MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Tuesday, January 10, 2006
10:04 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
NANCY KANE, D.B.A.
RALPH W. MULLER
ALAN R. NELSON, M.D.
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: While we're getting finally settled, let me begin. Welcome to all of our visitors for the public session. This is the meeting at which we vote on recommendations for our March report, and all of those votes will occur at some point today. Most of them relate to update for the various payment systems, but then there are a series related to the RUC process for the relative value system for physicians.

I'd like to note, Sheila Burke is absent today and she wanted me to be sure to mention that it is an unavoidable absence. She knows this is an important meeting but the Board of Regents for the Smithsonian scheduled on very short notice a meeting that she absolutely had to attend, so she could not be here.

I think that covers everything I need to say at the beginning, so the first issue of the day is the assessment of payment adequacy for hospitals.

* MR. ASHBY: Good morning. Our first of several sessions today on the adequacy of payments in the fee-for-service sector will address payments for hospital inpatient and outpatient services. I would remind you as we start

that we assess the adequacy of current payments for the hospital as a whole, encompassing hospital-based home health and SNF, inpatient and psych, and graduate medical education, along with acute inpatient and outpatient services. Our session this morning will conclude with a discussion of outpatient hold-harmless payments.

Summarizing from our last two meetings, we found that most of the Commission's indicators of payment adequacy are positive. We've seen a net increase in the number of hospitals, as well as an increase in hospital service capacity in recent years. And volume is increasing, including both inpatient admissions and outpatient visits, along with increases in case-mix index for both inpatient and outpatient services.

Our quality of care results are mixed with mortality and process measures generally improving, but with mixed outcomes for patient safety.

Finally, access to capital is good as most directly evidenced by the substantial increases in hospital spending for new and expanded services in recent years. The hospital industry is experiencing an almost unprecedented construction boom.

This is a good place also to remind you that Medicare pays separately for capital expenses in the acute inpatient PPS, so our update recommendation will apply to operating payments only, which encompass about 92 percent of the total on the inpatient side, and to the single base rate encompassing both operating and capital expenses on the outpatient side.

This next slide updates our overall Medicare margin estimates from the December meeting. The margin in 2004 was minus 3.0, as we said in December. But we have updated our projected margin for 2006 from the preliminary number presented in December, minus 2.0, to the minus 2.2 that you see here. This 2006 projection, by the way, reflects the impact of 2007 policy other than the updates that we are deliberating today.

We've also assessed the impact of the Deficit Reduction Act and found that it would have a very small, positive effect on our 2006 projection, less than 1/10th of 1 percent. A number of the Deficit Reduction Act provisions affect hospitals, but measured in aggregate terms across all hospitals and all payments none of the provisions has a large effect, and we also have some offsetting increases and

decreases.

However, while the overall effect is not enough to change our projection of minus 2.2 percent, the effect on rural hospitals is more pronounced, raising their margin by about 7/10ths of 1 percent. This comes primarily from changes in the Medicare-dependent hospital program which gives additional inpatient payments to qualifying rural hospitals -- this was not done budget neutrally -- and to extension of hold-harmless payments which avoids a reduction in outpatient payments for certain rural facilities.

Turning to hospitals' cost growth, the rate of increase in hospitals' unit cost using a measure that reflects all services across all payers was unusually high in 2002 and 2003, but moderated to 4.5 percent in 2004. This figure averages higher growth for inpatient services and quite low cost growth for outpatient care. Several preliminary sources suggest that the rate of increase will be between 4 percent and 5 percent for 2005.

Although moderating in 2004, the high cost growth of the preceding two years still impacts our margin estimates. Two broad factors appear to explain these large cost increases. First, hospitals faced unusual cost

pressures at the time, such as high wage growth attributable in large part to a shortage of registered nurses, a spike in malpractice insurance premiums, and high growth in ancillary service costs, particularly medical supply costs which may be influenced by increased use of expensive devices.

But the second factor behind the unusually high rate of cost growth is a lack of financial pressure from private payers. Over a 20-year period we have found that costs grew slowly when hospitals were under significant pressure from the private sector to control their costs, and grew faster when that financial pressure diminished. Since 2000, the financial pressure on hospitals has dropped considerably, as evidenced by an 11 percent increase in the private payer payer-to-cost ratio to the highest level of private-sector profitability that we have seen in the last decade. That coincided with the largest cost increases that we have seen since the early 1990s.

In two other analyses relating to hospitals' Medicare margins we found first that hospitals with consistently negative Medicare margins have lower occupancy, higher costs and higher cost growth compared with positive margin hospitals. We generally found that the facilities

are not competitive in their own markets, as evidenced by higher cost and lower occupancy compared to neighboring PPS hospitals.

Second, we found that the roughly one-fifth of hospitals with consistently high costs pull down the industry-wide Medicare margin by more than two percentage points.

Now Craig will overview some new material on hospital occupancy rates.

MR. LISK: At the last meeting you requested some information on hospital occupancy rates. Specifically, you were interested in the relationship between financial performance and hospital occupancy rates as well as what has happened to hospital occupancy rates over time. A brief discussion of hospital occupancy rates has been included in the hospital chapter of the March report.

In this analysis hospital occupancy rates are measured as the ratio of total inpatient bed days to total available bed days in the hospital over the cost reporting period. Theoretically, bed days available is supposed to be staffed beds that are available for inpatient services. That is, staffed in the sense that the units are open and

operating, but it does not necessarily mean they are staffed for a full patient load in that unit on any given day. Our analysis of occupancy rates also excludes critical access hospitals.

Hospital occupancy rates have been rising since 1997, as you can see in the chart. On the chart we show the trend in occupancy rates for urban and rural hospitals, and as you can see they have risen for both groups of hospitals. Urban hospital occupancy rates have risen from 57 percent in 1997 to 64 percent in 2004, a seven percentage point gain. For rural hospitals occupancy rates grew from 44 percent in '97 to 48 percent in 2004, a four percentage point increase. As you can also see then, occupancy rates in the aggregate are much higher for urban than rural hospitals in 2004. There was a sixteen percentage point difference.

Now if both urban and rural hospitals were at full capacity we would not necessarily expect rural hospitals with their smaller size to have occupancy rates as high as urban hospitals because they need to be able to adjust for the greater variation in patient volume that comes their way.

The second issue we wanted to discuss was the

relationship between occupancy rates and financial performance. In this analysis we simply divided hospitals into groups based on their occupancy rates and looked at their margins, dividing them into four equal groups, into quartiles. What we see is the hospitals with lower occupancy rates, those in the bottom quarter, have lower Medicare and total all-payer margins than hospitals in the top quarter of hospital occupancy rates, and we see that trend goes through all four quartiles.

For example, in 2004, the aggregate overall Medicare margin for hospitals in the bottom quartile of occupancy was seven percentage points lower than the hospitals in the top quartile of occupancy rates. We see a similar relationship, although a smaller difference, for total all-payer margins with hospitals in the bottom quartile having lower margins than hospitals in the into top quartile.

Interestingly, however, this relationship between occupancy rates and financial performance only holds for urban hospitals. We do not see any clear relationship for rural hospitals, which may partly be due to their greater role of hospital outpatient departments play in their

business as well as post-acute care departments.

So with that we'll move back to Jack.

MR. ASHBY: This brings us to our draft update recommendation. Our assessments of access to care, volume growth, quality, and access to capital generally present a positive picture, but we remain concerned about the trend in Medicare margins. Yet our analysis suggests that more efficient hospitals may not be performing as poorly as the industry's aggregate margin would suggest. Our draft recommendation balances these considerations.

It is that the Congress should increase payments for the hospital inpatient and outpatient PPS's by market basket less half of expected productivity growth. Our current productivity factor is 0.9 percent based on the 10-year average of total factor productivity growth in the general economy, so the update would be market basket minus 0.45 percent. The update in current law for both inpatient and outpatient services is market basket even.

This recommendation would reduce spending for fiscal year 2007 by $50- to $200 million for outpatient services, and $200- to $600 million for inpatient services. And then over five years by less than $1 billion for

outpatient, and from $1- to $5 billion for inpatient.

Finally, we expect the recommendation to have no effect on hospitals' ability to furnish care to Medicare beneficiaries.

At this point we turn to Dan who will discuss the outpatient hold-harmless payments.

DR. ZABINSKI: An issue the Commission discussed at the November and December meetings is our finding that without hold-harmless payments the financial performance of rural hospitals under the outpatient PPS would be much worse than their urban counterparts. The problem facing the rural hospitals is that the hold-harmless payments expired at the end of 2005.

Another topic we discussed in November and December is our data analysis that reveals that low outpatient volume appears to contribute heavily to the relatively poor financial performance of rural hospitals. Based on that finding we believe that the most targeted policy for addressing the relatively poor financial performance of rural hospitals is a low volume adjustment in the outpatient PPS, and we discussed the possibility of recommending a low volume adjustment.

However, as we were analyzing this issue other policies addressing the poor performance of rural hospitals have been developed by other parties. In particular, CMS began using in 2006 a policy that increases outpatient PPS payments for sole community hospitals located in rural areas. These hospitals had been eligible for hold-harmless payments. Also, both houses of Congress passed the Deficit Reduction Act which provides for nearly full hold-harmless payments from 2006 through 2008 for rural hospitals with 100 or fewer beds.

Now because of the following three points, first that because the policy environment has changed and is still a little bit uncertain; second, because the two policies listed on this slide recoup most of the revenue that rural hospitals lose from the expiration of hold-harmless payments; and finally, because the Commission did not reach a consensus on how to address the financial circumstances of rural hospitals under the outpatient PPS we have decided for the short-term to postpone any recommendation that addresses the relatively poor financial performance of rural hospitals under the outpatient PPS.

Now I turn things over to the Commission for their

discussion.

MR. HACKBARTH: Thanks. Just a couple clarifications. Jack, right at the outset you distinguish between the inpatient update and the capital update, and we're voting on the inpatient. Just so all the commissioners are sure to understand, could you just explain a little bit more about the process for the capital update and how that happens?

MR. ASHBY: The capital update is not set in law, so it is set annually by CMS and generally it is set in the neighborhood of the increase in the capital market basket. We have assumed that level of increase in doing our projection.

MR. HACKBARTH: Let me just do another clarification or addition to what Dan was saying about the rural hold harmless. Last time when we discussed that issue the discussion focused on two questions. One is the nature of the adjustment; how low in volume was low enough to qualify for the additional payment? Then the second was the distance requirement; how far must a rural hospital be away from the next provider of services in order to qualify for low volume adjustment?

As Dan indicated, we talked about both those issues. There was not a clear right answer to either one of them, at least not evident to me. So rather than having a bold-faced recommendation, what we envision is discussing those issues in the text and some of the pros and cons of a low volume adjustment.

Then my last clarifying point relates to the draft recommendation on the update. Jack, the way it reads currently is, hospital market basket index less half of expected productivity growth for 2007. I'd like to suggest a change in wording to say, less half of the productivity expectation. The point that I'm trying to make clear here is that our productivity number has always been a policy expectation as opposed to an empirical estimate of improvement in hospital productivity. So it's a policy factor as opposed to an actual estimate. The way this reads right now it sounds a little bit like it's an actual estimate of productivity growth.

Do people understand the change I'm proposing and why? People feel comfortable with that?

MR. MULLER: I'd like to talk the adequacy determination as well as the market basket update. Our

findings, both in the presentation today and in the material that was sent to us indicate that payments are adequate because access and the other indicators we look at are good. But we also know from the material that we were presented and you've given us, again a lot of this is due to the fact that payments in the private sector are really carrying the hospital sphere. So I think it's much more likely that whatever adequacy we have is coming from the private sector and masking or covering the inadequate payments in Medicare.

The chart that we have and the text that you gave us show that the margins have been declining steadily since 1997, both the overall Medicare margin and the inpatient margin. There's probably not much reason to think it won't continue to decline in the year that we're forecasting. So whether we're at the minus 3 we were at in 2004 or the minus 2.2 we're forecasting for 2006, I would say when you have nine years of declining margins and the last several of actual negative margins, there's good evidence there that the adequacy is no longer there, and in fact whatever adequacy there is in the payment sector comes from the private margins, not from Medicare, per se.

So I think there's arguments to be made, can be made and I'm making them, that the payments are inadequate.

Secondly, in terms of the market basket update, while there is some abatement of cost increases we have consistently underestimated the cost increases from year to year. The charge that you've given us and the text that was sent out in advance shows that over the last years we have consistently underestimated that. Therefore, our track record is for underestimating that, and it may be that we are underestimating it again for 2006.

So with that evidence that we consistently underestimate that, the market basket may also be somewhat understated.

I'm also appreciative of what Glenn has said, that we should have in this sphere, productivity expectations. We've talked different times about how one mixes productivity expectations with considerations of payment inadequacy, and sometimes we blur those distinctions. I think Glenn and others have spoken to the fact that maybe next year or so we can make those more clear. But I do think we should acknowledge, as we have in the text, that if there's adequacy in this sector it's coming from private

payments, not from the Medicare program. It may be in the time of the general budget restraint that's going on it may be difficult to state that Medicare payments are inadequate, but I do think there is considerable evidence that they are inadequate.

DR. WOLTER: I just wanted to point out a few things that I appreciated in the chapter. I thought there was most balance about the cost increases and the causes of those and I think that's appreciated. I appreciated the acknowledgment that the technology pass-through doesn't really cover for some of the looming investments in IT that are needed in the industry. I think that whether or not the pay for performance approach will help us cover that we'll have to address in the future.

The comments about quality and tying more of either the base payment or the update to quality I think make a lot of sense in terms of what we're trying to create overall as a framework, and that's appreciated even though we don't have a specific recommendation on that at this moment in time.

I also thought you made the case, maybe the best that you have, in terms of the fact that there is a subgroup

of providers who seem to have adequate Medicare margins even under the current circumstances. And if our goal is to target efficient providers, this was probably the strongest case that you've made.

Having said all that, I think what you said on page three and what we say in our chapter on page three is accurate, and that is that the indicators of margin adequacy are mixed, which is probably from my standpoint a little bit better way to say it than that they're mostly positive. Because certainly when you look at the number of institutions that have negative margins that's a mixed picture.

As I said last month, I also think the correlation between cost increases and private sector payment may not represent true causality. One could also make the argument that the negative Medicare margins are creating cost shirting into the private sector, I think essentially is what Ralph was just saying. So how to look at that correlation, I'm sure there's going to be different people on different sides of that particular issue.

I also believe, as I've mentioned in the past, that at some point we need to address the fact that

outpatient margins are sitting at about negative 11 percent. I think some day, as the years unfold, we're going to find people making investment and other decisions that may not be the most balanced in terms of what the communities need, if we don't address the fact that that is a different payment system, it's still relatively new and it may need some adjustments to create appropriate balance in the system. So those would be my comments.

MR. HACKBARTH: Other questions or comments?

DR. SCANLON: Ralph on other occasions has raised the issue that we seem to be shifting our framework in terms of thinking about the update. Since this is only my second year I guess maybe I'll confess the last two years we've consistent. But from looking back I would say maybe we have, and maybe it's a positive thing to do, to have shifted our perspective, and to focus not on the margin alone but to focus on the components. Namely, to be looking at what is happening with cost.

Before the PPS, to be fair to the designers of Medicare, in the beginning they went in saying, we're not going to pay whatever the hospitals want; we're only going to pay costs. That turned out to be incredibly

inflationary.

So then we said, we're going to do a PPS and we're going to create an incentive to be efficient. But there's a confusion about efficiency. Efficiency involves producing something at the lowest possible cost. It doesn't say what you're producing. So Toyota, which we might think of as a relatively efficient company, can produce Corollas and Camrys both at efficient levels, but at very different cost.

So the question I think we have to be asking ourselves is, how do we know what we're buying in terms of -- this goes back to Ralph's issue of adequacy. How do we know what we're buying when we're paying the cost of providers that are serving Medicare beneficiaries? I think what we've seen in terms of the pattern with respect to how much money is available through the private sector on the revenue side and the shifts that have occurred there, and I guess the lack of an outcry in terms of what happened to the product when the private sector revenues were restricted and the lower margins that existed then, that I think we're making a tentative judgment that's saying, we would like somewhat less of a product and we think we've been paying an adequate amount for that somewhat less of a product.

Now the big problem we have here is information. When we talk about the impact of this less than half a percentage point difference in terms of payments, what are the consequences for care? We don't know that. That is, I think, our fundamental issue. We're being very tentative because we don't have that information. At the same time we're facing the big issue of the costs of health care are growing so rapidly that we feel like we're getting priced out of the Camry market and we want to be closer to the Corolla market, but we don't understand what the difference is between these two products are but we think we need to move in some direction.

I agree with Nick in terms of some of the cautions he portrayed, but at the same time we need to move in a direction that says, what is the product that you're giving us and what's the minimum cost to produce that, because that's what we really want to be paying for, not necessarily what is the cost that reflects the product for which you had money available to provide.

MR. HACKBARTH: Others?

DR. REISCHAUER: Just a footnote on the automobile analogy here, and that is, as is the case with cars,

hospital services or medical services are called the same thing year after year but improve. So the Corolla gets bigger and bigger and has more and more gadgets on it each year, and we say you are buying a Corolla. But you're buying a very different car than you were 10 years ago. I think some of this is how rapidly we want the improvement to take place as opposed to a degradation in the nature of the service, which is what you implied.

MR. HACKBARTH: Just a couple points. First, related to whether we are being consistent or not. I think it's important to keep in mind that our legislative mandate in fact changed in MMA. New language was added to our charge specifically requiring that in recommending updates that we take into account the cost of efficient providers, as opposed to just looking at the average. As we speak, our tools for doing that are not as strong as I would like them to be and not as strong as I think they can be, and hopefully in the not too distant future.

Arnie Milstein has said that his ideal is that we would be able to develop an index of true efficiency, a combination of cost and quality, array providers on that in a distribution and target some percentile of that

distribution as the efficient provider, and then base our updates on payment adequacy for those institutions. Conceptually, I think that's where we ought to strive to be. We're not there today.

But yes, the emphasis is a little bit different, Ralph. I think that's true. The reason it's different is because Congress gave us a difference assignment. So I think it's appropriate that it be a little bit different than it was four or five years ago.

The second point is about the productivity adjustment. The recommendation here is that we take half of our usual productivity expectation and do that in view of the fact that the average margin has been declining, as Ralph points out. There is no right answer to what the right update should be. This is a judgment. It's not ultimately something that you arrive at through careful analysis. Analysis can inform it, but it doesn't lead to a single right answer.

Ralph has presented well, as always, the case for maybe looking at a full market basket increase. Ultimately, I'm not persuaded by that because I think it is important that we have an expectation of improved productivity for

hospitals, and all providers, even when the average margin is negative. I believe it's important because as I see it, in a way what we're trying to do is mimic what would occur in a competitive marketplace, which currently does not exist. We have an administered price system.

One of the features of the competitive marketplace is that there's consistent, unrelenting pressure to improve productivity, and sometimes that pressure is very, very harsh and the people who pay the bills to finance the Medicare program experience that in a very harsh way in terms of lower wages, lost health benefits, lost pensions, lost jobs.

Health care is one of the boom industries in America and a lot of people who pay the bills to finance rapid growth in health care are not so fortunate. I think it is a reasonable, appropriate requirement to have a productivity adjustment, even half of one, when hospital margins are negative, or for dialysis facilities as we will discuss later. I think it would be a very bad thing to do to give up on that adjustment. So that's my view for whatever it is worth.

Any other comments before we move to vote?

Okay, so the recommendation is up and you will recall that the wording changed in the last line, which I don't think changes the substance at all.

All opposed to the draft recommendation?

All in favor?

Abstentions?

Okay, thank you.

The next discussion is about payment adequacy and updates for dialysis facilities.

* MS. RAY: Today's presentation is the last in a series of three presentations on the adequacy of Medicare's payments for outpatient dialysis services. During today's session I will follow up two questions that were raised last month about where facilities are located, and the auditing of renal cost reports.

Next I will review our findings on payment adequacy and present a draft recommendation about updating the composite rate for calendar year 2007.

I will then discuss with you a distributional issue surrounding the payment for composite rate services and present a draft recommendation that reiterates our recommendation for eliminating differences in the composite

rate between hospital providers and freestanding facilities that we made last June.

You'll then have the opportunity to discuss these findings and vote on both draft recommendations which will be included in our March 2006 report.

Last month the question was raised about where facilities are located, particularly those owned by the four largest chains. We have mapped facilities according to their location and ownership, dividing them into freestanding, the largest for chains, freestanding regional chain, freestanding independent that is not affiliated with any chain, and hospital-based. We obtained this information from CMS's Compare database that we downloaded in December 2005.

Here you see the 2,700 facilities that are affiliated with the largest four chains in blue. They have found in nearly all states -- 48. They are concentrated in the East, Middle Atlantic, South Atlantic, South-central regions and the West.

Now let's add the 600 freestanding facilities owned by a regional chain in yellow. They're also focused in the East, South, and West. I've now added the 600

freestanding independent facilities in red, and they also tend to focus in the East, South, and West.

Here you see all dialysis facilities. It includes the 600 hospital-based providers that are in green, and they are focused in the East, North-Central region, and the East.

These maps do not yet include information about where patients live. That information is not readily available as it is for some other sectors. We will try to include this information next year. What I can tell you is that the U.S. renal data system reports that the greatest number of dialysis patients reside in California and Texas, which is consistent with where the greatest number of facilities are located and where the greatest number of the largest four chains are located.

You also asked a question regarding the location of facilities according to their size, so here we have mapped dialysis facilities according to the number of hemodialysis stations. The smallest facilities are represented by a green dot, and the largest facilities are represented by a blue dot. This map suggests that the larger facilities are located where the four largest chains are concentrated. Recall an item included in the chapter

draft, the largest four chains are, on average, largest in terms of the hemodialysis stations, followed by freestanding regional chains, and freestanding independent. Hospital-based providers are possible the smallest on average.

To conclude, the largest four chains are found in nearly all states and they account for 60 percent of all facilities and 70 percent of freestanding facilities. They are largest on average compared to the other freestanding facilities and hospital-based providers.

A question came up last month about getting some more background about CMS's auditing of dialysis cost reports. The chapter draft includes more background. Prior to the BBA, ProPAC, one of our predecessor commissions, raised concerns about the reliability of renal cost report data. ProPAC corrected facilities' costs based on audits conducted by HCFA in 1988 and 1991. The BBA required that facilities be audited once every three years.

Like HCFA, I have also calculated differences in non-audited and audited cost reports, using more current data, 2001, for the same facilities. We have conservatively applied the audit factor to those facilities whose reports are not yet settled by CMS. We have not yet done this for

other providers because this information is not available for them. There is no statutory requirement for auditing other providers.

I've dealt with the two items from last month's meeting. Now I'd like to review our adequacy results. First, here is the Medicare margin for both composite rate services and dialysis drugs, 2.4 percent in 2003. Our most conservative projection for 2006 is negative 2.6 percent, and this assumes a drug margin of 2 percent. A less conservative assumption about the drug margin would give us a margin of negative of 1.4 percent. That assumes the industry attains a 6 percent margin on average in 2006 for dialysis drugs, which is consistent with how CMS will pay them in 2006, ASP plus 6 percent.

Under the Deficit Reduction Act, the Congress would update the composite rate by 1 percent in 2006. This improves the 2006 margins by about one percentage point. Margins would range from negative 0.3 percent to negative 1.7 percent.

You saw this table last month and it shows the variation around the 2003 margin. It ranged from negative 0.3 percent for non-profits to 3.7 percent for the

facilities in the largest four chains. Recall they provide about 70 percent of all treatments. The variation you see is due to the level of cost and the proportion of payments associated with dialysis drugs.

Let's review our other indicators of payment adequacy, and most are positive. Our analysis of beneficiary access suggests that specific patient groups like African-Americans and dual eligibles are not having systematic problems accessing care. Providers' capacity is increasing as evidenced by the increased number of dialysis facilities and the growth in dialysis stations. Volume of services, dialysis treatment, and dialysis drugs is increasing. Quality continues to improve, particularly for dialysis adequacy and anemia status.

Providers appear to have sufficient access to capital as evidenced by the growth in the number of facilities and access to private capital for both large and small chains. Per unit cost growth was moderate between 1997 and 2003, and cost per treatment declined by about a point between 2002 and 2003.

The second part of our process is to consider cost changes in the payment year we are making a recommendation

for; that's 2007. CMS's ESRD market basket project prices will increase by 3.1 percent in 2007, and our productivity expectation is 0.9 percent.

Based on the mostly positive indicators of payment adequacy, but considering the negative Medicare margin for composite rate services and dialysis drugs in 2006, the draft recommendation is that the Congress should update the composite rate by the projected rate of increase in the ESRD market basket index less half the productivity expectation for calendar year 2007.

This draft recommendation will increase spending relative to current law, $50 million to $200 million for one year, less than $1 billion over five years. It will help assure beneficiary access to care. Beneficiary copayment will increase; provider payments will increase. I forgot to say, there is no provision in current law for an update to the composite rate in 2007.

Let's move on to draft recommendation two. This is a distributional recommendation. As mentioned in the chapter draft, CMS pays hospital-based facilities $4 more on average for composite rate services than freestanding facilities. The Congress has not yet implemented our

recommendation to eliminate differences in the payment rate for composite rate services between the two facility types. It is timely to renew this recommendation given CMS adopted one of our other recommendations that we made in our June 2005 report, that dialysis drugs be paid the same for hospital-based and freestanding facilities.

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

The implications for this draft recommendation is that there is no change in spending relative to current law. As we said in our June 2005 report, this would be done budget neutral. And we don't anticipate any effect on beneficiaries and providers.

MR. HACKBARTH: Just a couple quick comments. In recommendation one we would modify the language consistent with the way we did for hospitals, so it's productivity expectation as opposed to expected productivity growth.

Let me just say a word about recommendation two. Ordinarily we discuss recommendations twice before voting on

them. This was not in the package for December and I asked that it be added based on conversations that I had with commissioners between meetings. I felt it was appropriate to go ahead and include it this time even though it wasn't in the December package because it is something that we've addressed very recently, the June 2005 report, and embodies a basic principle of ours, which is that we ought to have consistent payment levels without regard to the type of provider. So given that recent history I thought it was appropriate to add it and re-emphasize this point in the case of dialysis.

Questions, comments?

MS. DePARLE: It's not on these two recommendations, it's on this chapter, if I can do that.

At the last meeting and I think even last year -- I'm losing track of time, but in the last couple of years we've talked about our work concerns about nutritional status of dialysis patients and we make the point in the chapter that you've made before that while there are some areas where there have been quality improvements in the adequacy of dialysis that Medicare patients receive, this is a area that has not improved. Perhaps wouldn't argue that

it's deteriorated but it certainly hasn't improved, and it's a very important measure.

In the chapter we make that point again and we say that Medicare doesn't cover oral nutritional supplements, coverage policies for other treatments are restrictive, enteral tube feeding and parental nutrition. Anti-kickback provisions in the statute limit the ability of providers to furnish patients with nutritional supplements at reduced prices. Then we make the leap to, so what should happen here is that the Secretary should use nutrition as one of the ways in which to link quality to payment.

I guess I think we've skipped a point here or skipped a step, which is -- I see it's not a recommendation but shouldn't we at least consider whether the payments should be changed to cover oral nutritional supplements, and whether the restrictive coverage policies are appropriate given that we think this is a problem for these beneficiaries?

Then maybe you would say, if providers achieve a certain level of increase in quality then payment rewards should be linked to that. But if we're saying that currently the payments aren't -- the word adequate isn't in

here, but the way I read this we're saying the payments aren't adequate to cover that. In fact it's restricted. So the dollars have to come from somewhere and I don't think they should come from the existing composite rate structure.

So I don't know if there's a way to reflect that in the language. I see that it's not a recommendation, but we've made this point before that nutritional status is important, and it's not improving, and right now I don't think it's made very effectively given where we are.

DR. MILLER: What I was going to prompt you on is we've had this discussion on nutrition and some other things like the vascular access and those types of things when we've talked about the notion of going to a bundled payment. I'm just trying to prompt you, is that the thinking there?

MS. RAY: Yes, I think there is that notion that if you went to a broader payment you would think about what services a dialysis patient needs and include that in the broader payment, and I think nutrition as well as the vascular access services are two of the important groups of services that would be considered there. I think under the current payment system, looking at payment policies and coverage policies, that's something that we could

potentially explore for the next cycle.

MS. DePARLE: I guess I think that should be explicit. What scares me about a bundled payment is what would be included and what wouldn't be. If we think this is important, I don't think we should be trying to say that it should come from the existing payment scheme, and that seems to me to be the import of what's in here.

DR. MILLER: I think the other thought about the bundled payment is once you arrayed -- I'm asking because I'm not remembering precisely -- once you arrayed all of the various services that you think are appropriate, given the current state of care for dialysis patients, you'd then ask the question, what is the right amount of money for that?

So I think what I would suggest here -- again, if I'm following the question and the answer -- is we do have some of this more robust discussion I think in the June chapter or in an earlier chapter where we've talked about the direction we want things to go, and bring that into this so we can be clear that those types of services need to be considered and that the long run direction here is for a bundled payment. Does that deal with it or are you thinking --

MS. DePARLE: Yes, because right now I think it sounds like we're saying we think that providers should be held accountable for this even though we very explicitly make the point that some of these things aren't even covered. So I don't think that's fair. If we think they're important we should talk about how we think they should be covered under the payment and reimbursement to them.

DR. MILLER: Nancy, that's what they've been thinking; is that right?

MS. RAY: Right.

MR. HACKBARTH: Other questions or comments on this recommendation and chapter?

Okay, on draft recommendation one, all opposed?

All in favor?

Abstentions?

Okay, thank you, Nancy. Oh, I forgot two. Draft recommendation two, all opposed?

All in favor?

Abstentions?

Okay, thank you.

We're going to shift gears here for the remainder of the morning and move away from update recommendations and

discussion to talk about two physician issues. One, the developing work plan for looking at alternatives to the SGR a system. And then second, going back to work we've discussed before on valuing physician services in the RUC process.

Cristina, are you going to lead the way?

* MS. PODULKA: You will remember that we discussed the shortcomings of the SGR system in concept in our March 2005 report to Congress. As part of that discussion we suggested several possible modifications that included subsetting the SGR into multiple target pools. Further, the Congress has indicated their interest by assigning us a report on subsetting the SGR into multiple target pools in the proposed Deficit Reduction Act. We are now following up with a description of our proposed work plan which includes an empirical analysis of these alternatives. Although the focus of this discussion is on SGR modifications, MedPAC recommends that physician payment updates be based on cost. We will close our discussion today with additional policy options to make Medicare a more prudent purchaser of physician services.

Because of rapid growth in Medicare spending on

physician services in the 1980s, Congress established a fee schedule and an expenditure target system based on growth in the volume of services. Problems with the initial system led to its replacement as part of the 1997 BBA. That law established the sustainable growth rate, or SGR, as the new expenditure target for Part B services. The basic SGR mechanism is to compare actual spending to target spending and adjust the fee update when there is a mismatch. If actual spending is less than target spending then SGR calls for a fee update that is greater than cost growth. Conversely, if actual spending is greater than the target then SGR calls for a fee update this is less than cost growth. A wide enough gap between spending and the target results in fee reductions.

The SGR formula is based on four factors: input prices to measure the cost of operating a medical practice, the number of beneficiaries in fee-for-service Medicare, gross domestic product, and the effects of changes in law and regulation. When the SGR system was established in the BBA, GDP, which is the measure of goods and services produced in the U.S., was included as the allowance for volume growth because Congress saw growth in GDP as a

benchmark of how much volume growth society could afford.

In the years before and immediately following the enactment of the BBA this allows for volume growth was adequate. The SGR system called for fee increases every year but one, when it reduced fees to recoup excess spending from overly high updates in the previous two years. These incorrect updates were the result of prior estimation errors which had underestimated actual spending and overstated GDP.

However, recently volume has been growing, contributing to spending growth. Aside from spending concerns, some volume growth may be desirable. For example, growth arising from technology that produces meaningful gains to patients or growth where there is currently underutilization of services may be beneficial. But one indicator that not all growth is good may be its variation. Researchers at Dartmouth have found that volume varies across geographic areas and that care is often no better in areas with high volume.

Beginning in 2000, the volume of physician services began to exceed SGR's allowance for this growth. Under SGR's system of cumulative spending targets, excess spending that is not offset in one year accumulates in

succeeding years until it is recouped. SGR responded to excess spending as it is designed by calling for fee reductions. The MMA overrode these fee reductions with specified fee updates in 2004 and 2005, but did not adjust target spending. The fee increases have combined with continued high volume growth to result in spending that exceeds SGR target. The gap between actual and target spending is now large enough for the system to call for annual updates of about negative 5 percent for six consecutive years.

Many observers are concerned with the projection of unrealistic negative updates. For the purposes of our work plan discussion we do not address the accumulated excess spending and the scheduled string of negative updates. Our focus here is more conceptual, to provide a framework for establishing a sustainable update system going forward.

MedPAC has consistently raised concerns about the SGR, both when it had set updates both above and below the changes in input prices. Our criticisms are based on the following. First, the SGR is flawed as a volume control mechanism. Because it is a one-size-fits-all target there's

no incentive for individual physicians to control volume. In fact individual physicians have an incentive to increase services.

Secondly, it is inequitable because it treats all physicians and regions of the country alike regardless of their individual volume-influencing behavior. Also it treats all volume increases the same whether they are desirable or not. Finally, payment updates are disconnected from the cost of producing services. Although costs are included in the formula, updates are ultimately determined by how actual spending compares to target spending.

The Commission recognizes the desire for some control over rapid increases in volume. However, instead of relying on a one-size-fits-all formula, MedPAC prefers a different course, one that involves explicit consideration of Medicare program objectives and differentiating among physicians. However, the Commission also recognizes the Congress may wish to retain some form of limit on aggregate volume and has therefore noted modifications that could be made to the existing SGR system to enhance its ability to set updates appropriately while controlling spending growth.

Now Cristina will discuss alternatives for modifying the SGR system.

MS. BOCCUTI: Now I'm just going to take you through some of the mechanisms we've discussed in last year's March report and in presentations that Joan Sokolovsky gave last year. These mechanisms focus on multiple target pools and varying conversion factor updates among them. The notion here is that the SGR model could be more effective if it applied to smaller, more cohesive groups.

One thing to keep in mind through these groupings that I'll go through is that the Deficit Reduction Act calls for MedPAC to analyze these strategies.

The first one up there is to divide the United States into geographic regions. This approach draws from the work of Wennberg and Fisher who have both found considerable regional variation in per capita service use. Furthermore, these volume differences are not associated with health outcomes.

The second bullet there is to adjust fees differentially by type of service. As you've seen me present in our physician update analyses, volume growth in

some categories such as imaging and non-major procedures is more rapid than other categories.

The third bullet is to create one or more alternate pools based on membership in organized physician group practices or networks. Group practices state that they are able to implement evidence-based protocols and information systems which reduce unnecessary volume. There could be a separate pool for group practices which, if volume were lower, would have a more favorable conversion factor. Or along these lines, Medicare could allow groups of physicians to voluntarily opt out of the main SGR pool. Groups whose volume growth was less than the SGR pools could potentially share in that savings.

A four pool could be based on hospital medical staffs. Research shows that hospital medical centers can function as de facto systems of care. So this alternative follows some of the same logic that I just discussed for the physician groups.

A final target may include physicians who appear to be outliers with respect to volume. A closer volume analysis can help identify, for example, physicians for whom high volume is explainable by the health status of their

patients. Spending targets for these physicians could therefore be adjusted accordingly.

So first steps for this project would be to analyze Medicare physician claims for 2000 through 2004 to determine the rates of volume growth and resulting physician fee updates by the five groupings that I just discussed on the previous slide.

All of the groupings raise many questions about design, implementation and policy. For example, for the purposes of our study we'll need to account for differences in risk, numbers of beneficiaries, and other factors that affect volume. In addition, because reducing volume growth would be more difficult for groupings where the volume of services was already low, we'll have to take into account initial volume levels.

Some data challenges exist, particularly for identifying physicians who practice in groups and hospital medical staffs. Also, defining the outliers may be difficult, but some of our current work on physician resource use may be helpful for this analysis.

So for later steps in the project we will begin to model the impacts of the alternative target pools. In doing

so we'll encounter several policy implication issues. These include the attribution of beneficiaries to pools. For example, we might want to model ways to attribute the services received by individual beneficiaries to groups without necessarily locking patients into receiving care from any specific group. Risk adjustment issues will also need to be addressed to remove incentives for patient selection by the target pool.

Other questions to consider are, should targets be hard or soft? That it, should targets be more like corridors so that the oscillations from year to year could be smoother? Should targets be cumulative or not, so past year's performance does not really bear on the next year's target? Should the Secretary have discretion to change targets? Under the VPS, which was the previous expenditure target system, the Secretary had more discretion to adjust the formula based on other factors, such as access, technology changes, health status, et cetera.

A final consideration, although I'm sure there are many more, but the final one on the slide is that we could also consider what really is the correct standard or metric for assessing volume and spending growth. For example,

analysis could examine metrics of GDP plus 1 percent or 2 percent, those kind of changes.

Finally, it's important to keep in mind that other initiatives also address volume control. For example, Medicare could measure physician resource use over time and feed back the results to physicians. Physicians would then be able to assess their practice styles and revise accordingly. MedPAC has discussed this issue in the past and is pursuing empirical work on the topic, which I think you'll hear a little bit more about tomorrow, or at least discuss the issue tomorrow.

Then at the organizational level, an analysis of physician resource use can look out provider network systems. Networks could provide natural mechanisms for improvements in care coordination which could lead to more efficient service use. Karen Milgate and I will be discussing care coordination issues also tomorrow, so stay tuned for that.

Finally, beneficiary incentives are a mechanism that could work in concert with provider networks to encourage efficient volume use. So I will say that we are at the very nascent stages of this project, so we turn this

discussion over to you and we appreciate any input you have on the work plan. Thank you.

MR. HACKBARTH: Comments, questions?

DR. NELSON: I'll try to be brief free there's a great deal I'd like to say about this chapter. First to point out that the congressional mandate that we think will be coming down calls for us to analyze alternatives to the SGR. It doesn't specify that we have to endorse any. And each of the specified alternatives have serious implementation problems that I can see right off the bat that I think as we proceed with the chapter we'll have to pay a lot more attention to the practical problems in implementation and possible unintended consequences and prepare that logic for Congress.

And as you point out, there's a potential for a conflict of this concept with our pay for performance initiative, understanding that there are ways that they could intersect, but nonetheless, there would be a possible potential for conflict.

Dividing the United States into regions doesn't recognize the wide variations that may exist in any particular region that we really ought to address. We'd

have to anticipate the possibility of redistribution of services consequent to that with facilities or clinicians deciding to relocate or to locate in one of the regions that's more favorably treated within their SGR. Obviously it doesn't impact the individual decisions around care.

If we adjust fees differentially by service or types of service you have the problem of assigning to any particular clinician or facility who is responsible for order the resource. Also it doesn't discriminate adequately between appropriate growth, such as immunizations, or inappropriate growth.

Alternate pools based on memberships and organized groups of physicians or other kinds of alternate pools again seems to me to be duplicating what we intend to present with respect to pay for performance and gets to the difficulty of accurately assigning the resource uses. Right now it's pretty near impossible. If we set targets according to hospital staff it ignores the reality that a lot of physicians have privileges at more than one hospital, for example.

So I think that we will have to pay attention to these implementation difficulties and it may very well be

that we should suggest other ways of trying to deal with inappropriate volume, many of which we've considered before, that has nothing to do with the SGR such as reducing the perverse payment incentives, selective use of certificate of need, restricting direct to consumer advertising, rewarding efficiency just within the pay for performance rubric, appropriate benefit design, and enforcing self-referral prohibitions, all of which have the potential for dealing with this on a more individual basis than simply trying to put lipstick on the pig of the sustained growth rate which still leaves it as a pig.

MS. HANSEN: I appreciate that this is at the very ground floor of this so my comments are probably in two areas. One is on the whole beneficiary impact side of it as well as the whole profile of the beneficiary, which is a different framework somewhat in terms of approaching it but perhaps gets closer to the pay for performance side of it. So let me start with the impact.

I know that in all the recommendations that we normally do we always have an impact analysis on the beneficiary. One of the things I would wonder if it could be emphasized a little bit more strongly with the SGR

approach to begin with is looking at the impact of the beneficiaries' out-of-pocket expenses in terms of total expenses, both the premium changes as well as the copayments that are involved, because this is somewhat addressed by, it's one thing to have the price go down but if the volume increases the actual impact to the beneficiaries is there's more out-of-pocket cost. So if that could be more clearly delineated as an overt section of focus so that everything is always tallied in terms of that impact.

The second point is on the profile of the beneficiary. As I looked at some of the ways that we would look at it relative to the physician valuing I wonder if somewhere in the document we can take it from looking again at the beneficiary with the profile of the beneficiary. By that I mean, these are segmented services and specialties of activities, but instead taking a look at what tends to hit the typical 65- to 75-year-old crowd, the 75 to 85, and then especially the 85-plus because that is probably a very high user of physician and other services. And taking a look at that a little bit more and cross-tabbing it with some of the other data that we do have in terms of collecting on utilization. And with that the ability to -- and I

emphasize the 85-plus because that would be an interesting area because of the high utilization that would be normal for that in terms of appropriateness.

With looking at the profile of the individual including -- I don't know if it's possible -- but looking at even the pharmaceutical and device use that would go along with this. It's really probably more by the diagnostic conditions, but it's a different cross matrix. Then part of it is, if their condition is such and our outcome should be at this level, then what is the resource use that may need to go to it. So it's flipping it somewhat rather than doing the structure, but starting really with the beneficiary clinical, issues. And as I say, it ties to the pay for performance as to what the quality and the outcome should be. So it's a harder matrix but it takes it back to the core of where the Medicare dollars should be going.

DR. KANE: I was thinking about the beneficiary too but a slightly different take on it. I thought it would be useful to try to pool the high use beneficiaries and then see what their profile looked like. A little bit different angle than Jennie's but then again a beneficiary focus rather than a provider focus might teach us something about

who it is out there who is the highest utilizers. I'm particularly interested in knowing whether they have Part B coverage as well as age and diagnostic condition, and to see if there is something about the beneficiary themselves and whether there shouldn't be something done about -- if it turns it's because it's only people with Part B coverage that are higher utilizers perhaps we need to think about what incentives they are facing to seek additional care. So I reinforce Jennie's idea of let's take a look at the beneficiary not just the provider.

Then in looking at the providers, I'm wondering, when we say volume, volume is kind of a broad brush approach and I'm wondering, are we concerned about the physician's own use of his or her own time, or do we want to look at the volume of what is ordered? I would say perhaps we want to emphasize what's order and not delivered directly by the physician as much as -- if we are going to start with a priority, I would start with that priority over the types of services the physician delivers themselves. I'm noticing that imaging and arthroscopies seem to be the high growth area and those are referral types of services. Perhaps we should start off finding high utilizers in terms of what

they refer as opposed to their actual own volume. So those are my two cuts on it.

DR. CROSSON: It's probably not surprising that I'm generally in support of this direction. I think it's entirely consistent with the whole body of work that we're engaged in, although we may not necessarily conceptualize it as that, and tend to look at that as, how can we make changes to the Medicare fee-for-service system to get some of the advantages that we recognize existing in the population-based payment portion of Medicare. We're going to talk about others of these, the care coordination on, for example.

This has to do, I think, fundamentally with is it possible to make changes to the physician update system, or perhaps even the hospital update system, that provide incentives for control of volume, perhaps analogous to the way hospital prospective payment contained within it a mechanism to manage costs within the context of one admission.

Having said that, it's my personal belief, obviously, that the population-based payment makes more sense and that efforts to move along the spectrum are going

to be only partially successful.

Second -- and I'm starting with cautionary notes here -- I think the history of the volume performance standards, the SGR itself, and the difficulty now in dealing with the cumulative target and the impact of that would have to inject caution into anybody designing yet another system, and I think that is appropriate because of the problem of unintended consequences that Alan raised. I also think in looking at volume, the point that some volume increases are absolutely necessary and desirable is absolutely correct, and whatever we do we would have to design this in such a way that it acknowledges that.

Having said that, my sense is that where we may end up after the analysis is a consideration of a combination of some of the approaches that have been suggested. I don't know what that would be exactly but something that has a geographic component to it, something that relates to practice setting, and perhaps even an element related to differential updates with respect to the services themselves. Now that might get us into a lot of complexity but the system we have now I agree is not working.

I have a little trouble understanding the sense of conflict with pay for performance, certainly not the thrust of pay for performance right now which is primarily directed towards quality. I don't see a conflict between paying for quality and then trying to manage volume at the same time, particularly because I think the discussions in the pay for performance environment that have tried to relate to the issue of efficiency have been less than robust to date, and this might be another way of looking at that issue.

In going through this there's going to be, as we analyze it, a pretty obvious trade-off between the size of the group subject to a payment update target -- big, lots of physicians, or small, smaller number of physicians -- and in that case the larger the size you're dealing with, the less the problem, I believe, of attribution. Certainly a larger geographic areas is going to eliminate the likelihood that people will move in and out of that target pool. On the other hand, the smaller the group, the greater likelihood that the dynamic over time would actually result in people working together to try to manage volume. That's the problem we have now with the national pool. So there's going to be a trade-off conceptually, and certainly with

respect to any implementation in that. Nevertheless, I think the hope is that something along those lines could be designed.

And then I'd just make one point with respect to the text. A couple of places in the text it makes the statement that physicians do not respond to collective incentives but only individual incentives. It then goes on to say, we're going to look at targeting smaller groups of physicians. I think that just considered categorically is not correct. I think it needs to be modified by something that realizes that physicians do respond to collective incentives in an organizational or institutional context. Outside of that I would agree with the statement, and suggest maybe we modify that because otherwise it is not consistent with the rest of the intent. Thank you.

MR. SMITH: In no particular order, I agree with Jay. I don't think, Alan, progress, if we can make it on SGR reform, is inconsistent with progress on pay for performance.

DR. NELSON: Can I clarify that? Because I didn't mean that they were operationally in conflict because efficiency is one of the dimensions of quality. I meant

that it may be politically in conflict where as an alternative to going through the effort for pay for performance there would be quick and dirty decisions made just to go into different SGR's.

MR. SMITH: That conflict may exist but there's no reason we can't walk on both feet on this front. Not to suggest that SGR reform is easy but it isn't at war with trying to reward both quality and efficiency.

To pick up on Jay's big-small point. One of the reasons I was attracted when we originally thought about this to geography as the new metric rather than specialty or group practice or hospital affiliation was that it would be universal. That you wouldn't have the problem of some doctors in, some doctors out, some doctors unable to get in because they didn't have access to a group practice. I still think that that's a virtue. It also helps with the attribution problem. But you are surely right, Jay, too big we simply duplicate the SGR problem of no single doctor has got an incentive much larger than their incentive under the national system. But I do think geography has got those other two attributes which make it more attractive and, Nancy, help address your concern, did you order or did you

perform evaporates if we use some sort of zip code based, beneficiary-based system of looking at service use.

I think Jenny's point, one of the things that is buried in here -- and it's not even buried, it's only implicit and I'd like to see if we can't make it explicit, is the impact of volume growth on out-of-pocket costs. It's serious on its face and it may have had another volume problem that I'd like us to see whether or not there's any way to get to a handle on, which is foregone service. We've got a 20 percent increase in services per beneficiary. Are those reasonably evenly distributed or do we have some evidence that beneficiaries without a Medigap policy or without some gap filler are getting a significantly less portion of that 20 percent with no discrimination between the good and bad portion of the volume growth. I think that's important missing piece of the analysis here and if we can get a handle on it, it would help.

DR. WOLTER: One question I had about the title, Alternatives to the SGR Formula -- and I don't know how the language is worded in the proposed legislation -- but one possibility would be that we would look at targeting payment policy through smaller groups, but it wouldn't have to be

based on anything even similar to the current SGR. So that, for example, the unit of analysis might be annual beneficiary cost or something like that. I don't know whether we have that flexibility in this mandated study because it might still be very wise to move away from a formula to something that is a little bit more rational.

I think Alan made some good points. I think that in the system we have now there are areas of profitability that are large enough they're incredibly seductive. And it's almost the opposite of the logic that went into the SGR but I think it does drive volume. To the extent that we could have good information about profitability that might be an area of analysis in this area.

It's interesting to think about taking our target from the universe of all physicians down to smaller groups. But an equally revolutionary part of this analysis is that we might be taking it from individual physicians to something somewhat larger than that at the same time. That's something that's interested me for a long time because I think that if we're going to successfully tackle these cost and quality issues, as Jay said in his comments about physicians only have individual incentive, I agree I

don't think that's true when there is some sort of an organizational context.

So one of the powerful things that could come out of this is reimbursement policy that incents the coordination of physician groups, or perhaps even the coordination of physician groups and hospitals, to look at how care is delivered. That is a very different thing than what we have in policy today. As we've said in the past, to the extent that some pooling of Part A and Part B dollars might creep into our thinking on this, that could also be part of where we might go with this.

MR. HACKBARTH: The issue of what exactly the proposed mandate means and what constraints we would have in answering it is obviously a critical one. As a matter of course one of the things that we will do is talk to the people who have drafted it and get as clear as possible understanding about their goals, their expectations, what the product is that they want us to produce. As Alan points out, regardless of what those constraints are it's still up to us to decide whether we recommend. We can evaluate alternatives and say, we don't like any of them and we think a different approach is better. But we will certainly

endeavor to understand exactly what they have been mind by this statutory mandate.

DR. REISCHAUER: First just a comment. Much of the discussion has been that there's no good versus bad volume increase under the SGR. The fact of the matter is that what the SGR says, I believe, is that volume growth that does not exceed per capita increase in GDP is acceptable and above that is too much, given the overall constraints that our economy faces. So it's sort of setting a budget without identifying which elements should fill that for increased volume over time. Now maybe that's too low or too high, but that's a separate issue.

I think this is going to be a very interesting exercise, but I am more skeptical than Alan and the others that after we forage around that we would be able to come up with anything that is even as minimally flawed as the SGR, because I see in almost all of these other approaches, smaller geographic groups, segmentation of the providers, just a gazillion other complexities, both implementation and philosophical, that raise themselves. Then you overlay them over a geographically-based political system and you will quickly run and retreat to the SGR.

The SGR doesn't do the job and I think we have to think about some other alternative here, but I think, like Alan, would see maybe a heavy emphasis on efficiency, notwithstanding the difficulties that Jay has raised, as the possible long run response to something like this. Because if you are doing P4P with an emphasis on efficiency you will then create the right incentives among the right groups to behave, to moderate the growth in volume even if the payment is not done on a population-based system.

DR. STOWERS: I just wanted to build a little bit on Bob's good growth-bad growth thing. I think we all know there's a certain amount of growth that's going to occur for pay for performance. I think maybe it's going too far on this, but I think we have the opportunity as we march forward with this to quantify that a little bit. That's been done in the private sector some. So if their hemoglobin A1c rate is a certain amount now and we see it rise to double the amount being done because of success for pay for performance, that would have a dollar value to it. I could go with eye exams and on down the line.

So we could almost put in a factor there for the success of pay for performance against the total spending

that's occurred in the formula, which might make at least some adjustment factor that we could quantifiably justify as the good growth-bad growth type thing. I think we all know and hope in the long run pay for performance with increased health and all that's going to be a good return on our investment. But we all know on the front side there is a short-term investment in improving health, so I'd like to see that somehow built in here. We all talk about it all the time, but I think as long as we leave that nebulous volume thing out there, cost thing, about pay for performance there's always going to be a way that people can cloud the issue over that.

So if there would be some way to get more specific I think it would be a big contribution of MedPAC to this whole issue.

MR. HACKBARTH: Okay, much more on this topic in the future. Let's now turn to valuing physician services.

* MS. KELLEY: Over the past few months we presented to you information about the process for reviewing the relative values for physician services, focusing on the role of CMS and the RUC in the five-year review process. Today we're going to review the Commission's findings, discuss

some issues that were raised at the December meeting, and then review draft recommendations that should help improve the five-year review process.

The Commission has concluded that the process does not do a good job of identifying services that may be overvalued. This is because CMS relies too heavily on physician specialty societies to identify services that merit review and to provide evidence in support of increasing or decreasing the relative values of services under review. CMS historically has not succeeded in identifying overvalued services itself.

In developing recommendations, MedPAC has four objectives. First, to achieve greater balance in the perspectives brought to bear during the process. Second, to improve the identification of services that merit review, particularly overvalued services. Third, to establish a method by which CMS can collect its own evidence in support of changing a service's value. And finally, to ensure that all codes are reviewed periodically.

We should note here that MedPAC understand the value of the RUC's role in the five-year process. The Commission's recommendations are not an attempt to supplant

the RUC, but instead are intended to augment it.

At the December meeting several commissioners voiced concerns that MedPAC's recommendations will increase demands on CMS. As you'll note in your mailing materials, the chapter draft now takes not of the fact and goes further to urge the Congress to provide CMS with the financial resources and administrative flexibility it needs to undertake MedPAC's recommended changes.

Another issue discussed in December was the RUC's composition. Commissioners considered a draft recommendation calling for increased representation of primary care physicians on the RUC. The Commission decided not to make this recommendation but to retain in the text of the chapter a discussion of the issue urging the Secretary to call on the RUC to review and revise its membership to be more representative of the care furnished to Medicare beneficiaries.

The chapter draft now also includes a discussion of MedPAC's future work on the mispricing of services in the fee schedule. Such work will include consideration of geographic payment adjustments, payment locality boundaries, practice expense RVUs, and the fee schedule's unit of

payment, as well as disparities in remuneration between primary and specialty care and the implications of those disparities. In addition, the draft makes note of the Commission's intent to consider opportunities to improve the value of services purchased by Medicare.

Now onto the draft recommendations. I'll go over the recommendations first and then discuss the implications at the end. Recommendation one is intended to move CMS into a lead role in identifying overvalued services. Note again that we are not proposing to replace the RUC. The RUC provides valuable expertise and plays an important role. But the review process would benefit if CMS received guidance from experts who are not financially invested in the outcome.

The draft recommendation is that the Secretary should establish a standing panel of experts to help CMS identify overvalued services and to review recommendations from the RUC. The group should include members with expertise in health economics and physician payment, as well as members with clinical expertise. The Congress and the Secretary should ensure that this panel has the resources it needs to collect data and develop evidence.

The expert panel would play a regular role in the process, particularly at the beginning when CMS is seeking to identify misvalued services. The panel would review the codes that CMS's data analyses identified as potentially misvalued and consider which services warranted further consideration by the RUC. The panel would then develop additional evidence providing support for correction, for example, by conducting its own provider surveys. This supporting evidence would then be forwarded to the RUC for RUC evaluation.

To ensure that the panel has sufficient expertise in considering whether services are misvalued it should include representatives from CMS's network of carrier medical directors, experts in medical economics and technology diffusion, private payer plan representatives, and a mix of physicians, particularly ones that are not directly affected by changes to the Medicare physician fee schedule, such as those employed by managed care organizations or academic medical centers.

Carrier medical directors have a wealth of knowledge about current medical practice and local coverage decisions that could assist the panel in its review

activities. Experts in medical economics will help CMS decide how to adjust RVUs to account for any economies of scale that accompany growth. In the case of technology diffusion, the valuation process should specifically address the efficiencies that accompany the learning by doing associated with new services. And private payers bring the feedback they receive from the marketplace that may provide evidence of distortions in payment rates for physician services.

The next recommendation would help CMS improve the identification of misvalued services. Currently, the vast majority of services that are reviewed during the five-year process are identified by physician specialty societies and are likely to be perceived as undervalued rather than overvalued. It's important, therefore, for CMS to identify codes that may be overvalued and submit them to the RUC for review along with supporting evidence. Analyses of Medicare data, such as changes in length of stay, site of service, volume, and practice expense could provide crucial information to support agency claims that services are overvalued.

So the draft recommendation is that the Secretary,

in consultation with the expert panel should initiate the five-year review of services that have experienced substantial changes in length of stay, site of service, volume, practice expense, and other factors that may indicate changes in physician work.

As I mentioned, the recommended expert panel could assist CMS by reviewing the codes identified through data analyses and considering which services warrant further consideration by the RUC.

The third proposed recommendation would help ensure accurate payment for recently introduced services by instituting automatic reviews of work relative values for selected new services after a specified period of time. The recommendation reflects the fact that we expect the work involved in furnishing many new services will change over time.

The draft recommendation is that, in consultation with the expert panel, the Secretary should initiate, after a specified period, reviews of the work relative values for selected recently introduced services. Where appropriate, services should be assessed by the RUC as soon as is practicable; reviews should not be postponed until an

upcoming five-year review.

The Commission would specify that CMS should also assess established services for which the newly introduced services are substitutes. As the use of newly introduced services grows, the type of patients using the established services could change. If this occurs, the severity of patients receiving the established services could increase or decrease. In turn, such a change could affect the resources needed to furnish those services.

The final recommendation addresses services that have not yet been reviewed by the RUC. Since the fee schedule was first implemented most of the services furnished to beneficiaries have had their relative values reviewed. Yet that review has not occurred for about one-sixth of the RVU volume. Consequently, the original valuation of the services established more than 15 years ago may no longer reflect current medical practice. The improvements we recommended above should help CMS identify and correct a higher proportion of misvalued services.

But inaccuracies could remain in the fee schedule. Some may persist because due to low volume the services have not been identified for review. Other inaccuracies could

remain because a service did not experience a large change in any single factor that flagged it for review. Rather, it may undergo small changes in several factors that in combination would warrant reevaluation.

So that the draft recommendation is that, to ensure the validity of the physician fee schedule the Secretary should review all services periodically.

We recognize that the resources of the RUC and the Secretary are limited. There are different ways to achieve the review we propose here, and the Secretary should choose a strategy that best fits the agency's resource constraints. One approach is for CMS, on a annual basis, to select a sample of codes from those that have not yet been reviewed and have its own panel of experts consider the valuations. Those services that appear to warrant review could be forwarded to the RUC. The RUC in turn would use its regular process to review the services and make recommendations to CMS.

The chapter will include the implications of these recommendations. We anticipate that the recommendations will not change benefit spending but may require additional program funding. We expect that the implications for

beneficiaries will be minimal. To the extent that the recommendations result in greater payment accuracy there may be some redistributive effect for providers.

That concludes our presentation and we look forward to your comments.

MR. HACKBARTH: Questions or comments on this chapter and recommendations?

MR. SMITH: I think both the chapter and the presentation capture what we talked about last month. I had two minor suggested language changes, which I don't think change substance.

In recommendation one it seems to me we ought to say misvalued rather than overvalued.

In recommendation three, I'd remove the unnecessary qualifying language. I'd remove selected. It seems to me that the process that comes -- after a specified period of review for selected recently introduced. It seems to me we wanted to say all recently introduced. You could decide that no further review is possible but this suggests a two-stage selection process which doesn't seem to me to make sense.

Then I think I'd get rid of waffly, unnecessary

the first part of the next sentence, where appropriate, services should be assessed as soon as practicable. Services should be reviewed as practicable. We don't need to say, where appropriate. We're saying the same thing twice. Its not a substantive point I don't think.

MR. HACKBARTH: Can I go back to your suggestion on recommendation one? Changing overvalued to misvalued in the second line, is that what you proposed?

MR. SMITH: It just seems to me to be a gratuitous whack that we don't need to take.

MR. HACKBARTH: As I said at the December meeting, my own evolution on this issue has been to come to accept that the people who work in the RUC process are investing a lot of effort in doing this and my concern about it have become that the process is inherently skewed toward looking at services that are undervalued as opposed to overvalued. That's what they has an interest in bringing to the table, an interest in investing the resources in data collection and the like.

So the fundamental thrust of this chapter and these recommendations from my perspective is that for this process to work we need to rebalance it, and we need to take

care and develop some mechanisms that will assure that overvalued services are identified as well as undervalued. So I think that the pointedness of this statement is exactly what's called for, given the context of the review and our findings in the review.

MR. SMITH: I agree with everything you said except the necessity to be pointed. Recommendations two, three and four are designed to do exactly what you describe as necessary and appropriate. I agree with that. It doesn't seem to me we need to use recommendation one to suggest -- the process is flawed here rather than -- the process invites consideration, as you say, which look undervalued to practitioners. We've suggested in recommendations two, three and four ways to make the process less tilted in that direction. I don't want to belabor this. It just doesn't seem to me we need to use one to say they're bad people.

MR. HACKBARTH: Let me be absolutely, unquestionably clear. That is not what I see as the implication of recommendation one. There is no implication in my view that they are bad people. The process is, however -- it just has inherent incentives in it. In fact

an important part of rebalancing is in fact the establishment of this panel in saying that we can't expect the RUC process as currently designed to go after overvalued. We need an alternative mechanism. It is the mechanism described in recommendation one for the first time. So I think it's appropriate there to say their job is, first and foremost, to rebalance the system, and that is to identify, help CMS in the task of identifying overvalued services.

DR. REISCHAUER: You also don't want them spending a lot of energy spending what the RUC is going to find anyway.

MR. SMITH: I don't disagree with that. I think recommendations two, three and four explicitly take that on, but I --

MR. HACKBARTH: So let's again look at the text language. I want it to be absolutely clear that there's no attribution of bad motives, but the process does have certain incentives in it and I see this as a way of dealing with that.

Just remind people about the proposed change in recommendation three, Dave.

MR. SMITH: What I was suggesting is that we simply ought to remove the word selected from the third line. Over a specified period we should review all recently introduced services. And then, where appropriate, should be assessed -- it seems to me we're establishing a two-step process here where only one is necessary. There ought to be a presumption that recently introduced services, people have learned to do them better, there's been a volume effect so that we ought to look at them, not necessarily reduce them, which was the discussion we had last time. And where appropriate, the review should take place as soon as possible.

DR. REISCHAUER: But I think what Alan pointed out is that there are a class of new codes or whatever that one wouldn't expect, the cognitive ones and all that --

MR. SMITH: Right, but then the review would conclude that.

DR. REISCHAUER: The question is whether to give them a free ride up front or later on.

DR. MILLER: That's exactly what we're trying to craft here, because in that conversation beyond the automatic discussion there was the differentiation that Alan

was making on new. So what we're trying to say is when a new service is introduced, the Secretary and this panel would look at them and, in a sense, tag certain of them to be reviewed soon.

I definitely see some of your other changes. I could see coming along here and saying, in consultation with the expert panel the Secretary would initiate reviews of the work values for selected recently introduced services. Then in the second sentence say, these services should be assessed by the RUC as soon as practicable. What we're saying is, for some new services, identify those that should be reviewed soon, and some of what we're trying to say here is -- Sheila was concerned that they not wait till the next five-year review.

MR. SMITH: Let me belabor this one. What I'm trying to avoid here is the, before we know anything new, presumption that we're not going to learn anything. So what I'm suggesting is that we look at all recently introduced services. Some will fall into Alan's category and we will learn that. But why have the presumption that we know the answer at the date that we introduce the new code? I'm not suggesting that we undertake a process of reducing all new

ones. I'm saying, let's look at it and have this evidence based rather than our best guess based.

DR. SCANLON: Can I ask a question? The issue for me is, who's the we? Is the we the Secretary and the panel or the we the RUC? Because I think --

MR. SMITH: I think it's the Secretary and the panel.

DR. SCANLON: It's not clear in this language. We used review in two different ways. We talk about reviews of the work relative values; should initiate reviews of the work relatives, the Secretary in the first sentence. Then in the second sentence in the second part of that, reviews should not be postponed. But these are RUC reviews in the second sentence.

So if we're clear -- and I had the same problem. Part of my first read of when we talked about selected procedures I thought, no, we shouldn't be biasing this in any way. We should be looking at all in some way. I think that if we make clear that it's the Secretary and his expert panel that reviews all procedures and decides which ones should then go to the RUC for a RUC review that would solve it for me.

DR. MILLER: That is the concept that we were trying to capture here, that new services are brought in, the Secretary of the panel -- just to be absolutely clear about this -- looks at these services and says, some of these are going to change in the short run and should go back into the RUC review process earlier than a five-year review process. That's the concept that we're trying to capture here.

So with that can we maybe go back to the language here. Bill, you're looking for a tighter connection between the Secretary and the panel in the first instance?

DR. SCANLON: The first sentence as it stands alone would be fine. I think that the question would be in the second sentence whether it should be, where appropriate, the selected services should be referred to the RUC for a RUC review -- a review by the RUC. There's two reviews that we're talking about. There's the screener and then there's the RUC review.

MR. HACKBARTH: So what you're saying is that for the second sentence you'd like it to be clear that the Secretary's panel is referring services to the RUC for their review as soon as practicable.

DR. SCANLON: Yes.

DR. MILLER: How does this work on that concept? The second sentence would read as follows. These selected services should be referred to the RUC for assessment as soon as practicable.

DR. KANE: Isn't the problem what the word selected means and when it occurs? I thought we were saying that at the beginning when the code is first approved it's going to be reviewed in a shorter period and then determined whether it needs a special -- whether it should be selected. That's what the Secretary and the panel are doing is doing the selecting.

MR. HACKBARTH: I don't think there is a major substantive disagreement. It's a matter of presentation here. One of our recommendation says the all codes ought to be periodically reviewed, so I've thought of recommendation three as saying not just that everything should be reviewed, even all new ones, but somebody needs to exercise some judgment here. They need to highlight certain codes, new codes that are particularly likely to experience this downward cost curve and make sure that get reviewed early. So the use of selected was to convey that fact that there is

an exercise of judgment. A counseling code isn't likely to experience that, whereas another procedure code might.

DR. NELSON: Or a blood test. Some of them are endocrine hormone blood tests, they now have a code.

MR. HACKBARTH: To pretend that all new codes are equally likely to be referred I just don't think is right. Potentially if it's done that way is a waste of scarce resources, which is another point we make, that their resources are limited. At the end of the day though I don't see that there's disagreement about the substantive point. It's just all in the presentation.

MR. SMITH: Just simple, where appropriate, services should be reviewed by the RUC. Selected, I already said, makes the sentence less readable rather than changes the point.

DR. SCANLON: -- an edit not on the fly. That would be to change the first sentence to remove selected and end it with, to identify those services that should be reviewed by the RUC. Then drop where appropriate and say, those services you should be assessed by the RUC as soon as is practicable. Those reviews should not be postponed until the upcoming five-year cycle.

MR. HACKBARTH: One more time, Bill, the first sentence.

DR. SCANLON: In the first sentence we'll drop selected and we will add to the end of that sentence, to identify those services that should be reviewed by the RUC. Then in the second sentence drop, where appropriate, and say, those services should be assessed by the RUC as soon as is practicable; those reviews should not be postponed. Does that capture what we're saying? Two sets of reviews.

DR. REISCHAUER: In a sense, I think you drop the stuff about not postpone till the five year and just put that in the text. It seems like we're saying the same thing twice.

DR. NELSON: Can we come back to that?

MR. HACKBARTH: Yes, I think that's the best thing. To try to edit as a group real-time is always problematic for me. If people want to tinker with the language, let's have the staff work on refining it and then we'll reserve a vote for the final language. Again, I don't think that we're talking about a substantive disagreement here but a matter of presentation.

DR. KANE: But it's still not clear whether you

want these services, once the code is approved, put in certain buckets right away or whether you want after a specified period for all to be reviewed and then the ones -- I remember originally we thought some should just go into buckets of don't -- do you want everything reviewed after a specified period or do you want --

MR. SMITH: I think what Bill just said captured what I thought I said, which is that the Secretary and the panel should look at everything. They should say, we have reason to think this one experiencing a downward cost curve, the RUC ought to review it. This one is a counseling code. We don't think there's any reason to expect a downward cost curve, the RUC ought not to review it.

MR. HACKBARTH: Let's move on from editing to other issues. Bill, did you have something else to raise?

DR. SCANLON: Just I would in part respond to what Nancy just raised which is, I was more comfortable with the way the recommendation -- even though we're about to revise this -- is on the screen as opposed to what was in the draft, because I think the consultation with the expert panel is a key part of this. It's the idea -- the draft suggests that we might be able to, in some respects, develop

a process that's almost automatic in terms of being able to put procedures into different buckets or to identify what is the right reduction, and I don't think it's going to work out that easily. I think you need the input of the expert panel.

This is the more general point. I think we shouldn't underestimate how resource intensive this activity is going to be. It's not just a question of an expert panel and the fact that the expert panel is going to have to have support in terms of data analysis. We don't have the data. It's the data collection. Data collection is the most expensive part of research and that's going to need happen to make this really work. I think right now in our text discussion of recommendation three that we imply that we can develop models and do this in some ways in an efficient manner. I think we need to be more cautious and underscore again that there is going to really be the need for input, both the expert panel and new data, and that we have to be willing to pay for that if we want this to work well.

DR. STOWERS: Mine may be a minor point. It goes back to Figure 3.4 in our chapter where we had the expert panel provides assistance in reviewing RUC recommendations

and a solid line going up to reviewing recommendations, all recommendations I would assume that come out of the RUC, and only a dotted line going back over to what we've talked so much about and that's identifying misvalued codes.

Recommendation one talks about identifying overvalued services, and even though we say in here the panel should not supplant the RUC which provides valuable service to CMS, we go on in the chapter only to talk about identifying misvalued codes.

I just think we need to be, maybe in the chapter, a little more clear about the part two review recommendations from the RUC. Where CMS, at least in my experience has used ad hoc committees to help them when RUC makes its recommendations before the proposed rule comes out, we're now going to have a much more, formalized body there. I just want to be sure that we're not creating on all RUC recommendations a body that has much more influence on CMS, and therefore, possibly diminishing the influence of the medical profession through the RUC on values of codes.

I just think we need to be a little more clear on that second function there or reviewing recommendations to the RUC, that we're not creating another wall between the

RUC recommendations and CMS and that it really, truly is there just to provide assistance and analysis of the RUC recommendations. I think we go through and do that as it applies to misvalued codes, but I don't think we go that next step and talk about the influence it might have on all recommendations from the RUC.

MR. HACKBARTH: Any others?

Okay, we will work on the language. We've got potential language changes on how many now? Was it one and three? Why don't we just do them all at once?

MR. SMITH: I think the suggested change on one, I think the discussion made it clear that we're on the same point.

MR. HACKBARTH: We'll just come back and vote on them all as a package. That's the way they ought to be considered. So are we finished on this?

Okay, thank you very much. We will now have our public comment period with the usual ground rules that you get so tired of hearing me repeat. Please keep your comments brief and not repetitive.

* MR. DOUGHERTY: Good afternoon. My name is Bob Dougherty. I'm senior vice president, governmental affairs

and public policy for the American College of Physicians. I just want to make a few comments in the context of the discussion of valuing physicians services. I think many of you know ACP represents internal medicine physicians and medical students and we are the largest specialty society representing both generalists as well as subspecialists in internal medicine.

A few comments. First of all, we appreciate the Commission's continued support for the need to evaluate the impact of payment policy on primary care. We see that we are facing a looming crisis in access to primary care services in this country and we believe that Medicare payment policy is a significant factor in creating a circumstance that primary care is less attractive for people to go into as well as making it less attractive for those already in practice. I just want to give you a few numbers to indicate how bad the situation is getting.

According to AAMC exit survey of graduating seniors, the number of students choosing general internal medicine as a career has dropped precipitously over four years from 12.2 percent in 1999 to 10.2 percent in 2000, to 6.7 percent in 2001 to only 5.9 percent in 2002. We're

hearing more recent reports that in many classes nobody is going into general internal medicine or family practice.

Another study found that in 1998 54 percent of third-year internal medicine residents plan to practice general internal medicine compared to only 27 percent in 2003. Strikingly, in 2003, only 19 percent of first-year internal medicine residents plan to pursue careers in general internal medicine. You see this when you look at the matches for family practice and internal medicine as well.

This trend is occurring at the same time that many established physicians are nearing retirement age and many are getting out because of the frustrations of practice. Since it takes a minimum of seven years to train an internist or family physician to practice primary care, unless there's action taken now to begin addressing the impact of payment policy on this trend it's going to be too late by the time the baby boom population hits Medicare age.

As the Commission works on these issues I would suggest and applaud you for concentrating in three areas I know are already part of your work plan. First, Medicare payment policy should reward physicians for doing better;

better in terms of quality, efficiency and patient experience measures, not just doing more. We thank Chairman Hackbarth for including ACP's new policy paper on linking payments to quality in the materials sent to the commissioners and we hope to work with you in trying to come up with recommendations to Congress on a pay for quality program that really would create the right incentives, including recognizing the substantial costs that physicians and small practices, particularly primary care physicians, have to acquire in terms of investing in the technology and supportive systems to improve quality of care.

We also believe an important point made in that paper is the rewards needs to be commensurate with performance. That those who are doing more to move the quality bar up should be able to get adequate reimbursement for doing so.

Secondly, that we agree that the processes and methods for valuing services need to be re-examined. We are supportive of the direction you're going in n terms of the expert panel to supplement the work done of the RUC to identify potentially overvalued or misvalued services. We think that's an important step and I think the RUC itself

would acknowledge that the current process is not very good for identifying potentially overvalued services.

We also support your call for the RUC to re-examine its composition. We are strong supporters of the RUC and have been from the very beginning, continue to support the RUC process. We think it's extremely important that medicine have an ability to influence discussions over the relative values of physician work. But we do believe that the RUC needs to re-examine its composition to take into account the contributions of different specialties and the role of different specialties in terms of taking care of Medicare patients. In 2004 almost half of all Medicare patient visits were to primary care doctors. We're pleased that the Commission will continue to monitor this situation as we work with the RUC, Dr. Rich, AMA staff and others. We've had some very good discussions with AMA and Dr. Rich about our concerns about the composition.

Third, we need new models for delivering and financing primary care that recognize the value of physician-guided care coordination. I know it's a topic you're going to be discussion later in the meeting. We believe such models should include payment reforms to

support the value of the physician's role in prevention, management and coordination of care for patients with chronic disease rather than just paying doctors based on the volume of services rendered to patients with acute illnesses.

In a couple of weeks we'll be releasing a new policy paper that's going to our board of regents for approval in two weeks. I assume they're going to approve it. What we're calling the advanced medical home. Now there's been a lot of literature about the medical home for years, but this is taking it in a different direction. This is saying that patients should have access to a practice where they have a personal physician who takes responsibility for the coordination of their care and that physician will practice in an office setting that will use proven methods that result in better quality, efficiency and better coordinated care, and we hope at lower cost. What we're going to be proposing is a series of changes in the financing of how we pay for services rendered in that kind of setting, support practices that qualify to do this kind of care coordination. In our model they would have to go through qualifications in order to qualify for additional

payments as well as see care management fees that would recognize the value of services provided outside the face-to-face visit.

Again I thank you for your emphasis on the issues related to primary care and payment policy. We look forward to working with you further.

MR. SCHLECHT: Mr. Chair, I just wanted to thank you for the opportunity to make comments here. I am Joseph Schlecht. My specialty is family practice. I represent the American Osteopathic Association. I am the AOA's advisor to the RUC and a member of the medical executive committee. This is a primary care group that has been evaluating the RVWs for E/M services.

I want to start off by commenting that the AOA strongly supports the RUC process and will continue to do that. The AOA also shares the medical executive committee's opinion the physician work involved in furnishing E/M services has increased over the past 10 years. It's interesting to note that there are 37 E/M codes, 28 of which the RUC has reached agreement on. But the problem lies in the fact that 9 remaining codes are the most critical codes. According to the Health Resources and Service Administration

2003 demographic report, adult patient needs for primary care physicians increase dramatically as they age. As everybody knows, we expect those over 85 over the next 20 years to quadruple; this with the United States Census Bureau.

The AOA believes that reimbursement rates for primary care physicians, whether this is a real or perceived, and I personally feel it is a very real problem, are a major factor in our medical students not choosing primary care specialties. We're losing the primary care specialties. The primary care specialties are the ones that will be delivering evidence-based medicine and quality reporting to the elderly population over the next 10, 15, 20 years and if we do not have them available to us then the Medicare population is not going to have the resource to be taken care of. Just my comments.

MR. SMITH: My name is Baldwin Smith. I'm a practicing neurology, member of the medical economics committee of the American Academy of Neurology, and a member of the RUC. We would like to thank MedPAC for their efforts to help our patients as we all share a common quest to improve their care.

In 1989, RBRVS was legislated by Congress with multiple goals. One of the goals was to correct the relative payment disparity of evaluation and management services versus imaging and laboratory services. This goal has not been met. The current system creates incentives to encourage procedural rather than patient-centered care. If we consider the Medicare system; i.e., RBRVS, as a market system we have problems with two components. One is the intensity. Another is the relative volume.

What is needed? Evaluation and management services have not kept up. Evaluation and management is currently being reviewed by the RUC for the first time in 10 years as part of the Medicare five-year review. We support the increasing intensity for Medicare services. Further, we would say we support and are committed to the RUC process.

A bigger problem, however, relates to the change in volume which was well pointed out by MedPAC in your discussions of November 17, 2005. I would specifically point to the bar graph that you presented on page 4 where you reviewed cumulative growth in volume of physician services per beneficiary from 1999 to 2003. It seemed that there was a disparity in the growth between E/M as well as

major procedures as compared with the group of "other procedures, imaging, and tests".

It is of interest that when we consider physician reimbursement, realizing that this is a complex matter with inputs from many factors including, but not limited to, market forces, supply, demand, et cetera, that we find some very interesting parallels to your cumulative data. When one reviews the median change in physician income over that same period, which MedPAC pointed out; i.e. 1999 to 2003, as reported by the Medical Group Management Association, it shows a significant, higher growth in median income of the groups of other procedures and imaging as compared to E/M. Or when we look at the major procedure, and we use general surgery as our surrogate, we see also increased growth in other procedures and imaging compared to the general surgery income.

We support the RUC in their review of those services that may create aberrant volume incentives.

Thank you for allowing me to make those comments.

DR. : Mr. Chairman, and members of the Commission, hello again. My name is Jim Reagan. I've told you the last few times, I'm a urologist down the street at

Georgetown. I'm a member of the American Medical Association. I also happen to be a member of the American College of Surgeons.

I certainly respect the comments of my cognitive colleagues and I would just urge you to remember that the five-year review process, specifically as it applies to E/M, is not done yet. I would like to think that reasonable heads will prevail and that we'll come to some reasonable conclusion to that in early February.

I would like to not hold you up much longer for lunch but I would like to talk about three things regarding the draft recommendations. This doesn't involve surgeons and non-surgeons. This is the house of medicine.

Number one, the appearance of fairness is very important in all this, and when you tell me that you're going to put on this expert panel private insurers alarms go off in my head, because my perspective as a caregiver is that they have different allegiances than I do. Sure they want to provide care to payers, but in many instances there are stockholders involved, et cetera. So be sure and strike a balance between the private insurers and the physicians, the clinicians on that expert panel. That's at least what I

would implore you to do.

The second thing is when you say that they will look at overvalued codes, what you're saying then is people who have overvalued codes, or when the panel identifies overvalued codes, they can come back sooner. As a physician who thinks I have an undervalued code, I have to wait till the five-year review. That's not fair either. So I think misvalued is the key there.

Then the third thing is that you're looking at -- and it applies to draft recommendation three -- you're talking about work relative value units, but remember, 40 percent of your payments are for practice expense. One of the things that I think CMS and we as caregivers have trouble with are the prices of all these supplies and equipment which change very dramatically. I think that's a very important thing that you need to include when you're looking at payment and reimbursement, not just work relative values.

Thank you very much.

MR. HACKBARTH: Okay, we will adjourn for lunch and reconvene at 1:30, which is a bit of a change in the schedule. And then the first order of business when we

reconvene will be to vote on the revised recommendations.

[Whereupon at 12:23 p.m. the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:40 p.m.]

MR. HACKBARTH: I know we've got just a few more people filing in but I'd like to get started.

The first order of business is to complete our discussion about the recommendations on valuing physician services. What I'd like to do is put up recommendation three. This is the recommendation that has been modified in response to the discussion. I'll give everybody just a quick minute to review it.

Any clarifications needed?

Hearing none, we will --

[Laughter.]

MR. HACKBARTH: Would you put up draft recommendation one and we'll proceed with our votes.

On recommendation number one, all opposed?

All in favor?

Abstentions?

Okay, number two. All opposed to number two?

All in favor?

Abstentions?

Number three, all opposed?

In favor?

Abstentions?

And number four, all opposed?

All in favor?

Abstentions?

Okay, we are finished. Thank you very much.

The first agenda item for this afternoon is the payment adequacy analysis and update recommendation for physicians.

* MS. BOCCUTI: First I'm going to review indicators of payment adequacy that you've seen before, but today I'm also going to introduce new data that was released by the Center for Studying Health Systems Change just yesterday. Then I'll talk about cost changes expected in 2007, and then go over a draft recommendation.

So a quick review of our findings on beneficiary access to physician services. Taken from several surveys we've found that most beneficiaries report little or no problems scheduling appointments and accessing physicians. A small share of beneficiaries, however, report having problems, particularly those who are transitioning beneficiaries such as those who've recently moved to an area or switched to Medicare fee-for-service coverage. Medicare

beneficiaries report similar access to physicians sd privately insured people age 50 to 64. And finally, large beneficiary surveys show that access was pretty much stable between 2003 and 2004.

Now I'd like to summarize new data released just yesterday from the Center for Studying Health Systems Change. As many of you probably know, HSC conducts the community tracking study which includes a physician survey component. This phone survey is designed to be nationally representative of physicians involved in direct patient care. It's now been conducted three times and the study years are up there on the slide. So the numbers on those cells of the slide are the percentages of physicians accepting Medicare and private patients by their level of acceptance. So you see all, most, some, and none.

We see here that in the most recent survey, 73 percent of physicians accepted all new Medicare patients and only 3 percent completely closed their practice to new Medicare patients. HSC's take-away is that while there was a dip between 2996 and 2000, we see some middling in 2004 that suggest stabilization. Further, flat out rejection of all Medicare patients continues to be at very low rates.

I'll note here that these results are consistent with those that I presented NAMCS before and in that national federal survey about 94 percent of physicians said they were accepting new Medicare patients. So you would compare that 94 percent number to the total of the all, most, and some cells there.

Another take-away from the HSC survey is that over the last decade physician acceptance of Medicare patients has followed a similar trend as privately insured patients, similar to what we found with the beneficiary access surveys. This suggests that overall health system dynamics have played a larger role in physician decisions about accepting Medicare patients than actual Medicare payment levels.

I've listed much of what I've just said on the first three bullets of this slide, but I thought it would be helpful to have them written up here since the study just came out. So now I'll just draw your attention to the last bullet. Specialists continue to be more likely to accept new Medicare patients, but the survey did show that they found a greater increase in Medicare acceptance rates for primary care physicians.

One other finding that's not listed on the slide is the reasons that physicians gave for not accepting new Medicare patients. For the 3 percent of physicians who said that they were no longer accepting Medicare patients or that they just don't, the top reasons they gave were inadequate reimbursement, billing and paperwork, clinical burden of Medicare patients, and their practice is too full.

So on this slide I'll quickly review the other indicators which you've seen before. All of these come from our claims analyses. For supply we found that the number of physicians billing Medicare has kept pace with Medicare enrollment. This held true even when we separated physicians by the size of their Medicare caseload. We also found that the difference between Medicare and private fees averaged across all types and service areas has steadied over the last several years. We did see a slight narrowing in 2004 which indicates that in 2004 Medicare grew a little faster than private fees on average.

We saw continued rapid growth in the use of physician services per beneficiary. Across all services, per capita volume grew about 6 percent from 2003 to 2004. Imaging, other procedures, that's like non-major procedures,

and tests grew the most. E/M and major procedures did not grow as quickly. As you know, these increases have resulted in substantial increases in Part B spending. In 2004 alone, CMS found that total spending on physician related services increased by about 12 percent.

Then for quality, this year we looked at ambulatory care quality indicators. We focused on two general measures, ones the captured the use of clinically necessary services and ones that captured the rates of potentially avoidable hospitalizations. We found that on most of these indicators rates were either stable or showed some improvement between 2002 and 2004.

So in sum, our adequacy analysis from available data suggests that beneficiaries are able to access physician services.

For the second part of our update framework we look at changes in costs for 2007. The preliminary forecast for input price inflation is an increase of 3.7 percent. That's provided in CMS's MEI. Revised quarterly estimates increased this number by one-tenth since the ones I showed you last month. I'll note that although PLI continues to be the fastest-growing input, PLI premium increases have slowed

from their extremely high rates in previous years.

On one other note, I want you to recall that the MEI is designed to account for an average price change for all physicians. In contrast, remember that the fee schedule is the tool that primarily adjusts for service and area. So when physicians have services that they provide that attached to higher -- like high risk, they can charge that with the service.

Then on to productivity. The other factor we consider in our input cost analysis is productivity growth. Our analysis of trends in multifactor productivity suggests a goal of 0.9 percent.

A couple of other technical details I want to mention here are that current law calls for a 4.6 percent fee cut in 2007. That's the year for which we are making the recommendation. Then for 2006, the Deficit Reduction Act holds the fees at 2005 levels.

So our adequacy findings, including the volume analysis, shows that beneficiaries are generally able to access sufficient services. With that summary we'll go to the draft recommendation here.

The Congress should update payments for physician

services by the projected change in input prices less expected productivity for 2007. Spending implications up on the slide are that it would increase Medicare spending by greater than $1.5 billion in one year and $5 billion to $10 billion over five years.

Beneficiary and provider implications are that it would increase beneficiary cost sharing and would maintain current supply of and access to physicians.

This last slide lists some additional comments to include in chapter with the recommendation. First, MedPAC does not support the cuts scheduled through 2011.

Second, the Commission is concerned that consecutive annual cuts would threaten beneficiary access to physician services. The Commission is especially concerned about how these cuts might affect access to primary care services. On that note I'll mention that timely monitoring of access will be important in 2006.

Finally, MedPAC considers the SGR formula a flawed, inequitable mechanism for volume control and plans to examine alternative approaches to it in the coming year.

I'm happy to take any questions.

MR. HACKBARTH: On the draft recommendation, we'd

make the same language change about productivity and we made in the preceding one to make it clear that it's the productivity expectation as opposed to projected productivity.

Questions, comments Cristina's presentation?

DR. WOLTER: Just a question. The potential increase in spending if this recommendation were adopted is relative to current law, which includes the decreases, correct?

MS. BOCCUTI: Yes. It holds, whether the increases -- what is really current law, which is the cut, or if it were the 2005 levels payments.

MR. HACKBARTH: So even if the Deficit Reduction Act is enacted and signed into law these amounts wouldn't change because they're big buckets.

MS. BOCCUTI: Correct, the buckets are so big and there are other restraints with the SGR that these estimates fit in with that given either.

DR. WOLTER: So we would see these increases in spending if the reconciliation bill passes? So these are increases relative to current or projected spending?

MS. BOCCUTI: That's correct, because remember it

was a 4.5 percent cut, so that's a big difference right there whether you're going from zero or higher. It's the percentage points different.

DR. KANE: So the $1.5 billion in year one is more expensive than zero or minus four?

MS. BOCCUTI: Both.

MR. HACKBARTH: Greater than $1.5 billion.

MS. BOCCUTI: Greater than $1.5 billion. There's no right side to that.

MR. HACKBARTH: Let's just go back and review the method that we use here. Because we don't have the capability to do specific point estimates for budget implications -- not only do we not have the resources here but there is an agency, namely CBO, that has that institutional responsibility, we try to avoid doing very specific estimates. So what we do instead is these big buckets, as Cristina said, and the top category is greater than $1.5 billion effect in year one, and this one is going to fall in that regardless of whether there's a 4.6 percent cut used as the baseline or a freeze used as the baseline. It's going to be over $1.5 billion.

MS. PODULKA: Also recall that this is for 2007,

and 2006 is what the Deficit Reduction Act refers to.

MR. HACKBARTH: Right. Then the same applies to the big bucket for five years.

DR. KANE: On the hospital inpatient ESRD we were able to get down to the difference between $50- and $200 million, and $200- and $600 million, but then we go over $1.5 billion we stop calibrating the impact?

DR. MILLER: Just to go through this. What we did a couple of years ago when Congress asked us to be more conscious of the budgetary effects and the efficient provider, what we did when we went through this process, we delineated the buckets. So 50 to 100, 100 to 200, that type of thing, for one year, and then we have different buckets for five years. $1.5 billion as the top bucket works for just about everything except this place where the baseline is driven so far down, any change off of that is like all four or five points right off of baseline and it just blows that top bucket away. That's what you're seeing happen here. This is something that we went through a couple years ago and delineated the buckets, and like I said for 95 percent of what we do they work just fine, and here is where we lose it.

Now I think the Deficit Reduction Act CBO estimate for the freeze, for example, I'm trying to remember the specific estimate that CBO said, the one-year effect. I've got a five-year effect of CBO scoring of $7 billion for the freeze, and then it begins over 10 years to become -- actually go back to zero because the SGR pulls the money out. So just to size it for you, the deficit reduction brings it up to zero for 2006 -- which is a completely different discussion but just to give you a sense -- it's a $7 billion impact. For most of what we do, we don't have buckets that big.

MR. HACKBARTH: Other questions or comments?

I have a couple if somebody else does. Can we go to the last slide about additional comments and the second bullet about consecutive cuts threatening beneficiary access, particularly primary care. I agree with that.

In addition to that, my concern is that repeated cuts or really stringent fee restraint extended out into the future may not only threaten access to primary care but in the long run threaten the supply of primary care physicians, which would in turn threaten access. But it's not that just, we'll have plenty of primary care physicians and they

just won't take Medicare beneficiaries. My concern is that the burden of this would fall disproportionately on primary care and it takes the health care system in the wrong direction. I think that's a point that based on previous conversations everybody shares, so I'd just like to expand it a little bit.

MS. BOCCUTI: In the text?

MR. HACKBARTH: In the text, exactly.

Then the other point was, going back to the data on access it's reassuring to see that HSC has come up with quite similar numbers to ours and that there seems to be stability. Often I hear from people, in my particular community that's not the way it is. In fact, literally, in my particular community these numbers probably would be very different. I think it's important for us always to recognize that.

The problem isn't that the aggregate numbers are wrong. The fact of the matter is that this access varies by market. In some individual markets like my own have unique circumstances that may contribute to worse access problems for Medicare beneficiaries, or for new patients in general. I live in a very rapidly growing community and from what I

hear talking to a wide variety of people it's very difficult for a new Medicare beneficiary moving into the community to find a primary care physician. But I think that has less to do with Medicare rates in the first instance than it does with the significant imbalance in the supply of patients and physicians due to rapid growth. I know there are other communities that are experiencing similar problems.

The solution for those problems is not an across-the-board increase in Medicare fees. In fact, as I say, often problems for Medicare beneficiaries go hand in hand with problems for privately insured patients new to the community as well.

DR. CROSSON: And that data seems to bear that out.

MS. DePARLE: I was interested in the Center for Studying Health Systems Change data that you presented. I just looked through the written paper and it isn't in there because it just came out, right? So you mentioned four reasons why physicians were saying they weren't accepting new Medicare patients and I thought that was really interesting. I wondered if you had the actual numbers, percentages behind each one of those. The one that I was

most interested in was the one about finding Medicare patients too clinically complex. So I'm interested in what the number is and how many of the people who were in the survey were primary care physicians versus specialists. Is that the first time we've seen that kind of --

MS. BOCCUTI: No, in fact the work that -- MedPAC sponsored the survey in 2002 and asked similar questions and these findings are comparable to those as well. Just recall that these are of the 3 percent that said they aren't, which I don't is in their paper either about -- did they ask this question to those who aren't taking private patients? And if so, what were those findings? But with that caveat -- so the percent of physicians who say that the reason is due to inadequate reimbursement was about 70 percent, billing 61 percent, clinical burden of Medicare patients which you asked for is about 45 percent, practice too full, about 41 percent, and another one about concern about audit was 28 percent.

MS. DePARLE: So this wasn't open-ended. They had a list of factors and they could check off the ones that applied?

MS. BOCCUTI: I believe so, right. So they could

check off more than one. These had to be moderately or very important.

MS. DePARLE: But your headline was the 3 percent hasn't changed really.

MS. BOCCUTI: Correct, and it is similar to the not accepting private patients. It's just delving a little bit further, when somebody doesn't take Medicare, why? So it delves into this. But practice too full, that's really -- you can start to ask --

MS. DePARLE: It's very judgmental.

MS. BOCCUTI: It's just is that a Medicare issue or not. It comes to what Glenn is talking about.

I saw that Annissa just handed this to you. So this is out. If anybody needs a copy we can get that to you. You also had a question about the number --

MS. DePARLE: About the specialists versus primary care.

MS. BOCCUTI: In terms of what's in this sample, let me look a little deeper and see if I can answer that for you. There's some more information on here about how they responded. But it's definitely focused on those who have direct patient care, but I have to look a little bit further

to say where they are in terms of share of sample size.

MR. HACKBARTH: Any others?

MS. HANSEN: This is in relationship to the recommendation and the impact to beneficiaries. If I could just pick up on the earlier comment perhaps delineating a little bit as to what that percentage of increase will end up affecting the beneficiary, whether it's the Part B side that we talked about earlier, just as a measure to track on a go-forward basis, just because -- for example, Social Security, one of the things I think that a certain amount of out-of-pocket -- excuse me, the amount should never higher, I believe, than the Social Security difference. If that's the case, just for us to keep track as to what percentage people are still having to spend out of that. So if we could just have that kind of personalized impact understanding over time.

MS. BOCCUTI: If we can try to put a little bit more information on how it would be split up. That's what you want? It's projected the future but we can do that.

MR. HACKBARTH: Anybody else?

If not, let's proceed to the vote. All opposed to the recommendation?

All in favor?

Abstentions?

Okay, thank you.

Next is skilled nursing facilities. Kathryn, before you begin let me just say a word about the post-acute providers as a group. We're now going to consider the update recommendations for the four groups of post-acute providers SNFs, home health agencies, inpatient rehab, and long-term care hospitals. As we discussed at the December meeting we are going to combine those recommendations in a single chapter about post-acute care. The chapter will lead with an introduction that provides an overview our concerns about post-acute payment policy. You have a copy of that -- it was in your notebooks -- and I hope everybody has had a chance to read it.

As I see it there are two basic concerns that we have that are overarching about these payment systems. One is that within individual systems we are not always confident that the dollars are allocated properly for different types of patients. That is, that the case mix systems are working properly. In particular that's a point that we've made repeatedly in the case of the home health

payment system and the SNF payment system.

A second concern is that we're not confident that patients are being assigned properly to the institution best able to meet their needs, with best able defined as provide a combination of quality service at the lowest possible cost for the program. For example, in the case of long-term care hospitals, when we did our in-depth work on that we came away convinced that some patients at least were going to long-term care hospitals at high expense to the Medicare program that could have been suitably treated in an alternative combination, some combination of SNF and home health, et cetera.

Both of those problems are very important and neither is a new message, but in December we agreed that that would be part of the overall presentation on these updates.

In addition, the draft in the notebook, quite appropriately I thought, included a discussion from earlier reports about potential directions that we might take to begin improving payment in the post-acute area. Much work remains to be done before those are concrete policy recommendations, but I think it was appropriate or is

appropriate to at least lay out those statements about general direction.

So with that preface let's now turn to the SNF update recommendation and adequacy analysis.

* MS. LINEHAN: As Glenn said, I'm going to do the first of four post-acute presentations this afternoon on skilled nursing facilities. I'll summarize our most recent evidence to inform three recommendations, one on the payment update, one on payment distribution, and one on quality measurement improvement.

To review briefly, our indicators of SNF payment advocacy are generally positive. The overall supply of providers remained stable in 2005 with the share of freestanding SNFs growing and the share of hospital-based declining. Volume as measured by total days, total stays, and total payments increased in 2003, the latest year for which we have data. Increases in the number of SNF stays, even with the loss of some payment add-ons suggests access for Medicare beneficiaries is good. We continue to have limited measures of SNF quality with two MDS-derived measures showing no change over time and one showing improvement. We were unable to update the readmissions for

the potentially avoidable conditions for this cycle but the data we have since the PPS was implemented through 2002 shows slight increases in rehospitalizations.

Access to capital for SNFs varies by nursing home control, size, and whether the facility is part of a larger organization. Several large changes that operate skilled nursing facilities saw their stock values increase over the past year and several chains reported construction or renovation. An analyst we spoke to said that investors see untapped value in nursing facilities and have purchased or expressed interest in purchasing nursing homes over the past year. The not-for-profits appear to face more limited access to capital although data on the demand for and access to capital is generally less available for the not-for-profits. But in general, analysts have a negative outlook for non-profit SNFs and public debt issuance for non-profits dropped again in 2004.

In fiscal year 2004, Medicare margins for freestanding SNFs, which are about 90 percent of all SNFs, averaged 13.5 percent. Margins for rural SNFs continue to be higher than those for urban facilities. As I discussed in December, we see other differences in margins between

facilities based on ownership status and other facility characteristics. For-profits had margins of 16 percent and non-profits had margins of 4 percent in 2004. As you know, hospital-based SNFs had negative margins. They were negative 86 percent in 2004.

We do know a few things about the cost and case mix differences between the for-profits and not-for-profits that I outlined in December, although nothing conclusive about the relative efficiency of these provider types. And similar long-standing differences between hospital-based and freestanding SNF margins have raised the issue of whether hospital-based SNFs are furnishing a different product or treating different patients than freestanding facilities.

One recent study by the Urban Institute found differences between hospital-based and freestanding SNFs, including higher routine costs -- that's nursing -- overhead costs, and higher non-therapy ancillary costs. They also found shorter lengths of stay and differences in case mix as measured by RUGs. The study concluded that in the absence of good risk-adjusted outcomes data to compare facility types it's unknown whether these higher costs though result in better quality and therefore whether they should receive

differential payments.

Another recent MedPAC-sponsored study conducted by investigators at the University of North Carolina looked at the question of outcomes differences between hospital-based and freestanding SNFs. Looking at unadjusted data, hospital-based SNFs have better outcomes on three measures, length of stay, discharge to the community after 30 days, and preventable rehospitalizations. They have better outcomes than freestanding SNFs. But the study found that controlling for selection of patients eliminates the majority of the differences on these three outcomes.

This finding suggests that some of the differences in outcomes among different types of SNFs are due to patient selection rather than practice pattern differences or differences in efficiency, and this complicates the interpretation of higher costs in hospital-based SNFs.

In future work we plan to investigate alternatives to the current SNF payment system, including more accurate targeting payments for non-therapy ancillary costs. In addition, we plan to look more closely at hospital-based SNF costs by looking at costs and payments for overall episodes of care, the inpatient and post-acute portions of the stay

together, to better understand practice patterns and costs for hospitals with hospital-based SNFs.

As Mark mentioned earlier, we also plan to visit hospital-based SNFs and other post-acute providers in markets where hospital-based SNFs have stayed open, where they've closed, to better understand the post-acute care environment and reasons providers have closed or stayed open.

Now turning to the margin projection for 2006. We estimate the 2006 Medicare margin for freestanding SNFs to be 9.7 percent based on policy in current law. Changes to bad debt reimbursement policy and the Deficit Reduction Act would reduce the overall margin to 9.4 percent. I can talk more about this provision and the details of this provisions on question if you'd like. The reduction between 2004 and 2006 is a function of a combination of SNFs receiving a full market basket update, but also RUG refinements and the accompanying elimination of temporary payment add-ons with the RUG refinements.

CMS estimates that in 2006 the combined effect of all these payment changes will be a 0.1 percent increase for all facilities, and a negative 0.4 percent for freestanding

SNFs. Hospital-based SNFs are estimated to recent payment increases. Urban hospital-based SNFs are expected to see increases of 4.6 percent and rurals 4.1 percent.

This brings us to the update recommendation we discussed in December, which is to eliminate the SNF payment update for fiscal year 2007. Current law provides for a full market basket update in 2007, but providers should be able to accommodate cost increases in the next year without an increase in the base rate for SNFs.

The implications of this recommendation are a reduction in Medicare spending relative to current law by $200- to $600 million for fiscal year 2007, and $1 billion- to $5 billion over five years. No effect on providers' ability to furnish care to Medicare beneficiaries is expected as a result of this recommendation.

This brings us to our second recommendation related to the distribution of SNF payments. Although the base payment rate is more than adequate to cover the cost of SNF care for Medicare beneficiaries, the Commission and others have long recommended RUG refinement to improve the distribution of payments and incentives in the payment system. As we commented on the refinements implemented by

CMS for fiscal year 2006, the changes they made don't address the fundamental problems with the case mix system, payments for non-therapy ancillary costs, payments for rehabilitation based on the actual or estimated amount of therapy provided, and the old data that the case mix system is currently based on.

Given that problems with the patient classification system have not yet been addressed we're still recommending that it be refined. This new classification should reflect clinically relevant categories of patients, should more accurately distribute payments for non-therapy ancillary services, should provide incentives to provide rehabilitation services based on the need for therapy, and should be based on more contemporary representative data than the current system based on time study data from 1990, 1995, and 1997.

As I mentioned, we will be pursuing research into classification system revisions including revisions to the RUGS as well as more fundamental changes.

There isn't a spending implication because it would be implemented in a budget neutral manner. This is expected to improve beneficiary access and have

redistributive payment effects on providers.

Finally, because of the limited set of currently used SNF quality measures and the need to compare outcomes across SNFs and across post-acute settings, we continue to investigate avenues for measuring SNF quality and ways to improve the data to assess SNF quality. The three MDS measures that are the only publicly reported SNF quality measures are limited for several reasons that I'm not going to review again here but I can on question if you'd like.

Last year we recommended additional ways to improve quality measurement for SNFs, including the assessment of functional status at admission and discharge from the SNF for all patients. We also discussed measures that have been developed by researchers to assess important dimensions of SNF care but are not currently publicly reported by CMS. These are rehospitalization and discharged to the community. They could be calculated from existing data but are not, as I said, currently part of the measure set.

This year we also reviewed literature and interviewed experts about additional possibilities for developing SNF quality measures. Experts told us that

process measures could be developed for SNF care and used to assess quality. Process measures include broad processes that would apply to all types of patients; things like pain management and pressure ulcer prevention. And some evidence-based guidelines are specific to certain conditions, such as congestive heart failure, diabetes and hip fracture. Appropriateness of developing process measures from clinical guidelines should be explored to assess the strength of the clinical evidence around and the level of consensus for various process measures for SNF care.

So in light of the need for quality measurement in SNF we're reiterating our recommendation from last year and adding an additional recommendation to develop process measures to collect better diagnosis data on the patient assessment instrument. Given the divergent cost across SNF providers and across post-acute care providers and the lack of quality in this setting, data on quality are integral to determining what the Medicare program is purchasing and the quality of care that beneficiaries are receiving.

So the Secretary should collect information on activities of daily living at admission and discharge,

should develop and use more quality indicators, including process measures specific to short-stay patients in the SNF, and put a high priority on developing appropriate quality measures for pay for performance.

There is no spending implication for this recommendation and we expect that this recommendation would support quality improvement and create minimal provider burden. A way to minimize provider burden, for example, could include collecting a subset of MDS data needed to generate quality measures rather than the whole instrument at admission and discharge.

This concludes my presentation.

MR. HACKBARTH: Questions, comments?

DR. SCANLON: I would just raise one thing with respect to recommendation two, propose a modification. That in saying that the Secretary should adopt a new classification system we in some respects are tying the Secretary's hands to an exact type of modification of the PPS. Whereas, the real goal is to modify the payment system so it more adequately reflects the cost of serving different beneficiaries. I think if we were just to say that, that we'd like the Secretary to modify the PS for skilled nursing

facilities to more accurately capture the cost of providing care, that we give them the discretion.

I raise this because of the prior work that I was involved with at GAO in terms of the non-therapy ancillaries. There are some non-therapy ancillaries that are important enough that you want to take them into account but they're rare enough also that you're not necessarily wanting to create a patient category to reflect them and you may want to deal with them in another way. They're not an insignificant part of costs for those particular beneficiaries, so I think if we give the Secretary more latitude they would have more ability to try to address the issues that we're concerned about.

MR. HACKBARTH: So you're proposing to just have the one-sentence recommendation and drop the other things or move to the text?

DR. SCANLON: It could be all the same except we modify the first sentence to, the Secretary should modified the PPS for skilled nursing facilities to more accurately capture the cost of providing care to different types of patients. Set the sentence up as a goal as opposed to saying that the goal is to change the classification system.

MR. HACKBARTH: Do you have any comment on that, Kathryn?

MS. LINEHAN: I think that's sound fine. It's broader but I think it still captures the spirit of what we're trying to do.

DR. MILLER: I have one question. So in your mind, does that close off the notion of using a different classification system if one were found to be better?

DR. SCANLON: No, it doesn't. In fact I would think that one of the things you would explore would be a new classification system. Another one you would explore is the distribution of costs that are adjusted through the classification system versus treated differently. And third, you might think about do you pay for some things outside of the PPS. So I think it gives you latitude in all those dimensions.

DR. REISCHAUER: Why wouldn't we possibly end up with a new classification system plus?

DR. SCANLON: I think that's actually where we probably should be. I think some of the concerns about the old data, the potential shifts in types of patients that are using SNFs that have occurred over time would suggest that

we really need to be focused on what's the right classification system. So improvements in that area may be necessary, but they might not be sufficient to solve the whole problem that we have. So what we're doing is saying, we think you should solve the problem and approach it from whatever perspective you need to to solve that problem.

MR. HACKBARTH: Does everybody understand Bill's the proposed change? Anybody need to hear it repeated?

MS. DePARLE: I have some questions about recommendations two and three. It occurs to me -- I probably should have raised this earlier although I think we handled it differently in at least some of the recommendations, and that is where we say the spending implications. Because for two and three, certainly, there would be additional administrative costs to CMS and the Secretary to develop a new classification system. Also, depending on how it was implemented, if we say the Secretary should collect more information, there could be implications for providers as well.

I was looking back through our earlier recommendations. I know with respect to the RUCs we've certainly talked about this and in our analysis of the

implications we said something like, no increase in benefits spending although there might be increase in program spending or something like that. So it's a small point in a way but I think it relates to the concerns that we raise repeatedly about whether or not CMS has the right resources focused on the right things. So I would just think we should maybe modify that somewhat to reflect that there would be probably increased administrative costs at least in the beginning of this.

MR. HACKBARTH: I think customarily we have used this format to refer to benefit costs, but I think we can certainly add that into the text adjacent to it to make the point.

MS. LINEHAN: So the recommendation itself won't change but this issue will be reflected in the text?

MR. HACKBARTH: In the text; exactly.

MS. DePARLE: If you look at the recommendation about the RUC at least one of them says no increased benefit spending but there could be increased program spending. Just something to reflect that we recognize that there are costs to doing these things.

MR. HACKBARTH: Any others?

DR. KANE: Where is the part where we try to get a common assessment tool across all --

MR. HACKBARTH: That would be mentioned in the preface that I alluded to at the outset as one of our overarching issues in post-acute payment.

DR. KANE: Does it come out as a recommendation or just as a -- I'm learning new language here. Is it in bold or is it just a sentence in regular black-and-white?

MR. HACKBARTH: I think previously we have made a bold-faced recommendation, a formal recommendation on that. Or was that just discussed?

MS. THOMAS: We discussed it in last year's June report as an issue but did not made a recommendation on it.

DR. KANE: Because you have a recommendation, draft recommendation two, that says this new classification system should reflect clinically relevant categories of patients and one would hope that would tie in to this broader assessment tool and I'm just wondering at what point do we start saying it should be related to these other?

DR. MILLER: I think some of what informs this is -- and I think this was happening just as you came on. We did some work where we tried to go through -- we had this

thought that we need to get to a common assessment instrument and start knitting these things together, and step one would be, let's jut go and look at the existing assessment instruments. You know in terms of domains and functions and things like that they have a lot of commonality, so how hard could it be to go across them and find common elements and begin to stitch together at least a starting point?

It turned out to be really hard. We reported that work out and talked through it and that was all in the June 2005 report, and just didn't feel there was enough critical mass to say, so now here's a recommendation to go to do it, because we couldn't describe how exactly to go do it. So now what we're saying, both in the preface to this chapter is we're stepping back and re-examining that issue. And I would view some of the recommendations here as more focusing on the existing payment systems and saying, let's try to get these things to function right so there aren't all these differentials and potential incentives to treat patients differently. Then on another track to be trying to think about how to get to this more unified assessment instrument that cuts across these settings.

MS. THOMAS: I think we have work planned for March and April along those lines. We've been tracking what CMS has been doing and we can report that out.

MR. DeBUSK: Have we not been through this once before and had a deadline of 2006 and to have this instrument in place, and didn't make the deadline, the common assessment instrument, did we not?

MR. HACKBARTH: Are you referring to the RUG refinements? I don't remember --

DR. KAPLAN: Are you talking about the congressional requirement that they report on the common assessment tool?

MR. DeBUSK: Right.

DR. KAPLAN: CMS was supposed to do that in January.

MR. DeBUSK: So we're revisiting the same thing again here. I thought we'd been through that once. I thought, I'm not hearing this for the first time.

DR. MILLER: CMS was asked to report to the Congress on this issue, how to get to a common assessment instrument.

DR. KANE: Just from an intelligent use of

administrative resources wouldn't you want to work on those not in two separate tracks but as a combined track? In other words, if you're going to go through the brain damage of redoing clinically relevant categories for SNFs why wouldn't you want to do it for all long-term post-acute care and not be setting specific -- trying to push towards this non-setting specific patient classification system that also carries eventually dollar signs with it?

DR. MILLER: For what it's worth, I think you've put your finger right on an issue and I think some of our thinking about a year ago was just that, can't we get above all this and begin to get a common assessment instrument at least to get the ball rolling. I think it is a completely legitimate question and I think some of the concern -- cast your mind to some of the other conversations that we've had around the table where we recognize that there's flaws in the payment system when we say we're working on it. And it's never as fast as anybody would want it to be.

If we tie all the changes, I think some of the thinking here is if we tie all the changes to these post-acute care systems to this one thing, a common assessment instrument, we've solved the problem -- it cuts across

everything -- I think we could potentially, at least given our current intellectual technology, we could be waiting a fair amount of time. Think of a conversation -- I know Bill was saying this. For example, let's just say that in the skilled nursing facility setting we determine through both our incremental research -- just our incremental research. Meanwhile, the assessment instrument is over here being worked on -- that just improving how we pay for non-therapy ancillaries results in a dramatic improvement in the skilled nursing equity of payments?

I think what we're trying to say with these recommendations is, let's do that, if we can get to that point. Unfortunately, perhaps, we're saying, and there's this other issue we really would like to do but we're just intellectually not there and able to do it at the moment.

DR. KANE: Just to follow up on that, you've got four recommendations under draft number two and one of them is, more accurately distribute payments for non-therapy ancillary services, which sounds like a great short-term fix. But the top one is, a new system to reflect clinically relevant categories of patients and I'm just getting nervous when you're going to do a new system three times over for

three different types of long term care instead of just doing one. So it's the first part of draft recommendation two, I'm just wondering if we shouldn't rethink just that part.

MR. HACKBARTH: I agree with the thrust of your point. In particular when administrative resources are so scarce there needs to be careful planning about which paths you choose and where you make your investments, so I agree with that. But I don't think that that is our strength. I think those are really decisions about which path to choose that need to be made by CMS, people who are much closer to the resources and what they can do. I think we're strongest when we're pointing a direction as opposed to trying to plan the work. I think that we're pretty consistent and clear in the directions we're pointing, but it leads to somebody having to make some decisions about what to do in the short run versus long run and how you get the most bang for your administrative investment.

If we wanted to do that work well we'd have to spend a whole lot more time understanding the nitty-gritty of what's involved in a new payment system, new classification system, what the competing demands on

different parts of the agency are, and I don't think we are in a position to do that. So I'd just as soon we stay at a higher level and point directions and then other responsible people are going to have to make triage decisions about how to implement them.

DR. SCANLON: I would also add that I agree with Mark that in some respects the problem with a common assessment instrument is the issue of intellectual capital that we have to draw on to design one, because we just don't want a common assessment instrument where what you get is information that's similar across all of these sites. We want an assessment instrument that allows us to discriminate in terms of who needs what kind of service, and also it allows us to differentiate or to calibrate the payments across these different sites.

I think that's an incredibly tall order. I was involved with long-term care for about 30 years and when I came in the question was, why are certain people in nursing homes and other people in the community? They look the same. Well, they're not the same and our ability to try to find the traits and the characteristics that differentiate them are very difficult.

Even though we've made advances in understanding why certain people would go into a nursing home, bringing some of those domains into Medicare would be new. Family willingness and family availability to provide services, structure of housing. ASPE did a review of disability among the elderly and found that the most effective thing that you could do in terms of reducing disability was housing modifications. Climate; what difference does it make whether you're in Minnesota or Miami in February when you've got your joint replacement in terms of where you want to have your services, or whether you want them on an ambulatory basis, whether you want them in an institution, or whether you're going to get them through home health. All of those things matter. They're all breakthroughs.

I think that we would get tied up into a really long process in terms of trying to achieve what is a good goals in terms of a common assessment instrument that will be effective in differentiating among these different settings. And we shouldn't do that and sacrifice the short-term victories we can have in terms of fixing systems incrementally in the meantime.

MS. HANSEN: To add to both Bill's and Nancy's

comments, actually all that you've described, Bill, you know I've lived for the past 25 years. But I think the whole aspect of what's going to the defined as this common instrument tool for even these for post-acute services, if there is some way to still get closer so that it isn't, the redundancy or the slightly modified definition isn't more clearly defined earlier on. Because now that we're looking at post-acute a little bit more from following the person as compared to just the institutional structures we may just need to start giving the broad direction of that's where some of the new focus can be.

It's beyond the scope of this commission, but somewhere, whether we shine the light to the fact that these kind of complicated issues do bear in mind to creating this tool, so that this is not for the weak of heart to go into but these are the factual realities that make the difference. So I just wonder if there is a way to put a little more muscle into that overarching paragraph about how complex it is. That while we do these iterative improvements to make sure that payments are better done, but in the meantime the issue is still the issue, and it doesn't fall solely in the silo of Medicare funding. It falls into

many other domains as you alluded to, but that's what it is. That is actually where some huge growing dollars are going to go.

So somewhere it is to Congress that we need to point this out, that it still has to get tackled, and in some way we have to get a handle on that. But in the interim, is there something that we can do to minimize redundancy as well as to funnel the funds appropriately to people, and make sure that the individual being served ends up in the best place for the best value with the best quality.

MR. HACKBARTH: Any others?

Okay, let's proceed to our votes. All opposed to recommendation one?

All in favor?

Abstain?

Recommendation two as amended by Bill. All opposed?

All in favor?

Abstentions?

Then draft recommendation three, all opposed?

All in favor?

Abstain?

Okay, thank you.

Next is home health.

* MS. CHENG: Next up is the last of three presentations on our payment adequacy consideration for home health. I'm going to recap the parts of the payment adequacy framework that we've been talking about at the last couple of meetings and then put up the draft recommendation for our consideration.

The first part of the framework that I'm going to recap for you are our findings on beneficiary access to care. In 2004, we found that nearly 90 percent of beneficiaries reported little or no difficulty accessing care, and rural beneficiaries in this survey actually reported somewhat better access to care than their urban counterparts. Geographically, we found that all substantially populated areas of the country were served by at least one home health agency in the past 12 months. Rural areas did have more zip codes that were served by only one home health agency or were not served by a home health agency in the past 12 months than more urban areas. These measures of access, we found, were basically unchanged from

2003 levels.

The next part of the framework that we talked about were changes in volume of care and supply of agencies. We found that the numbers of episodes and users have increased, and the number of home health agencies have increased. All three of these indicators have increased 6 percent or 7 percent over the past year.

The next part of the framework is where we use the publicly reported data from CMS on the Home Care Compare measures. We looked at the 12-month period ending May 2004 and we compared that to the 12-month period ending May 2005. We found comparing those two time periods that indicators of improvement in functioning, ability to bathe or to walk, had improved slightly, and indicators of the use of a hospital or the emergency room during a home health episode had not changed over that time.

The next part of the framework that we discussed is financial performance. Here we're looking at financial performance in our base year 2004. What this shows you is the total aggregate margin of 16.0 percent for freestanding home health agencies in 2004, and it shows you some of the variation by caseload of the agency. That is to say, the

location of their patients, and the type of control of the agency. Over the past couple of months we looked at one other variant and that was size. We found that margins based on size vary from about 11 percent to about 18 percent from the smallest to the largest.

From that base year in 2004 we then consider what's going on in the intervening period. The payment changes in current law include an update of 2.3 percent in January 2005, and in that year there was an increase in the outlier payments for home health agencies, and there was also the expiration of the rural add-on. Home health agencies did receive an update of 2.8 percent January 1, 2006 and they are transitioning to a new definition of metropolitan areas. That transition is going to be budget neutral once it's applied to all home health agencies. It's included in our model because it does redistribute payments somewhat among urban and rural agencies.

MR. HACKBARTH: Is the increase in outlier payments a budget neutral change or was there additional money?

MS. CHENG: When the home health payment system was set up they created a pool of payments equal to 5

percent that was going to be paid out in outlier payments. Since the implementation of the PPS that pool had never entirely been spent, so the increase in outlier payments was designed so that the pay-out in the future would be closer to that 5 percent pool that was taken out of the base rate. So it does mean that they will be receiving more dollars in the future but it wouldn't exceed the size of the pool that was set aside when the system was developed. So yes and no.

The next piece of our payment adequacy framework then is to consider the changes that would occur between 2004 and 2006 and then we produce a projected margin. So taking into account all of the changes that are in current law, the projected margin for 2006 would be 16.9 percent. To note then, current pending legislation would take away the 2006 update. It would also reinstate a rural add-on for 2006 of a bonus of 5 percent payments. The result, if the current pending legislation were to be implemented, the projection for 2006 would be 14.7 percent.

So for 2007 under current law home health agencies would receive a full market basket update. On the screen are all the factors that we have considered, and considering those factors suggests the conclusion that home health

agencies should be able to accommodate cost increases over the coming year without an increase to the base rate.

So considering all of those factors this leads us to our draft recommendation for home health services in 2007, which is that Congress should eliminate the update to payments for home health care services for calendar year 2007.

The spending implications of this would be a reduction compared to current law by $200- to $600 million for calendar year 2007 and by $1 billion to $5 billion over the next five years.

The beneficiary and provider implications, we would see no adverse impacts to be expected because this recommendation is not expected to affect providers' ability to provide quality care to Medicare beneficiaries.

Just the last part of the recap is to remind us that part of our discussion developing these ideas is also to look at this payment system and we've talked about some evidence that we're continuing to put together that suggests that this payment system also needs refinement or possibly reform. One of the areas that we've been looking here is the case mix system, but here too we would not take off the

table the idea that other parts of the PPS might also need refinement or reform. So we will be continuing this research agenda over the coming year.

With that, that's the end of my remarks and I will put the recommendation back up for discussion.

DR. NELSON: Sharon, if I understood you correctly you said that cost increases are expected to be modest or low. But since home health is so labor intensive and since health care labor costs seem to be inflationary with shortages of nurses and other health workers, and since to some degree they depend on individual transportation, cars and so forth, and gasoline prices going up, why don't they have the same kind of market basket increase in inputs that hospitals do?

MS. CHENG: Like hospitals, one of the things that we've looked at in this sector are historic cost increases. So in addition to looking at the costs and payments in the current year, we've looked back to 2001 and we've tracked the changes in the per-unit costs. Certainly since 2001 there have been increases in the cost of transportation and in labor.

What we see in this sector is in fact the costs

have not been growing as quickly as prices have been for the past three years. We measured average annual growth in costs to produce a unit of home health of 6/10ths of 1 percent per year. So that also adds to our analysis that for whatever costs would be increasing that the agencies should be able to accommodate those cost increases without an increase to their current payments.

MR. HACKBARTH: In that analysis, the unit of home health is an episode?

MS. CHENG: Right.

MR. HACKBARTH: So the content of that episode is changing in ways that offset unit price increases for fuels and salaries and the like.

DR. REISCHAUER: Just an observation about the interpretation of qualitative measures in a system in which you have the number of participants or episodes rising 6 percent, 7 percent a year. Now conceivably those additional individuals are being drawn off of other post-acute care, but my guess is that's not happening. That what we're doing is we're expanding the fraction of people given some kind of circumstance that avail themselves home health. And probably on average those beneficiaries are in less severe

condition than the cohort before them. So when we look at the fraction who have a better outcome from year to year you either have to make some kind of risk adjustment or some kind of adjustment for this rapidly growing fraction of the population that is receiving some kind of benefit.

MS. CHENG: Absolutely. The measures that we report from the Home Care Compare are risk adjusted for the attributes of the patients in that year. So for each cohort, the outcomes are compared to the expected outcomes, given whatever changes in case mix we can measure, to the best of our ability. But they are being adjusted for things like primary diagnosis, comorbidities, functional status. Those are part of the risk adjustment that go into computing those compare scores.

MR. MULLER: Can you remind me again in terms of trends of home care patients in terms of visits to the ER, admissions to the hospital, admissions to nursing homes, what's the trend line on that in terms of is it steady, going down, going up, do you know?

MS. CHENG: One of the things that CMS introduced to Home Care Compare data that we have new this year is a measure of the use of a hospital and the use of an ER. And

even though it's a new measure, they had data that allowed us to look back several years.

What they found is that both of those measures of the use of other services have stayed absolutely flat for the past two or three years. They're both in the 20 percent, 25 percent range of percent of patients that use the hospital or the ER.

Now those are both characterized as utilization scores. To Bob's point, the risk adjustment for both of those is acknowledged to be a challenge. So whether they've stayed perfectly flat because we've perfectly risk adjusted and it's absolutely the same patient doing the same things or not, even CMS has said, these are utilization measures. But as far as utilizations of those two services it has stayed about the same.

MR. HACKBARTH: Others?

Okay, shall we proceed to the recommendation? All opposed to the draft recommendation?

All in favor?

Abstentions?

Okay, thank you very much.

Next is inpatient rehab facilities.

* DR. KAPLAN: Today Craig and I will briefly review the factors for inpatient rehabilitation facilities, or IRFs, that we examined to assess payment adequacy.

Before we review the indicators we wanted to clarify where IRFs are located. Unlike long-term care hospitals, inpatient rehabilitation facilities are not concentrated in a few states. Although they aren't as ubiquitous as SNFs, they are dispersed more than long-term care hospitals, and as you can see from this map they are concentrated in general in areas where population is concentrated.

Now to review the indicators. For access, unlike for home health or for physicians, we have no direct measures of access. As we'll discuss in a minute, there was a big drop in volume of cases in 2005, but we don't know whether beneficiaries who need IRF level care are not getting it.

For supply, under the PPS, the number of inpatient rehabilitation facilities entering the Medicare program increased 2 percent per year. Volume was increasing rapidly from 2002 to 2004. However, that trend has changed in 2005 in response to the new 75 percent rule with an estimated 9

percent to 14 percent drop in cases.

To assess quality we examined the change in functional status from admission to discharge in two ways and found the difference to be stable under the PPS. IRFs appear to have adequate access to capital. Eighty percent of these facilities are hospital-based so they have access to capital through their parent institutions.

This chart shows the cumulative change in payments and cost per case since 1998. From 1999 to 2001 under TEFRA, which was cost-based reimbursement, we saw a reduction in payments and cost per case. With the introduction of PPS, however, we saw a large increase in payments per case, over 10 percent per year in 2002 and 2003 as IRFs transitioned into the PPS. Along with this rapid increase in payments came an increase in costs per case, an increase of 2.4 percent in 2003 and 3.6 percent in 2004. Needless to say, the big jump in payments lead to a rapid rise in Medicare margins for these facilities.

As you can see on the screen, the Medicare margin jumped substantially with the implementation of the PPS, from 1.5 percent in 2001 to 11.1 percent in 2002, rising to 17.7 percent in 2003 when all IRFs came under the PPS. In

2004 the Medicare margin was 16.3 percent.

Our projected margin for 2006 includes the estimated effect of the new 75 percent rule under current law incorporating policy for 2006 and 2007. The new 75 percent rule will require IRFs to have 65 percent of cases compliant with the rule in 2007. This will result in a large drop of cases, estimated at 29 percent. We anticipate that it will also have a large effect on the Medicare margin. In 2004 the margin was 16.3 percent, as I just said. Our best estimate of the margin in 2006 is 7.7 percent.

The factors we examined generally suggest that IRFs' payments are more than adequate. If the 2005 Deficit Reduction Act becomes law the margin would be about 1.5 percentage points higher. A higher margin would not change our conclusion about payment adequacy.

Current law is a market basket update. Several commissioners raised questions about the draft recommendation we presented in December. Based on that conversation we changed the draft recommendation. It now reads, the Congress should eliminate the update to payment rates for inpatient rehabilitation facility services for

fiscal year 2007.

The implications for this recommendation are that it decreases federal program spending relative to current law by $50- to $200 million in one year and less than $1 billion over five years. For beneficiaries and providers we expect no effect on providers' ability to furnish care to Medicare beneficiaries.

That concludes our presentation and we welcome your questions and comments.

MR. HACKBARTH: Questions and comments?

DR. NELSON: Refresh my memory, what was the condition that was removed from the 75 percent rule that comprised the largest category of admissions before, what was that?

DR. KAPLAN: Joint replacement. Single joint replacement.

MR. HACKBARTH: Let me just amplify on what Sally said about the recommendation. This is not the same draft recommendation as we reviewed in December. That one, as I recall, would have provided for an increase in rates equal to one-half the market basket, and we changed it to this recommendation based on the ensuing discussion and comments

from the commissioners, that in view of these projected margins that a zero update would be appropriate, especially when
you lay them alongside what we're seeing for hospitals and dialysis facilities.

Other questions or comments?

DR. REISCHAUER: Can I just get an explanation of what's going on with the reduced margins when the 75 percent rule is phased in? Is it that these are operating at lower than optimal capacity and they're unable to fill the beds with private patients?

MR. LISK: Right.

DR. REISCHAUER: So we have unutilized capacity basically.

MR. LISK: Correct.

DR. REISCHAUER: But that that would, in a sense, disappear over time.

MR. LISK: Right, we're assuming that 75 percent of overhead costs would remain in terms of fixed, and then in terms of variable costs, in terms of patient care costs, that 90 percent of those costs would go away for those patients who go out of the hospital.

It's also important to note that the 75 percent rule applies to all patients, not just Medicare. So it's a Medicare requirement but also for total patients meeting the requirement, so it's not just subject to Medicare patients, so they can't necessarily make up with private sector patients. If they don't qualify they then may not qualify again for the 75 percent rule.

DR. REISCHAUER: I guess my question is, what's the pool of potential people meeting the 75 percent rule out there who aren't in these kinds of facilities who could be drawn --

MR. LISK: They might be people who are in long-term care hospitals. It is more restrictive in terms of who can meet the requirement. You are taking a fairly large chunk of patients who are questionable in terms of their meeting the requirement before for polyarthritis and now that they're no longer included in the rule -- and those cases did account for 25 percent or more, the single joint replacements accounted about a quarter of the cases in these facilities to began with historically.

MR. HACKBARTH: But to get back to Bob's initial point, the reason margins fall is we assume the patients are

not replaced so the volume is lower.

MR. LISK: Yes, so the volume is lower, so the fixed costs are spread over fewer patients. And then that they don't completely economize on the regular patient care costs, that 10 percent of those costs still remain.

MS. HANSEN: Just given the fact that these patients no longer qualify, is there any capacity to find out where these people go?

DR. KAPLAN: We hope to be able to do that but we'd need at least 2005 data and that's not going to be available until next fall.

MR. HACKBARTH: Any other questions or comments?

Okay, let's vote on the recommendation. All opposed?

All in favor?

Abstentions?

Okay, thank you very much.

And the last of the update related presentations is on long-term care hospitals.

* DR. KAPLAN: As with the IRF, I'm going to briefly review the factors we've examined to assess payment adequacy for long-term care hospitals. Craig is going to stay here

also because he helped with these analyses just as he did with the IRFs.

For the payment adequacy factors we found beneficiaries' access increased from 2001 to 2004 as beneficiaries' use of long-term care hospitals increased 13 percent per year. The number of long-term care hospitals have increased rapidly since 1990, and the rate of increase accelerated under the PPS. The number of long-term care hospitals increased 9 percent per year from 2001 to 2004. The volume of cases increased 12 percent per year during this same period, and spending increased 25 percent per year. In the last year alone, spending increased almost 38 percent.

We found mixed results for three different types of measures of quality for long-term care hospitals. We found a small improvement in the shares of patients who died in the long-term care hospital or were readmitted to the acute care hospital, although these indicators were not risk adjusted. For patient safety indicators, all four of the risk adjusted PSIs that were stable and had face validity got worse from 2003 to 2004. But we believe caution is needed in interpreting these PSIs.

Long-term care hospitals appear to have adequate access to capital, evidenced by both for-profit and non-profit long-term care hospitals rapid entry into the program.

The chart on the screen shows the cumulative change in payments and costs from 1998 through 2004. As you can see, during TEFRA when payment was cost-based, on the left side of the graph, payments and costs grew together. But after the implementation of the long-term care hospital PPS, on the right side of the graph, we see rapid growth in payments in both 2003 and 2004.

The first year of PPS but essentially no change in cost per case for these facilities. In 2004, however, costs per case climbed almost 9 percent, possibly in response to the large increase in payments they received after the PPS implementation.

For Medicare margins this means that under TEFRA long-term care hospitals' margins were near or just below zero in the aggregate. Under the PPS, however, Medicare margins have increased rapidly to 9 percent in 2004.

In 2006, current law with 2006 and 2007 policies we estimate that long-term care hospitals will have a

Medicare margin of almost 8 percent. All these factors suggest that long-term care hospital payments on more than adequate. By the way, the 2005 Deficit Reduction Act makes no changes for long-term care hospitals.

Under current law the update is the market basket, but based on the indicators we've seen we recommend the Congress should eliminate the update to payment rates for long-term care hospital services for 2007.

Implications for this recommendation are that it decreases federal program spending relative to current law by between $50 million and $200 million in one year and less than $1 billion over five years. For beneficiaries and providers we expect no effect on providers' ability to provide care to Medicare beneficiaries.

That completes our presentation. We welcome your comments and questions.

MR. HACKBARTH: Questions or comments?

Payment adequacy fatigue is setting in.

Okay, let's turn to the recommendation then. All opposed to the recommendation?

All in favor?

Abstentions?

Okay, thank you.

Then the last presentation for today is on outpatient therapy.

DR. MILLER: Jennie, earlier when you asked a question, we are going to do data analysis to see about what happens with these people. But before -- this is on the cost 75 percent rule in the IRFs – we had a discussion with various orthopedic surgeons and various clinicians and it was interesting. There were a lot of concerns raised over the definition, as you know and as we've talked about in other meetings. But also it was interesting in listening to them in the mix, for their marketplaces, where people went. There was actually one who had no IRFs in his area and completely all his patients he worked through a home health type of network and he talked about the importance of getting to the patient early on and having them do exercise before and after the surgery and that type of thing. It was interesting; they really were talking about working their post-acute care to what supply was available.

* DR. CARTER: Today I'll be talking about outpatient therapy services.

Spending on outpatient therapy services has almost

doubled since 2000. In September we reviewed basic information about therapy services; what they are, how Medicare pays for them, the settings where they are furnished, and the patterns of spending in 2002. This month we're focusing on the growth in spending in users and spending per user, and the variations across providers. These spending patterns will help us assess which strategies to pursue to ensure that services being furnished are medically necessary while maintaining beneficiary access.

Just some background, I want to remind you that there are three types of therapy services, physical therapy, occupational therapy, and speech and language pathology services. Of the three therapies, physical therapy makes up the majority of Medicare spending and users. Payments are established in the physician fee schedule for each unit of service regardless of where the services are furnished.

The moratorium on the therapy caps that had been in place since 2000 expired last month and the caps are again in place. Two caps, one on physical therapy and speech and language pathology services, and a separate cap on occupational therapy, each limits spending to $1,740. Services furnished in hospital outpatient departments are

not subject to the caps. The Deficit Reduction Act of 2005 would require CMS to implement an exceptions process for beneficiary if the services are medically necessary.

Outpatient therapy services are furnished in many different settings. Physical therapist in private practice and nursing homes furnish the most services in terms of Medicare spending. Nursing homes furnish therapy services to long-stay residents and the services are paid for under Part B. These are not therapy services furnished to SNF patients. Those are included under SNF PPS and are included in the daily rates.

Therapists in private practice work in their own offices or as employees of a physician-owned group practice. Therapy services furnished as physician services -- that's the wedge up there that's in yellow -- are considered incident to and require physician supervision. Therefore, services provided in physicians' offices are included in all of this work and in two different segments, one in the physician services category, and for those therapists in private practice who are actually working in a physician's office you can see some of those services in the therapists in private practice.

Here I'm showing the variation in spending. On average the per-user spending was $883, but you can see that there was a lot of variation across settings. Per-user spending was the highest in nursing homes -- that's the green bar and it's about $1,300 -- and the lowest in hospital outpatient departments and that's in brown on the far right. Because information about patient diagnoses is poor and outcomes data have not been collected we do not know if the variation we see in settings is due to differences in the types or complexity of patients treated, or if the patients who receive more services had better outcomes.

Here you can see the growth in Medicare spending since the 1998. When the therapy caps were in place in 1999 spending decreased. Once the moratorium on the therapy caps was in place spending has grown rapidly, almost doubling since 2000. Spending in 2004 was $3.9 billion.

Since the therapy caps were lifted in 2000, spending decreased annually an average of 18 percent with considerable variation across settings. The largest growth took place in therapists in private practice which includes therapists who worked in physicians' offices. In part this

growth in this setting reflects the implementation of the SNF PPS in 1998 when SNFs cut back on the number of therapists that they employed. In addition, in 2003 CMS clarified its policy that therapists could be employees of physician practices and be considered in independent practice. Therapists would bill independently for services and physicians were not required to supervise the services that they were furnishing.

Between 2000 and 2004 the number of therapists in private practice more than doubled, and the spending for these services grew from 5 percent of all therapy services to about 26 percent.

The very large increase that you see here in spending for occupational therapy in private practice reflects the fact that the spending for these services is very small. Spending for services furnished as incident to physician services grew more slowly. But again, at 15 percent a year it still far outpaced medical inflation.

One reason the spending grew so quickly was that more beneficiaries received services. Across all settings the numbers of users increased 8 percent a year between 2000 and 2004. But you can see the variation on this slide. The

number of users treated by therapists in private practice increased three to four times as fast as the average. One factor for the expanded number of users is the increased number of elective surgeries there are appropriate for therapy services. For example, during this time period the number of hip and knee replacements increased 34 percent.

Spending also grew because users were furnished more services. Spending per user increased an average of 9 percent a year. Again, you can see the variation on this slide. Program spending per user grew the fastest in nursing homes and the slowest in hospital outpatient departments.

The increased number of users and the services of furnished and the large variation in spending raise questions about how to best ensure that beneficiaries get the services they need, yet not pay for services that are medically unnecessary. The exceptions process that the Secretary would be required to implement may help protect beneficiaries who have extensive care needs, but would need to be monitored so that only beneficiaries with medical necessity are exempted from the spending caps.

We also need to have a better understanding of the

differences across settings and the patients treated and their outcomes. Better diagnosis information and the collection of outcomes data will help evaluate which types of beneficiaries benefit from therapy, how much therapy is typically needed, and help identify when services of marginal value are being furnished.

The growth in the number of users indicate that we need strategies that help identify which beneficiaries need therapy services. Criteria supported by the medical literature need to be developed that delineate the types of medical conditions that benefit from therapy. Practice guidelines that are tailored to the elderly patient population and based on clinical evidence could educate therapists and referring physicians about when and how much therapy is likely to be effective for beneficiaries. Industry groups have sponsored efforts to gather clinical evidence and we look forward to learning how this information can inform guideline development for an elderly population.

This winter we'll have an expert panel consider the quality of the evidence and the feasibility of developing criteria and guidelines for therapy use by

beneficiaries.

The growth in the spending per use indicate that strategies are needed to ensure that the amount of therapy furnished is appropriate. CMS is considering three types of claims edits to identify potentially inappropriate service use. One edit flag would identify claims where only one service per day is typically covered. Another edit would flag claims with an unlikely number of time-based services on a given day. And a last edit looks for clinically illogical combinations of services. If the Deficit Reduction Act is passed, CMS will be required to implement code edits by this July.

Another strategy would identify unusual practice patterns by comparing individual provider practice patterns to typical services for similar clinical conditions.

A third strategy is to fundamentally change the way Medicare pays for therapy services. CMS is working on an episode groupings that might be used in a payment system. The current lack of information about functional status, functional outcomes, and other characteristics of patients hampers the development of a payment system and limits our ability to evaluate practice patterns.

The next phase of our work will focus on understanding why therapy spending is growing so quickly. In addition, as I mentioned, we will ask an expert panel to assess the feasibility of developing guidelines and criteria to ensure appropriate service use. Finally, we will consider what information needs to be gathered using a patient assessment tool for these services.

What I'm looking for here is your guidance on what information and analyses you would like to see us do as we explore alternative strategies to control therapy spending.

DR. NELSON: Presumably some of the outpatient therapy spending could result in reductions in Part A payments. I don't know whether it's possible to get any kind of a handle on that or not.

DR. CARTER: We've talked a little bit about that. We're also wondering whether these services substitute for services that had been included in other post-acute PPS. One of the questions we have is, given the incentives under the home health and the SNF PPS to do therapy we're not sure that at least these therapies are substituting for those.

If your question is, are these services substituting for services that had been provided in hospital

settings but with shorter lengths of stay some of this is moving to the outpatient arena, I have looked quickly at what share of therapy services were preceded by an inpatient hospitalization and it's only about one-third of the claims. So it's there and it's real but it's not the majority of outpatient therapy services.

MS. HANSEN: I would just like to offer a resource that as you're constructing the expert panel and looking at outcomes that you have an opportunity to tap CMS's data on all the PACE programs' use of therapy services because it collects it nationally. This is another situation where do you have diagnostic information and the use of all these three sets of services as well for clinical groups. So it's just another resource for you.

DR. CARTER: I'll look into that. Thank you.

MR. DURENBERGER: Thank you very much for the comprehensive nature of the report. I want to go to the strategies to ensure that users need therapy and tell you that I know little or nothing except by experience about the types of medical conditions that benefit from therapy. But I can imagine because I'm in an age and a population cohort that is going to increasingly benefit from therapy,

particularly if I applied before I had a need for it, because presumably -- again this is just experience -- there are a lot of important applications for OT and PT as therapy for conditions that could have been prevented. Particularly for people as they age and they don't do the kinds of things that they could do to prevent tendon, muscular, a lot of that sort of thing. Again I'm operating out of little or no knowledge of the specifics.

But it seems to me that there is a lot of us good policy, payment policy potential incorporated in this therapy caps issue that we could capture over time if we could be it in that larger context that I'm talking about. That is, where does public health, wellness, all that also come in? Every time I hear Mark McClellan speak her starts out by saying, Medicare is a public health program and we're going to emphasize...

So making an assumptions that we're not only talking about the accidents than people have no control over but we're talking about accidents, injuries, illnesses, dysfunction that could have been prevented. I'd love to see in the context of types of medical conditions that we expand our understanding, even though we might have difficulty

coming up with a policy for it, at least our understanding of what causes some of these problems as well as the issues about responsibility or accountability in applying OT, PT or other solutions.

DR. CARTER: I'm hearing two things in what you say. One is related a little bit to the physician volume discussion we had this morning which is, not all volume increases are the same. If one of the things you're talking about is some of this therapy could be preventive therapy, which is different maybe than some of the other therapy use, I guess I hadn't been thinking about looking through the literature for that kind of therapy use but I'll make sure that we do that. It's a good idea.

MR. DURENBERGER: Given what Jennie just said about looking at PACE and other programs, particularly ones she's had experience with, that's what jogged my memory about it as well.

MS. HANSEN: Just as a follow-up of that, Mark, when you addressed some comments to me about some interesting findings of the orthopedic surgeon who actually probably did some different kind of preparation of his patients before surgery, so whether or not that would be an

example of a whole other shift of a group that's high risk and going to go for surgery, but to prepare them for a better post-surgical recuperation would be a whole different shift as a more secondary prevention measure.

But going back to your other comment, Dave, about a primary prevention measure, there's some -- falls are just so common for people who are going to be 65 and older as a given, so whether or not the public health nature of the comment of Medicare as a program, the whole aspect of a very targeted -- instead of doing just the physical exam when you turn 65, whether you get some resources to make sure that you maintain your trunk balance as an older adult and have that be something that would be a preventive service that's paid for. So that really be very different as the model. But it's one of the things based on known research on people who have done exercise programs and created greater trunk stability and really then minimized their risk of falls to begin with.

DR. CROSSON: Just to reiterate that point, we have found that in hip surgery, pre-operative physical therapy and physical therapy education has a salutary effect both on the length of hospitalization and the need for and

the length of post-acute care.

DR. KANE: I was a physical therapist so maybe you should just dismiss everything I have to say, but I think physical therapy usually does have a great benefit. But I'm wondering if it's not equally amenable to fitting into this whole assessment tool that we want to use for institutions, but in fact I view outpatient physical therapy as just services delivered to a community-based person as opposed to a person based in an institution. But they may well have similar activities of daily living limitations, or balance problems, or repetitive stress -- if you're grossly obese, frankly, it helps a lot sometimes to have muscle strength, or you hurt your knees and you try to -- you may be living at home but you may still need physical therapy.

So I think it's still part of this whole, you need both a diagnostic and an activities of daily living tool, and I'd put the community-based physical therapy right in there along with all the other institutional-based post-acute care -- and some of it may not even be post-acute, but demand for these not acute services -- in the same tool. Maybe we'll never get it, but a lot of people live at home and get these same services that otherwise might be in a

facility.

I also wonder if some of these inpatient rehab facilities that are no longer doing single joints aren't just saying, go outpatient. I can see a lot of reasons why this volume is increasing that might be good, but I think without the condition, without the assessment tool it's really going to be impossible to judge. So I would just want to put the whole physical therapy piece into the context of you need a tool for assessing non-acute hospitalization and try to build it into that same exercise.

DR. MILLER: I think this is an area, since there doesn't seem to be much infrastructure here, where as we're working through it and seeing how it would work for outpatient therapy we could have an eye towards whether it could actually translate into the institutional setting, since we're not reinventing anything but instead building from the ground up. So I think that's a good point. Again, how far we get is, as always...

MR. HACKBARTH: Any other questions or comments on this?

Okay, thank you, Carol.

DR. MILLER: Just one quick procedural thing. I

think we bobbled Alan's vote on the long-term care hospitals. You supported the recommendation?

DR. NELSON: Yes.

DR. MILLER: I just wanted to make sure that that got recorded right. Thanks.

I guess I'll ask, was there anyone else who missed a vote or stepped out into the hall during a vote?

MR. HACKBARTH: Anybody else miss a vote because they were out in the hall? Nancy-Ann.

DR. MILLER: She's dealing with something, so I'll see if I can talk to her and do this process on the record tomorrow.

MR. HACKBARTH: All right, we will now turn to the public comment period.

Seeing nobody move to the microphone, we are finished and we will reconvene tomorrow at 9:00 a.m.

[Whereupon, at 3:35 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Wednesday, January 11, 2006.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building

International Trade Center

Horizon Ballroom

1300 13th Street, N.W.

Washington, D.C.

Wednesday, January 11, 2006

9:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
NANCY KANE, D.B.A.
RALPH W. MULLER
ALAN R. NELSON, M.D.
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

P R O C E E D I N G S

MR. HACKBARTH: Good morning, everybody. For our first item this morning we have an expert panel to talk to us about physician resource use measurement. Nial, will you do the introductions?

MR. BRENNAN: Good morning, everybody. This expert panel is part of our ongoing work relating to physician resource use and response to a request by the commissioners in November to have some people in to talk about how these analyses are reported to physicians and how physicians react.

Our first speaker today is Dr. Eric Nielsen. He's the chief medical officer for the Greater Rochester Independent Practice Association in Rochester, New York, a partnership of a hospital system and 640 physicians from the medical staffs of its two hospitals, contracting with several HMOs and taking capitated risk for 114,000 lives.

Our second speaker is Dr. Bill Taylor. He's the medical director for the Midwest region of Blue Cross and Blue Shield of Texas where he's responsible for providing medical support for on-site concurrent review and network credentialing for central, south and west Texas. Dr. Taylor

leads a cross-functional team which includes actuarial and network management and oversees the development of network methodology, policies and communications to create and maintain a more efficient and affordable network, Blue Choice Solutions.

Our final speaker is Tammie Lindquist, who's the vice president of strategic health informatics for HealthPartners which provides care and coverage to 630,000 members across Minnesota through a broad network of physicians and hospitals including HealthPartners clinics. Her focus is on improving decision support information available to health care providers, consumers, and the HealthPartners staff and leadership. Ms. Lindquist is a leader in the organization's focus on usable, actionable information for medical management and provider payment methodologies and practice management.

Thanks to all of them for joining us.

DR. NIELSEN: Thank you very much for this opportunity to spotlight what GRIPA in Rochester, New York has been doing. I'm going to start right in with the presentation.

What is GRIPA? We are an organization composed of

a hospital system in Rochester, New York that has a 33 percent market share for that community and the physicians organization formed from the medical staffs of the hospitals in the ViaHealth hospital system. There were four hospitals initially. There are only two now. New York State has consolidated many hospitals, closing many hospitals that were not up to snuff and not fully utilized.

Our group of physicians at the present time has 130 employed physicians, most of them by the hospital system, 510 private physicians, 240 are PCPs, 400 are specialists. We were formed initially to negotiate contracts with HMOs and to manage risk for its shareholders. We formed at the time that IDNs were thought of as the next best thing and we have persisted in that model, still being a partnership of physicians and a hospital system. The hospital system also owns a nursing home and home care systems.

We also wanted to be available as insurance markets changed to be able to market to self-insured employers, and that we have not done. We have basically been a risk model to date. Most of the market in Rochester, New York has continued through HMO risk products, but that

is changing now. It's slowly going down, about 10 percent per year.

Beginning in 1999 we developed care management, disease management capabilities as well as our own P4P program based on the withhold that we had to have for our risk model which was in the 10, 15 percent range. So we had money to work with there, plus we anticipated saving money and being able to pay our doctors more than they would get without us being there, and we did achieve that in some years; not every year.

Our pay for performance system started in 1999 when we implemented the MedInsight data warehouse system developed by Milliman and Robertson in those day. With that system we were able to accept the claims data downloads from the HMOs and to work on that data in our data warehouse and to use that for our pay for performance system.

As time went on we found that we needed better P4P measures. Doctors were complaining that we were not giving them actionable data, and one doctor said, my patients are sicker, and we needed to be able to risk adjust -- at least have information about how risk adjusted a particular physician's patients were. So we introduced the Symmetry

ETG/ERG product.

Just to describe that briefly, ETGs are developed from anchor records from claims data based on an E/M code or a facility code or a procedure code. ERGs are a way of looking over all the ETGs assigned to a patient to assign a risk factor to those patients which can then be summed up per physician. We developed also a clinical services report for our doctors to give them patient-level data on which they could make decisions about their patients. I'll get into that a little in a couple minutes.

Here's a sample of our report cards. We have quality measures is the first bunch of measures there. Then the resource management measures. The blue bar on the right shows a physician's score and the green bar shows the peer average scores, so that the physician can see how he relates to his peers. Then we compute a quality measure. You can see the measures are listed, patient satisfaction, glycohemoglobin, mammograms, cervical Pap smears, all those types of measures. Physicians are graded on whether they've met the benchmark and whether they've improved toward that benchmark if they were not at the benchmark.

Our resource management measures were for ED

visits per thousand, total PM/PM for all their patients, risk adjusted, and cost for all their diabetic patients, again risk adjusted. We also had bonus measures for referring patients to our case management, disease management program and for accepting Medicaid patients.

The next slide gives some detail on those. What we have on the left are bars. The blue bars show a physician's present score on a quality measure. The green bar shows their previous score, and then the light blue is the improvement score. So we're looking at their old scores, their new scores, improvement, and calculating a score for each measure based on those factors.

The ETG resource-based measures which we applied to our specialist report cards, as I mentioned the ETGs are related to particular E/M codes, procedures or hospital facility billing. We can see that the list that we show here, complicated pregnancy with or without C-section, we can calculate an average cost per physician and an expected cost, which is a risk adjusted measure, and we can then compute a resource utilization score for each physician and compare that to his peers.

With all of this we need to have physicians

engaged in all of this and we really haven't done any of this without clearing it with the physicians and getting their ideas and inputs. Our new measures, as we roll them out, are for information only for the first go-round. We send our report cards every six months. We want to have the physicians give us any feedback, but then unless they complain too much about it we use those measures for scoring on subsequent reports.

We have semi-annual meetings with specialty groups to discuss the new measures as well as to get their ideas. From these meetings the idea of a clinical services report developed, and I'll show that next.

Three months prior to the performance report end date we send the physicians a report, which I'll show you on the next slide, which allows the physicians to correct their data by sending us corrections, wrong diagnosis, not my patient, not diabetic. With this method they could potentially improve their scores on their upcoming report cards as well as improving care for their patients.

Here's a sample of that clinical services report that's sent to each physician, patient specific with the names. The column to the far left they can check, not my

patient, and then we would remove that patient from their denominator. Other columns they could indicate that the patient refused to have a mammogram, refused to have a Pap smear, is not diabetic, and they can refer to case and disease management. So we have found this a very useful measure and physicians have asked for this and they do actually utilize it. Not 100 percent, but they do utilize it.

Quality measures, how have we don't over time? A few quality measures we have removed over time because we've done extremely well. Generic drug prescribing, for instance, we're at the 97 percent level. It's not worth measuring that. There's not enough point spread to differentiate physicians on that score.

These are the scores that we're still using. There the ones that we mentioned before, mammograms, glycohemoglobin, well child visits, et cetera. You can see that there's been a slight improvement in quality measures. There was a bit of an inflection point when we started the clinical services reports back in 2003 and we're hoping that trend continues.

As I mentioned before, we have a withhold that we

take and we withhold until the end of the year to see how our performance has done. This is the spread of the withhold return to the physicians based on their report card scores multiplied by the amount of money we have to return for withhold and for gain share. You can see by this display that one physician received $9,000 extra on the extreme left and one physician was penalized $3,000 on the extreme right. The area under the curve on the left should equal the area under the curve on the right, but most physicians fell somewhere in the middle.

Now some years the baseline bar would be as high as 4 percent above 100 percent. So even though some physicians are getting less, they may still be getting more than they would have gotten if we had not had this program.

So that's what we've been doing the past several years. I'm going to go briefly over what we plan to do from here.

We have plans to connect all our physicians' offices to a secure web-based data repository. We want to collate data from all the data sources that we can, the local labs, x-ray offices, hospitals, payers, practice management systems in the physicians's offices, and

eventually EMRs as physicians adopt the EMRs. With this data we want to create a record on every patient of each of our doctors on this data repository to be accessible to all physicians with the proper permission to do so. We're hoping that this patient-level data will not only make it easier for physicians to practice medicine but would also provide them alerts and preventive care measures at the time and place of service.

If we've got a minute I can show you a brief display on how we hope that that is going to work. We have the clinical data repository in the center accessible through the web portal, electronic health record in the center which is populated as data flows in. A patient goes to see his physician down in the lower left corner and patient information is populated back to the clinical data repository. Lab orders are sent through the web portal and again populate the data repository. X-ray reports are sent to the portal and again populate the repository as well as going to the physician. Images are available by clicking on the portal. If a patient goes to a hospital or emergency room, that data is available. Referral management can be done through this system. Prescriptions can be handled

through this system. In the lower right-hand corner we have the IPA sitting there reviewing all this data and putting out reports to the physicians and updating their guidelines. This is how we hope it's going to work.

I don't know if you want to take questions now.

MR. HACKBARTH: Why don't we go ahead with all of the presentations and then we'll have questions at the end.

DR. TAYLOR: Good morning. I welcome the opportunity to be with you today and to talk a little bit about what we have done and to let you know what the physician response to it has been. This has been truly a work in progress. I'm going to go very quickly through the initial slides. They're really context and background. If you have questions about them then slow me down and let me know.

Basically background on BlueCross-BlueShield of Texas, concerns which I think we all have. They're not just employer concerns.

We started out in this project to meet a business need, to have a more affordable option for our employers in Texas who were really faced with not being able to provide health insurance coverage for their employees and were

looking for other options without continuing to increase copays and coinsurance and deductibles.

Quality always come up when we talk about this issue of selecting more affordable doctors. We do not use quality indicators as selection criteria for this network, for reasons which are listed there. Mainly, we don't have access to the lab data, pharmacy data, clinical data. There really aren't credible indicators that can be accessed through claims data for many of the specialties. Then there are the denominator issues at the individual doctor level.

We are very interested in the third bullet there which is looking at the network level of quality. We're most interested in responding to the question of, if you take the more affordable doctors, have you decreased the quality of care that's being delivered? In our initial looks at that we have not demonstrated that there is any degradation in the quality with the evidence-based indicators that we had used.

Our methodology in brief. We are on our third version. We're already planning for our fourth version. All the changes that have been made along the way really came as a result of conversations with physicians. We do

review when individual physicians question their eligibility determination. We've been out talking to the Texas Medical Association. We've talked to a number of physician leaders and advisors around the state and really have responded to the concerns that they've raised as we have gone along.

One thing we recognized and have continued to work with is the need to adjust for severity and comorbidity. Physicians always say, but my patients are sicker, and I think there really is a legitimate need to be sure that we are not biasing towards low severity, low complexity practices when we're doing an analysis based on the cost of care.

We do a peer review of utilization patterns as part of our credentialing process. There we're looking at the real extremes of utilization. So we have peer-reviewed chart-based review of utilization. One of the things we saw in our earliest versions was some discordance between our risk adjusted cost index and the results of that review. That really led us to look for a model where there was a clinically-based model of severity, which we found in the Medstat Episode Grouper. They also had diagnostic cost groups there and we worked with them to develop a risk

adjustment methodology that combined both the severity and the comorbidity, looking at the severity of illness for the patient in that particular episode as well as the impact of the comorbidities that the patient brings to that episode.

The results of the model really look like this. One of the things I want to point out here is that we are developing expected costs and when we're doing comparisons for physicians we're comparing episodes in each one of those 15 boxes or cells to other episodes within those cells. So a physician who may have a very complex practice who's up at the rear of the diagram and to the far right would only be compared to other physicians or other episodes which are in that same cell. So that's to distinguish it.

The other point to make here is that when you take in aggregate cost all the episode groups that would be in a physician's practice at this level of analysis it becomes very complex, and that really speaks to something we deal with in the physician responses. These are the number of doctors that we have evaluated, the 33,000 in the BlueChoice PPO, and it comes down to about 26,000 in the Solutions network. So we have sent out letters and reports to about 7,000 physicians telling them that they were not eligible

for this network. In our last round we sent letters to about 3,000 physicians telling them that while they were eligible, they are no longer eligible, which has created quite a bit of response.

The information that we are delivering currently is really essentially spreadsheets. It is rows of reports that show for the particular episode group, severity and comorbidity group. It's basic information about episode count, total cost and expected cost. That will run to a number of rows or many pages actually for a single physician. If we're talking about a multi-specialty group where it's broken for each specialty it can get to be a rather large volume of paper.

Then if we go down to the detail level and begin to show what the inpatient data looks like, the ambulatory data, and then a level of what are the doing, the CPT codes, the HCPCS codes that appear in their episodes compared to other episodes. We have, again, generated a lot of paper and generated a lot of detail for them to look at.

What we'd like to do going forward is move to more graphic representations of the data where we can begin to let physicians see pretty much at a glance where they are

compared to their peers. So this is one example. This is another one which I think I favor more in that it as you go from the left to the right the risk adjusted cost index is increasing and they can see what their average relative risk score per episode is. So the physician in the middle there who has the most complex practice actually is coming pretty close to our eligibility point at 1.0 but still doesn't get there.

We do offer a review to physicians if they question their eligibility. We present it to panels of practicing physicians. They have recommended that we change the eligibility in instances where there are outlier episodes that really skew the index and where the utilization patterns are otherwise appropriate. Sometimes attribution of episodes will land an outlier episode with a physician and it really doesn't make sense to be there. And occasionally we've had inappropriate peer comparisons. For example, a physician who's listed in our records as an internist who's actually a cardiologist. So we make adjustment for that.

The reporting, currently we publish an online directory for members who are using this network and then

the steerage is really according to the highest benefit level used. We're not doing a tiered benefit structure, per se.

Physicians' incentive to participate in this network is really access to members. While the membership is really quite low, given that we have about 4 million members in our PPO and all our products across the state, in particular communities this really becomes an issue if an employer who's a major employer in that area has decided to take this network and then physicians find themselves with patients calling up and saying, but you're not in my network any more. So there is that incentive for them to participate.

We've looked at payment incentives. We haven't worked through how we would deal with the impact that that would have on our current methodology for calculating the index. It would challenge the differential between our PPO product and the use of this network so we're still working on that.

Physicians on the whole accept our invitation to participate in this. We've had less than 1 percent actually decline. The reasons given are really that their preferred

consultants may not be in the network, they think our reimbursement is too low so they're restricting the volume to advantage their revenue, or they're just philosophically opposed to it. They think any kind of economic credentialing is just wrong.

Another thing which I've seen is the physicians who find a single episode and they go, I can't imagine how that particular episode is in my practice. Sometimes it's simply things like maybe the name of the episode group is croup and it's an internist and she goes, I haven't seen croup in years, and the episode group is really acute laryngotracheal bronchitis. So it's something that's really very common. They simply didn't recognize what was involved in it, but that one thing has led them to say, you're methodology is totally wrong and that's the end of it.

Some simply don't understand. At the same I've had some very thoughtful letters back from physicians and office managers where they have sat down, looked at what we told them about the methodology, looked at the data and really asked very appropriate questions about how we got to what we did. Some who say they don't understand really just jump into they're not accountable for the costs, how are we

to know what the costs are, we don't control what you negotiate with the hospital.

My reaction to those when I first heard them was, this is abdicating responsibility. As I've thought about it some more and talked with some more physicians I really begin to see it somewhat as expressions of frustration and exasperation. They know the cost of care is going up. They look at what their revenue is doing and they're going, but I'm flat so what are you bringing this back to me.

Other really look at it, do you consider what influences the costs for my patients, or who am I compared to; nobody else does what I do. Sometimes they really are questions which we need to pay attention to and answer. Other times, who am I compared to; no one else in this area does what I do. Maybe nobody should be doing what you were doing. It's just not adding value to the health care system.

Others have really appreciated what we're doing. They recognize it as a challenging thing. They recognize that it's important for physicians to begin to look at how we hold down unnecessary costs and not compromise quality. We've received some recognition for, this is better than

what you were using a year ago and we really like it. We think you can still improve it. I really appreciate those who just say, help us understand this. We need to work on this. This is a very important issue.

Then the last bullet up there really is a direct quote from a letter I received from a family physician last week who really says, sit down and talk to me about this.

MS. LINDQUIST: Good morning. I want to thank everyone also for the opportunity to talk with you today about what HealthPartners is doing in the area of efficiency measurement and information for all of the stakeholders in health delivery.

I'm just going to go through briefly who we are, how efficiency fits into our overall model, some details of our process, how we align these with our strategies, the impact and keys to success. I think the most important points I want to make are about a unifying quantitative model and strategies that cross what may have historically been separate silos, strategies across members, purchasers, providers and plan incentives.

Just briefly, we're an integrated health care organization at HealthPartners, truly integrated, with

insurance, a large multi-specialty medical group, a hospital, pharmacies, a dental group, research, so it's a great opportunity to think of broadly about every solution that we're implementing and challenges. We know that nothing is easy. We have set some stretch targets for ourselves and we're really trying to optimize the patient's experience, both in the areas of service and health, optimize the clinical care, and achieve affordability.

In the Minnesota market there's a large degree of provider consolidation. There are several very large multi-specialty physician practices, 500-plus physician practices. So while we have the healthiest state in the nation as reported by a couple of areas, while the Wennberg data shows that we're an efficient manager of health care resources, we still have a high price issue. The plans, the purchasers are very aware of our price position. I'd say our provider community is more familiar with the high level of quality that we have and our reputation for managing resources efficiently. That's something we all need to understand in order for us to really address affordability.

These next few slides just demonstrate that clinical variation remains high. This one, it shows a

series of measures that have been measured through our community project with the low provider, the high provider and the average rate for our market showing. Price variation is high -- about 50 percent -- and the large players definitely have negotiating power to get higher rates.

This chart shows the relationship between price and cost. So across our providers, the blue line are fee schedule rates and the red line is the total cost of care. If I need to explain that, just let me know. But it shows that some of our higher-priced providers are doing a good job on managing total cost of care and we want to pay attention to both of those outcomes.

We also want to set the context that about 87 percent of health spending is driven by physician decision-making.

We've been working with our provider community for over 17 years in terms of developing profiling information. Our initial focus was on utilization, then we would get into quality indicators. We've added patient satisfaction information, risk adjusted, total cost of information. We've involved the information over time we're at the point

where we really need to, as I said earlier, unify all of these quantitative models so that we're all seeing the same and the whole elephant on the table.

So we've set out to create a value model and our definition of value today is that it's optimizing stewardship of financial resources and optimizing quality. Again we've created a quantitative model and it's continuing to evolve. It's built from the ground up, but our hope is that we can use it from a top down to understand our overall performance and then dig down into the areas that we need improvement on.

The model serves both a purchaser plan perspective, a PM/PM, but it reconciles to a practice management view of information.

Then our accountability model is that physicians are accountable for all the patients and the processes in the facilities in which they practice, so we're not forcing a unique patient-provider relationship. We're not forcing the concept that one episode is managed by one physician. We're not forcing the concept that a primary care is always managing a patient's experience. But in fact we're trying to emphasize coordination of care and having practitioners

work together across the system to address the gaps that occur during hand-offs in coordination of care.

Then we also have decided that hospitals are accountable for pre-and post-hospitalization. That's something we're just now working through with our own hospital as our goal is for our own hospital that their total cost of care will be in the lowest one-third of our market while their quality will be in the top decile.

So just a quick overview of the value model. We're drilling down into the concepts of stewardship and quality. For quality measures, for primary care we're measuring about 73 facets of care, and for hospital care we also have about 73 facets. For specialty care there may be anywhere from nine to 12 measures or fewer of quality. That's a gap that we're hoping to fill quickly. Those numbers that I give you are inclusive of both patient experience and clinical quality.

We have indexes at multiple levels. So we have an overall quality index. We have a patient experience index, and a clinical quality index. Then those drill into specific measures around access, communication, respect, specific measures around prevention and disease management,

lifestyle support, and acute care and safety.

On the stewardship side our model is, right now, that efficiency times price is equal to your total cost of care. We are using the episodes approach, the ETG grouper to measure efficiency. Our model allows us to drill down into the components of both efficiency and price to look by service category, to look by specialty, to go down to the CPT code level. So essentially efficiency is defined as the actual resource use over the expected resource use.

The resource use is based on a single price neutral weighting scale that crosses all categories of care. We would love it if the Medicare RVU units were relative across the different types of care and solves this problem for us. We have specialty specific weights per ETG.

I talked a little bit about attribution and the shared accountability model so I'll skip that and go into how we are delivering information.

Right now our provider information is delivered in buckets. There's a report that goes out that's a comparative quality performance report. There is another report that goes out around patient experience with detailed information. We're just developing the reports that will go

out to providers around this stewardship side of the equation, the new models. Historically, we've had many versions, from utilization to price information, and I'll show you an example of what's emerging for this model.

Our plan focuses on group-level performance. We contract with the groups. Then we provide information to the group about individual practitioner performance that they can use with individual practitioners. Efficiency itself is not yet available to patients and members. We're working through the implications of sharing that. We're very concerned that people will efficiency as rationing, as something negative, and that they'll want to go to providers who are not efficient because they feel that that's where they'll get quality of care. We also need to get this information out to providers first so that they understand and have an opportunity to make changes and so they know their own performance before consumers do.

We also, honestly, are thinking about the impact of efficiency on contract negotiations. In a market where we have such high price variation there are some excellent providers who are delivering high quality; clinically high-quality patient experience at a low total cost of care and a

high efficiency rate. We have to be very considered on how much information we bring to the table that ultimately is impacting the purchaser price. We'd like to be bringing down price, improving efficiency of a set of providers.

We've also considered risk adjustment and we are not yet risk adjusting these total cost of care profiles. Historically, we used ACGs to do risk adjusted total cost of care on primary care. The results using episodes did not vary significantly, and we are investing our resources in the depth and the scope of the information. We'll be tackling risk adjustment probably in the future.

Here's an example of provider information. Basically this is the comparative efficiency score for providers, and you can see there's quite a bit of variation there. This would be a detailed report, and down the left side each row represents a provider and each column represents a specific type of episode or ETG in their practice area. We highlight with colors where they're performing well and where they have opportunities to improve their efficiency relative to the rest of the network.

The alignment model, we're using this information with patients and members. This is an example of our

introductory web page, if you're going to search for a provider. We've included now a score on the provider's quality and their cost. The member can drill down to the very detailed level of clinical quality measures, and not yet into cost information but in the future they'll be able to drill down into cost information for specific types of care for that provider. They can also create their own of comparisons based on the condition that they have.

For purchasers, here we're taking two approaches. One is to give them an aggregate profile of provider performance and where their employees are using care. Then we also give disease-specific profiles so that we can tell the purchaser what the prevalence, for instance, of diabetes is and if their members are using our best performers around diabetes care or if they're not. This will help us drive alignment in terms of network design.

So far the impact, this year during contract negotiations saw providers who had been asking for double-digit increases in prices for many, many years actually take flat or under 2 percent increases because they realized the transparency that is coming in terms of price and total cost of care. We've gotten engagement in new specialty areas to

develop best practice clinical quality measures because there are definitely specialties where we have gaps in clinical quality information. To the extent that we're using price and cost information, they want a full picture of their performance there, so this is excellent.

We do have one angry specialty and the groups have banded together. The primary issue is communication. We tend to have a thoughtful process where we involve physicians and groups in the development of our methods where they see their results before they're publicized to employers and providers. Last year in our haste to expand the scope of our tiered network design we pushed ahead in one specialty area without following that explicit process, so we definitely are feeling the implications of putting the cart before the horse and not going through a robust communication process.

As I said, our own hospital is engaged in developing this total cost perspective and how they're accountable for care pre-and post-hospitalization. And our community is working on a shared view of provider efficiency measurement focused on diabetes at this point in time.

In using these models we've developed a tiered

product that helps us offer a 6 percent to 8 percent potential savings. There is not a quality difference. In order to get into the low level tier you have to be high quality. You have to be higher than average quality and you have to have lower than average total cost of care.

We've seen that 4 percent to 5 percent of patients have moved into the tier one following the implementation of these programs. We also see that there is from 10 to 19 percent potential savings if our providers practiced at benchmark performance. Benchmark is defined right now as the top one-third performers.

Because we have this value model, we've studied the relationships between the components. We've found nine significant correlations out of 102 that we've looked at. Those that were related to efficiency, we found that primary care satisfaction with access is also correlated to high efficiency. Then, unfortunately, we found in cardiology that high performance on providing behavioral advice -- so advising people about tobacco and exercise and a healthy diet -- is correlated to low efficiency. Could be very much linked to the payment models for specialty versus primary care.

We do find that there's a limited number of providers, as I said earlier, who optimize on all of these. So they've proven it can be done and we want to, sometime in the near future, redo this study of value and find fare more correlations.

So accurate and actionable is key, coordination of peers, involving thought leaders in the provider community in our development, having completely transparent methods, aligning information across the continuum have been keys to success. We are aligning payment incentives. We have a pay for performance model and a subset of the measures that are used in tiering and used in consumer information are included in the pay for performance model, and also a bonus model for hitting stretch targets.

Multiple levels of information that reconcile to each other are very important so that all constituents see where the others are coming from. And I guess I'd like to recommend that we really leverage market competition in developing the models so that we speed the scope and the depth. I think that there was a bit of complacency as we moved ahead in primary care quality measures and we left behind specialty care. I would hate to see that happening

as the country is moving forward on this effort.

Thank you.

MR. HACKBARTH: Thank you very much. Excellent presentations.

Questions, comments from commissioners?

MR. MULLER: Let me echo what Glenn just said in terms of the excellence of the presentations. Could you each speak a little bit more to what you're really trying to achieve? One of the issues that the Commission often deals with is the search for the efficient provider and how to both incentivize that performance, which also requires how to measure that as well.

Tammie, I think in your presentation, just as the most recent one, in terms of what HealthPartners is trying to ultimately measure when you look at that kind of efficiency and price and quality. So for example, you spoke about trying to get people into the top tier of quality and a lower tier of price. One could also think about keeping costs down of hospitalizations and so forth.

So in terms of what you're trying to ultimately measure yourself by, is it keeping costs at a level below, let's say in our case here, the average premiums for

Medicare with reasonable quality. And let me ask the others to speak to that as well. Because you have, in some case, hundreds of measures but my guess is those hundreds of measures aren't all equal in terms of what you're trying to achieve. So when you look at your performance at the end of any period, whether it's a year or a multi-year period, what are you ultimately trying to measure? Because it's obviously very appropriate to try to secure higher quality, but my guess, all of you being competitive markets, have to stay within the payments that you're able to secure. So if you could speak a little bit to, at the end of your year or multi-year process, what are the ways in which you measure whether you're performing well.

MS. LINDQUIST: We actually have a project in progress to define affordability and what our affordability target will be. Our scope thus far is that it will be defined from a patient and payer perspective, but we have a long way to go. Also, our insurance company serves national employers so one of the goals is that we are no longer the high cost region that they're dealing with and they're not talking about shutting down operations in Minnesota because health care is so costly. So I can't give a quantitative

number but conceptually we're working through so that we can get to a quantitative number.

DR. TAYLOR: We're trying to achieve really a couple of things. One is, first that we deliver to the marketplace a more affordable network. By that I mean a network where our actuarial staff will allow us to go out with a significant differential from the PPO premiums. So if we can get a 6 percent to 8 percent premium differential, that our first goal. Then the interest in the marketplace, it depends on really which segment of the market we're talking. If we're looking at -- success is people buying the network. It's been most popular with very small employers -- under 50 lives -- where they're more concerned with cost, frankly, than they are with quality measures. When we get to our large national employers, self-insured, then we start having to have more discussions about quality.

The second thrust of what we want to do is to provide actionable information back to physician so that physicians can look at the data, can look at where are the places where we can make changes in our practice that would allow us to then be in this network. One of the things we recognize is that over time, you can't push a lot of volume

into the more affordable physicians because eventually you just run out of capacity. So one of the directions we want to go is, how do we bring more physicians to a more affordable level. Ultimately we will start with a premium differential and then over time what we would like to see is that the rate of increase or the trend for this particular network is perhaps lower or remains divergent from that of the larger PPO network.

DR. NIELSEN: In Rochester, we think that our group has done fairly well. We trend compared to the rest of the community. We don't have real data though on the costs incurred by the rest of the community, only by our network. But I see this as a journey. For value and efficiency, it's a distribution and we're trying to bring in the tails of the distribution in then shift that whole curve more to the quality side. We're doing both case disease management along with our P4P and it's tough to tease out which is having the most effect. We continue to struggle with that and we're working on it.

DR. NELSON: I have one very brief question for each. For Dr. Nielsen, have you had a different reaction and different performances from your employed versus your

non-employed physicians?

DR. NIELSEN: We've actually seen no difference. Our employed physicians do not feel themselves as being corporate doctors. Most of our doctors are private. We see movement back and forth from employed to private and vice versa. I don't think that the employed physicians feel that they're locked in to working for an employer. I don't believe that they see things much differently than the private doctors.

DR. NELSON: Thank you.

Dr. Taylor, with 10,000 potentially unhappy physicians who weren't taken into the Solutions network have you seen organized efforts around any willing provider activity? That would seem to be a response that one might expect and I wonder whether it had happened in Texas.

DR. TAYLOR: We haven't seen that. There is a statute in Texas which requires that if we're going to do economic credentialing we have to consider factors which may account for differences in the physician practices or in what we're seeing. So with our adjustment for severity and comorbidity we feel we're doing that.

DR. NELSON: For Ms. Lindquist, what is the

minimum size group within your network, and what kind of information technology capability exists throughout the network?

MS. LINDQUIST: There are very few groups who have smaller than 10 physicians in our community, so they range 10 to 550. The technology varies. The large multi-specialty groups have been the first to invest in electronic medical records and are the furthest along.

DR. NELSON: The small groups that haven't invested in that, how are they recovering the data, particularly the quality performance data?

MS. LINDQUIST: The health plan actually creates that information and provides it to --

DR. NELSON: From claims?

MS. LINDQUIST: Yes, from claims. We also do chart audits. We have an extensive chart audit process, and we also have a member survey process. Then our community is also collaborating so that each plan is not producing different sets of information but that we actually are working together to provide a common set of information on providers' performance.

DR. CROSSON: I'd also like to echo our thanks for

your presentations. They're very helpful.

One of the issues we've been wrestling with is ways to influence the volume of services provided over a year. This is physician services. I wonder if you could comment on the episode grouper methodology, and to what extent -- how far does that get you in trying to measure and then potentially reward appropriate resource use with the respect to the volume of services? I noticed in Dr. Nielsen's performance report one column there that wasn't filled in yet but had to do with PM/PM total cost for the year. I didn't see that in the other presentations. So one of the questions I think that we're wrestling with is, to what extent does the episode grouper methodology help you work on the issue of the volume of services provided in a year?

DR. NIELSEN: I'm not sure I can answer that question. We used the episode grouper methodology for our specialists. We don't see it pertaining to the PCPs because they have so many different diagnostic categories. The specialists are doing procedures, a lot of it is procedure, hospital driven, and that's where we have found the value. We have not found value on the primary care side.

To what extent have we affected costs here? That's another question I can't answer. I can tell you that the cost for our group as far as PCPs, the PCP costs are flat. The amount of money that we pay out to the PCPs has been flat over the last three to four years. For the specialists it has been going up at a significant rate, but not as much as hospitalists, hospitals and outpatient care.

MS. LINDQUIST: We find the grouper tremendously useful although it doesn't provide the final set of numbers. What the grouper does for us is allows us to profile generic prescribing, or hospitalization rates and length of stay, or use of radiology and lab services for clinically specific categories so you have meaningful comparisons. So that's an advance over historically just saying, here's your hospitalization rate per thousand. Now it's case mix adjusted.

The next step though is appropriateness of use. So we can identify variation in use and that is what we are providing to providers. The next step is appropriateness of use. The grouper as it comes does not do an assessment of appropriateness. There are other vendors who are developing and selling software that takes it another step, so looks at

the evidence base and codifies that so they can tell you when it was an inappropriate use of radiology not just a different use of radiology.

DR. TAYLOR: We base our comparisons on total allowed costs, which would be both the price and the utilization. So physicians who have higher costs, whether it is due to higher reimbursement because they contracted for a higher rate, or because they have higher utilization, either way they could be out of this network. So when we provide detailed feedback to them on particular episode groups, we provide them information on the hospitalizations per episode, on the length of stay within those episodes, within that particular episode group at that level of severity for that comorbidity group. Likewise, on the ambulatory side we provide them feedback that is broken out both as a summary of the total cost of care per episode for ambulatory services, for facility services, professional fees, office-based lab, radiology, and emergency room, and also services per hundred episodes on that, so that they do see the utilization piece of that.

So when I talk to physicians about this it really is, there's lots of different things which can push their

costs higher. Sometimes it's the utilization, sometimes it's the facility they use. Sometimes, as we look over into the CPT and HCPCS detail on it it's which procedures do they choose to do relative to their peers, because some may use more expensive procedures to treat the same condition where their peers use a less expensive procedure.

MR. HACKBARTH: Can I just follow up on that question? Many people are interested in the episode groupers as a way to start getting as the volume issue. Of particular concern with regard to volume is the rate of growth in imaging. Let's just focus on specialty care for a second. So you have an episode that may involve a hospital admission, various perhaps outpatient imaging results perhaps before the hospital admission. What I'm trying to get a feel for is the assignment of responsibility.

So this stuff is packaged together in an episode. Who is responsible for the growth in imaging? How do you deal with physicians about that? How do you assign responsibility for that within your systems?

MS. LINDQUIST: The attribution model that we assigns a patient's episode to any provider who had at least

25 percent of the management and surgery charges; the things that physicians bill for directly. If they had at least 25 percent -- and I should say relative value units because we throw price out when we make this attribution rate -- they get assigned it. So if four physicians are assigned to an episode and that episode has overuse of radiology and it shows up in the aggregate scores for those physicians, they have the ability to drill down and find out, I'm not the one ordering these but my referral partner has a high ordering rate. Again, to go to that coordination of care and discussions between physicians about practice patterns.

So I guess the short answer, multiple providers become accountable for that overuse issue, multiple providers are aware of it and can act to make changes.

MR. HACKBARTH: So the level of detail is such that the physician could say, the imaging group that I'm using is the cause of this? So it's actionable in this that sense.

MS. LINDQUIST: Yes, it's actionable in that sense. I want to clarify that that level of detail doesn't necessarily go out with the first round of information. It's available through an iterative discussion. We try to

make notes about -- we look at the information, we make notes about what we think is driving the variation and what we observe quantitatively so that people actually look at the information as opposed to the four-inch stack on their desk of information.

DR. TAYLOR: We have used multiple attribution methods. In our first two methodologies we used a very similar methodology where we attributed one episode to multiple physicians. There was a lot of unhappiness with that, so we have moved to a methodology now where we are attributing the episode to the physician who had the highest total relative value units in the episode. Now that tends to drive the episode to who did the procedure in the episode.

That's working reasonably well. There are a few things that are showing up which make me wonder if we would be better suited or if it would be better to use the physician who has the most evaluation and management codes within the episode, the most visits. I'm leaning in that direction and I think that's one of the things which we want to analyze in our current data set and see what the differences would be, which specialties would be impacted,

which episode groups would be impacted by doing that.

There are many different ways to do it. If we do it using a single physician attribution, that seems to be better to the physicians because then they owned it. It's much easier to say to them, you got this episode because you had the most RVUs in it, or you got this episode because you had the most visits in it. It's not because you just happened to get asked to consult on this particular case.

DR. NIELSEN: We've used a similar approach to what Dr. Taylor has described in looking at E/M codes billed by various physicians and looking at the most E/M codes during the period or the most recent E/M code.

MR. HACKBARTH: So it's a single physician model.

DR. NIELSEN: That's what we've done, yes.

DR. TAYLOR: Even when we do the single physician attribution, that idea of who's accountable for it and going back to, the radiology, if that physician didn't really order it, if he did a referral but he still owned the episode, then there still is that opportunity for him to go back to his colleague to whom he referred and have a discussion about, why are you doing that?

MS. DePARLE: I want to follow up on the questions

about inappropriate resource use and the specific example of imaging for just a minute. Most of what you've talked about are techniques that I would describe as closer to profiling, giving that kind of information back to the physicians at this point. I had understood, Dr. Taylor, that in Texas there was a discussion about, or perhaps your company has already implemented, some restrictions on self-referral of ancillary services in the doctor's office. Is that true, is that something that's being considered or that has actually occurred down there?

DR. TAYLOR: No, it hasn't.

MS. DePARLE: Is it being debated maybe by the legislature?

DR. TAYLOR: I think it has been debated in the legislature and it's one of those issues that's a very hot button for a number of people.

MS. DePARLE: In Minnesota, is that something that's being considered?

MS. LINDQUIST: Limits on self-referral? Minnesota is emerging from a more referral-based primary care capitated model into the open access world of freedom so now we're emphasizing your ability -- not for radiology

though, not specifically for radiology. An individual patient?

MS. DePARLE: No, I'm talking about physicians doing the imaging in their offices, MRIs and CTs, and there's been a debate about that, about whether that increases utilization in an inappropriate way.

MS. LINDQUIST: It's a concern that's come up. I don't think that there's been legislation around it. We have tried to address it by varying benefits based on the price of the imaging services. Then in this whole value model where physicians are placed in tiers based on how they manage resources, it will come back to impact the reports that are visible to purchasers and to consumers and where the provider lands if in fact owning an imaging center is leading to overuse of the imaging center.

MS. DePARLE: So indirectly that will feed back.

MS. LINDQUIST: Exactly.

DR. NIELSEN: From New York State there's no legislation pertaining to that issue that I'm aware of.

MS. DePARLE: I guess just your observations -- this is probably a quick answer. Our job is to figure out what Medicare policy should be around some of these issues

and how we can better promote improved quality for beneficiaries. Is Medicare payment policy at this point helpful, unhelpful or irrelevant to what you're trying to drive in your IPA and your health plans?

MR. HACKBARTH: Let me ask a specific version of that. Some have proposed that we make Medicare data available to private plans with physician identifiers on it so that you can combine that data with your plan-generated data. Any reactions to that proposal? Would that significantly enhance your ability, for example, to assess physician performance?

DR. TAYLOR: It would certainly increase the number of episodes that we had for many physicians. Whether or not it would really alter the outcomes and add a lot of depth and value and richness to what the scores are, if it would really change a physician's scores, I don't know. But the physicians would be happier if it were done that way because they will often say to us, you only have this small slice of my practice, and they would be happier, particularly on the quality side. I think that's the place where we really run into the denominator issues, is more significant than perhaps it is on the profiling

affordability.

DR. NIELSEN: We are a physician group so I don't know if that suggestion pertains to us. You're talking more about health plans. I would wonder then too if that information shouldn't be made available to the physicians, either at the individual or group level and they could designate someone like an IPA to receive that information and analyze it for them.

MS. LINDQUIST: It raises a number of questions so I'll just -- I don't necessarily have a position to talk to them but here are some of the questions and concerns that come up. The Medicare payment system is still a widget-based payment system and we're all trying to create incentives that are not about overuse but that are about appropriate use, so the extent that Medicare goes down the path it benefits everybody.

Cost shifting? I think there's cost shifting from Medicare to the payers where Medicare is paying pretty low rates, especially in primary care. That's a concern there. I think there's an opportunity to look at the relative value system for physicians. If you're a specialty practice, the new procedures and the technology that's necessary to

deliver those procedures is inherently built into the CPT system and the RVU system. So if you need a defibrillator, there's eventually a code and a payment.

If you're in primary care and the pressure is on you to coordinate care across systems, to manage diseases, to do proactive patient care, it's not built into the system. So your tool, your technology is probably IT, not a defibrillator that goes in a patient's body. So I think there's tremendous opportunity there.

The other question that I have, and I hesitate because we've not discussed this a lot or I've not been involved in discussions of this at HealthPartners, but our hospital is a trauma center, it's an educational center, so it's great Medicare pays more for those services. How that translates into a commercial market and the impact on the commercial market is somewhat of a challenge. Do those hospitals always get paid more? Are they always more inefficient because of the teaching services that they're doing? And how do you reward those hospitals and pay for that service but not penalize them in these emerging efficiency analyses that are linking payment to length of stay and overall efficiency? So those are the top questions

in my mind.

MR. BERTKO: I too would like to recognize with my fellow commissioners all the tremendous work you have done. I'm well acquainted with the efforts involves. So have a question here.

If you were sitting around a table as one of us or at the CMS agency, what first steps could you take if we had the results of the kind of analysis that you're doing? And would it require network differences or benefit structure differences to be effective?

DR. NIELSEN: Our whole system that we use, and Medicare is the model for every other system in the country is, again, as Tammie suggested, it's a widget model. We're paying procedures basically and we're paying for number of office visits that a PCP can generate. Is that the right model? I seriously question whether that's getting us where we want to be in the future. Exactly what to recommend as an alternative, I don't have a ready suggestion.

But the physicians are taking on responsibility for care of a patients, and PCPs for overseeing the management of the patient and relating to the specialists but are not compensated in a particular way for that. If

they do that without generating an office visit they're not reimbursed at all. PCPs are going to be complaining more and more about that. We're having difficulty recruiting PCPs. Were having difficulty getting medical residents to elect PCP specialties at all, at least in our area. So there is a need for something to be done, I agree.

DR. TAYLOR: I'll echo the previous remarks about evaluation and management code reimbursement. We do see physicians looking to places where they can bring in procedures, bring in machines, bring in things that they can do to generate revenue because they're not making revenue off of evaluation and management codes.

To your question, you could follow the model we did. That this to say, we can't really wait to perfect these things. Despite the imperfections and despite the need to basically tinker with this machine as we drive it, we felt we needed to get out in the marketplace with something that was more affordable. I think it does take a network design change. I think that to ask people who wish to use more expensive physicians to bear a greater portion of that cost is a reasonable thing to do.

There are times where it's simply a matter of

economics, where we can't afford to continue to have higher premiums and we can't afford to continue to drive this. There are physicians who are very good quality physicians who happen to cost a bit more given the way they practice. If I happen to like that physician then maybe I should pay a little bit more if I want to see them. And if there's a physician who's really saving all of us money and who is much more efficient, the practices that Tammie spoke of, then maybe it should be easier to get to those practices and there shouldn't be as much of a financial barrier to get to those practices.

MS. LINDQUIST: I really like that idea of creating differentials for the patients based on their choice of provider and how they're doing in managing quality and resources. I also agree with looking at E/M. I'd say focus on primary care reimbursement in terms of the RVU system that exists for primary care. Then in pay for performance I think it would be really interesting if the focus there was on specialty care. Historically there's been so much emphasis on primary care that we're overlooking an opportunity in the area of specialty. I guess I'm very concerned about driving primary care practitioners out of

the market. They are our most cost-effective way keeping people healthy, delivering care, so I think the incentives there are very important, without being burdensome.

MR. BERTKO: If I can ask an unrelated question. I think I heard you use three different episode groupers. If you've looked at multiple ones, do you have any comments on importance or why you chose the one you did?

DR. NIELSEN: We only looked at two and we chose the one that we thought would best fit our needs and was a bit cheaper than the other one.

DR. TAYLOR: We have used two. We went out to the marketplace sometime in the recent past because, one, our contract with the then-vendor was coming to an end and needed to be renegotiated; the hardware that we were running on it was obsolete. And in looking in the marketplace and having really analyzed what we were doing before with the other major grouper out there, we did say that there were places where -- this wasn't risk adjusted, so we were seeing places where, for example, an oncologist who had a practice which only seemed to be doing surveillance of people, it looked like it was women after breast cancer. It was surveillance procedures -- with no chemotherapy, had an

excellent risk adjusted cost index, because they were being compared to physicians who were providing chemotherapy.

So that really drove us, as we looked to find something that gave us a clinical model of severity and had within it the opportunity to bring risks to bear, because we really recognized that patients are complex, and the more complex a patient is, the more they cost. Doing the hospital concurrent review, I can look at a patient and they start listing off all the comorbid conditions of the person who had the MI or the pneumonia and I go, they're going to be there a while. And if it's a very short list or no comorbid conditions, they're going to go in a couple of days.

So that was very important to us to get into this methodology and it's why we spent the time that we did last year to really develop a methodology that brought the two together.

MS. LINDQUIST: We have had a longstanding relationship with the vendor we're using. The contract is coming up and we'll be looking at other vendors, considering risk adjustment but also considering that ability to interface with evidence-based analysis to complement the

information base.

MR. HACKBARTH: With running over time now so we need to go through a few more rounds very quickly.

MR. SMITH: I wanted to follow up on your answer to John. You had said in your prepared remarks that you had not tried to yet use the efficiency data with consumers because you were concerned that consumers would equate efficiency with stinting. It's interesting, Dr. Taylor's answer on the grouper technology where you said, we stinted -- or we didn't stint. We tried to find something that was cheaper and of high quality.

I wonder, Tammie, beginning with you but all three of you, if you could talk a little faith about how we use the increasingly sophisticated and potentially useful efficiency data with consumers in a way that addresses some of the concerns we had with and still continue to have with the MedicareAdvantage plans with folks being concerned that managed care or price-driven decisions will result in lower quality care?

MS. LINDQUIST: That's a big question. I think one of the gaps is consumers assume quality. Physicians are held in very high esteem, which they deserve and have

earned. There is a lack of recognition though that there's still variation, and that we can't afford to pay for everything, and therefore physicians do add value when they manage efficiency of practice.

I guess what I'm saying is, I think it's a public perception that insurance companies aren't going to change and there needs to be other market drivers helping consumers understand what the variation is and what it means to consumers and to our country if the variation continues. One start is engaging consumers in paying different rates out-of-pocket based on the performance, but I think it has to be accompanied with a unified message from providers themselves, from public policy, from entities other than insurance companies about the issues.

DR. NIELSEN: We'll need to address this at some point because we haven't now. We've made physicians responsible for the entire cost of our medical conglomerate, but really a lot of the cost is driven by patients. Ever since we had direct to consumer advertising for drugs, the cost of drugs has been going up 25 percent per year. It's directly related. That was an FDA decision in 1989. These kinds of things do make a difference. Patients want

everything. I saw an article in a magazine entitled The Infinite Cost of Futile Care. There's no limit to demand, so somebody is going to have to address it at some point.

MR. SMITH: Do you agree that the most promising route, even if the most difficult, is some sort of price differential?

DR. NIELSEN: I think that has to be done. I don't know of any other way.

DR. TAYLOR: It's a challenging question and I guess over my career now, 20-plus years in medicine and from the very beginning hearing about the need to educate patients, educate consumers, I'm a little pessimistic about that as a way to accomplish what we need to accomplish. People want what they want. There are very subtle ways that -- not just direct to consumer advertising, but there are subtle ways that the demand for services has increased. Sitting on the phone on hold at a gastroenterologist's office and the message is essentially, do you have heartburn? Talk to your doctor. And I'm thinking, this is an advertisement for an upper endoscopy.

I do think it has to be the cost-driven part. I like the idea of using a network model to do it or some sort

of tiering and an economic model to do it because people don't really think about these things until it comes to the time they pay for them. I never in an insurance contract, a health benefit contract, until I worked for an insurance company. I never get out and look up the information that I have from them until there's something that I or one of my family members have and then it's directly relevant to us, and usually relevant to us in an economic manner.

MS. LINDQUIST: Can I just add too that while I think the price differentials are critically important, I want clarify, they can't be based on efficiency alone, depending on how you use the word efficiency. We have to clearly demonstrate that, for instance, a provider where price is more appealing has both efficiency of resource management and good, high quality. So I think it's the incentives. It's also the information, and moving from a world of reputation and size driving value to a world where truly comparable quantitative metrics drive toward value, and that those things are completely linked to each other.

DR. TAYLOR: In my less pessimistic viewpoint, I think there are opportunities for us to use web portals to lead patients who have particular conditions to the place

where they can see how we profile doctors on quality, on evidence-based measures, on affordability, where we can provide them, if you will, the point of service, the point of need information that goes, this doctor may actually be the better doctor for my diabetes or for my mom's diabetes. Here's a doctor who somebody has looked at what they do and they recognize that they do a good job of it. That's something which we're currently exploring with one of our large self-insured clients.

DR. REISCHAUER: I'd like to thank you for three really first-rate presentations I think that have informed all of us.

I was a little surprised at how little attention there was to the sample size problem. Dr. Taylor in answer to a question raised that but it's been presented to us, particularly when we're dealing with individual physicians, that this becomes a huge problem, particularly if you're dealing with one-year time frames. I was wondering how many potential participants in this kind of evaluation drop out because of inadequate sample size.

In addition, I wanted to ask Dr. Nielsen about the relative size of the pay for performance incentives here.

If I looked at your chart correctly, two-thirds, three-quarters of the folks got somewhere between plus or minus $500, and a handful got real bucks, and a few got penalized. I was wondering as a percent of the total amount of resources that are given to them, is this 2 percent, 5 percent, 10 percent that you're capable of getting, and is the incentive really just to avoid being in that tail where you might get a minus $3,000 and your probability of actually gaining substantially from high quality was relatively small?

A question for Ms. Lindquist. Maybe I misinterpreted you but this consumer information chart, is that available to people now?

MS. LINDQUIST: Yes, it's on the web.

DR. REISCHAUER: I was looking at this and choosing my provider and it was clear that HealthPartners Uptown Clinic was where I wanted to go. It was four stars for quality and one star for cost. I was wondering whether you're seeing people move because the cost maybe really isn't that important because most of it's being picked up by a third-party payer, it's really who's four stars and closest to my home kind of thing. And whether, in a sense,

Dr. Taylor suggests a system that works because I think there's over-capacity, or excess capacity anyway, in the system, so if you move people they don't find access problems. I can't get to the good guy or the good provider because they're chock-a-block ful their book of business.

DR. NIELSEN: That was a lot of questions there. The amount of money that we had to play with to reimburse doctors more is not enough. I certainly agree with that. If we give them an aggregate of 4 percent we're doing good. I'd like it to be 15. I think it takes a lot more money to really get doctor's attention. But fortunately, doctors also like to be compared to their peers and to see that they're doing well compared to the group. I think we're using that mechanism as well. Physicians all want to succeed. They're high achievers, so we're using that against them I guess.

The sample size issue, statistically we'd like to have a sample of at least 30 for every measure for every doctor. That's what our statisticians tell us we need. On some measures we use as few as 15 because if we didn't we wouldn't have a big enough number of doctors that we could use that measure for. So it's a balancing act. We'd like

more but we'll go down as low as 15 on some measures, but 30 is sort of the benchmark.

DR. TAYLOR: We use 24 months of claims data to build episodes and we have at least three months of run-out on the end of it and we would like to have three months of run-in actually at the beginning of it. We also use a 30 episode minimum in order to profile somebody or to allow them into this network.

MS. LINDQUIST: We also use two years of data, and our profiling and our relationships are at the group level, so the sample size issue becomes less of an issue. But any time there's a negative score we also have a process where we can go through and actually validate that the results are realistic.

Regarding the impact on people, we've just recently studied and found that about 4 percent of people who are receiving care moved from a tier two provider to a tier one provider. We've not looked to see what their cost profile is. You would assume that people who have higher health costs would be the ones who are more incented to move. So hopefully those 4 percent are in fact people who are on the higher end of the average cost spectrum.

The access question is interesting because we have seen a decrease in our access satisfaction recently but have not done a study to see if that relates to this movement and I'd like to go back and do that. We assumed that we've raised the bar for access expectations in our community because so many people have implemented same-day appointment scheduling that we were thinking it was more of a perception issue than a real issue but that's a good question to look at now.

DR. WOLTER: I had a question about incentives too because we've talked about that a lot here, and particularly with physicians the issue of, do you need to be at 10, 15, 20 80 percent opportunity for the financial incentive to kick in. For Dr. Taylor and Ms. Lindquist, I wonder if you'd comment, more the issue is information or transparency or is being in or out of a network going to be enough of an incentive for physicians? And for Ms. Lindquist, I'm also wondering if in your experience you have thoughts about the relative efficacy of strategies that target individual physicians versus something at the group level.

DR. TAYLOR: We strive for transparency in providing information about the methodology and in providing

information back to physicians, and really feel that we have still some distance to go on what we've done with that. Clearly, if we have physicians coming back and saying, but I don't understand, I look at that and I go, we haven't explained it well enough or we have presented it in a way which makes sense to them and which they can understand.

We have talked extensively within our group, within our company about incentives, about payment incentives. We've talked boosting evaluation and management code reimbursement to the physicians who are in the affordable network. The challenge there, as the actuaries come back and point out very quickly is, then you might have a doctor who was at 0.99 on their risk adjusted cost index and because you increased their reimbursement now they're going to be at 1.02, so they're going to move from being eligible to not being eligible. Or that we will move the differential between the two networks and make it narrower. So that's something that we've struggled with.

There would be ways to go in and back out that additional payment, but then we're talking about additional analysis, additional resources. We're much in the process of thinking about that and looking at, and how it would be

done and what it would take, and would like to do something along those lines.

I don't know that just being in a network is enough. It currently is meeting the need which we had to get out to the market and to employers who really were striving to have something where they could continue to provide health care benefits to their employees.

MS. LINDQUIST: In our market, again, the idea of being in the network and not being in the network is not very realistic because of the large multi-specialty practices and having geographic coverage and the perception by purchasers. Each of our products may have very different networks very much driven by purchasers' needs. So the transparency for us is very important, and we find it's very effective in terms of the physician incentives.

I talked earlier about one particular specialty that was angry about the progress we'd made in measuring their performance and using it to tier our networks but had not necessarily involved them directly. They asked us to remove information from the public until we had worked through this process. So they found it very meaningful that their information was transparent.

The publicity or the rewards are not just financial, but also we find it's very valuable to providers to be recognized publicly. We have an annual awards dinner. Senator Durenberger was kind enough to speak at it this fall, and it's attended by the press and it gets in the paper and we recognize the high performers and that goes over. well.

The idea of working at an individual physician level or a group level, it's more efficient for us to work at a group level, but also philosophically, it again emphasizes the importance of systems. And that while we're driving toward a physician accountability model the infrastructure is not about the physician themselves to manage this but rather the systems that are put in place to support that effort. So we really strongly believe that group level work is of more value than individual work.

Now having said that, it's important to give individuals their own information, but the incentives around payment and the transparency of performance, we feel that that makes more sense at the group level.

MR. HACKBARTH: Thank you very much. I have three or more questions but we've run out of time. The

presentations were really excellent and this was very helpful so thank you for taking the time. Now we need to move on to our coordination presentation.

DR. MILLER: If I could just do something procedural. I was going through counts of votes yesterday and I was a little unclear on one set of notes. Nancy-Ann, for the last two recommendations on IRF and long-term care from yesterday, I wanted to be sure I had recorded your votes correctly.

MS. DePARLE: Yes, I had intended to vote yes and I was called out of the room unavoidably so I'd lie to be recorded as voting yes.

DR. MILLER: That's fine. So yes on both of those, just for the record.

MR. HACKBARTH: Whenever you're ready you can start.

MS. MILGATE: This discussion is part of our ongoing discussion on how to best support care coordination in Medicare. In October we discussed our findings on how performance measurement could improve care coordination, particularly in care transitions between physicians and at hospital discharge. In November we presented findings from

our data analysis on the role of physicians in treating Medicare beneficiaries and found that beneficiaries see multiple physicians but that many beneficiaries see only one physician for much of their care.

In this session we're going to summarize findings from our interviews and lay out potential models for care coordination. Up front though we wanted to acknowledge the complexity of this challenge. You'll see that we do find the types of services patients need fairly straightforward. However, the complexity comes in in trying to identify delivery systems and payment models to try to support those services. As one recent article described it, they described it as trying to fit a round peg into a square hole in the payment and delivery system. Because of this complexity we anticipate that your discussion today may identify additional models than those we'll outline in the back of our presentation.

We conducted over 35 interviews from August to December last year, in 2005, and the purpose was to identify key components of care coordination programs and also delivery mechanisms and financial incentives that support those care components. Many of the interviews were with

organizations who are part of either the CMS Medicare health support pilot or else the various demonstrations that they're working on. They included interviews with group practices, integrated systems, hospital systems, IPAs, representatives of a variety of different providers, insurers, care management vendors, researchers, accreditors, as well as CMS demonstration staff.

Through the interviews we identified two types of care coordination and we've talked about this distinction before. First, care transitions within and across settings for all types of patients, not just those that are complex, and we discussed this in some detail in October. There we found that there were a variety of new measures as well as ways to improve or use current accreditation standards to hold providers accountable for care transitions. We also identified the need to define a core set of information that would move with the patient and spoke about two different types of models for doing so.

In this meeting, however, the primary focus is care management for complex patients, which was the other type of care coordination that we heard about through our interviews. This is important not only because chronic

conditions, which are often what lead to complexity of patients, are highly prevalent but also because many of these patients incur high expenditures. A recent MedPAC analysis found that beneficiaries with one or more of only three chronic conditions, diabetes, coronary artery disease or CHF, account for 61 percent of inpatient expenditures in the Medicare program. Further, we know that many of these beneficiaries are not receiving necessary care. We also know that the current payment system focuses primarily on episodes face-to-face care, not the types of services such as patient education and ongoing monitoring these patients need.

In our interviews we identified two primary tools for managing complex patients. I should say at the outset, while we're summing this up as fairly clear what those are, there are many different ways that these played out in all the different programs we spoke with. But all the programs had a person and usually it was a nurse, but not always, as the care manager and the nurse care manager would provide education and ongoing monitoring. After a patient was identified as in need of this more intense care management, this care manager would assess the patient to determine

their level of intervention, educate the patient and their family about medication use and symptoms to look for for whether they needed to access the health care system, contact the patient regularly to assess their progress, and also make sure that the patient's physician was aware of the ongoing patient progress that they found over time.

In addition, the programs used information systems to perform a variety of tasks. First they used them to identify the complex patients, record their progress, and then interact with health providers. Sometimes this was electronic health record, particularly if this was done in a provider group setting. However, in other cases, and as our panel just described, there were also web-based portals that were used as databases for all to access, and in some cases if they were going to focus on a specific disease, patient registries were also used.

Another tool of information technology that was used was home monitoring, where the patient would actually record their symptoms or signs and it would automatically then go into a care management program's office.

Another finding from the interviews is the importance of physician involvement in the care management

program. We really identified two types of programs, speaking broadly; those that were integrated within a provider group and those where there was a care management program that was really separate from the individual physicians or hospitals.

In the models where the care management was done separate and we're talking about it here as a stand-alone care management program, they describe physician involvement as important as a source of referral. They also said when physicians were involved that patient compliance was much higher with the care management program, and of course, that physicians were central for the actual ordering of necessary services for that beneficiary. For example, the physician, him or herself, orders the HbA1c test for diabetes as well as records the results of those tests.

And they found that if there was a relationship over time that the care manager could actually speak with the physician and get medication orders changed more quickly without a visit, and also they found that this often prevented emergency department use if there was an ongoing relationship with a physician.

Groups of providers just noted who useful it was

to them to have both of those functions within their particular group itself.

Most of the programs that we spoke with targeted complex patients. They use administrative data or provider referrals, or both, to actually identify who those patients are who would be eligible for their programs. These are physician referrals. But if they have a hospital in the system, the group said it was particularly useful to get referrals right in the hospital because then they could start their care management right in the hospital stay.

They looked at the presence of number of chronic conditions as well as utilization patterns and then if they had the appropriate data, also the frailty of the patient. They said that while these programs were targeted at complex patients, they could apply to a much more broad audience of patients. However, because all the programs we spoke with tried to pay for the programs out of the savings from the programs, that they really had to target high utilizers who they were able to actually work with to change some of their utilization patterns to pay for the cost of the program. Because of this, the primary goal of most of the programs is reducing hospital use. They talked about this both in terms

of cost savings, but also as one of the primary quality goals for their programs.

We also heard, and this was primarily from those who were in provider groups, but that integrating the physician and other provider care with the care management program made the program particularly effective. For example, they could have nurse care managers right in the office with a physician and perhaps be the care manager for several physicians at a time and that would facilitate better communication between the provider and the program. And also, as I've mentioned before, those with hospitals found it was very useful to be able to work directly within the hospital to start the care management program as early as possible.

The other factor that they said helped in terms of the advantages of having it done in groups were the economies of scale. This came out in two ways. First, that provider groups had a sufficient patient population to identify the minimum number of complex patients necessary to make it worthwhile to put this kind of program in place. They said, for example, if a solo practitioner had only 10 or 15 complex patients it just may not simply be worth their

effort to try to do those kinds of programs. They also said, on a related note, that it was possible in groups of providers to actually share the overhead costs of hiring the nurse care managers and the investments in information technology.

So one question would be how the services are paid for, and we found three ways through our interviews. One was assumed savings. This was really mostly the mechanism that insurers used. They often use predictive modeling to calculate the savings, given their population target as well as the tools that they have available to them, and then pay for it out of those assumed savings. They pay directly; that is, they hire their own nurse care managers and put in place their own information technology systems, or will contract with a vendor who does that for them.

The model we heard about was at-risk care management fees. This was found both in the private sector but also in a couple of the CMS demonstrations. In this model the care management organization would be paid up front. This was usually a per-beneficiary per-month fee. Then there was a target savings level that was agreed upon by the program and whoever was paying for it. In the CMS

case it would be CMS. In the Medicare health support pilot, for example, the level is 5 percent. Then if the program does not achieve that 5 percent savings level then they have to pay part of the care management fee or all of the care management fee back, depending upon the model.

The third we heard about was a shared savings model and we only heard about this as being used in the CMS physician group practice demonstrations. Here there's no fee up front. The physician group practice has to take all those investment costs on themselves up front. CMS defines a population and at the end of a certain time frame calculates the expected costs of the population versus the actual cost and then if there are savings due to the care coordination activities, shares a portion of those with the physician group practice.

In the physician group practice demonstration, some of those savings are based on a level of performance on quality measures as well. Most of the programs had some performance on quality measures used as well but not really as much of a hard target as the savings level.

There are a variety of different ways that physicians were incented to involve in provider groups. It

was interesting that we heard less about specific financial incentives but that they described it at least as the physician seeing the care management program of their group practice, or whatever provider group it was, as helpful support to their efforts to delivery high quality patient care. In addition to that, more integrated providers had the group shared savings or at-risk care management fee as an incentive.

In the stand-alone care management programs where physicians were really separate from the program there are a variety of different strategies described. Some of them were just outreach to physicians, but in two of those we did hear some discussion of including some financial incentives for physicians, and in one in particular of sharing the care management fee with the physicians who saw their patients.

So given these findings, Cristina and I are now going to outline a few models just to help organize and stimulate our discussion on this. At the end of the presentation we will also list several major issues which we've yet to discuss. Our goal for this discussion is really for you to identify the model or models you want us to spend more time developing, so think about that as we're

going through our description. Just to keep ourselves oriented, the two functions that seem to come out of the interviews that need to be supported by whatever the Medicare program would do would be to make sure that there is the patient education and ongoing monitoring necessary between visits, and that would be the care management, but that also there is some ability to support physician interaction with their patients' care management program.

So we developed an illustration to help us talk through this a little bit. On the left-hand side you see the provider groups. This is the model that I spoke about where the care management program is actually integrated into a provider group. Again, we would assume here, although this could also be a discussion point, that the fee for these services would be at some risk for the level of savings that this group was able to achieve from the population that they manage. This isn't insurance risk, just to be clear about this. They're not taking any risk on for the cost of services, but just that there would be some target level of savings that they would need to achieve to get the fee or to get any savings.

These provider groups could be group practices of

various sizes. The PGP demo uses a minimum of 200 physicians. However, we heard models that were a lower number of physicians so it wouldn't necessarily need to be that high. Physician hospital organizations may be best suited for this, but there would be issues there of how it might affect hospital payment and the dollars the hospital could receive. The bottom line is those organizations would need to provide the services that we've described, and unless the Medicare program were willing to pay directly for it, accept some level of performance risk for those services.

Cristina is going to then describe the second model and the couple of iterations that that could take.

MS. BOCCUTI: Looking over on the right-hand side, the graphic on the right-hand side, this one addresses strategies for care coordination that would be provided by the solo practitioners or practitioners in small officers. And it illustrates ways these physicians can also take advantage of the services care management programs can provide to them for their complex patients.

We see really two ways that this model on the right-hand side can work. First, the care management

program with the performance risk that Karen had just mentioned can seek physician referrals. So you could perhaps think of those pink lines right there as depicting the freestanding programs seeking out or reaching out to physicians for the patient referrals.

In addition, it might be necessary to think of another model where Medicare provides a direct payment to the physician for interacting with the freestanding care management program. So in this scenario, if you're looking at the white lines, you can think of that as indicating that the physician is seeking the interaction with the care management program. And Medicare could pay a fee for the activities that are associated with the referral. So these activities could include medical record inputs, care plan oversight, review of labs, and so forth.

Go ahead. We're doing a little tag-team here.

MS. MILGATE: This slide is really just to quickly summarize the distinctions between the two.

The first, on the left-hand side -- and we'll go back to this slide for our discussion -- recognizes the utility of these services being performed in a group setting where both those functions are integrated.

The right-hand side acknowledges that many beneficiaries receive care or primary care from solo practitioners and so there may need to be a model for those types of situations, as well.

Just to note, they aren't necessarily mutually exclusive either. You don't have to choose one or the other. They could coexist potentially, but that would of course create their own issues.

MS. BOCCUTI: I'll go back to thinking again on the right-hand side to find ways to encourage the smaller practices to take advantage of the services that the care management can provide, like the nursing, the follow up, the IT.

So in that model, in developing strategies for the program to engage with the physician, that stand-alone program would be paid by the performance risk strategies. But in the one where the physician would be paid a direct fee which would cover some of the interactions with the vendor, that fee could take on perhaps two different kinds of payment options. It could be a care management code kind of option or a monthly fee option. So we could think of it that way. And that, again, would cover those activities I

mentioned.

I'll also bring up one thing here, that there is some precedent currently for Medicare to cover some non-face-to-face activities. This occurs in the fees that are paid to physicians for certification, recertification and care plan oversight, specifically for home health and hospice patients. Indeed, some of the activities that are covered in say the care plan oversight are similar to the ones that we're discussing here for the fee for complex patients working with the vendor.

MS. MILGATE: These are just several of the issues that would have to be addressed if we were to move forward with implementation either of these or all of these models.

First, how would patient eligibility be determined? We'd need to develop criteria. Perhaps it could include the number of chronic conditions or utilization patterns. Who would determine that? Would it be CMS or CMS and provider referrals, for example?

Also, will a sufficient number of provider groups or care management organizations be willing to participate if their payment is contingent on savings levels? The CMS demonstrations did have a fair amount of competition for

those contracts. However, it's unclear if it were to be implemented more broadly how many organizations would be willing to participate.

Also, how do these models interact with the current pilot and demonstrations in CMS? With the exception of a fee to physicians, CMS currently has a pilot and two demonstrations to test these two models and the question would be whether we should wait for results from those demonstrations or is the need great enough for the Commission to perhaps suggest moving forward?

MS. BOCCUTI: And then when you're looking at the smaller practices who don't house a full-fledged care management program we would need to think about which types of practitioners could bill for the fee that I was just mentioning for interacting with the care management program. And further, should only one physician per patient be eligible for those fees? If then so, would beneficiaries be the ones to select the physician who manages their care?

And then on to the final bullet, a point I'll raise is that care management models that Karen and I have been discussing certainly don't address all of the problems that physician's face when they're treating complex

patients.

So a final point would be that we could consider ways to encourage physicians and non-physician practitioners to take the time that they need to care for these patients.

Currently, within the fee schedule, there are add-on codes, for example, which are used for prolonged visits. But perhaps these aren't really matching with the needs that physicians are facing to treat these patients. so we might want to be looking a little bit more at the E/M visits for complex patients, specifically focusing on that and thinking about other strategies for that. And I think that was brought up by the panel this morning.

I think that's where we are so we look to you all for some input.

DR. MILLER: Just for context for just a half a second, both for the public and for the Commissioners, Karen made this point but I just want to reinforce it.

This area is really complicated to sort out and talk about. So the three models that we're talking about here today are really just to start this conversation. This is very early on and we're not trying to convey to the Commissioners or to the public that this is the way we're

going. This was our best way of organizing the conversation.

And so if you don't see something here that you wanted to see, it's fine. Bring it up and we'll go after it.

And the second thing is, on the physician fee side of things, we're talking about a coordination fee here, which is not to the exclusion of other conversations that the Commission is having about fees in general and the equity of fees between primary care and specialty. So that issue is also out there.

Here we're talking about coordination fees, but there's still this question that we're grappling with in the physician fee schedule more generally. And that's not to exclude -- we're not excluding that issue. We're trying to focus on coordination in this conversation.

MR. HACKBARTH: Maybe you addressed this and I just missed it. If you look at these two models, both what they have in common, is that there is a care management entity. It may be housed within a physician group or it may be a free-standing entity with which the physician and patient interact.

These don't seem to encompass a model where the physician assumes responsibility for care management and doesn't interact with any sort of care management program, assumes responsibility his or herself for that activity and has a code and an attached fee. Is that not included because you don't think it's workable or you've heard that it's not workable or is it somehow subsumed in this discussion?

MS. MILGATE: A couple points on that. One is that over and over again we heard that the key components were this care manager person that was not a physician. Not that they weren't sometimes associated with a physician office. And that they had to have adequate information technology systems to really work.

So when we considered that at the solo practice level -- and it's something that we could consider -- that we heard that that seemed to be too much for a solo practice take on.

So then the question in my mind at least comes to, on the left-hand side in this illustrations of the provider group, how small is big enough to actually perhaps do that? And there is another point of -- at least as we currently

heard -- these organizations are taking on that performance risk. So not only would they need to be able to provide those services but, depending upon the conversation here, we could decide that a care management fee would be appropriate. But that it might be difficult for a smaller size group to take on the type of risk.

So that's where those thoughts come from, but that's all up for discussion.

DR. NELSON: On this point, Glenn, I sorted that out in my mind by what was said at the beginning of the presentation. This is focusing on complex cases in which the pay-off comes in avoiding ER visits and hospitalizations.

There's another dimension of care coordination that is part and parcel of the practice of medicine that needs to be amplified and increased. And that's counseling on prevention, smoking, diet, depression, all of those kinds of things that are really important and are currently undervalued.

But it's a different category from congestive heart failure, diabetes which sort of, in my view, kind of like end-stage renal disease. They're a different category.

DR. MILLER: Alan, to respond to that, let me tell you sort of how some of our conversations have gone, and I think it's right on that very point.

There's almost this question of are physicians being reimbursed enough to spend time with their patients and, to be a little short-handed about it, to figure out what's going on and spend the amount of time? And that's almost to the balancing of E/M primary care services in the fee schedule.

And then let's say, from that group of patients, there's a set of patients that you want to move over into much more of a care coordination. And then we're implicating that discussion of how would you reimburse the physician or this entity to engage in that activity?

So I think we had that same thought in almost the way we've been talking about it.

MS. BOCCUTI: I just want to mention one thing. We're calling this care coordination, but it's so much chronic care management, too. And I think that that brings in this extra entity that when you're talking about, as Karen had mentioned with CHF, nursing follow up day after day, or multiple times a week, checking on your weight and

blood pressure, it becomes more than a small office can handle.

So if we think of this animal as more than just managing referrals and the coordination of making sure charts get forwarded, it's a bigger program. Does that help?

MR. HACKBARTH: Yes. The distinctions that you're making make sense in terms of how we communicate with the outside world about this, somehow we have to be able to draw a picture and show this continuum of activities, some of which may be referred to as care coordination or smaller scale of the sort that Alan was describing. And then we cross some boundary and we're involved in care management, which to the lay person sounds an awful lot alike. And we're talking about a different sort of enterprise with a larger scale required.

MR. BERTKO: First of all, good start on all of this.

I'd like to first recognize that I think this dichotomy of provider grids and what I'll call the 2A and 2B models, working with individual physicians, I think is pretty useful.

On the provider group side, I'll defer to Jay and to the other folks who know much more about that. I think it's all pretty useful but very limited in reach. So 2A and 2B have got to be very important for our discussion.

And there I'd like to bring up a whole bunch more issues, with the caveat that one of my roles in my organization is to serve as the troll under the bridge, chewing on vendors that come in with lots of hyperbole. That's the most pilot version.

So number one here in the fee-for-service Medicare system is data timeliness. And because we send data through FIs and then it sits there, there is an important delay in terms of when care and episodes come in. Some research on this shows there are usually incredible spikes. Some things like CHF are just a one-way street, where it just gets over and over again. Others are more a big spike and then a return, but at a somewhat higher level. And the sooner you get to the spike the better off.

So I thought you ought to think about that particular issue.

The next issue that I don't think you mentioned, but you may have, is take-up rates by members. And so for

every 100 people that you identify as being potential candidates, at least in the under-65 experience, maybe only 20 -- that little few of them -- actually will sign up. And so there's a question there of incentives, outreach, and all kinds of other things.

I know for a fact that on the MHS program, one of the challenges is going to be the outreach to get the sign-up rates above 50 percent or so. And in that sense, I'm going to encourage us, before spending money, real money, to wait and see how it turns out.

MR. HACKBARTH: Can I ask you a question about that? Does there need to be a sign up? If the patient isn't limiting their choice of provider, they're basically communicating, listening, counseling and the like. It's not clear to me why a sign up model is required? Could you just talk about that?

MR. BERTKO: Yes, and again, I'm a non-clinician analytic person. If they don't sign up, it doesn't work. And I think there are other alternatives to that, Glenn, and I think you might be right. But Jay's organization can perhaps do things that don't really require as much sign up.

But where we're working with 300,000 physicians

potentially, having the member actually knowledge that they're in this program, put the blood pressure cuffs on and stuff like that, is important.

MR. HACKBARTH: I assume that it's probably important as whether the patient perceives this as coming from their physician or coming out of the blue. If the nurse that calls them says I'm working with Dr. Smith and I'm calling on his behalf to follow up on your condition, you probably get one sort of response from a patient. Whereas, I'm Nurse So-and-so from XYZ Health Care, you might get a very different sort of patient response.

MR. BERTKO: Except let me give you yet another alternative to that. This is in the area of pharmacy benefits. A computer-generated voice that has been more effective than real people calling to talk to people about it because the folks on the line say this isn't anybody that knows anything about me. It's data off of a computer and I guess I'll listen. I mean, it's another data point.

DR. MILLER: We also had something of a conversation like this when we were talking to some outside folks, including clinicians. One way of thinking about this, and I'm saying this is just a way to think about this,

would be so here you are. You're sitting with your set of patients. You're talking to each of them. And then you have this smaller set of people that you think need to go into this management situation.

You might have something where it's almost a soft lock-in, as you will, with the physician. Because I think there is something to if this comes from a physician it might be perceived differently. I think you have this situation, I think you would benefit from this program. And for me to refer you to it, and then also to follow up, we have been something of an understanding here.

The beneficiary wouldn't be signing away their freedom of choice, but some recognition that I will come to you for my care first. I realize I'm talking about concepts that begin to threaten things like free of choice, but it could be viewed as something that's much softer than that.

Then the physician would say I have this relationship with the patient and this relationship with this care management organization. And so now I want the fee to manage this person's care.

This would be the one of those things. The criteria you could look at to assign for a physician to get

the fee, if you will. I'm not sure it's solves the problem but it's at least one conversation that came out of our conversation.

MR. BERTKO: Sure.

Let me continue down. I guess the next one is you guys had mentioned the identification, predictive modeling in some cases, and perhaps triaging seniors into seniors who have conditions that it can actually be effective.

So to Alan's question, I'm more in his category one which is immediate, high-cost, chronic stuff as opposed to other conditions which are longer term preventive care management ones in terms of where you spend the money.

So I guess I'm going to suggest a different approach, or at least a way to think about it, and I've labeled it at my peril here as an evolutionary process where I think MedPAC staff is best being another family of trolls, that you do really good analytical work on models that have emerged, as opposed to trying to think up and build new models.

So there might be literally thousands of models, including all kind of hybrids. And that you would then look at the kind of results there. I will tell you my own

experience on proving return on investment, people polling, there's incredible vendor hyperbole. That's as polite a way as I can put it. There are other words that smell worse.

And then the last issue that I would have to raise is one that you guys raised in your paper that I think is possibly addressable, which is does disease management care management really eliminate stays or merely defer them?

I think that as you look at the length of life here you might be able to do that. I would look to again organizations like Jay's, where people have lots of age-ins, Group Health of Puget Sound, maybe Geisinger and others, that have long-term processes in place. And look at people who have been under these conditions for 20 years and then use episode groupers from fee-for-service and see what's the result? Is it worth while long-term? Diabetes is not a short-term solution.

In the MHS, CHF will work, it will drive results. Diabetes, in three years, we won't probably know a thing.

And again, this might not be in the current sequence but would be something that I would strongly suggest we think about before we advocate spending money or vice versa, not spending money.

MS. MILGATE: Just one comment on your last point. I think it really is critical for what time period you would put around the savings, for example, because I've been reading quite a bit of literature on well, if we were to prevent certain diseases or disease progression, beneficiaries live longer. And there are two schools of thinking. One is that they then incur their higher costs just simply later on for other things.

But the alternative, which I haven't found as much support for but perhaps it's there and I just need to look a little harder, is that they live healthier longer. But I don't know that that means that you would necessarily put the program in place. Maybe you would do the savings within a shorter time frame, but I don't know if we can look at those as savings over him.

MR. BERTKO: Again at my own peril, let me give you a purely actuarial datapoint from that. Fifteen years ago we did a tremendous amount of work on retiree medical people, people covered by employer programs.

The cost curve looked like this. And then at the old-old, 85, turned over. We could only speculate that people who lived to 85 and beyond died quickly, didn't have

extraordinary efforts. And as a result, from the trust fund perspective, it's better to get them out there in they just die and don't cost much, versus being in care for six months when they're age 70 or 66.

Please take that all with the proper grain of salt.

DR. CROSSON: Just to take a non-actuarial clinical perspective, as I read the paper, all I could conceive of was that the at risk payment part of it was going to be very complex. Because as John intimated, this varies very much by disease.

In congestive heart failure, if you can just manage the volume load in a patient, you can prevent those frequent hospitalizations for congestive heart failure. And that's an absolute savings. Those go away. An individual with decompensation could have, as my father did in his terminal illness, seven or eight hospitalizations a year or not. And yet the disease progresses.

Whereas in diabetes, I think good glucose management could prevent one or two hospitalizations for diabetic ketoacidosis a year. But most diabetics are not hospitalized for diabetic ketoacidosis. The real cost comes

later in life with the long-term sequelae.

In grouping these chronic diseases together, you'd have some where active management could actually, within the course of a year, prevent some costly hospitalizations. And others where the impact might take a decade.

So at least to me it sort of pushes you to some sort of process payment. If you could actually measure, just so that you're assured that what needs to be done is taking place, that the person is enrolled in a program or something like that, as opposed to trying to get into real complexity about the at-risk part.

MR. MULLER: My question is along the same lines.

As you noted, all these programs basically have to pay for themselves through some kind of savings. And when the case management is paid for by the health plan in the classic managed care model, they have both utilization controls and price controls as a way of trying to secure the savings to pay for it.

When you look at the physician level, the physicians have less capacity to really affect price. They can affect utilization along the lines that John and Jay have just mentioned.

So the question I have, although Jay in many ways stated it more clearly, is that in some areas one can see those savings from utilization being secured fairly rapidly. In many other areas one can't. And that's why you have that kind of classic problem of what do you pay for in terms of a case management?

How, aside from looking at these various efforts around the country, how do you suggest that we target the kind of case management programs that seem to make more sense, given that some of them may take 10 or 15 years to pay for themselves? Do you just target the ones that have that kind of immediate obvious payoff like congestive heart failure and heart attacks and so forth? Or do you look at this as something that the Medicare program should pay for across this population because it makes sense? In a sense, we own our recipients and beneficiaries forever in the way that a health plan does not in the commercial population.

So do we invest in this across-the-board or do we focus more on the ones where the payoff on utilization is fairly immediate?

MS. MILGATE: I guess I can speak from our interviews. They targeted those not across-the-board. And

I think there is an important distinction between a payoff from CHF and diabetes that we really talked to folks that were looking at much more than one disease model. And while I recognize that's absolutely true, we heard much more payoff if you focus on CHF and slower on diabetes. It was almost a higher level than just one -- in fact, it was almost always a higher level than just one or the other.

We probably need to do a little bit more digging to get at this percentage but I'm going to throw something out. In a few of the interviews we asked what percentage of the overall population are you talking about? And how are you defining?

And they had different levels. For example, the Medicare high cost on beneficiary demonstration is designed to target very high levels of maybe they would say maybe 1 percent of your population, even in Medicare, would be this level of complexity. So that's not just I've got one chronic condition. That's multiple different issues for the patient.

But I would say, in general, it was more of a 5 percent maybe of the population. So again that's not going to be one chronic condition or another. It's probably going

to require or even just imply multiple plus some other high utilization patterns that you see.

So your question on would you do broadly or more specific, from the interviews we heard they were more complex. But again, that that was limited because of the cost savings assumption that they needed to pay for themselves. So that you could apply it more broadly if wanted to and pay for it with some type of fee.

MR. MULLER: In terms of provider organizations doing it you can see the mixed incentives because if, in fact, the fee comes out of the savings and utilization -- let me just pick some number to do some simple math. Let's say the average beneficiary is $20,000, the case management fee is 5 percent of that say $1,000 just trying to do a simple number.

If in fact, from the point of view of the program, you'd want to have savings of more than $1,000 to make it economically viable.

MS. MILGATE: Yes, I didn't actually say that. It was net of the fee.

MR. MULLER: So on the other hand, when you start reducing those seven hospitalizations that Jay referred to,

in due time the provider takes a bit hit on those, as well.

So how do you deal with that? At the health plan level it's obvious how they're saving money. On provider organizations, how do you get those incentives to work right?

MS. MILGATE: The organizations we spoke with that had a hospital within the system, and that's what you're primarily talking about because the lower utilization is usually the hospital, there was definitely some concern in those organizations that in the end the bottom line would show they had had a loss.

But we didn't have hard and faster numbers that people were willing to give us. They said they were willing to do it anyway, and that there were actually, they thought, potentially some savings for the hospital from readmissions from particular patients that might have longer lengths of stay otherwise.

Shared savings would allow them to share in the savings but might not necessarily make up the whole difference for the lost of admissions, for example. But yes.

DR. MILLER: I completely acknowledge that. ut

the other mechanism, Ralph, is if the organization gets this much out of the reduction in the admissions it holds some part of that out and brings it back into the group.

MS. MILGATE: Where in fact, in the physician group practice demo, if you don't have a hospital in your group somehow the hospital outside of the group loses all those admissions and has no opportunity to share in the savings.

MR. MULLER: The series that the Times is running this week on diabetes, the one today is very telling, where they had set up these diabetes management programs and in due time they all -- not all -- but many of them fell apart because the fee for the case management up front was nowhere near commensurate to what could be secured by seeing people who had complications from diabetes.

And those are just such real life problems out there that I think we have to acknowledge that that's how providers act. And we have to figure out some way of having that kind of shared savings model be powerful enough to cause them to keep investing in the case management models.

DR. REISCHAUER: There's been a lot of discussion here about how these programs aren't worth pursuing unless

they pay for themselves. And it's a very narrow definition of pay for itself. It's a financial threshold. And I just want to remind everybody that this is not the threshold we set for procedures or interventions of any other kind. It is conceivable that an intervention like this might increase the number of QALYs that one has but lead to either no reduction in cost over the lifetime of the individual or even an increase in cost.

But we would say it's worthwhile because for four years the individual has been kept out of the hospital before they fall off the cliff.

I think a lot of this has to do with the feeling that much of this care coordination maybe is more hype or promise or snake oil than the real thing. But we should be willing to, I think, expand our criteria for what makes something like this worthwhile.

DR. NELSON: Mine is very brief and it is the fact that the high cost case management projects form of disease management that we're talking about depends for a lot of its effectiveness on energizing patient compliance because the patients have to weigh themselves if they have congestive heart failure. They have to measure their blood pressure if

they have hypertension. They have to test their blood sugar.

And without a high level of patient compliance nothing that the nurses and the doctors do is going to work. That's the reason why enrollment of some kinds, forming some sort of relationship is so important.

DR. REISCHAUER: It also suggests that you might want to consider incentives for the patient like lowering copayments or coinsurance.

MS. HANSEN: I probably have more experience in that 1 percent, on that side of it. And one of the things -- so I really found the paper very helpful, by the way, in terms of the scale of interviewing all of these 30 sets of people.

But one of the things I was curious about was the ability to think about the QALYs's that I think that I know that Bob just mentioned. But when the ability to control the resources on the side when you really want to package all this together, it's not just the monitoring itself. What happens is with congestive heart failure the ability to have a diet that they really follow and monitor, whether they use the technology.

There are just some really site specific kinds of issues to the patient and the home, just getting to transportation.

So this starts bordering on stuff that I know typically doesn't come under the Medicare side of it. But if we're looking at the outcome of even the reduced hospitalization as one thing, how to take these into consideration, especially when you have more than one diagnoses.

I know I brought it up yesterday but so often the 85-plus population tends to have a series of diagnoses. And maybe the dominant one is CHF or diabetes. But how do you begin to look at that comorbidity aspect in care management and the non-traditional Medicare use of services that come into play that are necessary?

And then the other side of case management is whether or not in the next iteration we can get a sense of who are these case management organizations right now? And how do they operate currently, in terms of the national ones versus the individual ones? And what's the capacity in the field currently available to do case management? And what their fee range typically is, just so that as a consumer we

would understand that.

And then finally, just a question of the numbers of physicians who are in the group practice side as compared to the private or solo side, what is the split typically right now, that's there?

MS. MILGATE: I don't have those numbers off the top of my head but we've done a little bit of digging.

MS. BOCCUTI: In the mailing, I think I tried to say what it is. But I don't have it in front of me.

I think a third is in groups of physicians. Let me get back to you and get those numbers.

The NAMCS is a national survey and they start to break down nationally by sort of solo and two physician, three physicians. In fact, now that I think about it, this is actually in the SGR paper that I started looking at -- all of mine are merging together -- but in looking at where groups are, what size they are nationally.

So there's some survey data that might give us more information on that.

And you're right, that kind of information could belong in this project as well.

DR. WOLTER: Just a couple of things.

I thought Alan's point was particularly important, that there's a case management role for physicians, particularly in the patients that maybe aren't quite into this complex situation, that also could have good downstream effect. Although, there may be a role in this particular group of patients, as well.

Our organization is in the group practice demo, which used a base year, I think 2004. And then the first year of the actual performance began on April 1st of 2005. So we're headed into the end of the first year.

And although the demo is really focused on the total annual cost per beneficiary of all care, not just the care of complicated patients. And of course it has quality measures, as well. The leverage I think most groups see to affect that total cost is in this group of patients, and that's where most people are putting their efforts.

And I thought some of what we're currently looking and modeling might be instructive.

One, the cost of the infrastructure to tackle these patients is extremely significant. Although we're well into the implementation of one of the top clinical information system vendors, we had to go to a third-party to

help us right software to creative a registry of our diabetic patients. We had to sign one of our critical care RNs six to eight months full-time to develop that registry and put it in place. Multiple iterations of the software so that we could provide individual physicians with their own data about the percentage of patients getting hemoglobin A1c's, foot exams, et cetera, et cetera. Extremely time-consuming and expensive to put in place.

And quite frankly, we wouldn't be able to tackle these problems if we didn't at first know who the patients were.

And what we found in our experience was the assumptions around large groups being able to automatically retrieve that data were optimistic, to say the least.

And I think we'd be a reasonably representative group. We're not as sophisticated as Kaiser or Mayo or somebody like that. But we've been working on these problems for some time.

I was very struck by one of the comments in the paper.

By the way, I think the paper is a great job of summarizing some of the big issues and maybe where the

leverage points are. But is it really true that 61 percent of inpatient costs are from CHF, CAD and diabetes patients?

MS. BOCCUTI: They're not necessarily for care for those conditions, but patients that have one or two or three of those conditions, for all of their care whether it's related to those conditions or not, yes.

DR. WOLTER: So in and outpatient probably then? Or no, just inpatient.

MS. BOCCUTI: Just inpatient.

DR. WOLTER: That underscores what I wanted to say which is, for us, if we can reduce our congestive heart failure admissions by 50 percent, we will meet all of the financial goals that have been set for this project, that one intervention alone. Which to me, if you multiplied that across all congestive heart failure patients in the Medicare program. who probably have to have some subclassification to decide who really would make the most sense to enter these programs or not, you think of the cost savings that could be achieved by really being more targeted and how this all works. And it really could be significant.

Just a couple other things. I think there are some issues around how we look at these savings being

shared. And one of the flaws I think in the way we look at sharing savings is we try to do everything: number one, budget neutral; and number two, on a 12-month horizon. And we've had that point out to us in the past by other panel experts.

Because as we've shown at MedPAC, in any one year 30-some percent of patients with congestive heart failure might be high-cost but they may not be the same patients the following year.

And a model that we might consider is if the appropriate process interventions are done for a group of these patients annually. Maybe that should trigger some sort of incentive, even if you can't demonstrate in that particular 12-month period the same amount of savings that you might in another 12-month period.

And I think that's particularly important because some groups won't have large numbers of patients. So statistical significance gets in the way of how you drill the savings down to maybe a smaller group.

I'm interested to hear the insurers talk about whether or not it's worth investment, because if we don't get beyond that -- and we've heard it a couple times today -

- there's some investment that if we could figure out how to make it could prevent a fair amount of downstream cost at the same time that it improves some amount of quality of life.

But if may well be that in this chronic disease management we need to pay groups $2,000 per member per month to manage some subgroup of patients because it's expensive to do it. But these are $10,000 admission and maybe that investment will save the Medicare program millions and millions of dollars over a subsequent period of five or 10 years.

But right now we live in an environment where everything has to be budget neutral for the next 12 months. So it's very, very hard to think about models that might really get us to real improvement. And it's staggering to me what improvement we could see in cost and quality just in congestive heart failure alone if we were willing to think a little bit outside of the box about how we might set this up.

And then, just to get to the whole issue of how the incentives work, in our particular case we've modeled what we think we might be able to achieve over this three

year period. We think that we can save the Medicare program about $9 million. Because there's a 2 percent threshold before we get to share in any of the savings, we would only see about $3.5 million of that $9 million. However, we would lose revenues of over $2 million for those lost admissions. And we think we're going to spend about $1.8 billion to resource this care management.

So in other words, we will not quite cover our costs with the savings we'd get. There's got to be a better model going forward. Now that's our model. We may have different results than that. So I think there's some tweaking of how this all works.

On the other hand, if we can show, along with the other groups, that there's significant savings to be had and we improve our skill set on how to tackle these problems and we do it in a way that actually improves quality, it will be the basis for something important going forward. Which is why I think most of the groups are in it.

But the financial model right now has some significant flaws. But boy, there's some opportunity here if we can take what we know and put some interesting things together.

MR. HACKBARTH: Let me just pick up on Nick's point for a second.

I have this urge to see a picture that maps out the various strategies that we are pursuing, we might pursuing, in Medicare. Sort of basic components are, on the one hand there's the Medicare Advantage program where we say to a private organization you get a lump sum payment and you're responsible, you figure out how to do care management. You figure out which investments make sense. And it's a relatively clean and simple conceptual approach to take.

A second path would be embodied by the medical group demo. We retain fee-for-service. The patient, importantly, retains free choice of provider. But we look at aggregations of care and identify organizations willing to assume responsibility even in the face of patient free choice, no lock-in, as in the group demo.

Then the third category we're looking at developing a variety of different interventions in fee-for-service, traditional Medicare, free choice of provider, that go at much smaller units of care, if you go will. Whether it's care management or pay for performance based on

episodes of care. And they have their attendant issues, one of which is they're complex, they require a lot of resources to develop and implement.

On the other hand, Nick mentions a potential advantage there. You're not looking at one-year windows in making investment decisions as you are under Medicare Advantage or even under the medical group practice demo.

This isn't coming out as clearly as I would like.

I am worried increasingly about the burdens, administrative burdens, on CMS and the complexity of the initiatives we're developing and whether we have the wherewithal to be trying all these things and making them work. And I'm worried that we're not thinking, not just Med PAC but all of us in the Medicare policy community, not thinking strategically enough about which initiatives we pursue, where the payoffs are likely to be greatest, and whether we have an administrative structure that can do all of these things.

So I'd sort of like to step back and look more strategically at the paths that we might pursue and think more systematically about which ones we go down.

DR. KANE: I was going to say something along

those lines, that when we talk about care coordination it wasn't clear to me whether we were talking about a programmatic approach or kind of a payment approach. They kind of get jumbled up after a while, that if you have this program how do you pay people?

But to me, particularly in thinking about the fee-for-service population, perhaps this should be incorporated into the pay for performance kinds of goals rather than try to tell people how to do the program management or how to do the disease management or how the program should work, pay them for the outcomes. Not necessarily even the savings outcomes but the process outcomes and doing the right things at the right time for the right people.

I was thinking we shouldn't be getting down the path too much of deciding how it should be done, but we should certainly be investing our time and energy into making sure that certain targets are met and certain procedures are done or visits are made or counseling is done or whatever, and pay for that rather than the programmatic.

That was just one thought about yes, this is getting a little too complicated trying to figure out what program.

The other I had was that a lot of these diseases don't start at age 65. And I was thinking we might need to think more about insurance plan coordination than care coordination. Because when you think about obesity and coronary artery disease and diabetes, you really want this to start not when they're 65, but 55 or 45, whenever the condition becomes apparent.

We really have this mindset that suddenly we get these 65-year-olds dumped in our lap. But frankly, that's way too late for many of these people to be starting. I think the real savings are care coordination that starts way back when the first problem occurs, and making sure that when the Medicare program inherits them, that the right things have been done that far.

And I don't know what kind of payoff that means, but it seems to me we need to think more about incentives to get the under-65 population into the right care management or into some type of care management.

I know this is way out of the box, and we already wanted to simplify things and now I've just made it more complicated. But I'm more for saying let's measure the outcomes on the over-65s but let's start thinking about how

to create the incentives for when the condition first manifests, or even the preventive incentives. And I think you'll save a lot more money.

MR. HACKBARTH: We need to move ahead now. Look forward to hear more about this in the future.

Next up is the beneficiary education work plan.

DR. SOKOLOVSKY: Good morning.

This is a work plan and I will try to be brief. I know we've gotten pretty far behind.

As you know, Medicare began providing a voluntary prescription drug benefit to beneficiaries on the first of the year. At the last Commission meeting, staff discussed our plan for analyzing data on Medicare drug plan and Medicare Advantage drug plan offerings.

Today I want to discuss a second project connected to the Medicare drug benefit. We are conducting a series of studies on how beneficiaries learned about their choices, learned about the drug benefit, and the resources available to them in terms of learning. The study will have three components. First, a beneficiary survey. Secondly, structured interviews with beneficiary counselors. And lastly focus groups of beneficiaries and caregivers.

We are also considering a later round of interviews with physicians to ask about their experience talking to beneficiaries about the benefit and then their experience with the drug benefit itself.

Our focus in this study is whether beneficiaries had the information and help they needed to make informed decisions about the drug benefit. We'll look at their sources of information and which outreach and education strategies were most effective. Where did beneficiaries go, first of all, to get help?

Additionally, when beneficiaries were making choices, we want to know things like what factors were most important to them in deciding on a particular plan.

This work will give us the opportunity to evaluate what beneficiaries most valued in a drug plan and whether the range of resources available to them met their needs so they could make informed decisions about their choices.

As I think all of you know, beneficiaries have a wide range of choices. The number of stand-alone drug plans available to beneficiaries ranges from a low of 27 in Alaska to a high of 52 in Pennsylvania and West Virginia. In every state except Alaska and Vermont beneficiaries can also

choose their drug coverage through a Medicare Advantage plan.

As of December 22nd, CMS reported that somewhat over one million individuals had enrolled in stand-alone drug plans. In addition 6.2 million people dually eligible for Medicare and Medicaid were automatically enrolled in plans and 4.4 million beneficiaries who were enrolled in Medicare Advantage plans were automatically enrolled in their plan's drug benefit.

In total, CMS projects that about 20 million beneficiaries now have what they call credible drug coverage, which means drug coverage that is at least as good as the coverage available under the standard Medicare drug benefit. Their goal is to ha ve between 28 and 30 million out of the 42 million Medicare beneficiaries with drug coverage, credible coverage, by the end of the year.

For the past two years the Commission has been conducting research on the information needs of beneficiaries in relation to the drug benefit. In 2004, we studied the experiences of employers and employees when organizations changed drug plans. That study included site visits, structured interviews and focus groups.

Employers stressed the need for multiple and targeted communications with plan members. Both employers and employees and retirees, we had focus groups of retirees from these organizations, reported that most transition problems take place in the first few months and then are resolved. However, they can be quite disruptive when they occur. They stressed the need for adequately trained staff to handle these early problems.

Last year we studied the Medicare discount drug card program. We interviewed representatives from State Health Insurance Programs and from State Pharmacy Assistance Plans and asked them about their work explaining the discount card to beneficiaries, and also what lessons they learned from that process that helped to prepare them for implementing the drug benefit. I'll talk a little bit more about that later.

As I said, the first part of the study is a beneficiary survey. The survey will be nationally representative and question beneficiaries about how they learned about the drug benefit, who helped them make decisions about enrolling in a plan, what sources of information did they find most helpful, and why did they

choose to enroll or not to enroll in a plan.

And then the second part of the survey focuses on factors that were most important to them when they were deciding on a specific plan. Or if they didn't enroll, what were the main reasons for that decision?

In addition, this survey will have information on the age, the gender, the geographic location, the approximate income and educational level of the survey respondents. We're currently testing the survey instrument and it will be fielded at the end of the month.

The second part of the study is about structured interviews where we'll be asking counselors about what strategies they found most effective and the sources of information that beneficiaries found most useful. And we'll be asking them whether beneficiaries made choices after the counseling sessions. We'll ask them to evaluate how effective the Medicare plan finder was in helping them provide information to help beneficiaries choose among plans.

We expect to pay, on this part of the study, particular attention to their efforts counseling dual eligibles and those eligible for additional assistance. In

our earlier work with State Health Insurance Programs those counselors noted that they were best prepared to help mainstream beneficiaries but that they were much less experienced helping beneficiaries with special needs, for example dual eligibles, people in nursing homes, people with specific diseases, and people with limited English capacity.

So as this was a topic that came up very much in that study, we want to find out whether their experiences helped them reach that population this time and to what extent they saw and were able to help these populations with questions about the drug benefit.

A different aspect specifically about the SHIPs is that, unlike with the drug discount card program or with Medicare Advantage plans, SHIPs can actually enroll beneficiaries in specific drug plans. This is a new role for them and we'd like to discuss how this is working.

Finally, we plan to conduct between four and six focus groups. The focus groups will allow us to get more detailed responses from beneficiaries about their experiences learning about the drug benefit and their choices. The kinds of information, again, that was most helpful to them, whether anything confused them. We also

hope to have groups specifically with family members or caregivers and ask them about their experiences helping beneficiaries make choices.

Focus groups will include individuals who have enrolled in plans and those who have not yet enrolled. For those that enrolled, we'll be able to ask them about their early experiences using the drug benefit. We also expect to talk to beneficiaries about they saw the choice between stand-alone drug benefits and Medicare Advantage plans. And we want to ask beneficiaries about their experiences applying for additional low-income assistance.

For dual eligibles, we'd like to know how they learned that their drug plan was changing and whether they accepted the program that they were randomly assigned into or whether they chose a different plan.

We hope to come back to you in March with results from the survey and hopefully preliminary results from the structured interviews.

And that concludes my presentation and I welcome your comments.

MR. BERTKO: Joan, a couple of questions here about other components possibly to either your telephone

survey or the focus groups. Have you thought about talking to either children, family members, other advocates? Perhaps they've made a big part of the decisionmaking process. Or are you talking only to seniors?

DR. SOKOLOVSKY: For the focus groups, we hope to have separate focus groups specifically of family members.

MR. BERTKO: Another similar issue may be people in long-term care facilities. I'm at least aware that some of the facility operators are trying to coordinate things, partly for their own benefit but partly to sign up people. I wondered if you had thought about that?

DR. SOKOLOVSKY: The way we're thinking about the structured interviews now would be that about half of them would be with the counselors for SHIPs and the other half would be for much more specialized people like people in long-term care facilities.

MR. BERTKO: But the question is some of these have been -- I guess I'll use the word assisted -- I think that's correct -- by the people that run the facilities that they're in. I didn't notice that was on your list of structured interviews.

DR. SOKOLOVSKY: No, you're right. It's not

specifically listed.

MR. BERTKO: And then the last comment I would make is a question on timing of enrollment and experience to date from only one plan would say there was kind of -- I'll call it the November 15th through say December 15th period where people were investigating and there was lots of time. Then there was an absolute rush, a waterfall, a deluge, trying to sign up before December 31st. And then presumably there will be yet a difference post-January 1st.

I just suggest that you think about asking a question about that, so you might differentiate the kinds of response you get.

My guess is across the board the call volumes were gigantic in the last week of the year. And that would give you a different response on how difficult it was or how easy it was to get your questions answered.

DR. SOKOLOVSKY: I feel like this project is a balancing act, that I want to go out as late as possible, but in time be able to present material to you for the June report. It's kind of a delicate balancing act.

DR. CROSSON: This is somewhat similar.

You had mentioned that maybe in a second stage you

might be interviewing physicians. I'd suggest pharmacists, also. Pharmacists seem to be dealing with a lot of the discussions and probably have a concentrated perspective now on what the beneficiaries really do know.

The second one had to do with the timing of the information coming out in the June report with respect to CMS and their schedule for making corrections. Are there any deadlines there? Is that just a continuum? Is that going to be good timing or not?

DR. SOKOLOVSKY: In terms of enrollment data?

DR. CROSSON: No, in terms of what we might find, and then CMS might make some mid-course corrections.

DR. SOKOLOVSKY: I don't know the answer to that. I don't think any of it is good timing, in terms of -- because we do have to -- for a June report, we're essentially finished by April and May. Beneficiaries still have May 15th for the initial enrollment period.

MR. BERTKO: Could I just add, Joan, that this is a special year. Everybody has got to enroll this year and it goes to May 15th. But I think the timing could be good when you think already for year two of it, and what worked and didn't work. Enrollment will be much more concentrated

over only 46 days, but there will be fewer people presumably making moves.

But I think our June report could be pretty useful for tweaks in year two enrollment.

MR. SMITH: Thank you, Joan.

I know it's both theoretically and methodologically difficult, but I wonder if we've got a way to get at the question of how well did beneficiaries use the information that they had?

Now that's means hypothesizing the right decision, which is tricky. You can look back or you can look forward. If you look back, you're not looking forward and you may be making a dopey decision. If you look forward, you're making something up. So it is tricky.

But I wonder if there's a way to try to get at -- I did some both, as we all did, sort of family work and I did a little bit more formal work at a couple of neighborhood centers in Chelsea. And I spent an enormous amount of my time trying to help people get over their first dollar aversion.

Now to what extent -- it was clearly the right thing to be trying to help people do, but it wasn't at all

clear that it worked.

And that even though people in this case, I think, had access to both high quality information and a pretty extensive hand-holding operation, I don't have sense, any qualitative sense, of whether or not they took appropriate advantage of that.

So in some ways the work plan stops one step short of what I'd like to know, but I don't know if it's knowable. And I wonder if you've got any thought about other work that's going on or ways that we might modify this to try to get at the decision rather than simply the information?

DR. SOKOLOVSKY: One thing that we will know from the survey is exactly those lists of what were you looking for, a low premium first dollar coverage. I don't think we can connected that to what was appropriate for that particular individual, but we will know the kinds of things people were looking at.

DR. SCANLON: I guess I think this might be challenging but I believe it would be important to try and put what we learned here in the context of what the future is going to hold, because I think of this year as a total aberration.

Beneficiaries didn't really have a sense, or couldn't have a sense of what plans were going to be like until they were actually there, because the whole discussion beforehand was all in terms of the standard plan. It turned out to be an incredible minority of plans. And then you have all the permutations that did turn out to be present.

Combine that with the struggle that you dump this on CMS and they had to try and see how they could develop tools to assist beneficiaries, and that process hit bumps in the road.

And I think the plans themselves, they probably -- for most people, or for many of the people at least, there was a wake-up call when suddenly they saw who their competitors were and what their competitors were doing.

All that suggests there's going to be a major shake out for subsequent years. And I think that how we move forward is perhaps more important than what happened this year. But learning from this year was incredibly important.

So it's kind of two perspectives from this question. It's not an issue of we just want to record the history. We want to know what the history holds for a new

world that's going to exist come next Fall when the plans are announced again.

DR. MILLER: Bill, it may not have come across in the presentation but in our internal conversations that is what this is about. We don't see our role as kind of oh look, look at the collision that occurred. We know this is going to be a really tough anomalous year. It's what can you pull out of it and point down the road to? And particularly if more choice-based ideas or policies are going to be introduced into Medicare, how can it help you think about that?

DR. SCANLON: I understand that that's your perspective. I think part of this, though, is what kinds of information are we trying to get from various people in terms of their thinking forward in the future, plans as well as beneficiaries as well as physicians, et cetera.

DR. REISCHAUER: I agree very much with what Bill has just said.

With respect to can one ever figure out whether people acted rationally, the answer is clearly no. You don't know what their relative preferences are for the various dimensions of this. But also the fact is that for

the vast majority of plans, there's not a heck of a lot of difference. I went on and did it for myself, the 48 plans in Montgomery County. And there are a whole lot that are reasonable. There's a few loon-ball ones, and my guess is they'll disappear come next year.

I wonder about the amount of effort and energy we should expend on this given the fact that we're going to have to close the window before May 15th, and there's likely to be a huge rush before May 15th, as well.

And for me the really important issue here is who chooses, having been faced with the information available in the public, who chooses not to participate come May 15th? And we won't know the answer to that question at all.

People haven't signed up at this point who have modest drug bills. It isn't the most irrational thing in the world to sit around, wait for more information to come in, get some experience from your friends, is it working for you, the AARP plan or whatever? And then in the middle of April choose something.

So taking this selected group of people who did sign up or have not signed up but maybe will sign up after we close the window and find out a whole lot about their

thinking, sort of so what? This is a very strange kind of situation and it's not the real issue that we should be focused on, which is why some people would choose, when informed, not to participate and will they choose, come next November, to see the error of their ways?

DR. SOKOLOVSKY: The only part I want to add to that is, of course, we won't know but we are asking, both in the survey and in the focus groups, they're not limited to people who signed up. They're also including people who have said we're not going to sign up and people who have said we're not sure yet. And we're asking specific questions to each of those groups to try to get at some of that.

DR. MILLER: The only other way to react to that is to ask whether -- this would pull it out of the June report if we were to weight, or to do what we do now and then maybe supplement in another cycle to see what brought people in at the end. It's not impossible to look at it twice, as well. But I do hear your concerns.

MR. HACKBARTH: Thank you, Joan.

The last presentation is on the special needs work plan.

MS. PODULKA: Today I'm going to describe our work plan for reviewing special needs plans and relay some preliminary information, hopefully as quickly as I can.

But first I'd like to thank Scott Harrison and Sarah Kwon for their assistance in preparing information for this presentation.

Almost since the beginning of the program Medicare has included special plans for beneficiaries who tend to report lower health status, use more health care services and cost the Medicare program more than other beneficiaries. These special plans include PACE, Social Health Maintenance Organizations, Evercare and various demonstration plans.

Plans for beneficiaries who are dually eligible for Medicare and Medicaid face the additional challenge of integrating services from these two payers. In theory, these plans are designed to both improve care coordination for beneficiaries and reduce program spending. However, the inherent incentive to shift costs between multiple players raises the long-standing question of whether these plans do result in program savings for Medicare.

Congress created a new Medicare Advantage plan type known as a special needs plan in the 2003 MMA. They

did this to provide a common framework within the regular MA program for the existing special plans and to expand beneficiaries access to and choice among MA plans. This means that many of the existing special plans, which were operating as demonstrations, could switch to SNP status.

It is important to note that absent Congressional action, SNP authority will expire at the end of 2008.

For our study of SNPs, we proposed to address the following questions: what are the incentives for organizations to offer and beneficiaries to join SNPs? How many eligible beneficiaries will enroll? And will they come from Medicare Fee-For-Service or another type of plan? How many beneficiaries have been passively enrolled? And did they remain in the SNP? What effect will SNPs have on existing special plans? And how successful will dual-eligible SNPs be at integrating Medicare and Medicaid administrative requirements and funding?

I'm going to get back to these questions, but first I want to give you some background on SNPs.

SNPs function essentially like any other MA plan. In addition, they must provide the Part D drug benefit and additional services tailored to the special needs population

that go beyond regular Medicare services.

SNPs are paid on the same basis as regular MA plans, including the same risk adjustment method. Because risk adjustment is designed to predict cost differences based on demographic information and diagnoses, risk adjustment generally results in higher payments for special needs beneficiaries than for the regular Medicare population.

In 2006, 75 percent of MA plan payments will be risk-adjusted using the CMS-HCC system. In 2007, payments will be fully risk adjustment in this manner. In addition, CMS is exploring the feasibility of implementing a frailty factor for the entire MA program, which could also increase payments. A frailty factor is used for PACE and other plans that serve frail community dwelling beneficiaries to improve the accuracy of predicting costs by considering beneficiaries difficulties with activities of daily living.

CMS has said that the earliest the expanded frailty factor could take effect would be 2008.

MMA authorized Medicare contracting with SNPs for three types of beneficiaries: dual eligibles, institutionalized beneficiaries, and patients with severe

chronic diseases or conditions. SNPs may limit their enrollment to their targeted special needs population exclusively or they may enroll any other beneficiaries as long as their membership includes a disproportionate percentage of the targeted population. This means that the share of the special needs target population in the plan must be greater than the proportion that occurs nationally in the Medicare population. Must SNPs have chosen the first option, to limit their enrollment to their targeted population exclusively.

The number of SNPs have increased quickly since they were created. In 2004 there were just 11 SNPs. By 2005 that number had grown to 125. This year the total number of SNPs has more than doubled to 276, with the introduction of 150 new plans.

All three types of SNPs – dual eligible, institutional and chronic condition -- will be available this year. Most SNPs with be for the dual eligibles.

The last column on the table indicates the percentage of all Medicare beneficiaries that live in a county where a SNP is offered. In other words, 59 percent of the 42 million Medicare beneficiaries live where a SNP is

offered.

SNPs will be available in at least part of 42 states plus the District of Columbia and Puerto Rico. Eight states, D.C. and Puerto Rico will have at least one SNP available throughout the entire area. Several areas will have multiple types of SNPs available.

You can see on the map that less than half of the counties in the U.S. have a SNP. SNPs have clustered in more populous areas, which is how 59 percent of beneficiaries reside in their service area, even if they don't meet the eligibility criteria.

When we talk about a SNP or a regular MA plan we are referring to a benefit package that a beneficiary can enroll in. These plans are offered by MA organizations. For example, an organization can offer a basic plan and a premium plan. For 2006, CMS has signed 164 MA contracts with organizations that offer one or more SNP plans. Many of these organizations offer more than one SNP, either different types of SNPs such as one for dual eligibles and one for institutional beneficiaries, or more than one of the same type of SNP such as two dual eligible plans in the same county.

On the map, the blue counties have one organization offering a SNP. The counties in red have two organizations and counties in yellow have three or more organizations that offer SNPs.

Now I'm going to describe the three types of SNPs, beginning with some pertinent details on dual eligible beneficiaries. Dual eligibles are divided into several different eligibility categories based on their income relative to the federal poverty level and their assets. There are about 7 million dual eligibles. Of these most, about 6 million, are full duals. They qualify to receive full Medicaid benefits. Beneficiaries with somewhat higher income and asset levels are eligible for more limited Medicaid coverage under multiple categories collectively known as the Medicare Savings Program.

SNPs for dual eligibles are most common type. These plans may choose to accept all dual eligibles or limit enrollment to the full benefit dual category. In other words, an MA organization can offer two dual-eligible SNPs in the same county, one for fully eligible duals and another for all duals. Plans cannot limit enrollment to the Medicare savings program duals alone, as these tend to be

healthier individuals than their full dual counterparts.

Although this policy is designed to prevent selection, there may still be opportunities for selection. This raises the question of which enrollment design is of most benefit to plans, beneficiaries and the Medicare program.

All SNPs must apply the same premium and copays to all members. States must pay Medicare's Part B premium for all duals and cost sharing for all duals and QMBs. In addition, states may wish to pay SNP's premium and/or copays for certain members. The state may also contract with a plan for some or all Medicaid services.

If we go back to the table you can see that QMBs' benefits have more in common with the full duals than with their Medicare savings program counterparts. For instance, states have the option of extending full Medicaid benefits to QMBs.

The 1997 BBA allowed states to set providers reimbursement for dual eligibles equal to the Medicaid payment rate and prevented providers from balance billing. About one-third of states have set their rates at 80 percent of Medicare fee-for-service to limit their cost-sharing

responsibility. These states may be less likely to want to pay SNPs' premium and cost sharing for Medicare savings program eligibles because they will see no savings from lower cost sharing, since they have no cost sharing liability to begin with.

Full dual eligibles who were members of Medicaid managed-care plans that now offer SNPs were passively enrolled in their plan's SNP effective January 1, 2006. Plans had to send affected members a letter this past fall notifying them of their three choices: to remain in the plan, to switch to another MA plan, or return to Medicare fee-for-service. We will be exploring further what these beneficiaries chose to do.

There are many fewer institutional SNPs than dual eligible SNPs. These plans may enroll beneficiaries who reside or are expected to reside for 90 days or longer in a long-term care facility. These beneficiaries are not necessarily all dual eligible.

Institutional SNPs may also enroll beneficiaries living in the committee to require an equivalent level of care to beneficiaries in these facilities. With CMS approval, plans may also limit their enrollment in marketing

to select facilities within their geographic service area.

There only 13 chronic condition SNPs. These are designed for beneficiaries with severe chronic diseases or conditions, which CMS has not yet defined. CMS has stated that because chronic condition SNPs are a new offering, they did not want you to limit their potential application. Instead, the Agency evaluates proposed plans on a case-by-case basis. They consider appropriateness of target population, clinical programs and expertise, and how the SNP will cover the full spectrum of the target population without discriminating against sicker members. Plans that have entered the market and the diseases they focus on are listed on the screen.

I wanted to revisit the questions for our work plan. To answer these we plan to do interviews and site visits in some of the locations with SNPs.

This concludes my presentation and I look forward to your comments.

MS. DePARLE: I'm interested in the last -- well, you made this comment a couple of times -- about the chronic condition SNPs. Why are there only 13 of those? And also, is it possible to have a SNP that would serve dual eligible

and institutional and chronic condition? Can you mix and match the types so you have a SNP that would serve more than one of these three categories?

MS. PODULKA: Really, the only thing that distinguishes SNPs from other MA plans is their ability to limit enrollment. Certainly, within that caveat, they could certainly have a population enrolled that meets all three criteria. And I think often they do. We'll definitely be checking on that more.

MS. DePARLE: Do you have a sense, perhaps John or someone else, of why, with so much activities, 226 plans, there are only 13 that are serving these chronic conditions?

DR. MILLER: No. I think that's one of the things that we're going to be looking at. I mean, we had some of these discussions internally about why they've grown so fast, in general, and then some of the categories. And we have various speculation, positive and negative, about what might be driving this type of stuff. And that's precisely the kinds that we're going to drill down on.

I don't know if John or Jay has any other insight. But I think we're putting it out as a question.

MR. BERTKO: Let me only suggest that it may be

just a timing issue. I mean, we were all in a mad rush to get our bids in. The chronic condition ones, at least I'm guessing, would have taken a lot more effort and perhaps more time to set up. So that could be a limiting factor.

MR. HACKBARTH: Other questions, comments?

Okay, thank you Jennifer. We look forward to hear more about that.

We will now have our public comment period.

MS. MARESCA: Mr. Chairman, members of the Commission, Executive Director Miller, MedPAC staff, I'm Andrea Maresca and I'm the Associate Director of Medicare and Medicaid Regulatory Affairs for the National Association of Community Health Centers.

I'm here today because the topics on your agenda yesterday addressed payment adequacy to a range of providers but left out a key category of providers, community health centers.

We appreciate the opportunity to raise this issue with you about the impact of the current Medicare payment methodology on Federally qualified community health centers, or FQHCs.

Health center patients comprise the most

vulnerable population in America today, persons who even when insured remain isolated from traditional forms of medical care because of where they live and who they are. And they frequently have far greater levels of complex health care needs.

Unlike hospitals, physicians, home health agencies, and other providers who can control their patient mix, health centers can only be successful if public payers, including Medicare and Medicare, adequately reimburse health centers.

Underpayment to these centers is particularly onerous because the revenue to cover unreimbursed costs can only come from Federal and state grants intended to support services for the uninsured. This is precisely why the Congress chose to establish a new Medicare payment methodology system for FQHCs in 1990, under which they would be paid on a reasonable cost basis.

Unfortunately, the regulatory payment cap established by CMS in 1992 is forcing many health centers to provide services to Medicare beneficiaries at a loss.

Briefly, our own analysis of 2003 cost report data indicates that the cost per visit at 75 percent of existing

health centers is at or above the Medicare cap. In the aggregate, health centers are losing $50 million each year with some of our largest Medicare sites each losing over $1 million. These financial losses place a significant burden on already strained safety net providers.

MACHC believes this issue is appropriate for MedPAC to address. First, when it was initially applied by CMS, the FQHC payment cap was based on the data of rural health clinics, providers that have a very different cost structure than the more comprehensive set of services provided by FQHCs. We now have more than 12 years of FQHC-specific cost information that could be used to rebase the payment cap to reflect these vital differences.

Second, although new Medicare services have been added since the payment cap was created and these services are considered allowable costs for the purpose of a Medicare cost report, the cap has not been adjusted to accommodate these changes.

Finally, the inflation factor used to adjust the payment cap is adjusted by the Medicare Economic Index which measures physician costs and does not incorporate the other more comprehensive services provided by FQHCs, including

mental health and social worker services.

Health centers are important providers of care for the elderly and near-elderly and, as such, play an important role in ensuring continuity of care that improves health outcomes while reducing costs.

On behalf of the health centers, I urge you to undertake a review of the current methodology and recommend ways to modernize and improve the FQHC Medicare payment cap to ensure that the cap is fair and reasonable and does not hinder health centers ability to provide needed care in their communities.

MACHC would be happy to work with you and the Commission staff.

Again, thank you for your consideration of this issue.

MR. HACKBARTH: Okay, we're adjourned.

Thank you.

[Whereupon, at 12:27 p.m., the meeting was concluded.]