  
7 troubling news.

8 DR. NEWHOUSE: This is a second-order question but  
9 since the transfer payment DRG issue is likely to be around,  
10 I wondered if this differential length of stay in IRFs--I'm  
11 sorry, if the length of stay decline was differential by the  
12 transfer DRGs versus the non-transfer guarantees?

13 MR. HACKBARTH: Anyone else? Okay, Sally, thank  
14 you.

15 The last item for today, hospital margins and  
16 their uses.

17 MR. ASHBY: In this presentation we are going to  
18 review two types of hospital margins that we routinely in  
19 our payment policy work; that is the overall Medicare margin  
20 and margins for components of that overall Medicare margin.  
21 Then we'll talk briefly about one other margin used for  
22 context; the total margin.

1           The overall Medicare margin includes costs and  
2 payments for the largest six Medicare services that  
3 hospitals provide plus costs and payments for graduate  
4 medical education. You see the six services listed here.  
5 Its primary use is in assessing payment adequacy for the  
6 acute inpatient and outpatient payment. Specifically, this  
7 margin, or the cost and payment components of it, forms the  
8 basis for estimating our current payments and costs, which  
9 is one of several factors that we examine in drawing  
10 conclusions about the adequacy of payments.

11           We assess payment adequacy for the hospital as a  
12 whole because we suspect that the allocation of costs is  
13 biased in the Medicare cost report. Prior to the late 1990s  
14 hospitals had the incentive to allocate as much of their  
15 costs as possible to services other than acute inpatient  
16 because all of these other services were paid at the time on  
17 the basis of cost. As a result of that phenomenon we  
18 believe that the inpatient margin is overstated and all of  
19 the other margins are probably understated. Unfortunately,  
20 we don't know how much difference this bias makes, and we  
21 also don't know whether it has been reduced over time as the  
22 other services have come into their own respective PPSs.

1           Turning to the component margins, we have  
2           calculated margins for all six of the components of the  
3           overall Medicare margin, but we make primary use of the  
4           inpatient and outpatient margin. Their use is, for the most  
5           part, analyzing the distribution of payments within a  
6           specific PPS, including estimating the impact of policy  
7           options that the Commission has considered at various points  
8           along the way.

9           The overall Medicare margin does not work well for  
10          that purpose because it reflects payments and costs outside  
11          the PPS under consideration, which confounds the analysis.  
12          If we assess the analysis the impact of an outpatient  
13          option, for example, with this measure with outpatient  
14          comprising only 15 percent of hospital payments, large  
15          changes in outpatient payments would appear as small changes  
16          in the overall payments, and the distribution of changes  
17          would be different as well.

18          When it comes to comparing hospital margins to  
19          those of other sectors we have to remember that because all  
20          six hospital component margins are likely over- or  
21          understated, none of them can be compared with any  
22          confidence to margins in other sectors. The overall

1 Medicare margin provides a much better comparison to other  
2 sectors, and by other sectors I'm referring to freestanding  
3 SNF, home health, rehab, dialysis. The overall Medicare  
4 margin provides a better comparison to those sectors because  
5 it is netting out the overstatement and understatement of  
6 its components.

7           Comparing the margins of a hospital-based and a  
8 freestanding service with the same sector, like freestanding  
9 and hospital-based SNF is also difficult. If a margin for a  
10 hospital-based service is thought to be understated then a  
11 weighted average of the hospital-based and the freestanding  
12 is still going to be understated, but obviously to a less  
13 degree.

14           The last margin is the total margin. This covers  
15 revenue from all payers as well as non-patient sources.  
16 Non-patient sources include non-patient services like  
17 cafeteria, parking lot, that sort of thing, and also  
18 donations and investment income. The total margin does not  
19 play a direct role in MedPAC's policy decisions primarily  
20 because the Commission concluded that Medicare payments  
21 should relate to the cost of treating Medicare patients. To  
22 the extent that beneficiary access to care is an issue we

1 would like to develop direct measures of access to care  
2 rather than relying on overall financial condition as an  
3 indirect indicator.

4           There's also some question as to whether total  
5 margin even provides an accurate indicator of overall  
6 financial condition in larger organizations given that it is  
7 limited to the hospital corporation and does not encompass  
8 all components of complex corporate structures that have  
9 become commonplace in the field.

10           The difficulty of attempting to affect total  
11 margins through Medicare policy is exhibited in this  
12 scatterplot by the lack of any consistent relationship  
13 between overall Medicare and total margins. Hospitals with  
14 negative and positive overall Medicare margins are roughly  
15 equally likely to have positive total margins.

16           DR. ROWE: Is there an R value for that?

17           MR. ASHBY: It's 0.06 which is roughly like  
18 nothing.

19           MS. BURKE: Jack, just for illustrative purposes,  
20 can you give me an example of an institution at the extreme,  
21 one that might have an overall Medicare margin of plus-40,  
22 or some variation, and a negative overall margin? Give me



1 an example of what would end up in that kind of an array.

2 MR. ASHBY: More than anything else there are a  
3 number of academic medical centers, major teaching hospitals  
4 in that category--

5 MS. BURKE: Because of GME.

6 MR. ASHBY: --that do have very high Medicare  
7 margins because of the policy adjustments that Medicare  
8 gives them but don't fare as well in other payers and  
9 uncompensated care.

10 MS. BURKE: What about the reverse?

11 MR. ASHBY: But I want to point out that there are  
12 major teaching hospitals that are on the other side of this  
13 matrix as well, that have very high Medicare margins and  
14 still have high total margins as well.

15 DR. NEWHOUSE: The big public teaching hospital  
16 would be--

17 MS. BURKE: That would make sense to me. What  
18 about the reverse?

19 DR. NELSON: InterMountain Healthcare.

20 DR. ROWE: Pediatric hospitals where the overall  
21 Medicare margin was negative but a very small portion of the  
22 patients were Medicare--

1 MS. BURKE: Let me ask that question. Tell me  
2 what's included in this array. Would it include, for  
3 example, pediatric hospitals?

4 MR. ASHBY: No, it actually would not include  
5 pediatric hospitals, because these are PPS hospitals.

6 MS. BURKE: These are all PPS hospitals.

7 MR. ASHBY: That in the group, right.

8 DR. ROWE: How about the disabled patient who's a  
9 Medicare beneficiary who goes to a pediatric hospital?

10 MR. ASHBY: It certainly counts as Medicare but  
11 it's not a hospital that's under the prospective payment  
12 system so we don't include it in this.

13 MS. BURKE: Jack, give me an example of the other  
14 extreme, which is a very high overall margin and a very low  
15 Medicare margin.

16 MR. ASHBY: This would be a community hospital  
17 that has a large private payer business and has negotiated  
18 well in that private payer business, has limited  
19 uncompensated care and fills out nicely in its revenue.

20 DR. REISCHAUER: I think, Jack, you've already  
21 answered my question in that you knew the answers to these  
22 questions. But I was wondering if you had ever run a simple

1 regression of overall Medicare margins as a function of the  
2 relative importance of these various other types, inpatient,  
3 outpatient, Medicare, nursing home, et cetera?

4 MR. ASHBY: As a function of their mix of other  
5 services?

6 DR. REISCHAUER: Yes, the mix of other Medicare  
7 services. The overall as a function of the mix excluding  
8 inpatient. And then maybe adding onto that, percent of  
9 total revenue from Medicare and percent from Medicaid as two  
10 other--

11 MR. ASHBY: Right. We have not run that precise  
12 analysis. However, we did put together a similar  
13 scatterplot of the proportion of Medicare business covered  
14 by this and the total margin and it is a very similar blob,  
15 if you will. That varies all over the map too. So one of  
16 the key variants here is the amount of Medicare of all types  
17 they have. We have not really looked at it by those service  
18 components as you suggest, so we would have to go back and  
19 take a look.

20 DR. NEWHOUSE: I had three comments. The first  
21 was actually quite similar to Bob's. I thought we should  
22 try to explain variation in the total Medicare margin with

1 the product mix to tell us something about--which would give  
2 us an estimate of Medicare margin by service. Also, the  
3 second point is, if there is variation there, it doesn't  
4 make sense to compare hospitals with different product mixes  
5 in their total margin because it's comparing apples and  
6 oranges.

7 MR. ASHBY: When you say product mix, do you mean  
8 Medicare product mix now or the mix of Medicare and other--

9 DR. NEWHOUSE: Yes, I mean a mix of product lines.  
10 Do they have an IRF? Do they have a SNF? Do they have a  
11 home health agency, et cetera? So what are the product  
12 lines that are contributing to this margin?

13 My second question really goes also to the  
14 component margins, which is at some point in the past you  
15 were talking about trying to get a handle on these margins  
16 by using certain hospitals' cost allocation mechanisms.  
17 Where does that stand? Is that still going forward?

18 MR. ASHBY: That project is absolutely going  
19 forward. We have awarded a contract and the project just  
20 started just in the last couple weeks.

21 DR. NEWHOUSE: When will we hear something of what  
22 it found?

1           MR. ASHBY: That's always a risky question. We're  
2 shooting for next spring for the spring meetings, but there  
3 are a lot of unknowns in the meantime and it's a little bit  
4 hard to make any promise on that.

5           DR. NEWHOUSE: I understand.

6           DR. MILLER: We're not even sure how much hospital  
7 participation we're going to get in it.

8           MR. ASHBY: That's one of the biggest unknowns is  
9 how well we're going to be able to recruit hospitals, let  
10 alone the right mix of hospitals that we'd like to have,  
11 into this study.

12          DR. NEWHOUSE: Then a third question is, you've  
13 made the point several times in the past that the level of  
14 margins depends on what costs count as cost for the purpose  
15 of calculating the margin, and specifically the disallowed  
16 costs. I wondered if you have any plans to go into that.

17          MR. ASHBY: No, we don't. All of the hospitals in  
18 this scatterplot are treated equally in the sense that we're  
19 looking Medicare-allowable costs, as we always do, in our  
20 financial performance analysis. So all of them have some  
21 level of non-allowables and we're not looking at that.

22          DR. REISCHAUER: When we do the total margin do we

1 include those unallowable costs?

2 MR. ASHBY: Yes.

3 DR. REISCHAUER: That's interesting.

4 DR. NEWHOUSE: That is interesting.

5 MR. ASHBY: The total margin, you're using the  
6 financial data that the hospital generates, and they have no  
7 interest in dealing in allowable or non-allowable costs.  
8 Obviously we're on their platform when we do this measure.

9 DR. MILLER: It's not identified. It's just a  
10 total number.

11 DR. NEWHOUSE: For purposes of trying to  
12 translate, shouldn't we try to do some kind of crosswalk  
13 then?

14 MS. DePARLE: I think we should because that's  
15 something that they always raise, not only with respect to  
16 hospitals but others always raise, but you haven't counted  
17 the costs that you won't allow. Sitting here, I'm not even  
18 sure I could tick them off, so at least I think we ought to  
19 be clear about what they are.

20 DR. REISCHAUER: Do we have the ability to look at  
21 the ratio of unallowed to allowed Medicare costs by hospital  
22 and do a scatter diagram of that? And relate that to how

1 much Medicare business they do relative to all business?

2 Because the ones that are most upset about it, it could be a  
3 relatively minor thing in their overall book of business.

4 MR. ASHBY: The amount of non-allowables is not a  
5 readily available number actually. There's a very complex  
6 set of reporting and calculation that backs that up, so it's  
7 not something we could easily run and do.

8 MS. BURKE: Jack, what's the biggest category of  
9 non-allowables?

10 MR. ASHBY: We don't have complete data on that  
11 but we're told that one of the most major, if not the major  
12 category, has to do with home office costs with chain  
13 operations, because the chains are doing a variety of  
14 different things and some of their costs are not necessarily  
15 applicable to providing inpatient and outpatient care and  
16 the like.

17 MR. MULLER: This is along those themes. Since we  
18 know from our prior years' work that not the DSH, where we  
19 put in the whole revenue but don't put in the whole costs,  
20 therefore overstates the Medicare margin considerably. In  
21 the calculation we don't have the Medicaid costs in that, if  
22 you follow me. So the DSH hospitals always have a higher

1 Medicare margin just by definition, but probably have,  
2 because they're DSH hospitals, a lower total margin. It  
3 would be good to break that one out without the DSH payments  
4 because I think you might see a different plot, given how  
5 much the DSH payments affect those base. I seem to  
6 remember--I'm trying to remember now from our books in the  
7 last couple years, I think of the overall--the 14 or 15 that  
8 we show for inpatient doesn't about four to six of that come  
9 from DSH or so, some fairly high number?

10 MR. ASHBY: Right, it does. We have all of the  
11 cost of treating Medicare patients in the numerator or  
12 denominator here, depending how you--

13 MR. MULLER: We have the costs in. But we have  
14 DSH revenues in that therefore make the margin look bigger  
15 because some of the DSH revenues are for Medicaid patients.

16 MR. ASHBY: They're really not for Medicaid  
17 patients, per se. This is a Medicare payment. It's in the  
18 Medicare program as it stands now. The distribution of  
19 those DSH payments is determined heavily by the hospital's  
20 Medicaid penetration. But it's never really been offered as  
21 payment for Medicaid. There is a Medicaid DSH separate  
22 from--



1           MR. MULLER: No, I'm talking about the Medicare  
2 DSH which is calculated on Medicare and Medicaid.  
3 Therefore, in a sense, you get payment for your Medicaid  
4 patients even though you don't have the cost of those  
5 Medicaid patients in there. Am I accurate in that?

6           MR. ASHBY: The Medicaid costs are definitely not  
7 in there as it stands now.

8           MR. MULLER: But the payment is.

9           MR. HACKBARTH: Jack, correct me if I'm wrong, or  
10 Sheila, somebody correct me if I'm wrong. My understanding  
11 was that originally the notion behind DSH was that Medicare  
12 patients that were low income patients might have higher  
13 costs and we were trying to find an adjustment that would  
14 reflect the higher cost of treating low income Medicare  
15 patients. Over time, however, the rationale for the DSH  
16 adjustment and the amount of money involved in the DSH  
17 adjustment has changed. So now we've got a sum that is  
18 actually, I think, quite a bit larger than the amount that  
19 would be required to pay for the higher cost of low-income--

20           DR. NEWHOUSE: The higher costs were based on a  
21 study of Massachusetts only and didn't hold up a couple  
22 years later when you went to the nation. They aren't higher

1 cost.

2 MR. HACKBARTH: So now we have a payment  
3 adjustment that increases payments for Medicare admissions  
4 based on Medicaid and SSI volume without a clearly defined  
5 rationale of what we're compensating for. Is it the higher  
6 cost of Medicare patients? Is it for uncompensated care  
7 patients? It's, frankly, I think murky at this point.

8 MR. MULLER: I'm just saying, by definition it  
9 overstates the Medicare inpatient margin because in a sense  
10 you get credit for patients that aren't in the cost base.  
11 So in the ratio you get credit in the numerator for costs  
12 that aren't in the denominator.

13 DR. MILLER: But you can also say that the  
14 adjustment is supposed to be for a more expensive Medicare  
15 patient. This was the best proxy at the time. That  
16 relationship didn't show up, but the money is still flowing  
17 through. You're technically right about the Medicaid cost  
18 is not in there, but there's a whole different way to look  
19 at this transaction in terms of the dollars hitting the  
20 hospital.

21 DR. REISCHAUER: If you really want to be tough  
22 you could say this is just the same thing as the excess

1 payment in IME, over and above the justifiable payment.

2 DR. WOLTER: One other clarification on total  
3 margin that might be useful, at least as many institutions  
4 use that phrase includes investments, unrelated business  
5 income, subsidiaries that might not be really related to the  
6 operation of health care. I don't know whether we're using  
7 it that way here or not, but that would be important to  
8 know, because I think that really then muddies the picture.  
9 Some people use the phrase operating margin to refer to the  
10 operations of direct health care services.

11 MR. ASHBY: No, an operating margin is not  
12 necessarily restricted to health care services either.

13 DR. WOLTER: Not necessarily, but it's closer than  
14 the phrase total margin. That's all I'm saying. Total  
15 margin might include activities that are really quite  
16 separate, and it certainly would include your investments,  
17 for example, Jack.

18 MR. ASHBY: The main thing that a total margin  
19 includes that's an operation margin doesn't is investment  
20 income and donations. But all of the services, even if they  
21 have virtually nothing to do with health care--they could be  
22 operating a restaurant or a senior citizen living

1 arrangement, would still be in an operation margin.

2 DR. WOLTER: That may be true for some  
3 institutions, Jack, but I'm not sure that's universally so.  
4 The point I'm making is, total margin in any way is a less-  
5 good comparison to overall Medicare margin than something  
6 that's a little bit narrower than that. Maybe we can't get  
7 to that, but when you include investment income and  
8 donations--and many places would some of these other things  
9 you just mentioned in their total margin but not in their  
10 operating margin. But maybe not all. Maybe there's some  
11 imprecision there.

12 One other thing I just wanted to mention that's in  
13 the body of the paper, I'm not sure I would say that the  
14 overall Medicare margin is a good comparator to some of the  
15 component margins. It may give us some comfort when we look  
16 at--

17 MR. ASHBY: To margins in other sectors.

18 DR. WOLTER: Yes, but it's perhaps not a good  
19 comparator because it does lump many things together,  
20 whereas, in the other sectors we're just looking at one set  
21 of services. So that might be a slight overstatement.

22 MR. ASHBY: Right. Nick, that was a reference

1 primarily to the problem I was trying to explicate about the  
2 upward and downward bias in the component margin.

3 DR. WOLTER: I understand where it's coming from,  
4 but it's probably not a good comparator.

5 MR. ASHBY: So I used the word, better measure, in  
6 that sense because it's not hit by this bias problem. But  
7 that doesn't make it a good measure on all fronts, as you  
8 say.

9 DR. WOLTER: A minor point.

10 The thing I've wondered about this, I think this  
11 presentation describes fairly well what a cloudy lens we  
12 look through when we make update recommendations about  
13 individual component sectors, at least I think it describes  
14 that pretty well. I've wondered, if you were to say, where  
15 would the Commission want to be in three or four years, what  
16 course would we get on? Do we think that the individual  
17 sectors should have reimbursement that covers the cost of an  
18 efficient provider? Because we've talked about that  
19 framework. If we thought that, we would clean up the cost  
20 reports, we would get information that we don't currently  
21 have, and we would have a system that would do that.

22 Although we have gravitated to using the overall

1 Medicare margin to give us some comfort, the fact of the  
2 matter is that at times we dip to the level of the  
3 individual DRG to try to create reimbursement that covers  
4 the cost of an efficient provider. When we get into  
5 bundling conversations we're looking at another level of  
6 reimbursement that might or might not cover overall cost.

7           So I think it would be helpful for the Commission  
8 to decide what principles it would like to have, and then  
9 see if we could design a course to get there, recognizing  
10 that it would take several years. Because covering the cost  
11 of an efficient provider for each of the component sectors  
12 is different than having this somewhat cloudy feeling that  
13 at the end of the day that overall Medicare margin at least  
14 seems to be in whatever shape it's in. I'm not really sure  
15 what our goals are on this. I've thought about it a lot  
16 over the past year.

17           DR. NEWHOUSE: Nick, I think that's a great  
18 question and at the end of the day it's probably impossible  
19 because the reason these costs--one reason the costs differ  
20 is that the hospitals are allocating their joint costs. So  
21 in terms of how Ralph's salary is getting allocated at Penn  
22 is ultimately arbitrary. I mean, it follows accounting

1 conventions, but the conventions are arbitrary.

2           But beyond that, what that implies is that to  
3 cover the cost of adding a SNF unit, if you did the  
4 incremental cost of everything, you wouldn't cover the joint  
5 costs, unless you want to say something like, there's always  
6 going to be an inpatient unit so I'll put them there. But  
7 then I'm paying more than the operating cost of the  
8 inpatient unit. So we're stuck with that inherent issue in  
9 operating a hospital that does several different things.

10           DR. WOLTER: I haven't really presumed an answer  
11 to my question because I know these are difficult things,  
12 but we have said that our goal is to cover the cost of an  
13 efficient provider, and we have applied it to things like  
14 DRGs as well as component sectors as well as total margin.  
15 But then sometimes we go into other reasons for not getting  
16 there, such as the reasons you just gave.

17           I think some clarity about how we might want to  
18 look at all these things would be useful. The achievement  
19 of getting to something better would be very difficult. It  
20 seems to me we've moved to a great deal of PPS in recent  
21 years. There's much less in terms of reimbursement that's  
22 currently dependent on the cost reports. I don't know how

1 that is or isn't changing behavior around cost reports.

2 I also know that in our case our staffs spend so  
3 much time on filling those cost reports out, and there are  
4 some very specific requirements, so in theory you could  
5 imagine a cost report that tries to answer some of the  
6 questions you just outlined.

7 I just don't know whether it would be worth our  
8 while to define where we'd like to be and then decide  
9 whether it's worth the effort to try to get there. But we  
10 do have a pretty cloudy lens that we look through when we  
11 make specific payment updates, I think.

12 MR. MULLER: We do use basically the inpatient  
13 margin to cover the other five sectors over and over again,  
14 and our data has shown that what we'll call the product mix  
15 of these services does, first of all, it varies quite a bit  
16 in terms of scale; there's quite a bit of distribution, so  
17 not everybody has the same proportions of inpatient to  
18 outpatient to rehab, et cetera, and so forth. So a hospital  
19 that, in a sense, in theory had only an inpatient program  
20 could have a significantly high margin, and those that do a  
21 lot of outreach, do a lot of rehab, have broader needs to--  
22 have a broader role in the community, whether it's a rural



1 community or urban community and so forth, in a sense one  
2 could argue have a broader social role, get dragged down  
3 because we don't give them as much money in those other  
4 sectors and so forth, financially. So in a sense, one is  
5 punished financially for playing a broader role.

6           So I understand the discussion between Joe and  
7 Nick, but I do think understanding exactly, or trying to  
8 better understand--not exactly. I concede Joe's point, it  
9 can't be exact, but trying to better understand the  
10 components make a lot of sense. Because I remember when we  
11 went through the SNF discussion last year or the year before  
12 and we had margins of minus 70 and minus 30, and so forth,  
13 and we just said, oh well, it gets covered by inpatient and  
14 so forth. That's a lot to cover through inpatient. So I'm  
15 just hesitant to keep saying that the inpatient margin will  
16 cover all these other components for the foreseeable future.

17           MR. HACKBARTH: To the extent that the inpatient  
18 margins are inflated because of allocation of costs, the  
19 hospitals that haven't had the other lines of business never  
20 went through the practice of allocating the costs out. So  
21 presumably, I guess, all other things being equal, they  
22 would have lower inpatient margins.

1 MR. MULLER: I think that's what we want to know.

2 DR. NEWHOUSE: My regression is going to get the  
3 incremental costs.

4 MS. DePARLE: My question went to the same kind of  
5 issue that Nick was raising that we were just discussing,  
6 which is the quality of the data that we're relying on. I  
7 just wanted to be clear, am I correct that none of what  
8 we're looking at when we establish Medicare margins relies  
9 upon, or is influenced by, hospital charges? We had a  
10 discussion in July about charges and how that was something  
11 that did obviously affect--

12 MR. ASHBY: No, it very definitely is influenced  
13 by charges.

14 MS. DePARLE: Then it seems like we should have  
15 some discussion of that, because we had a long discussion in  
16 July, or fairly long, about the extent to which that had  
17 affected outlier payments in the notable case, and just what  
18 a house of cards it might all be. I wasn't clear that it  
19 was part of what you were relying on here. It affects the  
20 cost reports.

21 MR. ASHBY: It is part of what we're relying on  
22 here because charges are used in the cost report process for

1 allocating costs among services for ancillary costs. So we  
2 are at the mercy of hospital's charge-setting practices and  
3 the consistency of their markups.

4 MS. DePARLE: In the cost-to-charge ratio?

5 MR. ASHBY: Exactly. So we are affected by that,  
6 by all means. Now the study that we are undertaking is  
7 going to examine the charge-setting practices of hospitals  
8 to try and better understand what they take into account in  
9 setting their charges and what implications that has for the  
10 allocations that we do. In addition to, for a sample of  
11 hospitals, measuring the allocation of costs that they with  
12 their sophisticated cost accounting systems think is  
13 correct, which is not based on charges, or to a very small  
14 degree. So we'll have a comparison in that way of how much  
15 difference all of this charge problem has.

16 DR. REISCHAUER: How about a regression that  
17 related overall Medicare margins to the fraction of Medicare  
18 payments that were represented by outlier cost payments. It  
19 could be that a subgroup is doing quite well because it's  
20 gaming--

21 MR. ASHBY: I think CMS has pretty well announced  
22 that there is a subgroup that has been doing well.

1 MR. HACKBARTH: Any others?

2 Okay. We will have a brief public comment period.

3 [No response.]

4 Okay, thank you. We reconvene tomorrow morning at

5 9:00 a.m.

6 [Whereupon, at 4:44 p.m., the meeting was  
7 recessed, to convene at 9:00 a.m., Friday, October 10,  
8 2003.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom  
Ronald Reagan Building  
International Trade Center  
1300 Pennsylvania Avenue, N.W.  
Washington, D.C.

**Friday, October 10, 2003**  
**9:02 a.m.**

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair  
ROBERT D. REISCHAUER, Ph.D., Vice Chair  
SHEILA D. BURKE  
AUTRY O.V. "PETE" DeBUSK  
NANCY ANN DePARLE  
DAVID DURENBERGER  
ALLEN FEEZOR  
RALPH W. MULLER  
ALAN R. NELSON, M.D.  
JOSEPH P. NEWHOUSE, Ph.D.  
CAROL RAPHAEL  
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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MR. HACKBARTH: Good morning, Karen.

Our first item for today is access to care.

Karen?

\* MS. MILGATE: This session is a session on talking about what we see about the beneficiary perspective on their ability to obtain care in the Medicare program.

Last year, the Commission developed a framework for monitoring access to care and there were three dimensions of that. One is to look at the capacity of the system to deliver care. The second was to look at the ability for beneficiaries to obtain care. And the third was to look at the ability for beneficiaries to obtain the appropriate care. So this provides us some information on the second one, which is the overall ability for beneficiaries to obtain care in the Medicare program.

The information presented here is at a very general and high level because it's intended to be included in the context chapter that Anne Mutti described at last month's session that will go in front of the March report, giving a context for the update recommendations.

There will also be other information on access

1 that will be included in the specific setting chapter, so  
2 this is not all you will see on access to different types of  
3 care. But today what I'm going to do is present data from  
4 the beneficiary perspective, and essentially that's going to  
5 mean presenting data from three specific surveys of  
6 beneficiaries.

7           The first slide here is a bit busy but fairly  
8 straightforward. This is data presented from the Medicare  
9 Current Beneficiary Survey. You see here three types of  
10 questions that are asked on that survey. One is whether  
11 beneficiaries delayed health care due to costs. Secondly,  
12 whether they did not see a doctor if they needed one. And  
13 thirdly, if they had trouble getting health care.

14           You can see from 1991 to 2001, on the top two  
15 measures of delayed health care due to cost and did not see  
16 a doctor when they needed one, the trends have been good  
17 since 1991. And then trouble getting health care has been  
18 fairly stable over that period. However, you can see that 8  
19 percent really is -- that in 2001 less than 8 percent of  
20 beneficiaries reported any problems, for example.

21           In 2001, the largest problem reported was in the  
22 delay due to cost, and that was 7.9 percent of



1 beneficiaries. Those that said they did not see a doctor  
2 when they thought they needed one, 5.5 percent of  
3 beneficiaries. And those that reported trouble getting care  
4 in 2001 was 4.3.

5           The only thing I'd like to point out other than  
6 that is that there did seem to be kind of a bottoming out on  
7 the top indicator of delayed health care due to cost in 1998  
8 of 7.0 percent. In it's inched up slightly since then.  
9 None of those differences in each of those years are  
10 statistically significant. However, the difference between  
11 7.0 and 7.9 is. So it looks like something we might want to  
12 watch over the next coming years.

13           MS. DePARLE: Karen, did the word health care  
14 include pharmaceuticals?

15           MS. MILGATE: It isn't clear from the question, I  
16 mean that's all the question asked. But there are other  
17 questions actually on the MCBS that do look at that. I  
18 didn't look at those at this point in time in detail, but  
19 that's something that could be reported.

20           MS. DePARLE: I was just wondering if that  
21 significantly significant increase could be what we're  
22 observing also in the pharmaceutical area?

1 MS. MILGATE: Yes, it could include that. It  
2 certainly is not clear that it excludes that.

3 MS. BURKE: Although, there is actually a  
4 statistic that suggests that there was little difficulty  
5 getting prescription medicine which I found odd.

6 MS. MILGATE: We'll certainly have that discussion  
7 at the last slide.

8 MS. BURKE: I thought it was bizarre.

9 MS. MILGATE: I can say a few things about that  
10 because yes, that was an interesting finding in the CAHPS  
11 survey.

12 This next slide is data from the National Health  
13 Interview Survey which is actually not a survey specific to  
14 Medicare beneficiaries but it's asked of all persons. So  
15 here we're really talking about a subgroup of Medicare  
16 beneficiaries, those that are over age 65 and are on  
17 Medicare. So this does not include the disabled, for  
18 example, and the 65-plus.

19 Here, the question was whether the person failed  
20 to obtain care due to financial barriers in 2002. I only  
21 have one year shown here because the last couple of years  
22 were fairly stable so there was no real change to report.

1 But it may be interesting to note that there was some  
2 stability in the last couple of years.

3           Again, what you see here is the Medicare  
4 beneficiaries, or at least those over 65, seem very  
5 satisfied with their ability to get care and report few  
6 financial barriers. The national average is 4.7 percent  
7 suggest that they have failed to obtain care due to  
8 financial barriers. Those 18 to 64, the number is higher at  
9 6.2 percent. But then those over 65 report only 2.5 per  
10 cent.

11           DR. REISCHAUER: You don't have the answers for  
12 these questions for those who have insurance who are under  
13 65, do you?

14           MS. MILGATE: Those who have insurance under 65  
15 versus others.

16           DR. REISCHAUER: You know, to compare two  
17 populations that are in a sense similar because they have  
18 insurance. Do people with Medicare have greater problems  
19 than others or less problems.

20           MS. MILGATE: Does NHIS have that, Jill? I don't  
21 have them here but that is something we can look at, yes.

22           MS. BURKE: The disabled are included in the 18 to

1 64s?

2 MS. MILGATE: Yes, I believe they are. That would  
3 be right, the disabled under 65? Yes, because this is just  
4 an age break down, so this would include all persons.

5 MS. BURKE: So the Medicare disabled would be  
6 covered in the under-65s?

7 MS. MILGATE: Yes, so it would include all kinds  
8 of coverage under 65.

9 Interesting enough, I don't have this on here,  
10 those under 18 also have a lower level of reporting failure  
11 to obtain care. So it seems like for children and for folks  
12 over 65 that's the best category. And then in between I  
13 think you're seeing all the mix of different types of  
14 insurance and lack thereof.

15 Another question that's asked on the National  
16 Health Interview Survey that we reported on last year and  
17 wanted to update was whether people have a usual place to go  
18 for care in 2002. The difference isn't quite as stark here  
19 as the previous question, but you see once again that those  
20 over 65 report a higher level of having a usual place to go  
21 for care than the national average and than those who are of  
22 a closer age. Here I chose the 45-to-64 population to

1 compare to rather than the whole 18-to-64.

2 MS. BURKE: The usual place to go could be an  
3 emergency room.

4 MS. MILGATE: It could be.

5 MS. BURKE: So it doesn't qualitatively give us an  
6 indication of where they think the usual is.

7 MS. MILGATE: That's true. The CAHPS data that  
8 going to now says a little more about whether they see a  
9 doctor or a nurse routinely. But this is general in saying  
10 a place to go.

11 The MCBS also asks it generally and then breaks it  
12 down. And you'll see that the rates that are in CAHPS on  
13 going to doctors and nurses actually are very similar to the  
14 rates of those on the MCBS that say they have a regular  
15 doctor. And then there's a difference on top of it that  
16 people go to EDs or just don't have one.

17 DR. REISCHAUER: Not to be jumping all over this  
18 about the limitations of this kind of information, but  
19 there's also the problem that something like 12 to 15  
20 percent of Medicare participants don't go to a doctor during  
21 a year. And something like a third of the rest of the  
22 population doesn't go. It would be hard to have a problem

1 accessing care if you were healthy and never wanted to go.

2 MS. MILGATE: If you didn't try to go.

3 DR. REISCHAUER: And so if you were really doing  
4 these you would want to do the subset of people who wanted  
5 to see a doctor who then had a problem.

6 MS. MILGATE: Actually, the CAHPS data in some way  
7 does that because it asks if you needed to did you on most  
8 of the different questions.

9 DR. REISCHAUER: So is this a subset of that?

10 MS. MILGATE: No, I'm just getting to that.

11 DR. REISCHAUER: No, but you could do it.

12 MS. MILGATE: The next few slides are going to be  
13 from that, so that will give us a little more information.  
14 But you're right, that's true.

15 And I think it's important to note that these are  
16 questions that individual people are answering. So there is  
17 a lot of subjectivity. It's designed into the survey  
18 process. It's important information but it's unclear how  
19 much to act upon just this information.

20 The next three slides are data from the CAHPS  
21 survey and I want to just stop for a minute to say a couple  
22 of words about the CAHPS survey. This is a new tool in our

1 too kit of access and quality information. It's a survey  
2 that was originally designed for commercial health plans and  
3 then was altered a bit for Medicare+Choice. And then, in an  
4 attempt to make sure that they had information on fee-for-  
5 service beneficiaries as well, was again modified somewhat  
6 for fee-for-service.

7           This is one of the first times that I know of that  
8 these data that been reported publicly, so I just wanted to  
9 stay that this is kind of new and interesting information.  
10 It provides some of the same types of general information  
11 you see on the other surveys but digs in just a tad deeper.  
12 So it's kind of an interesting one to take a look at.

13           CMS is clearly continuing to change and modify.  
14 We found some questions we couldn't compare over years and  
15 that kind of thing, just to try to get a better handle on  
16 what beneficiaries were perceiving when they were answering  
17 these questions.

18           It's a large sample as well. There's 100,000 to  
19 120,000 beneficiaries are surveyed every year. So it's a  
20 nice large sample.

21           What the beneficiaries said in answer to the  
22 question that was presented on necessary care, and here's

1 the question just so we understand what they are thinking  
2 when they answered it, if you or your doctor believed you  
3 needed care, how much of a problem was it to get this care?  
4 So it's a little bit better than do you think you got care  
5 and whether you tried or not. We're going to presume they  
6 tried, because the doctor or them thought they needed it.

7           You can see here that for all three years 97  
8 percent or more of beneficiaries reported it was a small or  
9 no problem getting their necessary care. And then a very  
10 small percentage reported it was a big problem.

11           That's sort of an overall question, and then they  
12 broke it down by urgent care and routine care. So here you  
13 see the data for routine care. And again, here's the  
14 question. The question is if you needed care right away for  
15 illness or injury, how often did you get it as soon as you  
16 wanted? So it puts a bit of a timing issue in there. It's  
17 not did you get it, it's how often you got as soon as you  
18 wanted. So again, a little bit of subjectivity there.

19           Most beneficiaries in all three years, 92 to 93  
20 percent, said they usually or always got the urgent care  
21 that they perceived they wanted or perceived they needed as  
22 soon as they wanted.



1           However, you'll see that is a slight increase in  
2 those that said they never got urgent care and also  
3 sometimes did not get urgent care as soon as they wanted  
4 between 2000 and 2002. So it's a very small increase but it  
5 might be something to watch as well, as they keep using the  
6 survey.

7           For routine care, the question here was if you  
8 made an appointment for regular or routine care, how often  
9 did you get an appointment as soon as you wanted? So again,  
10 it has that timing aspect in there. Here we see that  
11 between 2000 and 2002, 90 to 92 percent of beneficiaries  
12 reported they always or usually got an appointment as soon  
13 as they wanted.

14           Again, you see a slight but statistically  
15 significant increase in those that reported never or  
16 sometimes. So again, it might be something to watch. This  
17 is a larger increase than you see in urgent care, so there  
18 may be some beginning of an issue here in the obtaining of  
19 routine care.

20           Another aspect of access the CAHPS survey gives us  
21 some information on is continuity of care. It's asked on  
22 other surveys as well. Here the data show that 89 percent

1 of beneficiaries have a regular doctor or nurse. So here  
2 they don't ask usual place. They say specifically do you  
3 have regular doctor or nurse. Almost 80 percent -- and I  
4 found the second bullet particular interesting -- of  
5 beneficiaries said they have seen their regular doctor for  
6 two or more years. And in 2002, 60 percent actually  
7 reported seeing the same doctor for over five years. So for  
8 a significant portion of beneficiaries, they have a regular  
9 doctor or a nurse and they actually have known them for some  
10 period of time.

11           50 percent of beneficiaries have actually been  
12 seeing the same provider since before they entered the  
13 Medicare program.

14           In addition to asking some general questions about  
15 access to physicians, they asked about specialists and other  
16 types of health services. The services they asked about  
17 were specialists, prescription drugs, home health, durable  
18 medical equipment, and PT/OT/ST or physical therapy,  
19 occupational therapy, and speech therapy.

20           Clearly the numbers of beneficiaries seeing these  
21 different services varies. That doesn't necessarily mean  
22 it's unimportant if a small percentage need one service or

1 the other, but I wanted to just put those numbers out there.  
2 Those reporting that they sought prescription drugs were 90  
3 percent of beneficiaries. Those reporting they sought care  
4 from a specialist were 48 percent. And then durable medical  
5 equipment was 16 percent. PT/OT/ST, 13 percent. And those  
6 reporting they needed home health in 2002 were 7.9 percent.  
7 So there's a difference of how many beneficiaries actually  
8 needed the different services.

9           What you see from the charts that were included in  
10 your background materials is that access to all types of  
11 these services appear as good. Almost 90 percent report no  
12 or a small problem for any service. However, there are some  
13 differences and I wanted to highlight a couple of them.

14           First of all, as Sheila noted before for  
15 prescription drugs, 96 percent of beneficiaries reported  
16 that they had a small or no problem obtaining prescription  
17 drugs. This number is similar to other surveys and also --  
18 is similar to other surveys that asks question in this way.  
19 And it's always been hard to interpret is what I've been  
20 told in talking to several folks about what does this mean.

21           You'll see this number when it's asked generally  
22 whether beneficiaries have access to prescription drugs.

1 However, other data show a higher level of beneficiaries are  
2 actually skipping doses, splitting pills, replacing drugs  
3 for other goods that they might otherwise have bought.

4           The other thing to note is this number is  
5 different for different types of beneficiaries. A recent  
6 Health Systems Change Survey found actually higher levels  
7 for both whites and African-Americans when the question was  
8 asked in the last year how often did you delay getting a  
9 prescription because of cost. So that's a little different  
10 than this question. That survey found that whites were 6.8  
11 percent more likely to say that and 16.4 percent of African-  
12 Americans said they were likely to delay at least one  
13 prescription due the cost.

14           So we have some conflicting data here on  
15 prescription drugs and it's important to understand this  
16 number in the context of those different surveys.

17           Specialist, 94 percent of beneficiaries said that  
18 it was a small or no problem to obtain a specialist. And  
19 then the other, I think, interesting number and particularly  
20 interesting to the Commission because of update  
21 recommendations was the home health number. And that number  
22 was relatively good -- I don't know relatively, it was a

1 fairly high level, 88 to 89 percent of beneficiaries said it  
2 was a small or no problem obtaining home health services.

3 But again we wanted to dig into this number little  
4 bit, to say of those who said they had a big problem, did  
5 they actually get it eventually? How big was the problem,  
6 of course, becomes the question.

7 So we looked at 2000 data, which was the most  
8 recent we had, of how many beneficiaries actually obtained  
9 home health services. We looked basically was there a claim  
10 for that beneficiary for home health. And found in 2000,  
11 7.5 percent of beneficiaries had a claim for home health.

12 And concluded from that that most of these  
13 beneficiaries are seeming to get home health because those  
14 in 2000 on this survey who said they sought home health care  
15 were 7.7 percent. So there's a .2, 7.7 minus 7.5,  
16 difference between those who actually entered a claim and  
17 those who said they sought home health care. It appears, at  
18 least from those data, that there may be a reported big  
19 problem but they do eventually get home health care.

20 So it doesn't mean there's not necessarily an  
21 access problem, but they are actually obtaining home health  
22 care. The barriers aren't so high that they aren't actually

1 getting the care.

2 In summary, I think what we see from these data,  
3 at least, that beneficiaries perceive they have good access  
4 to care. Clearly, these are national data so they can  
5 obscure important differences for certain types of  
6 beneficiaries and perhaps differences across geographic  
7 areas. But this gives us a good general overall picture.

8 DR. WAKEFIELD: Karen, I know these data are the  
9 aggregate data and you are providing them, they be included  
10 to provide context it sounds like. Because you mentioned  
11 that there will be some more precision around breaking these  
12 data down when that's relevant in subsequent chapters. So  
13 this is sort of a front-end piece?

14 MS. MILGATE: Exactly. Yes. It's intended to be,  
15 as you saw all the different charts that Anne Mutti showed  
16 last time of looking at the economy generally, Medicare  
17 trust fund, that sort of thing. And in that broad chapter,  
18 we say here is broadly what access to care looks like for  
19 beneficiaries.

20 DR. WAKEFIELD: I'm a little bit concerned about  
21 what this might wash out in these averages, but I also  
22 understand what you're saying, you're trying to do the big

1 picture view. Will there be any place where you might be  
2 breaking this down by, for example, difficulty obtaining  
3 care, didn't see the doctor, cost a factor? Are you going  
4 to try and break that down at all by minority status,  
5 income, age, region? Is any of that kind of cut on this  
6 data going to be included to give us a little bit more  
7 precision, in terms of what we're looking at?

8 MS. MILGATE: We hadn't planned on doing it  
9 broadly, but there might be particular places like what I  
10 just described for explaining prescription drugs, that it  
11 might be useful. So I guess that's the eye I would use is  
12 where it seems like it would be really useful, if it's seems  
13 like the averages are not necessarily giving a good enough  
14 picture, that we might include some information like that.

15 DR. WAKEFIELD: There's a level of specificity  
16 that a person will never get to because the data won't  
17 support it I'm sure, and the sampling is not going to  
18 support it, in some ways. So I think the case that I'm  
19 thinking about, but we'll never see it here, is I was just  
20 doing some visits to travel reservations talking with people  
21 about their care for elders among American Indians in my  
22 region of the country. And gosh, access is just a huge

1 issue for them and they are Medicare-covered. This is the  
2 program that pays for their care.

3 Now you're not going to get to that level of  
4 detail. You're not sampling at the level, and so on. But  
5 I'm wondering, somewhere between this, the big picture, and  
6 that, which you're not going to get to, can there be any  
7 slightly finer cut?

8 If this goes as it is, it suggests to me that by  
9 and large things are good in Medicare-land from a  
10 beneficiary perspective. And that may well be true. But  
11 I'm concerned about pockets. Again, minority pockets, age,  
12 income in particular, especially as we start to see changes  
13 in copays and so on, which maybe we're not picking up yet.  
14 But if the data will support that, it seems to me that would  
15 be a useful thing to do.

16 MS. MILGATE: Okay.

17 DR. REISCHAUER: What kind of identifiers are on  
18 these people? Is there a rural identifier?

19 MS. MILGATE: The CAHPS survey, which is really --  
20 well, you could do it --

21 DR. REISCHAUER: Because 100,000 is certainly big  
22 enough to do some cuts like that.



1           MS. MILGATE: Yes, and we are actually -- let's  
2 see, how should I say this?

3           The CAHPS data, and the analysis they have, are  
4 somewhat new. And so I am now talking to both CMS and the  
5 contractors they have worked with on the various things that  
6 we might be able to do with the data. They are identified  
7 at the county level, which means there are a variety of  
8 different ways we could cut it, urban/rural. And we're  
9 discussing with them the possibility of doing that.

10           I hate to promise it by the time of the next  
11 meeting or the next report, but we are talking to them about  
12 being able to look at urban/rural breakdowns and some racial  
13 breakdowns.

14           I would just say that CAHPS, in the future,  
15 provides us a lot of different possibilities that we could  
16 build on.

17           DR. REISCHAUER: I think what Mary's suggesting is  
18 just even a paragraph that said preliminary analysis  
19 suggests that in rural areas the number might be higher and  
20 over time we'll be able to hone in on this.

21           MS. MILGATE: The other thing that Sarah said that  
22 we should point out is that we do have some information by

1 supplemental insurance status. So that's one thing we could  
2 include in there.

3 DR. ROWE: This is the CAHPS fee-for-service  
4 survey, right?

5 MS. MILGATE: Right.

6 DR. ROWE: Is there a CAHPS M+C survey?

7 MS. MILGATE: Yes, there is. This was modified  
8 from that, essentially.

9 DR. ROWE: Are those data available now, also?

10 MS. MILGATE: They are available in a different  
11 way and I should have said that. I am planning for us to  
12 include some comparison because we do have some comparisons.  
13 What they've done with the M+C is create composite rates  
14 from a variety of different questions. So we could  
15 certainly compare the scores on the composite rates. I  
16 found the level of detail included in individual questions  
17 in some ways more useful and interesting for fee-for-  
18 service, but there is a higher level comparison that could  
19 be done.

20 DR. ROWE: Also, it would be interesting with  
21 respect to the race and ethnicity information whether or not  
22 there have been any improvement over time, rather than just

1 the differences these disparities seem rather intractable.  
2 None of us are going to be surprised by finding another  
3 disparity, there's one under every rock and behind every  
4 tree. But it would be nice to see if we're making progress,  
5 since you now have longitudinal data here.

6 And I think it would be interesting to compare  
7 those changes over time in the M+C versus the other, the  
8 fee-for-service.

9 MS. MILGATE: I don't know if they've broken the  
10 M+C by race, but I suppose you could.

11 DR. ROWE: Yes, they have.

12 MS. MILGATE: Okay.

13 DR. ROWE: The data that we get from the CAHPS  
14 survey for our beneficiaries includes race and ethnicity.

15 MS. MILGATE: We will also be able to compare -- I  
16 should say this, there is another set of indicators we're  
17 running for quality purposes that we will use also probably  
18 for some access information, and that's the ACE-PROs that  
19 we've talked about before that looked at the provision of  
20 clinically necessary services in the ambulatory setting.

21 And there we are looking at a racial analysis, as  
22 well as urban/rural breakdown, that will give us some

1 information both for quality and access purposes.

2 DR. ROWE: The interesting question here that  
3 everybody is familiar with, but when these disparities were  
4 found in the fee-for-service population and people looked at  
5 the M+C population, it helped in answering the question of  
6 whether or not it was the lack of a primary care physician  
7 that was part of the limitation in access. Because in the  
8 M+C program, by definition everybody has a primary care  
9 physician. In fact, it made no difference. People still  
10 had the access problem.

11 So here they were. They were insured and they had  
12 access to primary care physician and still report -- I think  
13 the Commonwealth Fund supported some work that was published  
14 that show these rather significant reductions in Medicare  
15 beneficiaries, in getting beta blockers after a heart  
16 attack, getting follow-up after mental health admissions, et  
17 cetera.

18 So I think that one of the values of comparing the  
19 datasets is that in one dataset we know there's a primary  
20 care physician, and certain other services are provided. In  
21 another dataset it isn't. And we can start to answer some  
22 questions.

1           MR. HACKBARTH: Karen, my recollection from my  
2 previous life at Harbor Community Health Plan was that we  
3 tended to get different results based on the type of survey.  
4 For example, an annual member satisfaction survey versus a  
5 visit-based survey. So if you asked people to reflect back  
6 over the course of the past year consistently we tended to  
7 get higher satisfaction levels than if you asked them right  
8 after a visit.

9           I don't know what explains that. It could have to  
10 do with at the time of the visit maybe they have a health  
11 problem and there's a higher level of anxiety, whereas if  
12 you asked them to reflect back over longer periods. But  
13 there is some -- biases isn't the right word, but there are  
14 some real tendencies depending on the type of measure you're  
15 using. It was our experience that you tended to get the  
16 most favorable results when you asked these sorts of  
17 questions.

18           The other thing that was striking to me in that  
19 experience was how different the response of different  
20 population groups would be. Seniors tended to have the  
21 highest levels of satisfaction. So even if you asked a  
22 senior and a younger population using the exact same

1 facility, controlled as closely as possible, they had the  
2 same access, the same physical facilities, that the seniors  
3 will always give higher scores to everything.

4 MS. MILGATE: Just a couple of comments on your  
5 second one. The older you get, the better it seems  
6 actually, also. On some of the surveys that break down  
7 Medicare beneficiaries by age you'll often see high rates of  
8 satisfaction for those over 80 than those 65-to-74. And  
9 that's kind of interesting.

10 MR. HACKBARTH: So in the chapter, when we talk  
11 about comparisons across groups, we may want to have  
12 something that reflects the fact that there are some.

13 MS. MILGATE: I would just say one thing though,  
14 about the CAHPS survey. It's sort of in between what you  
15 describe because they do at least six months. They don't  
16 ask the whole year. I don't know if that was by design or  
17 it made it more convenient for their administration. So  
18 they do do it by six months, but I don't know that that  
19 means that there's any difference really.

20 And then the other thing is that in the future,  
21 when they get the hospital CAHPS, because they're also  
22 working on a CAHPS that will be okay now you were just in

1 the hospital, tell us about your experience. That might  
2 give us some other really interesting information, because  
3 it is right after the event occurred.

4 MR. SMITH: (off microphone) On the visit-based  
5 stuff they pick up the Newhouse computation.

6 MS. MILGATE: The Newhouse computation. I don't  
7 know about that phenomenon....

8 MR. HACKBARTH: I don't think Joe was ever a  
9 member.

10 MS. BURKE: Karen, a terrific job, it's  
11 fascinating stuff.

12 I am, however, as concerned at the point that Mary  
13 has raised, and that is that we may leave a false impression  
14 of living -- if you'll forgive me -- in Lake Woebegone, that  
15 everybody's above average and all is well. When in fact, if  
16 you begin to differentiate among the populations, there are  
17 significant differences in how they experience treatment and  
18 how they access it. And so I think a paragraph that notes  
19 that is critical.

20 But I also wonder, particularly around the issues  
21 around income and around race. I mean, there are certainly  
22 geographic issues as well that we're well aware of,

1 particularly around certain services. But the generic  
2 impact of income on access and the difficulty of gaining  
3 access and around race because of the disparities issues, I  
4 feel that to the extent that we can, we need to highlight  
5 that because a lot of the work that suggests that in fact  
6 the low income elderly are incurring greater and greater  
7 out-of-pocket costs, larger percentages of their income go  
8 towards the purchase and access to care, their difficulties  
9 in accessing.

10 And I would worry about appearing -- I mean, the  
11 drug number sort of underscored that sort of disconnect with  
12 at least the reality that some people face.

13 And to the extent that we can do that with a  
14 paragraph, suggesting that these are averages in a sense.  
15 But to the extent that we have any data that allows us to  
16 begin to separate out some of those groups, I think would be  
17 a very important for the overall context of the debate.

18 MS. MILGATE: I think we can certainly add some  
19 more context to the context. But we also have already  
20 planned to do some on the cost-sharing levels for different  
21 types of beneficiaries. So we'll meld that together more  
22 directly with the access piece, as well.



1 MS. BURKE: Okay, great.

2 MR. MULLER: On the same theme that Mary and  
3 Sheila have raised, looking at the subsets, we probably  
4 don't have any language markers and so forth. But when you  
5 start looking at -- I think for L.A. County there's like 100  
6 languages or more, something like that, some enormous  
7 number. I know that my experience has been that a lot of  
8 times people will travel a long way, three or four or five  
9 hours, to go to a physician. a nurse, et cetera, who can  
10 speak the same language because of the difficulty of  
11 communicating a lot of the technical aspects of medical  
12 care, having somebody that precisely knows the language as  
13 opposed to just generally is very helpful.

14 So I don't know whether we have any kind of  
15 indicators of that, but I think in certain pockets you would  
16 find that. That's one theme.

17 Another one is, to go back to some of the supply  
18 questions in some of these pockets, where there are  
19 indicators of physicians per thousand or beds per thousands  
20 and so forth have any kind of impact on access. Because I  
21 think that we're going to find the access problems -- again  
22 in these subsets -- that 4 or 5 percent can capture a lot of

1 variety. And while it gets lost in the overall samples with  
2 people being okay at the 90 to 92 percent level, I think  
3 there's a lot of action in that 7 or 8 percent.

4           So the question is how to try to identify that how  
5 much of that is supply-based, how much is on the classic  
6 factors of disparity that Jack and Sheila have mentioned,  
7 and so on.

8           So since we have a large enough sample here to  
9 keep looking for what some of the indicators of the  
10 difference may be, it's helpful.

11           MS. MILGATE: Geographically, also.

12           MR. MULLER: I think there's a lot of suspicion  
13 that supply could have an effect, whether the supply numbers  
14 of CAHPS have a small enough granularity to -- if it's at a  
15 county level, then you really won't notice the difference.  
16 It really has to almost be below a county level, and so  
17 forth.

18           MS. BURKE: This goes back to Bob's earlier point.  
19 Do we have the capacity to test these questions against  
20 people who actually sought out and accessed care? Or does  
21 this number include those people who did not, for whom  
22 there's no problem because there was no problem.

1 MS. MILGATE: It depends on the survey. CAHPS I  
2 feel like did about as good a job as you can.

3 MS. BURKE: But just in the way the survey is  
4 structured, does it survey --

5 MS. MILGATE: Who does it survey? It surveys  
6 randomly. So it would be those who wouldn't have tried and  
7 those who would have. But what they do before every  
8 question is say did you seek. So if you didn't seek a  
9 doctor or a specialist or you didn't seek prescription drugs  
10 or you didn't seek home health, then you're not --

11 MS. BURKE: You wouldn't get picked up as someone  
12 who didn't have a problem?

13 MS. MILGATE: Right. Necessary care. Did you or  
14 your doctor think you needed necessary care and you tried  
15 to get it? If you did, then how much of a problem --

16 MS. BURKE: So hopefully, the way it's structured  
17 will sort out those.

18 MS. MILGATE: On CAHPS, yes.

19 MS. BURKE: Because I do worry, there are a huge  
20 number of people who have no problem.

21 MS. MILGATE: Right. Now some of the other  
22 surveys aren't as granular, but the CAHPS survey I think

1 they did a pretty decent job at that, yes.

2 MR. FEEZOR: Just to pick up on a comment that  
3 Sheila made, that I think our readership interest would be  
4 significantly higher if we could have some sub-national  
5 numbers and geographic. Not just urban and rural. but if  
6 there are some significant regional variations, I think  
7 picking that up, if not this time at least subsequently I  
8 think would be very helpful to some of our decision makers.

9 MR. HACKBARTH: My understanding is, at least in  
10 the non-Medicare population surveys I've seen, there are  
11 significant regional differences in satisfaction.

12 MS. MILGATE: Possibly.

13 MR. FEEZOR: If there are.

14 MS. MILGATE: It's possible to do. I haven't  
15 looked at it, so I don't know what it looks like for this.

16 DR. STOWERS: I was just going to make a comment,  
17 it sometimes brings it home, like Sheila was talking the  
18 variance in come, that Medicare is only picking up 55  
19 percent of the total health care bill there. So there's a  
20 huge part that is out-of-pocket or coinsurance or whatever.  
21 So sometimes I think they need to be reminded of that, that  
22 Medicare is not picking up the majority of that.

1           MR. HACKBARTH: Karen, could you go back to the  
2 initial graph on difficulty in obtaining care?

3           MS. MILGATE: Yes. You want me to put it on the  
4 screen?

5           MR. HACKBARTH: To me the big news there is the  
6 long-term decline in the percentage saying that they delayed  
7 health care due to costs. I was sitting here trying to  
8 figure out why, what happened over this time period that  
9 resulted in this very significant improvement.

10          MS. BURKE: I'm still trying to figure out what's  
11 going on in 1991.

12          DR. NEWHOUSE: A depression was going on, or a  
13 recession. The economy is getting better.

14          MR. HACKBARTH: Good for Medicare people.

15          DR. REISCHAUER: Another hypothesis, which is  
16 relative to private payers, Medicare becomes a better payer  
17 during this period.

18          DR. NEWHOUSE: This is delayed health care due to  
19 costs which sounds like it's a beneficiary.

20          MS. BURKE: But is this a Medicare population?

21          MS. MILGATE: Yes.

22          MR. HACKBARTH: So Medicare hospital payments went

1 up but beneficiaries never see that anyhow.

2 MS. DePARLE: The only policy change was the  
3 physician fee schedule during that time really, wasn't it?

4 DR. NEWHOUSE: [off microphone]

5 MS. DePARLE: And you had the outpatient  
6 coinsurance going up, up, up. So I think beneficiary income  
7 went up.

8 DR. REISCHAUER: This is the period of the huge  
9 increase in HMO participation and the overpayments, and so  
10 people fall into a kind of insurance that they don't have  
11 copays or very low copays.

12 MS. DePARLE: Not really, though, Bob. That  
13 really didn't start occurring until like '95, '96, '97. The  
14 peak was 1998.

15 MS. BURKE: You may be looking at 3 percent in  
16 '91, maybe 3 or 4 percent.

17 MR. HACKBARTH: We could sit here for several  
18 hours generating notions. But to me, it sort of gives me  
19 pause when I look at these results when there are patterns  
20 like this that I can't readily explain, it just sort of puts  
21 my antenna up about everything else that comes afterwards.

22 MS. MILGATE: I can give you a couple of thoughts

1 but this is not based on any serious analysis.

2 DR. REISCHAUER: [Off microphone.] As opposed to  
3 ours.

4 [Laughter.]

5 MS. MILGATE: Yes, I know. I thought they would  
6 be much more intelligent on this than I. But I'll jump in a  
7 bit.

8 M+C enrollment went up during that time. I don't  
9 know about income of the elderly, but that was a fairly  
10 significant increase in the -- the economy did pretty well  
11 during that time. So I'm wondering if the income of the  
12 elderly simply went up.

13 And then Sarah was saying that the QMB/SLIMB  
14 programs went in around that time, for more lower income.  
15 So there could have been more on the side of the  
16 beneficiaries' ability to cover these costs than having to  
17 do with payment. That's the lens that I would suggest might  
18 be more directly involved.

19 DR. NEWHOUSE: So did Medicaid expand in these  
20 years?

21 MS. MILGATE: Yes, not for the elderly, though.

22 MS. BURKE: [Off microphone.] That's a lot of the

1 kids --

2 MR. FEEZOR: [Off microphone.] The private sector  
3 market at this time in the late '80s and early '90s was --

4 MS. DePARLE: That's what I was going to say.  
5 This is the Clinton health plan period when it was the  
6 response of all those health care plans and Congress was  
7 really looking at it. It makes you wonder if the  
8 beneficiaries were just reflecting some of that insecurity.

9 And then, as we all know, it disappeared in the  
10 early '90s. And maybe that's where Joe's explanation comes.

11 MS. BURKE: [Off microphone.] But just on the  
12 face of it, it seems counterintuitive to me that you delayed  
13 care due to cost but you didn't have trouble getting care.

14 MS. MILGATE: That's what I found interesting,  
15 too, Sheila. I said wouldn't it show up in your trouble  
16 getting health care. They delayed it but eventually got it,  
17 I guess.

18 MS. BURKE: [Off microphone.] It's a huge bell  
19 curve.

20 DR. REISCHAUER: [Off microphone.] But a delay  
21 isn't trouble.

22 MR. SMITH: [Off microphone.] A delay may mean



1 you didn't seek it, so the answer to the second question is  
2 no.

3 MS. MILGATE: No, you needed it, but delayed it  
4 is...

5 MS. BURKE: [Off microphone.] Delay means you  
6 sought and delayed. It didn't mean you didn't ask.

7 MS. MILGATE: Yes.

8 DR. ROWE: [Off microphone.] It was delayed, it  
9 wasn't cancelled.

10 DR. REISCHAUER: Could we have a panel of  
11 respondents to this at the next meeting?

12 DR. MILLER: What I was going to suggest is I  
13 think it would make sense for us to look at the supplemental  
14 trends at the same time for Medigap, M+C, Medicaid coverage,  
15 as it relates to the Medicare population and see how those  
16 are tracking at the same time.

17 MS. MILGATE: And we can include some discussion  
18 to the extent we feel we learn something that we can  
19 conclude on this because it is an interesting question.

20 MR. HACKBARTH: Any other questions? Dave.

21 MR. DURENBERGER: All the good questions have been  
22 asked, but it may not be a question or thoughtful responses

1 given, as an observation. That is when you read this, you  
2 say well everybody's really happy with the Medicare program.  
3 And whether it's Lake Woebegone or some other place, people  
4 ask can you see a doc? Do you regularly see the doctor?  
5 Can you get to a hospital? Do you get whatever you need?  
6 People will say yes.

7 But if you ask people if they're happy with the  
8 system, if their doctor is pleased with the system, if they  
9 have to take a relative into the hospital with them, those  
10 kind of questions there's a lot of unhappiness in the  
11 system.

12 And if you push on it with the providers of care -  
13 - you don't even have to push on it. They will volunteer  
14 and they will say the problem is Medicare. And the private  
15 payers will say the problem is Medicare.

16 And I don't mean what they mean is -- they don't  
17 mean the adequacy of the benefit structure. They mean the  
18 adequacy of the financing. Or the way in which the  
19 financing is provided.

20 So if I have a question it's simply so what? What  
21 value does this particular piece of analysis add to our  
22 consideration of appropriate financing of the various parts

1 of the health care delivery system? Do you understand my  
2 question?

3 MR. HACKBARTH: I think I do, yes and so much of  
4 what we do in Medicare payment policy is designed to  
5 insulate the beneficiaries from that. And so it either  
6 works to their advantage by reducing out-of-pocket payments,  
7 coinsurance, and the like, or they are not exposed to it at  
8 all, in the case of say hospital services. But these are  
9 clearly not measures of system satisfaction, system health.  
10 It's much more narrow than that.

11 I think one of the themes of all of the comments  
12 has been that we want to be careful in how these are  
13 presented. We don't want it come across as oh, everything  
14 is okay. And I know you appreciate that. And some of the  
15 questions and the sensitivities -- wait, wait.

16 We don't want it to be a simplistic statement that  
17 this shows that everything is just fine. There is a lot of  
18 good things happening but there are also real issues. So  
19 it's a careful balance that needs to be struck.

20 DR. REISCHAUER: And now the other side of the  
21 argument. This is a problem of is the glass half full or 90  
22 percent full or 10 percent empty? The fact of the matter is

1 I think most of us at this table were surprised by these  
2 numbers, the degree of satisfaction and the lack of -- well,  
3 you aren't because you saw them before.

4 MS. DePARLE: Beneficiaries like Medicare.

5 DR. REISCHAUER: But we're looking at this in  
6 general. There might be pockets of problems. In general,  
7 the thing is working pretty well from the standpoint of  
8 access. And we've gone through a decade of turmoil and it  
9 doesn't seem like the turmoil has upset the apple cart  
10 tremendously. And I don't think we should shy away from the  
11 fact that it's working pretty well on this dimension.

12 Can things be better? Yes, they can. Are there  
13 specific problems we should focus on? Yes. But you don't  
14 want to look at something where 92 percent of people were  
15 satisfied or they're getting what they want and say oh, god,  
16 7 percent, let's change the system.

17 DR. NEWHOUSE: I'm with Bob. If the numbers had  
18 come out triple in terms of problems we would have said it  
19 shows that what we thought was right. I agree with Bob, I  
20 think these are somewhat surprising and there's a sort of  
21 reluctance to accept that there might be some good news.

22 MR. DeBUSK: There's a regional issue here that

1 could come into play.

2 DR. NEWHOUSE: We have to see those data.

3 MS. BURKE: [Off microphone.] I don't think  
4 there's a reluctance to agree --

5 DR. REISCHAUER: Turn on your microphone when you  
6 say that.

7 MS. BURKE: And I absolutely agree with Bob but I  
8 think -- I mean, we would all agree that Medicare has done  
9 an extraordinary job. Having said that, I think we do need  
10 to be cautious about not masking that there are these  
11 pockets.

12 So I would not suggest that we say oh, whoa, it's  
13 only 90-something. But I think we say great, it's 90-  
14 something but there are still pockets that we need to be  
15 concerned about. But I don't disagree with you at all.  
16 It's the little engine that could. The big engine that  
17 could.

18 MR. HACKBARTH: I think that's well put, Sheila?

19 Any other comments? Okay, thank you.

20 Next up is outpatient PPS and specifically the  
21 outlier policy.

22 DR. WORZALA: Good morning.

1           We're back in the details of the outpatient PPS.

2    Hope I don't -- never mind.

3           My presentation will have three parts this  
4    morning. First, a conceptual discussion of the rationale  
5    for outlier payments cutting sort of across systems.  
6    Second, a presentation of the outpatient PPS outlier policy  
7    as it was implemented this year, 2003. And finally, a  
8    discussion of some policy questions that the Commission may  
9    want to consider for the March report.

10           Outlier payments provide additional funds to  
11    providers when the services they furnish are exceptionally  
12    costly compared to Medicare's payment rates. Conceptually,  
13    the outlier payments serve as a kind of insurance protecting  
14    hospitals against unexpected large losses. By providing  
15    these additional payments, the program takes away some of  
16    the incentive to avoid costly patients and thereby helps to  
17    promote beneficiary access to care.

18           If we look at outliers as a form of insurance,  
19    that suggest two situations where you might want an outlier  
20    policy. First would be when there's considerable variation  
21    in the cost of providing the services included in the  
22    product that Medicare is paying for, such as the inpatient

1 case or the outpatient APC. This is because Medicare sets  
2 payments based on average cost. Thus, if a payment group  
3 has great variability around that average, the provider is  
4 more likely to treat a beneficiary with extraordinarily high  
5 costs. This variability in costs is likely to be linked to  
6 the product definition. Is the product defined broadly or  
7 is it defined narrowly?

8           A little bit of contrast to get that concept  
9 across, the inpatient, of course, is a very broadly defined  
10 product covering the entire stay. If you look at the  
11 outpatient PPS, it's a much more mixed product definition.  
12 There are some broad APC groups such as pacemaker  
13 implantation and others are very narrow, an x-ray, an  
14 electrocardiogram, a drug.

15           The other situation where you might want an  
16 outlier payment is when the potential losses are great. In  
17 that situation providers would be at increased financial  
18 risk so you would want to diminish that risk through an  
19 outlier policy, both to help the provider and to protect  
20 beneficiary access to care.

21           Of course, when these two things coincide and  
22 there is a lot of variation in the costs and the potential

1 losses are great the need for an outlier policy is  
2 magnified.

3 I would note one additional situation where you  
4 might want an outlier policy and that's when the risky cases  
5 or the expensive cases are not randomly distributed across  
6 providers. If one set of providers is more likely to treat  
7 the costly beneficiaries then the outlier policy would  
8 shield them from financial losses.

9 This chart shows what the outpatient payment  
10 system looks like when it comes to the size of the potential  
11 loss. What we've got are the APC groups and their payment  
12 rates. We see that most of APC groups have low payment  
13 rates per unit. So two-thirds have a payment rate of less  
14 than \$500 and 75 percent of the APCs have a payment rate of  
15 less than \$1000.

16 There are, however, some highly paid services.  
17 For example, insertion of a cardioverter defibrillator as a  
18 payment rate of \$17,000. What this chart shows is just the  
19 distribution of the APC groups. It doesn't have the volume  
20 in there, but much of the volume is in the lower paid APC  
21 groups.

22 MR. DeBUSK: [Off microphone.] Does this have the



1 C-code information in it?

2 DR. WORZALA: Yes, it does. This is 2003, so most  
3 of the devices are packaged.

4 MR. DeBUSK: [Off microphone.] Packaged? Okay.

5 DR. ROWE: The \$17,000 includes the device?--

6 DR. WORZALA: In the case of the cardioverter  
7 defibrillator, I would have to go back and double-check  
8 whether that's still a pass-through in 2003 or not. I  
9 apologize, I don't know that detail.

10 DR. ROWE: That would be a very high rate just to  
11 insert it.

12 DR. WORZALA: It probably does but I would have to  
13 go back and double-check.

14 A number of payment system have an outlier policy  
15 and they do have certain elements in common. The first is  
16 eligibility, which services can qualify for an outlier  
17 payment. The second is the cost threshold, how high must a  
18 providers costs be to qualify for an outlier? Third, the  
19 marginal payment factor. If you're eligible for an outlier  
20 payment, how much additional payment will you receive? What  
21 share of the costs above the threshold will be covered by  
22 Medicare? Finally, the target amount. What percentage of

1 total payments will be set aside to fund the outliers?

2           The outlier policy for the outpatient PPS is  
3 required by statute. Like the outlier policy in other  
4 settings, it is budget neutral so CMS reduces the payments  
5 for all APCs to fund the outlier payments. Congress set an  
6 upper bound on the outlier payments of 3 percent. CMS has  
7 so far targeted outlier payments below that limit. In 2003  
8 the set aside was 2 percent. If actual payments exceed or  
9 fall below that target of 2 percent, no effort is made to  
10 modify the conversion factor to try and recoup or return  
11 those funds in later years.

12           In 2003, the outpatient PPS provided outlier  
13 payments to all APCs except for pass-through drugs and  
14 devices. This includes both the broadly defined APCs ---

15           MS. BURKE: I'm sorry, can I just ask a question?  
16 If you could go back to the prior, just remind me. If, in  
17 fact, the adjustment is made, is it made prospectively?

18           DR. WORZALA: Yes.

19           MS. BURKE: Essentially if there's an overpayment  
20 in the following year, they essentially adjust downward?

21           DR. WORZALA: No, they never try to adjust. They  
22 set the target, they reduce the conversion factor, but

1 there's no look-back. There's no look-back to say I paid  
2 too much last year, therefore I'll reduce the conversion  
3 factor more.

4           So in 2003 we had outliers for everything except  
5 pass-through drugs and devices. This includes both the  
6 broader bundle such as the surgeries and very narrowly  
7 defined groups such as a x-ray or an electrocardiogram. And  
8 CMS estimated that a cost threshold of three-and-a-half  
9 times the payment rate for the APC and a marginal payment  
10 factor of 45 percent above the costs of the threshold would  
11 meet their 2 percent target. So to qualify for an outlier  
12 payment, the cost must be three-and-a-half times the payment  
13 rate. Any costs above that threshold are reimbursed at 45  
14 percent.

15           You do have a detailed example in your briefing  
16 papers of how the outlier was calculated. Here I'm just  
17 going to review the process that's followed. Outlier  
18 payments are, of course, based on the estimated costs and  
19 the FIs estimate costs by taking the current charges  
20 submitted on the claim and multiplying them by a cost-to-  
21 charge ratio that comes from the most recent tentatively  
22 settled or settled cost report.

1           But even using the most current tentative settled  
2 cost report generally results in a time lag of one to two  
3 years between the date of the cost-to-charge ratio and the  
4 submitted charges. So you come up against the situation  
5 where charges have increased at a faster rate than costs in  
6 the intervening period. The CCR will result in an estimate  
7 of costs that are higher than the actual costs.

8           And we have seen some evidence in recent years  
9 that charges have been increasing faster than costs on  
10 average, and for some hospitals at a much faster pace.

11           There are, of course, many reasons to increase your  
12 charges faster than your costs. But no matter what your  
13 motivation, the pattern will result in unwarranted outlier  
14 payments and those payments will be paid for by other  
15 hospitals. So since the outliers are budget neutral that  
16 can, of course, have a distribution affect which we'll look  
17 at in this slide.

18           This shows the distribution of outlier payments  
19 among hospitals across three different groupings, location,  
20 teaching status, and ownership type.

21           DR. ROWE: This is just the outpatient?

22           DR. WORZALA: This is just the outpatient outlier

1 payments. I didn't put that in the title, I apologize.

2           The percentages in each cell should cum to 100.  
3 They don't exactly due to rounding and also an inability to  
4 classify hospitals.

5           So you can see from the table that in each group  
6 one type of hospital received a disproportionate share of  
7 the outlier payments. It doesn't however tell us why. This  
8 could be explained by differences in either costs or  
9 charges.

10           So if you look at it by location, hospitals in  
11 large urban areas received a greater share of the outlier  
12 payments, 57 percent, than they did of the APC payments, 46  
13 percent. If the outliers were completely randomly  
14 distributed, or the cases really and the outliers, we would  
15 expect those two numbers to be the same, 46 percent of APC  
16 payments and 46 percent of outliers. But you see a  
17 disproportionate share of the outlier payments going to  
18 hospitals in large urban areas. Of course, for hospitals in  
19 other urban and rural areas, the share of outlier payments  
20 was lower than the share of APC payments.

21           If you look at it by teaching status, the major  
22 teaching hospitals received a greater share of outlier

1 payments than APC payments. And looking at it by ownership,  
2 the for-profit or proprietary hospitals received a  
3 disproportionate share of the outlier payments, as well.

4 MS. DePARLE: Chantal, how did you define other  
5 teaching?

6 DR. WORZALA: It is defined by the resident-to-bed  
7 ratio. And so it's the exact same definition as we would  
8 use in our inpatient hospital analysis.

9 MS. BURKE: Chantal, I was just interested in your  
10 comment that the disproportionately is in fact driven by the  
11 issues around costs and charges. Is there any impact of the  
12 acuity of the particular patient? The distribution of APCs  
13 may be what they are, but is there not an impact among APCs  
14 and their allocation based on the acuity of the patient that  
15 may drive the charge?

16 DR. WORZALA: Yes, I think that would be where you  
17 really are seeing this driven by differences in cost  
18 structure and the cost could be a function of the patients  
19 that you see. It could very well be that the risky  
20 patients, the more expensive patients, are not randomly  
21 distributed across hospitals and certain hospitals may, in  
22 fact, see more costly patients.

1 MR. MULLER: [Off microphone.] We know that.

2 DR. WORZALA: Exactly.

3 MS. BURKE: So I would only caution you about the  
4 use of the term disproportionate because in fact, it may be  
5 appropriate. That's my only concern, is that the resulting  
6 allocation, the share of the outliers, may in fact track the  
7 acuity of the patient and not simply a function of some  
8 people are bigger piggies than others.

9 DR. WORZALA: I didn't mean for disproportionate  
10 to be used that way. It was just a different in proportion  
11 of the APC payments versus the outlier payment. I tried to  
12 predicate all this with the explanation it could be charges,  
13 it could be costs, and we can't disentangle that from  
14 what's in front of us. And hopefully additional analyses  
15 that we do over the next few months will help us disentangle  
16 some of that.

17 Here are some policy questions that we might want  
18 to ask. The first would be does the outpatient PPS need an  
19 outlier payment? I think there are a number of arguments  
20 supporting a no response to that question. First, many  
21 outpatient services have a narrow product definition, and  
22 this includes a lot of ancillary services and inputs that

1 are paid separately which would suggest that the variability  
2 in costs will not be great.

3 I haven't shown you any analyses by service type  
4 because I want to make sure everything is right before I  
5 present it, but our initial results are suggesting that some  
6 of these sort of fairly simple ancillary services are  
7 receiving a fairly high share of outlier payments, which I  
8 think poses some questions.

9 Secondly, as we saw earlier, the APCs generally  
10 have low payment rates so the size of the potential loss is  
11 not that great. Third, I think there are some equity issues  
12 here. This is a budget neutral system, so the base payments  
13 are lowered to find the outliers, but we know that the  
14 outlier payments themselves are not evenly distributed.

15 In addition, there is the potential for outlier  
16 payments to be made in responses to increases in charges not  
17 necessarily increases in costs. Again, I think that's an  
18 equity issue.

19 Finally, the outpatient PPS is the only ambulatory  
20 setting with an outlier policy. However, many of the  
21 services provided can also be provided in physicians'  
22 offices or ASCs. So when you have an outlier policy in one



1 setting and not the others, you have just one more  
2 difference in how the services are paid for across settings.

3 I do believe that Ariel has heard from some ASCs  
4 who would like an outlier payment.

5 However, there are also arguments supporting a yes  
6 answer to the question of does the outpatient PPS need an  
7 outlier policy. There has been a shift toward more  
8 sophisticated and more costly services being performed in  
9 the outpatient setting. That's a pattern that's likely to  
10 continue in the future.

11 Second. this is a pretty new payment system and we  
12 know that CMS has had some difficulty setting the payment  
13 rates given the data they have available. So some would  
14 argue that the outlier system provides a cushion in the  
15 event that rates really are just too low.

16 Of course, it would be best to fix the payment  
17 rates but in the interim maybe there is a role for the  
18 outlier.

19 And third, as we've been discussing, I think the  
20 distribution of cases across hospitals may not be random.  
21 And so if you're routinely seeing more expensive cases, the  
22 outlier helps to compensate you for those additional costs.

1           Finally, if we decide that the outlier is  
2 appropriate for the outpatient PPS, are there any changes to  
3 the design that are warranted? Currently most services are  
4 eligible for outlier payments, including electrocardiograms,  
5 x-rays, setting a cast. These all can be given an outlier  
6 payment.

7           Does that makes sense or should we limit the  
8 eligibility to certain types of APCs such as surgeries or  
9 more broadly defined products?

10           Second, currently the threshold is set as a  
11 multiple of the payment rate regardless of the actual dollar  
12 amount. So if we go back to the example of  
13 electrocardiograms, they have a payment rate of \$19. Does a  
14 low-cost service like that provide a sufficient financial  
15 risk to warrant an outlier payment?

16           Other outlier polices do have an absolute dollar  
17 threshold that must be met before an outlier payment is  
18 received. Is that something that might make sense in the  
19 outpatient setting as well?

20           And of course, changes along these lines may have  
21 implications for the target amount as well. If fewer  
22 services are eligible for outliers, then you need less funds

1 taken out of base payments to fund outliers.

2 And very quickly, over the next few months I will  
3 bring you additional data to help inform these policy  
4 questions, looking more at the distribution of outliers by  
5 hospital to look at some of the distributional issues. And  
6 then looking at outlier payments by APC to inform some of  
7 these discussions of design.

8 And finally, I'm planning to bring you data from  
9 2002 although I've come up against some data issues so we'll  
10 see what happens there.

11 DR. NEWHOUSE: Chantal, you could do some analysis  
12 that would help me think about this, which is for the higher  
13 paying APCs what is the coefficient of variation? That is,  
14 you pointed to a narrow bundle being a reason not to have an  
15 outlier scheme. And in the narrowest of bundles there would  
16 be one service and there would be no variation at all so he  
17 wouldn't need an outlier scheme. And we have outlier  
18 schemes when we think there is variation as in PPS, and I  
19 think also in home health.

20 So what is it here and how did the variability  
21 compare to these other systems?

22 That seems to me also would inform us in thinking

1 about how much should be set aside for outliers because if  
2 it was say somewhere in between the one extreme of the  
3 physicians system and probably the hospital system or the  
4 home health system, we'd have a payment percentage that was  
5 in between.

6 And then on a separate issue, if there is an  
7 outlier scheme I think as a matter of principle we would  
8 want to fix dollar threshold as in the hospital PPS.

9 DR. REISCHAUER: How do you calculate the  
10 coefficient of variation?

11 DR. NEWHOUSE: A standard deviation over the mean.

12 DR. ROWE: [Off microphone.] [Inaudible.]

13 DR. REISCHAUER: Thank you, Professor.

14 DR. ROWE: Even I know that and I'm a doctor.

15 DR. REISCHAUER: I can get my Ph.D. taken away  
16 from me by Professor Newhouse.

17 What's the data that you use?

18 DR. NEWHOUSE: But you have the threat of taking  
19 my professorial title away.

20 DR. REISCHAUER: Don't you have to use the stuff  
21 that the hospitals are submitting, which maybe is biased?

22 DR. NEWHOUSE: Yes, that's right. What do we use

1 in the hospital system? I'd still like to know what.

2 DR. MILLER: Can I ask one question on this, and I  
3 want to be clear on this which is why I'm asking. In some  
4 instances, isn't your point that it is effectively coming  
5 down to one service? But I wanted to also just make sure  
6 that that point was clear to everyone, that often it is one  
7 service that we're talking about that the calculation is  
8 being taken on.

9 MS. DePARLE: I'm sorry, can I just ask a  
10 contextual point? It's been a while since I looked at this  
11 and I thought it was in the paper but it isn't.

12 How much is Medicare spending? What's the 2002  
13 data on outpatient spending? And what has the trend been  
14 over the last few years, I guess since '98?

15 DR. WORZALA: We had a really sharp increase in  
16 2001 that took us up to \$18.6 billion under the outpatient  
17 PPS. And the projections are for continued rapid growth.  
18 There was real growth in the '80s and the early '90s and  
19 there was a little bit of a slowing down in the mid- to  
20 late-'90s with real acceleration since the implementation of  
21 the outpatient PPS.

22 DR. MILLER: [Off microphone.] Chantal, I thought

1 the last COACT number was --

2 DR. WORZALA: That is for 2004 protected.

3 MR. DeBUSK: I've got two or three points here.

4 In assessing the outlier policy under the outpatient  
5 prospective payment system I notice in the last bullet point  
6 we're looking at using data from 2002. Do we have access to  
7 any more recent data? Isn't there some claims data that CMS  
8 has access to?

9 MS. BURKE: We were using '96.

10 DR. WORZALA: I've presented data from 2001. We  
11 have up and running the 2002 CMS data but we're having a few  
12 data issues and we may have to go back and get a new  
13 dataset.

14 MR. DeBUSK: Yesterday I got out of the penalty  
15 box because Nick took up the issue about my normal complaint  
16 about the availability of data. I guess we're right back at  
17 the same place, the data is not current enough to even  
18 discuss the subject hardly. But anyhow, let me go to the  
19 next piece.

20 Eligibility, all APCs except pass-through of drugs  
21 and devices. Last year, we were talking a lot about the  
22 implantables and the costs and the overrun, the last two

1 years. Now that we're into full-blown use of stents and  
2 what have you and drugs, do we have any idea what this looks  
3 like? Is there any data out there to tell us?

4 That is outside the budget neutral piece, is it  
5 not? These C-codes that still exist.

6 DR. WORZALA: No, the pass-throughs are also  
7 funded budget neutral.

8 MR. DeBUSK: The drugs?

9 DR. WORZALA: The reason we don't have outlier  
10 payments on pass-through items is because pass-through items  
11 are paid 100 percent of cost. And so there's not a fixed  
12 payment rate to compare the costs against.

13 DR. MILLER: But to Pete's point, if the pass-  
14 through payments exceed the budget neutral amount, then  
15 there's a pro rata reduction. And I think we're not a  
16 position at this point to calculate whether it's going to  
17 exceed that; is that a fair statement? Is that what you're  
18 driving at, Pete?

19 MR. DeBUSK: Yes, it is. Is that set at 2 or 2.5  
20 percent?

21 DR. WORZALA: I'm going to be honest, I'm  
22 struggling in my mind whether it's 2 or 2.5 percent. It's

1 2.5 in 2003 and 2 percent in 2004 is my recollection, but I  
2 would need to double-check that.

3 But is your point that in 2002, for example, when  
4 there was a pro rata reduction that pass-through items  
5 should have been able to receive outlier payments?

6 MR. DeBUSK: I was just wondering, when I look at  
7 being neutral, we actually spent more money. Wasn't there  
8 an overrun of about \$600 million in 2002; isn't that right?

9 DR. WORZALA: In 2001, we know that there was  
10 considerably more spent, almost four times -- well, three  
11 times what was set aside. In 2002, I don't think we know  
12 yet. We need to look at the data to tell me.

13 MR. DeBUSK: There was a projection though of \$1.7  
14 billion right, initially? Isn't that right?

15 MS. BURKE: On pass-through.

16 MR. DeBUSK: On pass-throughs. But that was never  
17 actually reached. It turned to be something more like \$600  
18 million dollars.

19 DR. WORZALA: I honestly don't think we know yet.  
20 That number was the 2002 projection and I haven't seen any  
21 data from the 2002 claims to see how much was actually spent  
22 on the pass-throughs.



1           MR. DeBUSK: The biggest thing here, I guess, is  
2 we don't have any ability to look at what's happened after  
3 the program memorandum of January in regards to the  
4 statewide averaging?

5           DR. WORZALA: That's true. Yes, we don't have any  
6 2003 data on the outliers although potentially we could get  
7 the first three months or something of 2003.

8           DR. MILLER: Or to put it differently, to the  
9 extent that that problem was still in play it would be  
10 reflected in this data. To the extent that the program  
11 memorandum -- corrected anything, we have not seen the data  
12 to see what the effect is. I think that's your point.

13           MR. DeBUSK: Yes, that's fair enough.

14           MR. FEEZOR: Thank you, Chantal, a good  
15 presentation. A couple of things.

16           I guess I would echo Joe's comments that if it  
17 does look like we're going to be proceeding on this, some  
18 staff work around a dollar threshold, I think would be very  
19 helpful prior to going into that.

20           Secondly, when you breakout more information on a  
21 hospital-specific basis, my first instinct would be I'd love  
22 to know which are the financial or billing systems the

1 entities are using. That's probably not feasible. But  
2 perhaps hospitals that are under common ownership might be  
3 an interesting array. I won't say anything more.

4           And then third, follow up I guess on Mark's  
5 observation that it's largely maybe one or two procedures or  
6 issues we're talking about here. I wonder if some effort to  
7 sort of look into the future in terms -- and I mean near  
8 future, next three or five years -- of what might be  
9 evolving to the outpatient basis, so that we would have some  
10 idea whether it's going to be that limited.

11           And then the final thing is, I shared with one my  
12 colleagues on the Commission here that your back ground must  
13 have been with Aetna or an intermediary and the financial  
14 example that you used, you're off about \$100 that you have,  
15 the example used was not calculated properly. So you  
16 probably need to correct that.

17           DR. ROWE: I object.

18           [Laughter.]

19           MR. FEEZOR: And as a payer, I used to appreciate  
20 those.

21           DR. ROWE: That was the old Aetna.

22           DR. WORZALA: I apologize. Feel free to pass

1 editorial comments on paper.

2 DR. ROWE: A couple of points. One is I think my  
3 answer to the question of whether there should be an outlier  
4 for this is yes. I'm concerned about the fact that we don't  
5 want to have any payment policies that influence the site of  
6 care in a way that has care take place in other than the  
7 best place for it to take place. And if we have an outlier  
8 policy in the hospital and we don't have an outlier policy  
9 out of the hospital, and if some of these hospitals that are  
10 having a "disproportionate" share of outlier payments now  
11 because of the kind of things they're doing in the  
12 outpatient setting, which we think is the direction we want  
13 to go, it would start relocating those back into the  
14 hospital in order to get this protection. Then we would  
15 have set a policy up that was in the wrong direction.

16 So that's my concern. Maybe that's included in  
17 your reasons that you articulated and that you have in the  
18 paper but it's not said quite that way. I think that we  
19 should make sure that we're not setting policies that have  
20 that unintended effect. I don't know how big an effect that  
21 would be.

22 MR. HACKBARTH: Jack, but it may be that having an

1 outlier is conceptually reasonable for some types of  
2 outpatient cases but not others.

3 DR. ROWE: I would say so. After I would say yes  
4 to that, then I would certainly say yes to certain types of  
5 cases. I think that outliers for some of the simple things,  
6 like putting a cast on, might not be costs or patient-  
7 specific characteristics. They might be provider-specific  
8 characteristics. I mean, if they're particularly bad at  
9 doing something and they have to redo it over and over  
10 again. Or it may be another way to pay for medical  
11 education or something else. I don't know what would be  
12 driving the outliers in some of these fairly simple things.

13 So I would say what we want to do is we want to  
14 point out certain.

15 MR. MULLER: Was that a [inaudible] -- slur there?

16 DR. ROWE: No, I'm just imagining. I'm remember  
17 when I was a resident, I kept doing it. You're going to run  
18 this play until you get it right. So I would pick some  
19 complex things or look at the last payments in the past and  
20 choose the most important ones.

21 The other comment I would make while I have the  
22 microphone is I would not support the idea of taking Bob's

1 Ph.D. away. I think we might revisit his role as Vice  
2 Chairman of the Commission but not...

3 [Laughter.]

4 MR. MULLER: I'm also in favorite having an  
5 outlier policy. Remind me again, the loss on the patients  
6 was about the 15 to 17 percent range?

7 DR. WORZALA: You're talking about the margins?

8 DR. WORZALA: Yes.

9 DR. WORZALA: Yes, -15.

10 MR. MULLER: So to have a component, or whatever  
11 we called it yesterday, that on average has a negative  
12 margin of 15 percent, with all that caveats of Joe's about  
13 the cost allocation process, but still it's one in which  
14 there are considerable losses on average.

15 Secondly, in the example you gave of how the  
16 outlier works, even after the outlier payment in that  
17 particular case the hospital, the place was getting less  
18 than 50 percent of cost. So in a sense it mitigates some of  
19 the extreme losses but doesn't mitigate it very much the way  
20 the formula is calculated with that 2.5 times threshold and  
21 then the 45 percent of marginal cost. It's really a pretty  
22 modest payment for the wide variation in costs that could

1 occur, probably due to acuity and other things that we're  
2 going to understand more fully.

3           So to both have a program area in which there are  
4 considerable -- let's say there's a pretty high negative  
5 margin -- and the outlier policy doesn't go very far towards  
6 mitigating that loss in extreme cases. So from my point of  
7 view, this is a pretty damp outlier and it doesn't do much  
8 mitigation, especially if we're in favor of limiting the  
9 number of APCs to which it applies and perhaps not have some  
10 of the more narrowly defined APCs put into outlier policy.  
11 That's even more reason perhaps to focus the outlier on the  
12 ones that have more bundling going on, that have more  
13 variation and more range.

14           The examples you gave in the document that you  
15 sent us I think was very well done. It does indicate that  
16 some of these APCs are a little closer to DRG bundles. And  
17 I think focusing on the ones that are a little closer to  
18 that makes a lot of sense.

19           And so if we could, as we elaborate on this work  
20 over the course of the year, to get a little bit more  
21 information on the ones that have the more variation -- I  
22 think that's when Joe was asking in his initial comments --

1 I think would be very helpful. But I think we should keep  
2 reminding ourselves this dampens very modestly a program in  
3 which we already have considerable losses. So it really  
4 doesn't -- unlike the inpatient outlier policy where there's  
5 some evidence that CMS has responded to that considerable  
6 margins can be achieved through the outlier policy, positive  
7 margins can be achieved through the outlier policy, this  
8 just dampens a pretty considerable loss. It doesn't really  
9 , it strikes me from the evidence we have, put certain of  
10 these APCs into a high margin.

11 To go back to Nancy-Ann's point about the growth,  
12 the grown again, as we've shown over the course of the last  
13 few years, is much more technology driven and utilization  
14 driven and so forth. I don't think the evidence is as clear  
15 yet, if there's evidence at all, that there's high margins  
16 per procedure on this, as opposed to a considerable increase  
17 in utilization. So that the 18 or 20 percent increases that  
18 are going on, I would suspect are more utilization driven  
19 rather than high margin per case driven.

20 MR. HACKBARTH: Ralph, help me out. I think of  
21 this is as a distributive issue. These dollars wouldn't  
22 disappear, they would go back into the base. So with regard

1 to the overall average margin of hospitals for outpatient  
2 services, this is a neutral policy. Whether you have the  
3 outliers or not, or constrained or not affects the  
4 distribution of payments among types of hospitals, but not  
5 the overall margin.

6 MR. MULLER: Correct, but if in fact, if the  
7 outlier does what it's intended to do, which is act as an  
8 insurance policy on some cases in which there is extreme  
9 variation, then in fact having some kind of appropriate  
10 payment for those cases I think is an appropriate  
11 distributional effect. And therefore, having some of those  
12 APCs or the patients in those APCs have some of fair  
13 approximation of costs, I think is a fair way of thinking  
14 about it.

15 Even though in some of these cases the provider  
16 may be losing 80 or 90 percent on that, and that's not a  
17 good policy to have to be losing at that level. Because  
18 even as I say, in the case that Chantal gave, they were  
19 still losing about 60 percent or so, a 60 percent loss. So  
20 to have APCs that are that far off coming closer to break  
21 even, I don't think is a good distributional policy to have.

22 I follow your point but the reason that we have



1 outliers and have circuit breakers and so forth is to take  
2 into account the fact that they're still -- and since it's  
3 based on averages, there can be some considerable variation  
4 and there should be some accommodation for that variation.

5 MR. HACKBARTH: And I agree with that and I think  
6 that leads you to thinking about outliers in terms of the  
7 APCs where there is a potential for large variation in case  
8 costs.

9 MS. DePARLE: I just wanted to respond to that.  
10 Based on everything I've heard this morning, I'm not  
11 convinced there is such a strong rationale for an outlier  
12 policy here. If there is to be one, I think it should be  
13 more limited and specifying some dollar thresholds, I think  
14 that's what Joe and others have said here today. And I  
15 would hope if there's anything we can contribute to a policy  
16 that would help CMS to avoid the kind of problems that have  
17 occurred in the inpatient area, I would hope that we would  
18 do that.

19 I'm also troubled by the fact that we do not --  
20 that this is not available in other settings, where these  
21 same procedures are being performed. And we have said  
22 before that we wanted to create a more level playing field.

1 And so I like to be convinced that that's fair here.

2 DR. WORZALA: I just want to mention one thing  
3 that I didn't put in my presentation but was in the paper.  
4 In the proposal rule for 2004, CMS points out the case of  
5 the community mental health centers that provide partial  
6 hospitalization services. They did find pretty significant  
7 evidence that a subset of those providers were, in fact,  
8 gaming the outpatient outlier system. They found charges --  
9 well, it ended up that a subset of providers received as  
10 much in outlier payments as they were receiving in their  
11 base payments for these services. Then they were finding  
12 that the charges for the services for some of these  
13 providers were actually higher than an inpatient psychiatric  
14 stay.

15 So there's potential on the outpatient side, and  
16 it apparently has been acted on by some providers. And CMS  
17 has responded by proposing to set a higher threshold for  
18 that particular set of providers than for hospitals because  
19 they felt like it was a sufficiently isolated case.

20 MS. BURKE: I agree with much of what Nancy-Ann  
21 has said, although I do fundamentally believe in an outlier  
22 payment policy. I think the nature of a reimbursement

1 system that's based on averages suggests that in fact there  
2 are legitimate variances that must be dealt with if they are  
3 extreme, which suggests that -- has been proposed -- I think  
4 it is not only a question of a threshold amount which puts  
5 an institution at risk but it is also the variance that  
6 exists in the individual cases that I think has to be  
7 tracked.

8           So I think we would be well guided to look at both  
9 what a threshold would be, that in fact is a significant  
10 risk, where there is in fact variation, going to Joe's early  
11 point, what can we track in terms of those particular  
12 instances where this is warranted and reduce substantially.  
13 I mean, to suggest that it ought to be applied to all  
14 treatment is crazy by the nature of what goes on in those  
15 settings.

16           The other question, however, is this question of  
17 whether it ought to apply outside of an institutional  
18 setting to non-hospital based programs. And I don't know  
19 that I know what the right answer to that is.

20           I do think we have to be worried about setting  
21 different incentives, which is something we've talked about  
22 repeatedly over the last couple of years, that depending on

1 the setting we essentially -- by the nature of how we pay --  
2 lead people in certain directions. Although I was quite  
3 concerned, I noted that description of the mental health  
4 provider was frightening in terms of what the risks might  
5 be.

6 But I do think there needs to be some analysis of  
7 whether or not it should legitimately apply, particularly if  
8 we're able to narrow the types of cases that are, in fact,  
9 where there are huge variances that we may be able to  
10 control that in an environment that's not in the hospital-  
11 based environment. So I think all of those things ought to  
12 drive us in terms of further analysis and whether we can  
13 narrow it down. But I do fundamentally think we ought to  
14 have an outlier policy.

15 DR. REISCHAUER: I basically agree with Nancy-Ann  
16 also on where we should go with this.

17 I was wondering whether we had any information  
18 about how private plans pay for outpatient procedures and  
19 whether they have outlier types of mechanisms or a payment  
20 system which in practice makes adjustments for acuity and  
21 other kinds of things?

22 The other comment that I'd make is looking at this

1 outlier payments by hospital group chart, I wondered if we  
2 could do some more refined analysis here. Because the thing  
3 that leaps out at me is the proprietary line and the  
4 knowledge that few of those hospitals are major teaching,  
5 and many of them are in other urban locations.

6           And if you do your mental arithmetic here, you  
7 might find that the gap is really very, very large which  
8 then would raise a set of questions because of what we know  
9 about the inpatient abuses that have taken place with  
10 respect to outlier payments.

11           DR. WORZALA: I should note that charges are set  
12 for all payers by law and so you don't have a different  
13 charge for an refer ancillary service when it's provided on  
14 the inpatient side versus an outpatient side. So when  
15 you're talking about escalating charges, a lot of those  
16 charges apply on both sides of the line.

17           DR. REISCHAUER: Isn't the real question who pays  
18 charges? I mean, you know, Saudi princes?

19           MR. MULLER: The allegation in the inpatient was  
20 that some providers had doubled their charges overnight.

21           DR. MILLER: Also, with respect to Medicare, it's  
22 which services you choose to increase your charges on.

1           MR. MULLER: No, to take advantage of the cost of  
2 charge calculations.

3           DR. MILLER: Even if you have to charge it  
4 similarly, it's which ones you choose to set the charges  
5 high on, if you're trying to have an impact on Medicare.  
6 Although, in some of the stuff that went on, really the  
7 sense is that the charging practices that they were engaged  
8 in were actually to drive both Medicare and private pay  
9 outlier type policies.

10          MR. MULLER: Bob, the privates do have outlier  
11 circuit breaker-type policies. They are more inpatient  
12 focused than outpatient focused and they have different  
13 thresholds but they do exist.

14          DR. ROWE: You're referring to stop loss?

15          MR. MULLER: Yes. There's various kinds of  
16 circuit breakers. But I think one of the questions that  
17 we're starting with, to use the inpatient analogy, is when  
18 people inappropriately jack up prices 100 percent. I mean,  
19 one can make arguments that charges should go up two, three,  
20 four, five. It's a lot harder to say that when somebody  
21 takes over the hospital you have to increase the charges 100  
22 percent, as some of people did and the stuff that hit the

1 pass this summer. There's probably not much warrant for  
2 that, in terms of a cost structure, to increase your charges  
3 100 percent.

4 Then given how some of the modifications that CMS  
5 has made in the inpatient policy, tries to take that into  
6 account. Also there was some room to play with the  
7 hospital-specific cost-to-charge ratio vis-a-vis the state  
8 cost-to-charge ratio. So there clearly gaming going on  
9 there.

10 I agree with Nancy-Ann, we shouldn't have policies  
11 that invite gaming that quickly and unfortunately, one  
12 shouldn't necessarily throw out the whole policy just  
13 because there might be some people who game it. And  
14 obviously, having cost-to-charge ratios does invite that  
15 kind of gaming to go on whether one does it by looking at  
16 settings in which charges blow up by some unreasonable  
17 number and how do you define unreasonable and so forth,  
18 might be one way of dealing with it. But certainly that  
19 was, I think, what happened on the inpatient side.

20 DR. ROWE: Can I ask Nancy-Ann a question? Do you  
21 find my concern just unpersuasive or you don't think it's --  
22 you have so much more experience than the rest of us here in

1 this about relocating stuff back into the inpatient in order  
2 to protect themselves on outlier side. You don't think  
3 that's going to be a problem?

4 MS. DePARLE: I guess, in looking at the data that  
5 Chantal has presented, we have now what 600 APCs? This is  
6 more granular than any other payment system we have now.  
7 And you start to wonder are we even really bundling anymore.  
8 I guess I just have some questions about where we're going  
9 with this in general.

10 DR. NEWHOUSE: But then there won't be much  
11 variance.

12 MS. DePARLE: And therefore I don't find it as  
13 compelling, Jack, that we need an outlier policy in this  
14 setting as I do certainly in the inpatient setting. I  
15 didn't say that I -- I just said I wasn't convinced. I  
16 don't find it is convincing, especially when we look at some  
17 of the examples that Chantal gave. Obviously, we have to  
18 look at all of them. And an example of setting a cast for  
19 \$19, I hope she's going to tell us that she did not find any  
20 evidence that CMS paid outlier payments for that.

21 DR. REISCHAUER: But doesn't an inpatient one have  
22 a dollar threshold that's very high and so it eliminates



1 virtually all of these.

2 DR. ROWE: It's a stop-loss.

3 MS. DePARLE: I was there when we implemented  
4 this, so perhaps I should have seen that then, but I'm just  
5 saying it seems to me clearly that we need some sort of  
6 threshold for this. I don't think, even if you find Jack's  
7 arguments more compelling even then I did, you would not say  
8 that it should apply to everything, I think. You didn't say  
9 that.

10 DR. ROWE: I didn't represent that.

11 MR. MULLER: There is a threshold in there.

12 MS. DePARLE: Not in the outpatient. That's the  
13 problem, so it could apply to this setting a cast APC for  
14 \$19.

15 MR. MULLER: Well, 2.75, I'd call that a  
16 threshold.

17 MS. DePARLE: But that's a threshold of the  
18 payments. That's not a threshold of which things it should  
19 apply to. I guess I think that's what the outlier policy  
20 should be designed around.

21 MR. HACKBARTH: Nancy-Ann, what I hear you saying  
22 is if we do Joe's analysis and find for selected APCs that

1 there is a lot of variation, you wouldn't be opposed to an  
2 outlier policy in those limited cases. But you want  
3 specific -- not just across the board.

4 MS. DePARLE: I would be interested in a dollar  
5 threshold, as well, although if we find -- I mean, it's  
6 quite interesting, at least to people at this table I guess  
7 -- if we found that for something like the example the  
8 Chantal used, the \$19 procedure, there was that much  
9 variation, I would want to bring Karen and the equality  
10 people up here and say what's going on in some of these  
11 hospitals.

12 MR. HACKBARTH: We use variation and that's  
13 shorthand for variation beyond the control of the provider,  
14 so it's variation in the patient and the needs of the  
15 patient as opposed to just variation of what they're doing  
16 is ideally what we want.

17 MS. DePARLE: That's what we'd be looking for but  
18 I'd be very interested in knowing that, if that's the case.

19 MR. HACKBARTH: That's exactly the problem.

20 DR. WORZALA: I can just tell you, just as a  
21 cautionary tale, and I will certainly bring you back things  
22 that show the coefficient of variation by service. But as

1 Bob pointed out, this is all dependent on the data that the  
2 hospitals submit. And so all of these motivations are in  
3 there.

4 And I will tell you that there are  
5 electrocardiograms where the charges are \$140 in my dataset  
6 and that will be picked up as part of the coefficient of  
7 variation.

8 So in theory, we think that a small bundle should  
9 have lower variability, but I don't know that that's going  
10 to show up in the data because of all the motivations that  
11 are in play right now.

12 MR. SMITH: Very briefly, I found Jack's argument  
13 persuasive but persuasive at a very high level, which seemed  
14 to me that there ought to be a pretty high dollar threshold  
15 and perhaps some APC limitation. You're going to have  
16 distributional data both on amount and APC. That will give  
17 us some sense of how to constrain it. But it does seem to  
18 me that we have an access issue and we have a site of  
19 treatment issue if we don't have an outlier policy and  
20 there's no particular reason to do that if we can figure out  
21 how to narrow the universe to which it applies.

22 And I suspect that also argues for a similar

1 outlier policy in other outpatient settings. I doesn't seem  
2 to me we can argue that we're concerned about shifting  
3 treatment back into the hospital if we get rid of the  
4 outlier policy but we're not concerned about shifting stuff  
5 back into the outpatient department if we don't apply the  
6 outlier policy more broadly. So narrow it and expanded it.

7 DR. ROWE: Let me give you an example of what I  
8 was thinking about, just to be specific. I think it was at  
9 Duke University where some really fabulous guys developed an  
10 outpatient bone marrow transplant program, which is just a  
11 terrific idea because these patients are at risk for  
12 infection. You want to keep them out of the hospital. When  
13 you put them in the hospital you have to create an  
14 environment around them which makes believe they're not in  
15 the hospital, et cetera, et cetera. And I may have the  
16 details wrong, but I think it was at Duke. And I think  
17 their results are excellent.

18 The last thing you want to do is stem that kind of  
19 innovation because these are very sick patients and they may  
20 have some whatever, and have a bad experience and have the  
21 hospital say look, we can't afford this anymore.

22 So I'm thinking of this very high end stuff and I

1 don't know what the threshold is, but I'm trying to foster  
2 innovation is what I think we need to do with the policies.  
3 That's where I was coming from.

4 MS. DePARLE: I agree and I think I remember that.

5 Remember, there's also an issue though, and  
6 Chantal mentioned this, as to which procedures are  
7 appropriate for the outpatient setting and that's a separate  
8 issue. You talked about it a little bit in the paper. We  
9 didn't talk about it here.

10 DR. ROWE: [Off microphone.] We should let  
11 tomorrow's doctors decide that.

12 MS. DePARLE: I was going to say my view is that  
13 CMS has expanded it, perhaps not enough. Perhaps, both in  
14 the hospital outpatient setting and in the ASCs, there  
15 should be more flexibility there. That's a separate issue.

16 But also remember we're not talking about taking  
17 these dollars away from the outpatient hospital setting.  
18 We're simply saying, at least it's my belief, that they  
19 should be targeted towards truly appropriate cases. And  
20 what we're talking about here is defining those. And I just  
21 don't think that they have been defined adequately so far.

22 MR. HACKBARTH: I have Joe and then Ray, and then

1 I think we need to move on.

2 DR. NEWHOUSE: I certainly agree with Jack's  
3 intent, but to the degree there is an issue it's a much  
4 bigger issue than outliers. That is, there could be no  
5 variation within each APC, in which case there would be no  
6 need for an outlier scheme. But there could be quite  
7 different reimbursement for the outpatient setting than the  
8 inpatient setting. In which case payment policy could  
9 conceivably influence site of care. Whether it did or not  
10 is another matter.

11 Maybe at some point staff wants to look at the  
12 different payments for things that could go back and forth.  
13 We've seen the practice expense on the office, the ASC, and  
14 the outpatient department and the non-neutrality there. And  
15 we've seen some non-neutrality in the post-acute side.  
16 Maybe we should also look at it here. I don't recall seeing  
17 any data like that for inpatient/outpatient.

18 DR. STOWERS: I think I'm kind of saying what Joe  
19 was saying, but Jack, I see your example more as setting an  
20 appropriate APC for outpatient bone marrow rather than a  
21 variance between the cost of doing that from one patient to  
22 another.

1 DR. ROWE: Sure.

2 DR. STOWERS: I think that's where the innovation  
3 has to come, as in quickly bring in new APCs to cover new  
4 procedures. But I think it's important in this chapter not  
5 to get that confused.

6 DR. ROWE: Okay, I accept that. I think that's a  
7 good addition. I do think that when you're innovating, the  
8 variability in your experience is greater and it gets really  
9 hard, until you have a lot of experience, to set the right  
10 price. And so you're making it up as you going along.  
11 You're innovating and you really don't know.

12 So I agree with you that if you get the right  
13 price, then if you get enough cases and a reasonable  
14 variation around it, everybody will be okay. But early on  
15 you're putting some people at risk and that was really what  
16 I had in mind.

17 MR. HACKBARTH: Thank you, Chantal.

18 Next up is the work plan for ambulatory surgical  
19 centers.

20 MR. WINTER: Good morning. I'll be providing a  
21 brief update on the ambulatory surgical center payment  
22 system, discussing the factors we use to assess payment

1 adequacy, and presenting preliminary data on growth in the  
2 number of ASCs.

3 Medicare uses a fee schedule to pay for facility  
4 services provided in an ASC. The fee schedule divides  
5 procedures into nine payment groups and the rates for these  
6 groups are based on cost data from the 1986 survey of ASCs.

7 CMS conducted a new survey in 1994 but rates based  
8 on the survey were never implemented due to congressional  
9 action. The agency recently said that it has developed a  
10 new survey instrument, however it has not yet been fielded.  
11 CMS also said that it is exploring ways to revise the ASC  
12 payment system so that ASC rates are better aligned with  
13 hospital outpatient and physician office rates. This does  
14 not necessarily mean paying the same rate in each setting.  
15 It could mean using similar relative weights for services in  
16 each setting.

17 The annual update for ASC rates is based on the  
18 increase in the consumer price index for urban consumers.  
19 In March, the Commission recommended that the update for FY  
20 2004 be eliminated. The House Medicare bill would reduce  
21 the update by two percentage points from 2004 through 2008.  
22 The Senate bill has no such provision.



1           A full update of 2 percent recently went into  
2 effect for FY 2004. Medicare payments to ASCs totaled  
3 almost \$2 billion in 2002, the second consecutive year in  
4 which payments increased by 17 percent. This amount is less  
5 than 1 percent of total Medicare spending.

6           In March CMS published a final rule that updated  
7 the list of procedures eligible for Medicare payment when  
8 performed in an ASC. The rule added 300 new codes and  
9 deleted 144 for a new total of 2,400. The list had last  
10 been updated in 1995. CMS expects that these changes will  
11 expand the volume of ASC services and increase Medicare  
12 spending by \$5 million a year.

13           CMS assigned new procedures to one of the nine ASC  
14 payment groups by matching new codes to codes that are  
15 currently on the list based on their clinical similarity and  
16 use of resources. As I mentioned earlier, the current rates  
17 for these groups are based on fairly old cost data.

18           It is worth noting that CMS thought about ways to  
19 minimize disparities between ASC and outpatient rates for  
20 the same services when developing this rule. For example,  
21 they considered assigning new codes to the ASC payment  
22 groups that were most similar to the outpatient payment

1 rates for these codes. However, they decided not to use  
2 this approach because it could have resulted in new ASC  
3 procedures being paid different rates than similar  
4 procedures currently on the list.

5 In addition, CMS found that certain procedures met  
6 the criteria for inclusion on the list but would have been  
7 paid much more in an ASC than other ambulatory settings,  
8 even if placed in the lowest ASC payment group of \$340.  
9 Because adding these procedures to the ASC list could have  
10 created financial incentives to shift these services to  
11 ASCs, CMS excluded them from the list.

12 As we did last year, we will again assess the  
13 adequacy of Medicare payments for ASC services. Although we  
14 lack recent data on the cost of ASC procedures, there are  
15 several other factors we can use to judge the adequacy of  
16 payments which are listed here. We will look at the recent  
17 entry and exit of ASCs from the Medicare market on the next  
18 slide.

19 But before we get there, I want to mention that we  
20 have a research project underway with RAND that we hope will  
21 shed light on the quality of care provided in ASCs. One of  
22 the project's goals is to development measures that will

1 allow us to compare outcomes for services provided in ASCs,  
2 outpatient departments, and physician offices. These  
3 outcome indicators could eventually be used to assess  
4 changes in the quality of care provided in ASCs. Although  
5 this project will not be completed in time for the March  
6 report next year, we hope to be able to use the findings in  
7 the update process for FY 2006.

8           Our preliminary analysis of new data from the  
9 provider of services file shows that there is continued  
10 strong growth in the number of Medicare-certified ASCs. At  
11 the end of 2001, there were almost 3,400 centers. As of  
12 June 2003, there were over 3,700. The number grew by 6.7  
13 percent in 2002 and at an annual rate of 7.7 percent in the  
14 first half of 2003.

15           During 2002 over 300 ASCs entered the Medicare  
16 program while 83 closed or merged with other centers. Most  
17 of the new centers are freestanding for-profit entities  
18 located in urban areas. This is also true of existing ASCs.  
19 ASCs tend to be geographically concentrated. Over 40  
20 percent of centers are located in five states that account  
21 for 26 percent of beneficiaries.

22           As part of our study of specialty providers which

1 we discussed at last month's meeting, we will analyze the  
2 market factors that are associated with ASC location. The  
3 factors we plan to look include the presence of certificate  
4 of need rules, population growth, household income, and the  
5 supply of hospital beds and physicians.

6 This concludes my presentation and I welcome any  
7 questions or comments.

8 MR. HACKBARTH: Ariel, remind me where we stand on  
9 getting cost data? Is anything in progress or imminent on  
10 that?

11 MR. WINTER: In the rule this past March, in which  
12 CMS updated the list of procedures on the list, they said  
13 that they've completed a survey instrument but there's no  
14 information about when they plan to field that instrument.  
15 They do say that, based on prior experience, it takes about  
16 two years to field the survey, collect the data, audit it,  
17 and analyze the.

18 DR. REISCHAUER: This is a general comment about  
19 the way we structure these analyses, so this is to Mark as  
20 much as to you, Ariel. That is, I think we should preface  
21 always our discussion of entrance and exit into the  
22 importance of Medicare to that type of provider's business.

1 And if 5 percent of ASCs' business is Medicare, it's clearly  
2 not the Medicare tail that's wagging this dog, it's  
3 something else. And lots of people coming in and going out  
4 isn't really relevant, and access to capital is another  
5 thing that you should do the same way.

6 MR. WINTER: That's a good point and we estimated  
7 last year that Medicare accounts for about 20 to 30 percent  
8 of ASC revenue, but that's going to vary by the kind of  
9 ASCs. So ASCs that specialize in cataract procedures are  
10 going to much be higher, endoscopy could be lower.

11 MR. FEEZOR: Ariel, the factors again you're going  
12 to be analyzing in the market, CON, bed supply, physician  
13 supply, and there were a couple of others.

14 MR. WINTER: We talked about household income,  
15 median household income, population growth which could be a  
16 factor in where they decide to locate. Faster growing areas  
17 might be more attractive. We would also look at demographic  
18 factors, percent of non-white residents.

19 We're also going to look at the presence of other  
20 kinds of specialty providers like specialty hospitals and  
21 freestanding imaging centers.

22 DR. ROWE: [Off microphone.] Ariel, I think the

1 time has come to look at this differently. In the  
2 beginning, when there weren't that many of these it was fair  
3 to lump them. But now we're up over 3,000 and this is not  
4 one of these you've seen one redwood you've seen all the  
5 redwoods. They are very different kinds of facilities, some  
6 of them specialize, as you say, in cataracts, others in  
7 other kinds of procedures. They vary in their size. They  
8 vary in their ownership.

9 I think it would be helpful maybe even working  
10 with the professional organizations that represent these  
11 facilities, maybe they have a classification of them. Maybe  
12 the literature includes -- I don't follow this literature.  
13 But rather than just show us the volume blame changes in the  
14 3000, let's see if we can develop some subcategories that  
15 tell us something about what's really happening here from a  
16 policy point of view if we're going to try to make some  
17 suggestions.

18 I don't know what that categorization would look  
19 like, but I think it would be worth trying to develop one.

20 MR. WINTER: We did publish a table in last year's  
21 report on the breakdown of ASCs by their specialty based on  
22 industry data. What we're planning to do now is actually

1 look at what the distribution is based on their provision of  
2 Medicare services. So using Medicare data, what are those  
3 that specialize in ophthalmology procedures, endoscopy, et  
4 cetera. We also want to look at them by the number of ORs,  
5 which is provided in the provider services data and other  
6 characteristics.

7 MS. DePARLE: I feel like a broken record on this  
8 because I've said many times that I'm very uncomfortable  
9 with basing our assessment of the adequacy of Medicare  
10 payments to ambulatory surgical centers on 20-year-old data.  
11 I think it's really bad that CMS hasn't done the survey and  
12 that we don't have better data.

13 But that sad, if we are going to use other things  
14 as proxies, which we did last year, and it appears we're  
15 headed in that direction this year, I agree with Bob that we  
16 should try to be a little more precise about exactly what  
17 we're looking at. And to the extent that it's possible -- I  
18 don't know if it is possible Ariel -- but among the new  
19 entrants to the market, you've described several things that  
20 you're going to look at. I might suggest -- I don't know if  
21 you said physician supply as one of the things. Did you say  
22 hospital beds, too, in patient hospital beds?

1 MR. WINTER: Yes.

2 MS. DePARLE: So I might suggest that if there's  
3 any way to look at not just the importance of Medicare to  
4 ASCs in general, which you seem to indicate we have some  
5 data on, or on average what the ASC revenue is and how much  
6 of it is attributable to Medicare. But is it possible to  
7 look at that based on the new entrants, whether they are in  
8 fact following that same trend?

9 Because I've seen information at least anecdotally  
10 that would seem to indicate that they're not.

11 MR. WINTER: I'll look into that, whether we can  
12 address that.

13 MR. HACKBARTH: I share your concern, Nancy-Ann,  
14 about the lack of data. We really do not have much here on  
15 which to base a recommendation. The fact of rapid growth,  
16 in and of itself, is not necessarily a bad thing. It  
17 reflects changes in medical practice and may be good for  
18 patients, physicians. I'm not biased in anyway against  
19 doing more in ambulatory surgical centers. What makes it  
20 suspect is the fact that these rates are based on such old  
21 data. And then there was the added fact of the disparity in  
22 payment between what we pay for the hospital outpatient



1 department in an ASC. That's what sort of raised the  
2 potential flags about this.

3 MS. DePARLE: But it's not all in the same  
4 direction. Remember, we had that discussion before. Some  
5 of the rates are higher in an outpatient setting. Not all  
6 of them, but we did have that discussion before.

7 MR. HACKBARTH: And so it's frustrating to hear  
8 that we're going to be in essentially the same position in  
9 terms of hard information for at least the next couple of  
10 years. I wish there was something we could do about that.

11 DR. REISCHAUER: Do we have any information about  
12 how many of these ASCs, either new ones or existing ones,  
13 are not Medicare-certified? Because they don't have to be  
14 to serve Medicare folks. And a test of whether payments are  
15 adequate is whether they choose to serve them, particularly  
16 the new ones. And if they do, it would suggest that  
17 Medicare payments are at least covering marginal costs.

18 MS. DePARLE: [Off microphone.] For some  
19 procedures.

20 DR. REISCHAUER: Yes. But you either do or you  
21 don't, I would gather. So it's sort of on average.

22 MS. DePARLE: By an ASC doesn't have to do every

1 procedure. So it could be that you'd make the decision that  
2 for some things it's adequate, so you want Medicare  
3 certification. But I agree with you.

4 MR. WINTER: If I could just address that, the  
5 list we have is only for Medicare-certified ASCs. I don't  
6 have a list of those that are Medicare-certified and those  
7 that are not. I've heard from the industry that many of  
8 them, even if they're not serving any or many Medicare  
9 beneficiaries, do get certified because private payers  
10 require that or give some incentive for doing so.

11 Our numbers track pretty closely to numbers that  
12 have been published by an industry survey, so they not --  
13 they track very closely to that. So that would suggest that  
14 most, if not all, ASCs that are serving private payers  
15 exclusively are also Medicare-certified.

16 MR. HACKBARTH: Any others?

17 Thanks Ariel.

18 Next is a preliminary review of the information on  
19 SNFs, market factors.

20 DR. SEAGRAVE: Hello. Today I will present some  
21 preliminary information on recent trends in SNF market  
22 factors. I'm going to cover these five market factors that

1 we always look at.

2 First, I want to quickly address Bob's earlier  
3 comment, and just clarify something on this slide. When we  
4 look at SNFs entry and exit, we're looking at the entry and  
5 exit of Medicare certification only. We don't actually look  
6 at Medicaid-certified facilities. We look at Medicare only  
7 certified and Medicare/Medicaid. So we're looking at entry  
8 and exit into the Medicare program in this case.

9 With regard to SNFs entry and exit from the  
10 Medicare program, the 2003 data indicates that the trend  
11 that we've seen for the last few years continues. In the  
12 period 2002 to 2003, in the far right column of this slide,  
13 we see that the number of hospital-based SNFs participating  
14 in Medicare decreased by about 9 percent between 2002 and  
15 2003. And the number of freestanding SNFs participating in  
16 Medicare increased by about 2 percent for an overall  
17 increase among all SNFs of about 1 percent. These  
18 percentages are essentially the same percentages that we saw  
19 for the period from 2001 to 2002.

20 In 2003, the number of hospital-based SNFs  
21 participating in Medicare is about the same as it was in  
22 1993, I just wanted to point out. Part of the reason for

1 that, even despite the rapid decline in these facilities in  
2 recent years, is as you can see the percent change in the  
3 number of these facilities from 1992 to 1998 was 61 percent.

4 I also just wanted to show you that there has been  
5 some entry of hospital-based SNFs into certain areas as  
6 well. The numbers in the far left column represent the  
7 number of hospital-based SNFs in 1997 in hospital service  
8 areas. The numbers across the top represent the number of  
9 hospital-based SNFs in those the same hospital service areas  
10 in 2001. As you can see, about 92 hospital service areas  
11 that didn't have a hospital-based SNF in 1997 did have one  
12 by 2001. So there has been some entry.

13 As well, when we look at the number of beds by  
14 freestanding and hospital-based in these areas in 1997 and  
15 2001, we also find that freestanding SNF beds have perhaps  
16 substituted for some of the loss of hospital-based SNF beds.  
17 For example, in the 308 hospital service areas where there  
18 was one hospital-based SNF in 1997 and none left in 2001,  
19 the average number of freestanding SNF beds in those areas  
20 increased from 336 to 352.

21 Recall from the last meeting that a  
22 disproportionate number of hospital-based SNF withdrawals

1 from the Medicare market since 1997 have occurred among for-  
2 profit SNFs operating in urban areas. In addition, this  
3 chart shows that per diem cost tended to be higher among  
4 hospital-based SNFs that exited the Medicare program. The  
5 reported aggregate per diem cost in the hospital-based SNFs  
6 that left the Medicare program at \$321 a day in 1998 were  
7 about 43 percent higher than those of the hospital-based  
8 SNFs that remained in the program.

9           Moving on to our second market factor, the volume  
10 of SNF services, we can see that the volume of SNF services  
11 increased in 2001, the most recent year for which we have  
12 data on this factor, with total payments to SNFs increasing  
13 by about 22 percent, total number of discharges increasing  
14 by 6 percent, covered days increasing by 8 percent, and  
15 average length of stay increasing by about 2 percent.

16           We are still collecting information on recent  
17 trends in beneficiaries access to SNF services for 2003.  
18 OIG studies in 1999 through 2001, and the focus group of  
19 hospital discharge planners we held in October 2002 you may  
20 remember, all suggested that beneficiaries needing  
21 rehabilitation services generally had no problem accessing  
22 SNF services, but that certain patients with complex non-

1 rehabilitation therapy needs may have experienced delays and  
2 accessing these services. These patients may have stayed in  
3 the hospital longer in some cases, although it's uncertain  
4 whether this is a worse outcome for some of these patients.

5 I did want to mention the fact that we are still  
6 collecting information on this for 2003 and I hope to bring  
7 that to you in subsequent meetings. Also, the OIG now plans  
8 to do a study on access to SNF services, to be released  
9 sometime in fiscal year 2005. This is very good news for  
10 the future, although obviously it won't help in our analysis  
11 this year.

12 I wanted to bring you some preliminary information  
13 from our analysis of readmission rates on quality. As you  
14 can see, it doesn't look -- the measures that we have seen  
15 so far don't indicate big changes in the quality of care  
16 delivered in SNFs between 1999 and 2001.

17 I wanted to explain these five categories of SNF  
18 readmissions to the acute care hospital were analyzed by  
19 researchers at the University of Colorado Health Sciences  
20 Center and found to be the types of readmissions that were  
21 most preventable if SNFs were delivering quality of care to  
22 patients. We used the Colorado methodology and analyzed the

1 SNF readmissions for these years ourselves and we found that  
2 if you adjust -- I wanted to point out too that these are  
3 all adjusted for the case-mix of patients and based on the  
4 national average rates across all SNF admissions for these  
5 years.

6 We see small increases in the rates of  
7 readmissions for two of the five conditions, electrolyte  
8 imbalance and congestive heart failure, but virtually no  
9 change in the other three measures.

10 Finally I want to briefly discuss our preliminary  
11 findings on access to capital. As you know, the nursing  
12 home sector is a fragmented industry with only about 16  
13 percent of the beds accounted for by the top 10 largest  
14 chains. The nursing home industry is also dominated by for-  
15 profit companies, about two-thirds of nursing homes are  
16 owned by for-profit.

17 Access to capital for some has always been  
18 limited, particularly for small and nonprofit providers. In  
19 addition, equity issuances have been a source of capital for  
20 the nursing home industry in the past but there were no  
21 issuances in 1999 through 2001.

22 Publicly traded bonds were a source of capital for

1 this industry in the past and still are today but at lower  
2 levels. Furthermore, debt ratings have been downgraded,  
3 leading to higher interest rates charged to nursing homes  
4 for debt. Still, despite all of this, the stronger nursing  
5 home chains may still have continued access to capital.

6 Other sources of capital for this industry include  
7 bank loans, real estate investment trusts, and federally  
8 guaranteed loans of which about \$1.2 billion in fiscal year  
9 2002 were issued.

10 The bottom line for all of this is that the  
11 situation with SNFs' access to capital has worsened recently  
12 due in large part to reduced Medicaid nursing home payments.  
13 However, it was also due to the expiration of two temporary  
14 Medicare payment increases mandated by BBRA and BIPA and the  
15 increasing costs of liability insurance for nursing homes.  
16 Still, financial analysts continue to view Medicare SNF  
17 payments in a positive light. Fitch Ratings, for example,  
18 said in its recent analysis of the nursing home industry  
19 that it "views Medicare reimbursement favorably as Medicare  
20 is generally a profitable payer for most nursing homes."

21 I just wanted to mention that in the chapter and  
22 the next time, we will be discussing more about the



1 proportion of Medicare that's accounted for in nursing home  
2 payments.

3 This concludes my presentation. I welcome any  
4 questions the Commission might have.

5 DR. MILLER: If I could just say one thing  
6 quickly, your point about the Medicaid, the expiration, and  
7 the increasing costs of liability insurance, this is what  
8 the financial analysts are saying are driving their  
9 conclusions on capital?

10 DR. SEAGRAVE: Yes, that's right.

11 MR. SMITH: It might be useful to note, or at  
12 least ask the question, of whether or not the huge increase  
13 in SNFs between 1992 and 2003 has something to do with the  
14 decline in activity in the capital market in the past year.  
15 This is an industry which one might conclude had expanded  
16 too rapidly, there was overcapacity, and the capital market  
17 is reacting to that, or that and the changes in the payment  
18 system.

19 DR. ROWE: I have a general question but one small  
20 point first. Most studies, I think, of the admission rates  
21 showed that, in addition to congestive heart failure, hip  
22 fracture is a diagnosis that has a traditionally very high

1 readmission rate. Did that come up? I noticed that wasn't  
2 on your list.

3 DR. SEAGRAVE: Yes, the researchers in the  
4 University of Colorado very carefully chose these five  
5 admission rates.

6 DR. ROWE: These weren't necessarily the five  
7 highest?

8 DR. SEAGRAVE: No, they were chosen specifically  
9 because these were deemed if a nursing home could implement  
10 processes or perform their care and monitor the patients in  
11 such a way that they would have a pretty good chance of  
12 keeping these people out of the hospital for these five  
13 conditions.

14 DR. ROWE: Thank you, Susanne.

15 The question I had has to do with how do we  
16 approach a situation where the Medicare margin is positive  
17 or favorable, the overall institutions aren't doing well for  
18 other reasons, you know, Medicaid payments are down, access  
19 to capital is down, their ratings are down, their interest  
20 rates are up, whatever is going on, but if they go away,  
21 then access to their services is diminished for Medicare  
22 beneficiaries?

1           We don't want to go down a pathway of just paying  
2 more and more and more to keep them alive. On the other  
3 hand, there is the other hand. It seems to me it would be  
4 interesting, I know we dealt with this before, but here's a  
5 stark example. If you start with Bob's suggestion at the  
6 beginning of the chapter about how important are these, yes  
7 or no, it's going to be small proportion of their budget but  
8 it's going to be a big proportion of their margin if they  
9 have any, right?

10           MR. HACKBARTH: I think, Jack, you're actually  
11 restating a point that Dave made last year when we talked  
12 about the SNF update, expressing very similar concerns about  
13 access. The problem that we face is that given Medicare's  
14 low share of the total revenue base of SNFs, about 10  
15 percent as I recall, is that right Susanne, 12 percent?

16           DR. SEAGRAVE: 12 percent, yes.

17           MR. HACKBARTH: That's a very small base on which  
18 to rest the financial stability of a whole industry. But  
19 even more problematic than that from my perspective is that  
20 the tool that we have at our disposal is to increase  
21 Medicare payment rates. And it doesn't get the money to the  
22 right places. So the most money would go to the SNFs that

1 have the largest Medicare patient loads and the lowest  
2 Medicaid patient loads, and have the highest margins.

3 And so it is a very --

4 DR. ROWE: [Off microphone.] If you're talking  
5 about access, that's most -- --

6 MR. HACKBARTH: So it's a very poor tool to deal  
7 with what is perhaps a Medicaid problem principally. I'm  
8 sort of old-fashioned. I think if you have a Medicaid  
9 problem you ought to fix it in Medicaid as opposed to try to  
10 fix it with Medicare add-ons.

11 DR. ROWE: If you have a Medicaid problem, from  
12 the point of view of the budget of the institution. But  
13 we're here to serve and protect the Medicare beneficiaries.

14 MR. HACKBARTH: We're here also to --

15 DR. ROWE: So I'm a Medicare beneficiary and I  
16 can't get in a SNF and I call you. Are you going to say  
17 well, call the governor?

18 MR. HACKBARTH: We're also here to advise the  
19 Congress, that's our principal purpose, on what is the best  
20 policy for dealing with problems facing the Medicare  
21 population. And I don't think the best policy is to try to  
22 balance the books of a whole industry through Medicare

1 updates.

2 MS. RAPHAEL: I was just going to say, this is  
3 certainly a very, very important issue. But 19 states  
4 actually cut the Medicaid rates that they pay to nursing  
5 homes in this last fiscal year. So there's clearly great  
6 stress in the Medicaid system that finances nursing homes in  
7 this nation.

8 MR. HACKBARTH: And I wonder what would happen if  
9 Medicare says we'll assume responsibility for the welfare of  
10 the industry. If you're a governor facing a deficit, that  
11 seems like an invitation to further cut.

12 MR. DURENBERGER: The point would probably not --  
13 and I did not know it when I raised it and you re-raised it,  
14 the point in not is the Medicare program the answer? The  
15 point is are members of Congress an important part of the  
16 answer to the problem of adequate access?

17 It's more in how we deal with this issue in the  
18 advice that we give people where we see capacities strained  
19 or capacity declining that we can make a contribution with  
20 the kind of information that we've developed as it relates  
21 to all of these factors that she has laid out here.

22 I mean, I agree with you that it is difficult if

1 not impossible to use Medicare policy directly to accomplish  
2 it. But I think the members of Congress need to understand  
3 it isn't 19 governors or 19 legislatures alone who create  
4 problems in the decline in Medicaid revenues going to  
5 subacute or to nursing homes and so forth. It is a  
6 combination responsibility of policymakers at a national and  
7 a state level.

8 MR. HACKBARTH: Just one additional point. In the  
9 one area where we did have some reason to be immediately or  
10 more immediately concerned about access to care for Medicare  
11 beneficiaries is in the more complex patients. And in that  
12 instance we made a specific recommendation how to deal that  
13 particular problem, mainly reallocating the add-on dollars.

14 Now in fact, it wasn't accepted, but where there  
15 is a problem we tried to make a specific concrete  
16 recommendation.

17 DR. REISCHAUER: I basically agree with you,  
18 Glenn, on this issue but it is a bit more complicated  
19 because, of course, many people enter the nursing home as a  
20 Medicare patient and the benefit is of limited duration or  
21 their private sources decline and then become a Medicaid  
22 person in terms of being paid for. But they are still a

1 Medicare person when they go to the hospital or have a  
2 doctors visit or anything else as the primary payer. So it  
3 is a little bit more complex. If they don't have the care  
4 through Medicaid in the nursing home Medicare's spending on  
5 acute care services might rise.

6 MR. HACKBARTH: Others on this issue?

7 Okay, thank you.

8 Last is a similar update on home health.

9 MS. CHENG: Hello. This presentation is the first  
10 of three to develop our update recommendation for the home  
11 health sector for this year. Today I will cover three  
12 factors, beneficiaries' access to home health services,  
13 entry and exit of agencies from the program, and the  
14 agencies access to capital.

15 In my next presentation I'll be adding information  
16 on the volume of services and the relation of payments to  
17 costs. I also planned, in my next presentation, to add a  
18 new indicator of quality which I'd like to introduce to you  
19 today.

20 By way of context, I'd like to start with a  
21 description of the home health sector. This table shows you  
22 the composition of the 7,000 or so Medicare-certified

1 agencies in terms of the number of agencies. The categories  
2 refer, in the first case, to whether they are freestanding  
3 or whether they are based in a hospital, SNF, or other  
4 health care facility. In a second case it refers to the  
5 location of agency. And in the third case to the type of  
6 control of the agencies.

7 As you can see, most agencies are freestanding and  
8 many of them are in an urban setting. Many agencies are  
9 proprietary in this sector but not a majority. A small but  
10 significant number are operated by state, city, or county  
11 health agencies.

12 As part of our work on volume, what we can do is  
13 break the episode volume down into these categories if you'd  
14 like to see data on that kind of breakdown.

15 We have two questions regarding access to care for  
16 beneficiaries. First, are there providers in beneficiaries'  
17 communities, and can beneficiaries access those providers.  
18 This map is an indicator of the answer to the first  
19 question. It indicates that 99 percent of Medicare  
20 beneficiaries lived in an area that was served by a home  
21 health agency in the past 12 months as of May, 2003.

22 This suggests that access for beneficiaries, in



1 terms of whether there is a provider in their community, is  
2 very good. Some of the largest white areas on the map,  
3 indicating there were zero home health agencies, include  
4 deserts, swamps, and timberland.

5 The map is based on the zip code area of the  
6 beneficiary residents. In most cases, zip codes allow us to  
7 look at a sub-county level, although in some cases there are  
8 zip codes that will encompass more than one county.

9 The data is based on the zip codes as reported by  
10 the nurses or the therapist in the field as part of their  
11 patient assessment. Some providers have identified some  
12 discrepancies in the data as such as field reported. The  
13 database administrator at CMS has listened to these  
14 providers and received this data and eliminated where  
15 possible obvious discrepancies such as a provider in Florida  
16 who cared for a beneficiary in Nebraska.

17 This map may tend to understate the areas of  
18 service because it can only reflect where an agency actually  
19 delivered service. So if there was an area that it would be  
20 willing to serve but did not have a request to do so in the  
21 past 12 months, then it wouldn't show up as a service area  
22 for that agency on this map.

1           On the other hand, it may tend to overstate the  
2 service area of an agency because if an agency is only  
3 willing to serve a quarter or a portion of a zip code, then  
4 this map would reflect the entire zip code area as having  
5 been served. But that's a limitation of any time we try to  
6 describe service areas with a geographic unit.

7           MR. HACKBARTH: Sharon, on the first point that  
8 there simply was not a request for service, you may be able  
9 to deal with that a little bit by looking at multiple years?  
10 Is that possible? Are these data available for more than  
11 one year?

12           MS. CHENG: This is the first year we have this  
13 zip code level data. We could look at county level data and  
14 we could then use multiple years. One of the features that  
15 they're trying to maintain this database is to make it  
16 current so it actually rolls. So the 12-month period will  
17 roll forward, so it actually will contract that a little bit  
18 rather than expand it, as this database is developed.

19           In addition to most beneficiaries having access to  
20 one home health agency, as the map showed, we also found  
21 that most beneficiaries have a choice of providers. 97  
22 percent of beneficiaries lived in an area served by two or

1 more home health agencies.

2 Our second access question is whether  
3 beneficiaries can obtain care from the providers in their  
4 community. Our indicator for this is the most recent CAHPS  
5 surveys of beneficiaries. The proportion of beneficiaries  
6 who sought some home care and reported little or no problem  
7 with home health is about the same as the proportion who  
8 report they usually or always can make an appointment for  
9 routine care with a doctor or nurse, about 90 percent.

10 Of those who said they had a big problem, we do  
11 believe it appears that the problem was not an inability to  
12 obtain care because it seems that almost all beneficiaries  
13 who sought home care did receive it. We know that 7.5  
14 percent of the beneficiaries used home care in 2000 and this  
15 is very close to the number of beneficiaries who sought home  
16 care in that year. According to the CAHPS surveys, 7.7  
17 percent of beneficiaries sought some care, and we don't know  
18 how many of those beneficiaries were eligible for the  
19 benefit.

20 Our next indicator is entry and exit of agencies.  
21 In 2003 the number of agencies showed a very slight uptick.  
22 This year there will be about 7,100 agencies certified to

1 serve Medicare beneficiaries. Along with evidence that  
2 mergers and acquisitions have picked up pace, this suggests  
3 that there are more and possibly larger agencies in the  
4 program than there were at the beginning of the prospective  
5 payment system. The composition of the agencies certified,  
6 as described earlier, has remained essentially the same for  
7 the past four years.

8           This time series shows how the number of agencies  
9 has changed over the past 10 years. Today's number is about  
10 the same as it was in the early '90s before the pace of  
11 entries became quite rapid.

12           The final indicator I'll discuss this morning is  
13 access to capital. Access to capital is not a strong  
14 indicator for the home health sector. Access is determined  
15 more by the size of the industry and perceptions of risk  
16 than seems to be determined by the adequacy of Medicare's  
17 payments for this sector. The sector is small and the  
18 players in it are small compared to many that seek  
19 investors' dollars. Total expenditures in 2001 for home  
20 care services was \$33 billion, compared to \$450 billion for  
21 hospital care or even \$100 billion for nursing homes. The  
22 largest publicly traded home care company has only a 2 or 3

1 percent market share.

2           That said, Wall Street has a positive outlook for  
3 the industry, predicting that will outperform the S&P 500  
4 over the near-term. However, the publicly traded agencies  
5 have moderate ratings despite good margins and growth  
6 potential, usually due to perceived high risks for the  
7 sector from legal challenges such as subpoenas or  
8 legislative uncertainty related to the copay or a reduced  
9 updated in legislation. Medicare is noted in several of  
10 these industry reports as being the higher payer margin  
11 payer in the industry.

12           My final slide is a starting point for the  
13 national quality score we plan to bring you in the next  
14 presentation. The trend you see here is based on the scores  
15 for several activities of daily living and instrumental  
16 activities of daily living from a proprietary database of  
17 about 2.5 billion patient records. The score captures the  
18 average improvement or stabilization in a patient's  
19 functioning on each of these activities. Thus, if a  
20 hypothetical patient were to improve her ability to get  
21 around, stabilize her ability to dress her lower body while  
22 her ability to dress her upper body became more difficult,

1 the score would be one. This is the average of two points  
2 given for the improvement, one point for the stabilization,  
3 and zero points awarded for the lack of improvement on the  
4 third ability.

5           Since this score is an average of all of the  
6 patients in the database, and the goal of care for many  
7 patients is the stabilization and their ability to perform  
8 these tasks, we would expect the scores to cluster around  
9 one, which they do this chart.

10           MedPAC staff is working with the creators of this  
11 score and we plan to do a couple of different extensions.  
12 First, we're going to extend this trend back into time and  
13 look at 1999. That's before the implementation of the PPS.  
14 We're also going to take it forward to 2002, so that we have  
15 a year of PPS experience. We'll also expand the database  
16 from the proprietary database that this trend is drawn from  
17 to a national OASIS database. We will also review the  
18 outcomes that you see in this chart and we will make sure  
19 that the ones that we choose are policy relevant, clinically  
20 appropriate, and operationally sound.

21           With that, I'd like to take your questions on the  
22 data and especially your reactions to this score and any

1 changes you'd like to see to it. Thanks.

2 DR. NELSON: Sharon, I think that's very  
3 important, but there's a dimension that hasn't been dealt  
4 with with respect to the impact of payment policy on what  
5 the beneficiary can access in terms of home care. And that  
6 is the contraction of the menu of available services that  
7 agencies have adopted under financial pressures. Whereas  
8 they may have offered diabetes education, ventilator care,  
9 other labor-intensive services in the past, some of them  
10 have modified the services that they offer in order to  
11 maintain a positive bottom line.

12 What that results in obviously is an impact on the  
13 beneficiary that has to be taken into account in addition  
14 just to whether there is an agency available in their area  
15 and what their access to capital and so forth is.

16 MS. CHENG: I tried to nip at that a little bit in  
17 the paper to suggest that when we think about access there  
18 are really three dimensions. Is there a provider in your  
19 community? If there is, can you access that provider, can  
20 you get through their door -- or in this case can you get  
21 them through your door? And then the third would be once  
22 they're there, are you getting what you need? Do you have

1 access to the services once they're through the door?

2           The access measures that I have here, I really to  
3 think we're looking at the answers to question one and  
4 question two. And I guess what I'd like to do is run down  
5 the third question by looking at outcome scores like this to  
6 say all right if they're getting what they need then  
7 hopefully we're going to see a good outcome for that care.  
8 So let's look at changes in the outcomes. We're certainly  
9 going to have to adjust it for the severity of the patient  
10 because we think that the product is changing. But let's  
11 make sure that they've got a good outcome when they're gone.

12           DR. NELSON: But there may be a dimension of that  
13 in terms of what's desirable and not being provided,  
14 socially desirable, desirable from the standpoint of well-  
15 rounded care or whatever. When I'm suggesting is that it  
16 maybe that the trade associations or others can give you  
17 some information on services that formerly were provided  
18 when times were better and that no longer are being provided  
19 even though there may be a need or a perceived need for  
20 those services.

21           And the substitute for some of those, such as  
22 ventilator care, may be nursing home care. That is there



1 may be more expensive substitutes. And that needs to be  
2 taken into account with respect to our payment  
3 recommendations.

4 MR. HACKBARTH: Alan, have you seen some data on  
5 agencies reducing services or is this just your personal  
6 experience?

7 DR. NELSON: No, I've seen data but not across a  
8 broad universe. I've seen reports from an integrated system  
9 that has a home care presence. And whereas two years ago  
10 they were showing red ink, it's a well-run outfits so that  
11 they've made changes. The changes they've made have been to  
12 contract the menu of services that they offer in their home  
13 health product. And so now it again is in the black. But  
14 it's been at the expense of a reduced menu of services.

15 Now, how generalizable that is, I don't know.  
16 That's the reason why I raised this as a question. But it  
17 may very well be that the trade associations have collected  
18 data on how the menu of offered services has changed.

19 MR. HACKBARTH: In some ways, this takes me back  
20 to our conversation yesterday about bundling of physician  
21 payment, in that if you're talking about a bundle and a  
22 prospective system that creates an incentive to reduce

1 costs, even if an agency has a high margin and they think  
2 that this is a service that they can reduce without damaging  
3 their position in the market or reducing quality, they have  
4 the incentive to drop it anyhow even if they have a lot of  
5 money.

6 So it goes to the question of how important is it  
7 from a quality standpoint? And do we have quality measures  
8 refined enough to detect that sort of reduction in quality?

9 DR. NELSON: [Off microphone.] You may not be  
10 able to detect it in the short-term. That's my point. I  
11 mean, diabetes education is a case in point.

12 MR. FEEZOR: Alan asks exactly the question I was  
13 going to, and from my narrow geographic perspective, a  
14 similar observation and actually some -- as I look over the  
15 operation sheets of a couple of regional home health I have  
16 seen a significant contraction in the array of services.  
17 And I was just going to urge that we try to see if we can  
18 get any sort of measure on that.

19 MS. RAPHAEL: I think we have seen some site  
20 shifting because we see an increased in admissions to  
21 nursing homes, I believe, at the same time that admissions  
22 to home care were declining. So there may be some site

1 substitution, although I don't think we know enough to reach  
2 that conclusion.

3 I was going to make two points. One is that I  
4 would like to see some of the data broken down by type of  
5 agency because home health care is a very heterogeneous  
6 field and you have very small agencies and large public  
7 companies. And Wall Street is focused on the large public  
8 companies.

9 I think it is important to look at the whole array  
10 of agencies and how their faring, because I think what Glenn  
11 was commenting on before it is an issue that home health  
12 care agencies face in tandem with nursing homes, although a  
13 larger share of home health care payments come from  
14 Medicare. That is, those agencies that tend to serve  
15 Medicaid patients or the uninsured tend to have very low  
16 total margins although their Medicare margins are good.

17 And their survival or their ability to provide the  
18 whole panoply of services is at risk as Medicare payments  
19 begin to decline. So I think we need to keep that in mind  
20 because that can ultimately affect access in some of these  
21 areas where you don't have too many agencies currently  
22 available.

1 DR. STOWERS: I think a thought too, needs to go a  
2 little bit into changes in the package that came from CMS.  
3 The no IV drugs at home and that kind of thing now.

4 I've got actually a family member with  
5 osteomyelitis following a knee replacement that is going to  
6 have to spend six to eight weeks in the hospital getting IV  
7 drugs.

8 MS. RAPHAEL: We're the only ones in New York City  
9 still providing infusion nursing. Everyone else has left  
10 the marketplace. And we're doing it at a loss.

11 DR. STOWERS: So there's some other of those  
12 related access things, too, that might need to be looked at  
13 that are tremendously inefficient for the system.

14 MR. HACKBARTH: Is it on this point?

15 MS. DePARLE: Not on this point. I wanted to ask  
16 Carol her view of this quality measure and whether you think  
17 we're going in the right direction.

18 MS. RAPHAEL: Well, I am concerned about using  
19 this as sort of the benchmark for quality even though it's a  
20 large database. There are two areas where we're seeing some  
21 sort of patterns that I think are cause for concern. One is  
22 rehospitalization rates. Our rehospitalization rates have

1 gone up and our emergency room visit rates have gone up.  
2 Now we may be aberrational, but I consider those very  
3 important indicators.

4           And also, this has to do with the refinement of  
5 OASIS. We just believe that OASIS, and understandably, is  
6 very geared to what's measurable and very task oriented.  
7 And it doesn't pick up a lot of things that have to do with  
8 functional ability, cognitive impairments, that really can  
9 make a huge difference in whether you can rehabilitate and  
10 restore functioning.

11           So I just think there needs to be the next level  
12 of refinement of OASIS. I think it's done a very good job  
13 but we can't rest here and assume that it's really capturing  
14 all of the variables in terms of recovery and restoration of  
15 function.

16           DR. WAKEFIELD: Just a comment, Sharon, that I  
17 shared with you on the side the last time that we met. And  
18 that is I really like the use of the zip codes this time  
19 around because it gives us a sharper focus on one hand in  
20 some areas of the country than we had the last time we were  
21 looking at this data.

22           On the other hand, we lose some precision to the

1 extent that zip codes, as you indicate here and so I'm  
2 really pleased to see that recognition, we lose some  
3 precision when zip codes cover larger areas than a county.

4           For example, when you go out west --  
5 notwithstanding the fact Joe that yes, you do have Teddy  
6 Roosevelt State Park there on the western part of North  
7 Dakota, notwithstanding that -- some of our counties in the  
8 western part of the state are over 1,900 square miles.  
9 That's a pretty large area.

10           So if you've got a home health agency that's five  
11 miles over the border or 10 miles in or 15 miles in, just as  
12 an FYI, we lose the rest of the picture there. So you've  
13 got it identified but we do lose the rest of the picture.

14           And probably not a whole lot of folks out there  
15 maybe, but we don't know. And we don't know what proportion  
16 of folks that are out there are Medicare beneficiaries, for  
17 example, as opposed to 30-year-old ranchers, or whatever.

18           So it's just so important, I think, to have that -  
19 - I kind of like this western talk here.

20           So I think it's really important that we've got  
21 that caveat there because I look over here and I see 99  
22 percent of beneficiaries covered and that's terrific.

1 That's great, good news. And on the other hand, we don't  
2 really have the complete picture because we might just have  
3 parts of counties and even less than a county almost, now  
4 that we're using zip codes, reflected.

5 And we do have the home health add-on that's  
6 expired now, that provided some protection for rural home  
7 health agencies. And so I think it is going to be  
8 important, all of these things coming together, to track on  
9 that what impact that might have, if any.

10 I think in one of our earlier reports, for  
11 example, and I don't know where it's at now, but we saw that  
12 there were longer lengths of stay in rural hospitals. And I  
13 think we thought in part that might be attributable -- we  
14 didn't know for sure -- but in part that might be  
15 attributable to a lack of availability of post-acute care.

16 So we're casting abroad our net, in some  
17 instances. We've got a congressionally legislated add-on  
18 that's expired. And we know that there was something going  
19 on, at least historically, with those longer lengths of stay  
20 but we don't know exactly what they were due to. So it's  
21 just making sure that this is reflected to be as tentative  
22 as it is.

1           And at some point in time, maybe we can go back  
2 and look at what's happening to lengths of stay to give us a  
3 measure. I don't know. Maybe we could look at a couple of  
4 counties and drill down in a case study sort of a way and  
5 see what is really happening there. But I just wanted to  
6 make sure that those issues are adequately reflected at some  
7 point.

8           Then the question I've got for you is, we've got  
9 99 percent of beneficiaries covered and on our table one  
10 we've got a big problem for 12 percent for beneficiaries  
11 that sought access to home health care services. And that's  
12 statistically significant, a slight increase, but it is  
13 statistically significant. Do we know anything but that  
14 subset, that 12 percent? Do we have any characteristics of  
15 that population? It's small but the rise is statistically  
16 significant. Can we know anything about them?

17           MS. CHENG: I'd have to double check with Karen.  
18 This is the CAHPS data that we were talking about this  
19 morning, and I know we talked a little bit about how much  
20 you can slice and dice that. To the extent that we could,  
21 we'll give that a shot. I don't know what we'll be able to  
22 find out about that subset.



1 DR. WAKEFIELD: If you'd look, that would be  
2 great. Thank you.

3 DR. REISCHAUER: I wonder if we have spent too  
4 much time looking at institutions. This applies to the home  
5 health area, the SNF area. Do I really care whether the  
6 number of agencies has gone up or down? Or do I really care  
7 about where services are provided or available, and the  
8 number of services per unit of need over time?

9 I look at these things and you don't know if  
10 they're big or small, or are all the hospital-based SNFs 10  
11 beds and all the other ones 50 beds? What's happening to  
12 the total volume of services? And should we be really  
13 looking at a chart that shows the fraction of Medicare  
14 beneficiaries who receive this kind of service over time?  
15 And is it rising or falling? And maybe you could adjust it  
16 for the changing age composition of the Medicare population.

17 But in a way, the number of institutions doesn't  
18 really make any a difference at all, I don't think, to what  
19 we're concerned about.

20 MR. HACKBARTH: And I think in the past we've  
21 noted that that's a particular problem with home health  
22 because the elasticity of the units. What I hear you saying

1 is at some point the qualifications are so many that we  
2 ought to just stop doing them.

3 Others?

4 Okay, thank you, Sharon. We will now have a brief  
5 public comment period.

6 MS. FISHER: Karen Fisher of Association for  
7 American Medical Colleges.

8 I have four hopefully brief points. First, we  
9 appreciate the discussion on the outpatient outlier  
10 payments. In our comment letter submitted on the most  
11 recent proposed rule, we also pointed out the fact that with  
12 the current threshold the amount of absolute dollar costs  
13 that very high cost items would have to achieve to even  
14 qualify for an outlier payment is vastly different than a  
15 high-cost item. So we feel similarly to where the  
16 Commission is on that.

17 We also believe, though, that I don't believe was  
18 discuss this morning, that if you believe in the merits of  
19 an outlier payment policy then not only should you look at  
20 the threshold, but we believe the Commission should give  
21 some thought and discussion to the payment percentage for  
22 those services that meet the threshold. It's currently at

1 45 percent of cost above a threshold and CMS is proposing to  
2 move that to 50 percent. The inpatient payment percentage  
3 is 80 percent.

4 We believe if these are legitimate high-cost,  
5 extraordinarily high-cost, services that merit an outlier  
6 payments and the hospital has to eat the cost up to the  
7 threshold, that to be consistent with the inpatient system -  
8 - and it's just a matter of fairness -- that that payment  
9 percentage should be increased.

10 On two related but separate items, we're concerned  
11 about the expiration of the transitional corridor payments  
12 that occur at the end of 2003. Our look at the data, those  
13 transitional corridor payments were meant to be a three-year  
14 set of cushion payments so that no hospital would fare  
15 extraordinarily poorly when the PPS was implemented. Our  
16 analysis of the data and hearing from some of our members,  
17 they are relying a fair amount on those corridor payments  
18 and are concerned about what will happen when those corridor  
19 payments end at the end of 2003.

20 I think it would be useful for the Commission to  
21 examine those payments for multiple purposes. I think it  
22 was a useful mechanism at the implementation of a new

1 payment system and then to see what goes forward.

2           Finally, in terms of the suggestion about  
3 encouraging innovation in the outpatient system, I'd like to  
4 raise an issue to you that has perplexed us over the past  
5 several years. That is the outpatient payment system  
6 contains an inpatient only list. And that is a list of  
7 services that CMS has determined will not be paid for by  
8 Medicare if performed in an outpatient setting. They are  
9 deemed to be provided for only on the inpatient setting.

10           We have had problems with this list from the get-  
11 go. First of all, we believe that there are other checks  
12 and balances for determining when care can appropriately be  
13 moved from the inpatient to the outpatient setting. So we  
14 believe the role of CMS even in this setting is not  
15 necessary.

16           That being said, the criteria for which CMS  
17 determines when a service moves from the inpatient setting  
18 to the outpatient setting is perplexing. Because this area  
19 issue arose to me at the meaning I don't have the exact  
20 detail, but as I recall the criteria was a significant  
21 number of hospitals had to be performing the service on an  
22 outpatient basis in order for it to be moved from an

1 inpatient to an outpatient basis.

2           That doesn't make sense when you're looking at it  
3 from a major teaching hospital perspective where these  
4 services will first be performed. They have to start  
5 somewhere, the outpatient setting, before they can be  
6 defused to other places. So for basing your criteria to  
7 move it off of the list that you have to have a significant  
8 number of hospitals providing it, doesn't make sense to us  
9 and we think could quell innovation in that area.

10           So we think that is a straightforward type of a  
11 potential recommendation for the Commission that we'd like  
12 you to consider. Thank you.

13           MS. SMITH: My name is Elise Smith, and I'm with  
14 the American Health Care Association. I have just three  
15 points.

16           First, a comment on the issue of the possibility  
17 that skilled nursing facilities are actually increasing.  
18 Our association has somewhat different data. We have OSCAR  
19 data that seems to suggest that, in fact, the certified  
20 facilities are decreasing. We have a number of about 17,  
21 014 from June '99, going down to about 16,347 in June of  
22 2003. We will provide our data and hopefully discuss this

1 issue with the MedPAC staff.

2 But I bring it up here because I just want to  
3 remind you of the phenomenon out there that if you think you  
4 are seeing an increase in certified units or beds, it may be  
5 in great part due to the increase in dual certification.  
6 There are states out there that are on an increasing basis  
7 requiring Medicaid nursing homes to provide Medicare and  
8 vice versa. So we believe that this phenomenon, if indeed  
9 it exists as an increase, may be in part due to that. We  
10 just bring your attention to that and we're going to try and  
11 find out more information about that.

12 My second point is the issue of capital access.  
13 It doesn't really matter who might, in numbers, dominate  
14 this industry. I simply wish to bring your attention to the  
15 fact that the capital access problem is widespread  
16 throughout the entire sector, affecting multis, affecting  
17 SNF freestanding facilities, both for-profit and nonprofit.

18 Just one sentence out of the CMS market report,  
19 the outlook for the smaller and not-for-profit facilities  
20 may be bleaker compared to the larger for-profit facilities.  
21 That starts on page 21. And if you want some pretty bleak  
22 details and a bleak picture, you will find it --

1 unfortunately, you will find it there.

2           Last, but not least, the issue of total margins.  
3 Ms. Raphael's comments on trends in Medicaid rates regarding  
4 nursing homes is crucial. It is an increasing problem, as  
5 you all know. You only have to look at the latest Kaiser  
6 report to see some pretty bleak trends. Not a day goes by  
7 on Capitol Hill that there isn't a hearing involving the  
8 increased Medicare crisis.

9           What is the bottom line with all of this? Well,  
10 as you probably would see it coming, what I want to  
11 emphasize is that the focus should be on the health of the  
12 entire sector, and that requires looking at total margins.  
13 I believe Jack Ashby yesterday said that you have looked at  
14 total margins in the hospital arena for context. At a  
15 minimum, we would appreciate the same contextual approach.  
16 But really, we believe that the time has come to try somehow  
17 to move towards an analysis of total financial health not  
18 only of the SNF sector but all of the provider sectors.

19           Thank you for your attention.

20           MR. FENIGER: Randy Feniger with the Federated  
21 Ambulatory Surgery Association. We're the largest trade  
22 group of ambulatory surgery centers. And just a few

1 comments and observations on the work plan that was  
2 discussed earlier.

3 First, as you look at reasons for growth in the  
4 industry, I think it's very important to look at the change  
5 in medical technology and anesthesia techniques over a  
6 period of time which has certainly contributed to the  
7 ability to move things from more complex inpatient settings  
8 to settings of outpatient ambulatory surgery-type  
9 arrangements.

10 Look at the efficiency of the ASC versus the  
11 hospital for the same service. If the hospital takes an  
12 hour to turn around the endoscopy suite for the next  
13 patient, and you can turn the same room around in your ASC  
14 in 10 minutes, the efficiency will drive the doctor and the  
15 patients into that environment. So I think that's a very  
16 important issue to consider as you do.

17 Also, from the point of view of the physicians,  
18 their control over the quality of the service that is being  
19 delivered. They have control over staff, other kinds of  
20 things that they think are important, that they may not have  
21 in a hospital setting. So I think those are issues that  
22 should be incorporated as you go forward and look at that.



1           The regulatory environment at the state level is  
2 extremely important in the distribution of ASCs, and it's  
3 critical that you look at that very carefully. And also,  
4 measure -- since Medicare is a static rate across the  
5 country, distribution is going to be driven in large part by  
6 the private insurance climate in given parts of the country.  
7 Those that favor ASCs, you're going to find more use of  
8 them. Those that tend not to, you will probably find a  
9 different distribution. So we would encourage you to  
10 incorporate some of that analysis within your work.

11           As you look at access to capital as a measure, and  
12 I know we went around on this issue last year as a proxy for  
13 determining why the industry was growing, there really are  
14 two different capital markets you have to look at. One is  
15 publicly traded companies like AmSurg and some of the others  
16 who are essentially going to Wall Street to get their money.  
17 But a group of doctors who finances something locally,  
18 through the local bank, that's a different capital market.  
19 And I think you really need to look at both.

20           I think that gets to the point was made earlier  
21 about not considering ASCs as a lump, as one thing. They

1 are different. They're different in their structure.  
2 They're different in their specialization. All of these are  
3 factors that I think should be incorporated.

4 We are more than happy to work with your staff to  
5 offer up what information we have that may assist in that  
6 differentiation, so you get a clearer picture of what's  
7 going on in the various sectors within the ASC industry.

8 Once again, we come back to gee, we have no data.  
9 We had none last year. We don't have any this year. And  
10 that complicates your analysis. The analysis is also  
11 complicated because you have an archaic payment system with  
12 a very limited number of buckets for payment compared to  
13 hospital outpatient department, inpatient DRGs, or any of  
14 the others.

15 This has prompted the industry, and Mark and Ariel  
16 were at this meeting, to talk to Congress and the conferees  
17 and now make a proposal to actually identify a way to  
18 collect data. We don't think the survey is probably ever  
19 going to get done. We have to find some alternatives.

20 And then, using that data and subsequent analysis  
21 of that data, to have CMS make recommendations to Congress

1 for changes both in the payment structure for ASCs as well  
2 as the coverage rules.

3 So this is a proposal that we, as an industry have  
4 put forward to Congress. Time will tell if they accept it,  
5 but we think that there is general agreement across the  
6 industry that what we have today is not working as well as  
7 it should. It needs to be changed. The fact that it hasn't  
8 been changed over these many years, well there's nobody to  
9 blame for that. It just hasn't changed.

10 But I wanted you to know that we have made this  
11 recommendation as an industry and we look forward to working  
12 with your staff again and with the members of the  
13 Commission. We invite all of you to visit your local ASC,  
14 and not as a patient, but as a visitor on a guided tour. We  
15 will arrange that for everybody, even in those most rural  
16 parts of America. I'll find one.

17 DR. WAKEFIELD: [Off microphone.] Or build one.

18 MR. FENIGER: You know I can find anything in a  
19 rural area, if I have to.

20 And we appreciate your consideration of these  
21 comments and look forward to working with you and the staff.

1 Thank you.

2 MS. ST. PIERRE: Mary St. Pierre with the National  
3 Association for Home Care.

4 I just wanted to let you know that we would be  
5 very, very happy and pleased to work with MedPAC on  
6 analyzing the data and looking at those areas within zip  
7 codes where there may not be the appropriate access to  
8 service that the beneficiaries need. We have close contact  
9 with the state associations and they are always ready and  
10 willing to help with projects like that.

11 I also want to let you know that NAHC has analyzed  
12 over 6,000 home health agency cost reports and we have that  
13 information that we're very happy to share with you. This  
14 is a project that we will continue to engage in for an  
15 indefinite period of time.

16 I think that the information that we have obtained  
17 in analyzing these cost reports shows a potential growing  
18 problem as far as margins for home health agencies that  
19 there is a large number of home health agencies that are in  
20 the red and an increasing number in the next year that will  
21 be in the red with the reduction in payment and we're

1 particularly concerned about the loss of the rural add-on.

2 I also wanted to mention that as the OASIS queen  
3 at the National Association for Home Care, I receive  
4 questions every day about how do I answer this particular  
5 OASIS item. And so I would be very pleased to volunteer my  
6 services to help in identifying which of the outcome  
7 measures may be more appropriate, where you're getting  
8 better input from the providers, more accurate input from  
9 the providers, that give a better management to the outcome  
10 and the care that they're given.

11 Thank you.

12 MR. HACKBARTH: Okay. Thank you very much and we  
13 meet next in December.

14 [Whereupon, at 11:59 a.m., the meeting was  
15 adjourned.]