MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Wednesday, January 15, 2003*
9:30 a.m.

COMMISSIONERS PRESENT:

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

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P R O C E E D I N G S

MR. HACKBARTH: Good morning and welcome to our guests, our many guests I guess I should say.

Today we will proceed through a series of discussions related to our recommendations on update factors for the various categories of providers. We are scheduled to have our public comment period at noon. Obviously that may be moved a little bit depending on how we proceed through the agenda.

This morning we begin with post-acute services, SNF and home health services. And then right before lunch we will turn to physician, outpatient dialysis and ambulatory surgical centers and then break for lunch. Then this afternoon we will address the hospital recommendations. And at the end of the day we will have a brief discussion on the chapter on paying for new technologies. And then a final public comment period, which is currently scheduled for about 4:30 p.m.

So we begin with SNF services, Susanne and Sally, whenever you're ready, go ahead. You look puzzled, Sally.

I forgot that Mark had a brief announcement. Thanks.

DR. MILLER: I'll do this in 10 seconds or less. The commission has worked on changing its mailing list from a mailing process to a listserv process for notice of things like meetings and other kinds of activities. We now have 930 people on our e-mail list. If there are people in the public who want to be on this list there are processes for getting on it. I would just encourage you, over the last several months we have worked to do this and we have basically accomplished it.

I just wanted to publicly thank several members of the administrative staff that worked on it. There was Anne, Cheron, Wylene, and Rachel all worked on this process, as well as Cynthia Wilson. I just want to thank everybody's efforts on this. I think this will make us much more efficient and I think we'll save money on our mailing cost.

DR. SEAGRAVE: Thank you. Good morning.

Today I will briefly review some of the market factor and other evidence that you have already seen regarding the context of MedPAC's payment adequacy framework. I will also highlight some new preliminary information on quality of care in SNFs since the SNF PPS, discuss some concerns that have been expressed with Medicare

margins for SNFs and request feedback from the commission on the draft recommendations. The final versions of these recommendations will go into MedPAC's March, 2003 report to the Congress.

First, I want to just briefly remind the commission of the role that skilled nursing facilities play in the Medicare program. Since you've seen most of this, I'll just highlight a few points.

SNFs serve about 1.4 million beneficiaries per year, representing about 3.5 percent of all beneficiaries. Prior to the implementation of the SNF prospective payment system, Medicare's SNF spending grew rapidly. In 2001, Medicare SNF spending totaled about $15.3 billion or about 6.5 percent of total Medicare spending.

I also want to point out that in 2001 about 10 percent of nursing home residents and about 56 percent of patients in hospital-based SNFs were paid for by Medicare. These represented about 10 percent of nursing home revenues and 2 percent of hospital revenues.

CBO projects the total Medicare payments to SNFs will grow an average of about 8 percent over the next five years, although CBO has indicated that this number may be

revised downward in its new baseline projections due out sometime between the end of January and March.

Each year MedPAC goes through a multi-step process in arriving at our update recommendations. We start by assessing current payment adequacy, which means we examine current market factors, evaluate the appropriateness of current costs, and estimate the relationship between current Medicare payments and SNFs costs for fiscal year 2003.

Next, we examine evidence of anticipated changes in SNF costs for fiscal year 2004. Based on this information, we determine appropriate payment update recommendations for fiscal year 2004.

Now, I will just briefly review some of this market factor evidence that you've already seen at the previous two meetings. With regard to entry and exit of providers we find that the total number of SNF facilities has remained relatively stable between 1998 and 2002, with the number for freestanding facilities increasing by about 3 percent and the number of hospital-based facilities decreasing by about 26 percent.

The volume of SNF services provided to Medicare beneficiaries generally increased in 2000, the most recently

available data, due in large part to an increase of approximately one day in the average length of stay. Although the total number of discharges remained relatively stable, the number of the Medicare covered days in SNFs increased by about 4 percent.

The available evidence also indicates that Medicare beneficiaries needing rehabilitation therapies generally had no delays in accessing SNF services. However, patients with expensive non-rehabilitation therapy needs may stay in the acute care hospital setting longer. It is unclear whether remaining in the acute care hospital longer is an inappropriate outcome for these patients.

Finally, our review of the evidence indicates that hospital-based SNFs have access to capital through their parent hospital organizations and this depends, of course, on the financial status of the hospital. And freestanding SNFs' access to capital may have diminished somewhat because of recent bankruptcies, payment uncertainties, and the high cost of liability and insurance. However, this may be outweighed by low demand for new capital to finance construction in the near term, resulting from large capital investments prior to the PPS.

Overall, the evidence suggests that the market factor evidence suggests that Medicare payments to SNFs are at least adequate to cover the cost of providing SNF services to Medicare beneficiaries.

Next, we evaluate the appropriateness of current SNF costs and find that prior to the SNF PPS reported SNF costs were believed to have been excessively high. There are a number of reasons for this which we've discussed previously. Under the SNF PPS, however, SNFs have strong incentives to reduce the costs of caring for SNF patients and SNFs have responded to these incentives accordingly by negotiating lower prices for contract therapy and pharmaceuticals, by substituting lower costs for higher cost labor, by decreasing the number of therapy staff they employ and by decreasing the number of minutes per week of therapy they provide.

However, this raises the question of whether quality of care, what's been happening to quality of care since the PPS with these decreases in costs. We reviewed the evidence and can find no evidence of decreases in the quality of care over this time.

Preliminary information from a national study of

SNF patients indicates no changes in several quality indicators including activities of daily living scores, walking scores, re-hospitalization rates, and incidents of mortality.

Similarly, preliminary evidence from a study of approximately 84,000 beneficiaries in SNFs in Ohio finds no change in most of the quality indicators examined since the SNF PPS. However, the study does find statistically significant improvements in re-hospitalization rates among certain facilities between 1997 and 2000 and improvements in walking scores from 1999 to 2000. This was not found to be the results of SNFs accepting healthier patients on average.

We also examined evidence of changes in nursing staff ratios. As you know, studies show that increased nursing staff time in nursing facilities is generally associated with improved quality of care. Recent evidence suggests that nursing staff time has increased by between two and five minutes per patient day since implementation of the SNF PPS and that the mix of staff time has shifted from more to less skilled. Although the first finding likely indicates that quality of care in SNFs is at least not decreasing, we did not yet know what the latter finding

might mean for quality of care.

Finally, SNFs have additional incentives to improve quality regardless of cost pressures because CMS has recently begun to publish nationwide reports that include individual nursing facility scores on certain quality indicators. CMS is also devoting resources to help nursing facilities improve their scores on these indicators.

We therefore can find no evidence of reductions in the quality of care, even as we find abundant evidence that costs have decreased in SNFS since the SNF PPS. Together, this information suggests that productivity in this sector has improved.

Finally, in assessing the adequacy of SNF payments we estimate the relationship between Medicare payments and Medicare costs for SNF services in fiscal year 2003 and find that the average Medicare margins across all SNFs are about 5 percent, with the average for freestanding SNFs -- I remind you that those are 90 percent of all SNFs -- around 11 percent and the average for hospital-based SNFs around negative 36 percent. We can find almost no efforts in Medicare margins by urban or rural location.

It is worth noting that we used a conservative

methodology for estimating the SNF Medicare margins this year. Had we not taken this approach, the margins we estimate would have been higher than the ones shown.

From this evidence we conclude that overall Medicare payments to SNFs are more than adequate to cover SNFs' costs of caring for Medicare patients. However, we remain concerned about the distribution of monies within the system.

Now, I want to turn to addressing a few concerns that have been raised about the SNF Medicare margins. One issue that has been brought to our attention is whether or not it is appropriate to present margins by types of providers, such as hospital-based or freestanding or part of a top 10 chain or not part of a top 10 chain. Some people suggest that underlying characteristics of SNFs such as their occupancy rates, location, Medicare volume or percentage of Medicaid days do a better job of explaining SNFs' financial performance. We discuss Medicare margins by provider type, hospital-based and freestanding, and by location, urban and role, because many of the commissioners and other interested parties find this information useful in thinking about the state of the industry.

However, at least in the short run we propose recommending adjustments to the system so that Medicare payments better track the expected resource needs of patients instead of recommending differential updates by facility type.

Another issue that has been raised is the SNF marketbasket forecast error. The forecasted SNF marketbasket, which is used to update payment to SNFs each year, has underestimated the actual SNF marketbasket for the last few years since the SNF PPS. MedPAC discussed this issue with the actuaries who compute the SNF marketbasket. They indicated that the forecast error has caused SNF payments to be about 3 percent lower than they otherwise would have been had the forecast error been corrected.

However, MedPAC's payment adequate framework implicitly takes this into account in determining whether current payments are at least adequate compared with current costs. Had the forecast error not been corrected, this would have raised Medicare margins above the ones that we report here but it would not changed our assessment of current payment adequacy.

Also, if CRS were to correct for the marketbasket

forecast errors that underestimate the actual marketbasket, they would also need to correct for forecast errors that overestimate the actual marketbasket. It is assumed that the two types of forecast errors balance each other out over time.

A final issue with the SNF marketbasket is the lack of a cost weight for professional liability insurance. We also spoke with the actuaries about this issue and they told us that they did not have the data necessary to include this component in the SNF marketbasket but that the weight for this component is captured in the marketbasket index, just not as a separately identifiable component.

In addition, they indicated that the Medicare cost reports would be the most reliable source of information for this but that few SNFs fill out this section of the cost report currently.

Finally, some have expressed concerns about rising labor costs in the SNF industry due to the nursing shortage. Rising labor costs are accounted for in the SNF marketbasket which MedPAC uses to increase costs each year in projecting Medicare margins. To the extent that nursing facilities are switching from using higher cost labor to lower cost labor

this would tend to offset some of a cost increases.

Finally, in our payment adequacy framework, I wanted to discuss the anticipated cost changes for 2004. First, we look for major quality enhancing new technologies that will be expected to significantly raise costs over the course of the next year and can find no evidence of this type of technology in the SNF sector. In predicting cost growth over the next year, we also look for evidence of cost lowering, increases in productivity, or changes in the product. As mentioned before, we find abundant evidence that SNFs costs of caring for Medicare beneficiaries have been decreasing since the SNF PPS. At the same time, however, we can find no evidence of decreases in the quality of care. We expect these trends to continue in the coming year.

Just one last step before I present the draft recommendations that you saw at the December meeting. I would like to remind the commission that last year we handled the SNF payment updates differently by recommending differential updates to freestanding and hospital-based SNFs. We did this because we believed that the development and implementation of a new SNF patient classification

system would take too much time. We recommended differential updates in the meantime.

This year we want to recommend more immediate measures to balance the distribution of payments in the system so they better track the expected resource needs of SNF patients and we feel that differential updates are no longer necessary as a short-run pressure.

Thus, because we estimate that overall Medicare payments to SNFs are more than adequate to cover the cost of Medicare beneficiaries, staff propose recommending that the Congress eliminate the update to payment rates for skilled nursing facility services for 2004. The update in current law is marketbasket minus .5 with the SNF marketbasket currently projected at 2.9 percent for fiscal year 2004. This, of course, is always subject to change.

Within the budget categories that MedPAC has developed, a zero update for SNFs would decrease Medicare spending relative to current law in the category of between $200 million and $600 million for 2004 and between $1 billion and $5 billion over five years.

Should I go through all the recommendations?

However, as mentioned before, we feel it is

critical to balance the distribution of resources in the system to better track the expected resource needs of SNF patients, especially since we have evidence that hospital-based SNFs treat a higher proportion of these types of patients.

Thus, staff proposes that we continue recommending, as in previous years, that the secretary develop a new classification system for SNFs. However, because this may take time to accomplish, staff propose recommending that the secretary draw on new and existing research to reallocate payments to achieve a better balance of resources between the rehabilitation and non-rehabilitation groups.

Further, we suggest recommending a more immediate fix to the distribution of money in the payment system. We propose recommending that the Congress immediately give the secretary the authority to remove some or all of the 6.7 percent payment add-on currently applied to the 14 rehabilitation RUG-III payment groups and as appropriate to reallocate money to do non-rehabilitation RUG-III groups to achieve a better balance of resources among all of the groups. We expect this reallocation of resources to be

spending neutral.

Finally, we recommend that the secretary continue an excellent series of studies on access to skilled nursing facility services. This recommendation would not have an impact on Medicare benefit spending.

Thank you. This concludes my presentation.

MR. DeBUSK: On the new classification system, where are we at on that? Does anyone have any idea how far that's progressed or is it stalemated, or what?

DR. SEAGRAVE: The indication in the Federal Register last year was that CMS thought that it might be close to suggesting a refinement to the classification system but they pulled back because they needed to look at the implications further. No one is clear on when they might propose such a refinement.

They're supposed to provide information on alternatives on January 1st, 2005.

MR. MULLER: While it's early to see the consequences of the change in the nursing mix, there is some evidence in hospitals when they started changing the nursing mix roughly about 10 years ago that, in fact, it did have an effect on quality of care. There are recent articles in

JAMA and the New England Journal on that. So I think it's something we should be tracking.

Again, I think also the amount of nursing care inside hospitals is greater than the amount in nursing homes, just on an hourly basis per day. But I would suspect as the evidence unfolds over the course of several years -- and it took about four or five years for that to unfold in the hospital setting -- that we might see some effects on the quality of care. Again, I agree with you, it was difficult to tell at the beginning of the hospital experiment but there is evidence that it did occur.

MS. BURKE: I was going to raise the same point Ralph raised. I am quite concerned that there is an indication that there may be a shift, and in fact there is evidence that that shift has, in the past, made an impact in terms of quality. So tracking that, in terms of the nursing mix, I think is quite important.

I also wanted to clarify what I believe I understood, but wanted to state it explicitly, and that is that the 20 percent add-on that was provided for and maintained in BIPA, with respect to the non-rehab RUGS, remains in place. It is not our intention to alter that;

correct?

DR. SEAGRAVE: That is correct; yes.

DR. WOLTER: Just a couple comments. First of all, I thought it was a strong chapter and I think the recommendation to reallocate the 6.7 percent payments that went to the rehab RUGS makes good sense given the other information we have. It's hard to know how that would play itself out however and how soon it would play itself out. And with the information that hospital-based SNFs are taking higher acuity patients and more complex patients with the rather high exit rates over the last few years of hospital-based SNFs, I am really worried about the potential that the care of these types of patients could be impaired in the short to medium term if this doesn't play itself out the way we'd like it to. I wonder if our recommendation would be stronger if we did include recommending an update for hospital-based SNFs if it takes a while to sort through how the 6.7 percent reallocation would occur.

I am very worried about the negative margins, the high exit rates, and this particular group of patients.

MR. HACKBARTH: Reactions to Nick's proposal?

DR. NEWHOUSE: One thing to put the exit rates in

perspective is the very high entry rates in the '90s. In effect, we're somewhat unwinding history. But I don't think we've gotten all the way back to where we were.

MS. BURKE: But Joe, as I recall in the '90s, the entry rate was largely on the freestanding side rather than the hospital-based side.

DR. NEWHOUSE: That was not my recollection.

MS. BURKE: My recollection is it may not been dramatic but I think that -- at least my collection is that there were more on the freestanding side. I may be wrong. That's actually worth looking at, but I also would agree with what Nick had said. I think there is this issue if, in fact, the Congress fails to respond to the recommendation and doesn't give the authority, there will be an issue in terms of the hospital-base that I think there's some consideration what the alternative might be.

MR. SMITH: I share Nick's concern and there ought to be a way to restructure this recommendation to make that point explicit.

I also thought, it's a picky language question, but that we ought to remove as appropriate. Our intent here is to argue that money ought to be shifted from the

rehabilitation RUG-III groups to the non-rehab groups. So the as appropriate suggests that it might not be appropriate. Clearly we think it is appropriate and we ought to be explicit about that.

MR. MULLER: Also to Nick's point, and I agree with it, is I think implicit in our recommendation here is that the negative margin of the hospital-based SNFs would be covered from elsewhere and part of the elsewhere -- since the higher positive margins is in the inpatient program. And I think over the course of the day we'll have probably a series of recommendations of where that higher inpatient margin is used to cover other things where they are negative. We should probably start toting up in our recommendations how many times that higher inpatient margin gets used to support other things. Because I think with the negative 20 or 30 percent, I don't have it memorized right there, on this, even for those hospitals that have considerable inpatients SNF units, that could be a considerable drain of their margins from elsewhere to cover that.

MR. DURENBERGER: Mr. chairman, I have a slightly different point I'd like to make on the initial

recommendation. My personal preference, and as you all know I'm just three or four meetings into being on the commission.

My personal preference is that we recommend a marketbasket increase less productivity and I just went to tell you why my instincts are that way. I think it's a well-done paper and we've been through this before and I understand the background and the research.

I'm challenged not so much by skilled nursing facility margins as I am by the adequacy of the way in which both Medicare and Medicaid programs provide adequate services for people who are, in many cases, somewhere near the end of life, in practically all cases dependent on others, in many cases suffering from one or more chronic illnesses, and for certain periods of time and for certain conditions they are hospitalized and/or placed in a different care setting or regimen within a skilled nursing facility.

So if I may to my colleagues make three points. One is the nature of the people served by the Medicare program are the kind of people that, from my standpoint, I would like to see cared for in a skilled nursing facility

rather than in a hospital if that's at all possible. And to the extent that there's time they have to spend in the hospital I'd like to see them in and I'd like to see them out.

And it's because the nature of the care that they actually need, the nature of the dependence on family to help them in that care, and the particular kind of staff is in the skilled nursing facility, it's not in the hospital. Because it's a broader kind of dependence and a multiple set of needs that experience tells us is better cared for in skilled nursing facilities. So my bias is towards the skilled nursing facility, the freestanding, whenever we want to call it.

Which gets me to the second point, and I raised this last time and it's sort of like the issue of subsidies. I don't think it's good policy to have institutional cross subsidies or provider cross subsidies. But I do think when you have two public programs that are like Medicare and Medicaid programs, and you have right now I guess some 6 million people who are called dual eligibles who are falling between both of these programs that there's nothing wrong with cross subsidization between programs. And I don't

know, maybe that's not our place to think about it, but I do think about it because, for a variety of reasons, I am looking at this issue not as are skilled nursing facility making 5 percent, 4 percent, 7 percent, 11 percent. But where is the best care being provided for these kinds of people.

I think we know about the dual eligibles. They're a relatively small percentage, in the teens I think, of both the Medicare and Medicaid program but they're consuming like 30 to 35 percent of the program money in each case. So it says to me that spending that money wisely, appropriately, is critically important.

For that reason is my instinct to prefer a relatively small increase, I guess, to no increase at all because the line is obviously coming down.

The thing, and this is what concerned me before and I mentioned this a month ago, and it is the use of the NIC report to in effect imply -- well, it doesn't imply, it says demand for capital is low. Another quote is no problem with access to capital. The implication, being that there's really nothing wrong out there on the skilled nursing facility side and, as a matter of fact quite the contrary is

true, and it's particularly true of the non-profits, I think, many of which are very small. They're run by religious orders or whether the case may be across this country.

So I called Bob Kramer who runs NIC. And I said this is the way this report is being used at MedPAC. And he said number one, the one the database is relatively old for this report. It goes back to '98-'99 when PPS was first being phased in.

He said that in that same report they indicate that net operating margins across the board are probably stable or better for about half of the nursing facilities but they're below average for another half. And this is in the 2001 report.

And then he went on to point out to me that there were five or six factors or circumstances that were not accounted for in that report. One is what's happened to liability insurance premiums, and he used this figure not I, have gone from an average of $30 a bed to $3,000 a bed, the state fiscal crises that we all know about, the utility rate increases, the labor costs, the GAO and CMS reports about the pressure to increase hours of care per resident, that

sort of thing that's going on.

And then the issue of the aging of the nursing home stock which is also a reality. That many of these nursing homes that we're talking about today are old. They were built in the '60s and the '70s in response to the payment signals that people were getting at that particular point in time.

And at least from the state level people are saying they would like to change the nature of those facilities but they can't afford to do it because of the income stream.

So it's my elaboration on a point I tried to make last time and because of the fact that we're really on behalf of all of these -- many of these people with two different programs, I'm left very uncomfortable simply saying I can look at this only as Medicare. I have no information about the Medicaid side in this report, as it relates to some of these facilities.

And so my preference is that we consider something other that a zero increase.

MR. HACKBARTH: I would just like to, for a second, pick up on the Medicaid point. Dave and I have

discussed this a bit, so I know you know what I'm about to say but I just want to share it with the larger audience.

I basically have three concerns about using Medicare dollars to offset Medicaid losses. One is that the Medicare patients represent on average a small percentage of the total patient volume, about roughly 10 percent. So I think that is a small base on which to hang the obligation for the financial stability of the industry.

Second, if you use Medicare dollars to subsidize Medicaid it actually puts the dollars in the wrong place. The facility would get more dollars to the extent it has more Medicare patients and a larger proportion of Medicare patients, and therefore a smaller proportion of Medicaid patients. So you're sort of misdirecting the subsidy.

And third, I'm concerned that if the federal government takes on responsibility for the stability of the industry basically that says to states, you can go ahead and cut the Medicaid budget, Medicaid rates for these services, the federal government will make up the difference and, by the way we'll do it without a match. I don't think, particularly in the current fiscal environment, that's the signal that we want to send to the states about Medicaid

rates.

So I'm just not sure that this is a policy, a federal policy, that would lead to the place we want to be.

MR. DURENBERGER: Just very quickly.

On the first, and you're right we have talked about this before. On the first -- and my experience goes from back in the '80s when we tried to correct all of this problem with regard to long-term care and we were doing very little if anything in long-term care to the present -- where I think whether it's 10 percent or 12 percent or whatever the percentage is, the marginal dollars makes all the difference in what a facility can do it terms of response.

Secondly, and this I get from people who are both in the Medicaid program, I guess, and in the skilled nursing or long-term care particularly side of skilled nursing, that where the Medicare reimbursement level is reasonable -- let's not say, I don't know how else to express it, but it is at least at break even or slightly better. There is an incentive on the part of the skilled nursing facility to offer and to seek out patients for this intensive post-hospital, the Medicare short stay. I just happen to think that's good thing. I think it is good for people to seek

that business because I believe that people are better served in the skilled nursing facility than they are served in a hospital. I tried my best to say why I believe that earlier.

I know that experience will tell us that some of the people, if you make a conscious effort to do this, some people are going to be able to go home. This is not just all hospital or people who are going to stay in nursing homes. Some people are able to be treated properly in the post-acute period and they're able to go home and it lessens the amount of money that they spend down into the Medicaid program.

Then finally, I just find it hard to believe that the Medicaid programs, I mean the governors and the states and the legislatures, are going to -- I mean, they've got enough other clever ways to cheat on the system to get more money than responding to a 2 or 2.1 percent increase in the SNF reimbursement level.

MR. FEEZOR: Thank you, Glenn.

I guess I share Dave's concern and compassion, and yet, as I had mentioned in the last meeting, I have a real concern about Medicare as you do subsidizing -- it's sort of

the tail wagging to dog to some extent.

Having said that, I am very, very concerned about the timing, and maybe it's coming from a state where we have a 35 percent budget deficit, of some of the what I call spike factors like labor costs, workers comp, professional liability coming at a time where both states are going to be reacting and we may be taking some recommendations separately.

I guess that causes me to, at a minimum suggest, urge -- and I think there is both in the staff narrative as well as some other input that I got -- that I'd like for us to consider urging the secretary or CMS to at least try to make sure that the marketbasket or its forecasting error is more accurate, is one item.

MR. HACKBARTH: I sort of assume it's a baseline, that they are trying to make it is accurate as possible but forecasting is always inevitably --

MR. FEEZOR: I just got -- because I did not get the issue briefs since I was in an extended en route, but I was looking at language that basically said that in fact if the forecasting error had been made up that the current SNF payments are 3 percent lower than they would have been if

CMS had been able to go back and correct the forecasting error. And as I have said consistently, I am very concerned about some of the input factors, how quickly they make their way into, in fact, the basis by which we are doing forecasts.

MR. HACKBARTH: Let me see if I can put this in context and if I do a poor job, Mark or Susanne and Sally, help me out.

CMS says that their forecasts have not been perfect. That's not a shock, that's usually the case. And they've quantified the magnitude of the error by looking back.

In our payment adequacy framework, as opposed to going back and correcting for forecast error which is something we used to try to do, we say well let's just look at the end result, look at the margin and see what the bottom line impact of that error is. So we project the average margin for the freestanding facilities at 11 percent for 2003 on their Medicare business even after this error.

So to say well, they have 11 percent margin, now we need to go back and add money to correct for a forecasting error wouldn't make sense. And so that's why we

don't specifically recommend corrections.

MR. FEEZOR: I guess my comment is less to try to justify the money as it is making sure that we have appropriate measure in terms of what that baseline should be, just some clarification if there's some elements of it that are changing. That was my intent.

DR. REISCHAUER: But I think what Glenn is saying is that the baseline should be what we believe adequate payment level to be. And if CMS badly underestimated the increase in costs but other events, such as improvements in productivity or structure of the industry or such to maintain adequate margins, we'd say well, it worked out okay even though we started off, in a sense, on the wrong foot. It's sort of a difficult process to go through, I think.

But you can't get back and correct for every mistake unless there are consequences of those mistakes on quality, access, whatever.

MR. HACKBARTH: Sheila, and then what I'd like to do is move on to the next step of trying to resolve the issue and reach a recommendation.

MS. BURKE: Just briefly back to the issues that Dave raised in terms of Medicaid and the creation of a

subsidy.

I recalled, and I asked Mark and had him double check with the staff, QMBs and SLIMBs are, in fact, paid under Medicare rates, I mean as Medicare eligibles. So in effect, there is a direct subsidy.

DR. REISCHAUER: Dual eligibles, everyone is if they're a Medicare patient.

MS. BURKE: Exactly. So there is inherent in that a subsidy that occurs. And the whole point of it is to allow Medicaid, in a sense, to buy into the Medicare program and, in doing so, essentially use Medicare rates.

I agree with Glenn's concern. I mean, I am sensitive to the issues being faced by the states, and this is an age old battle between Medicare and Medicaid. But I fundamentally don't believe that Medicare ought to be subsidizing Medicaid in ways other than explicit decisions to do so like the creation of programs like QMBs and SLIMBs where we buy in.

Yes, it is a small percentage but I do think that the fundamental policy is a solid one and I think we need to deal with Medicaid's problems in the context of the Medicaid program. We ought to be certain that the rates are

sufficient in the Medicare program. And to the extent that they trip over into that population in that way, in fact, there is assistance provided to the states in that context.

DR. REISCHAUER: Even if we wanted to address the problem that you raise, I think Glenn's second point was really the killer argument. And that is by increasing the payment to SNFs, you're going to disproportionately affect those SNFs that least need the adjustment.

You had two SNFs, one which was 80 percent Medicare, 20 percent Medicaid and another which was 10 percent Medicare, 90 percent Medicaid. You know, nine times more, eight times more would be going to the SNF that had 80 percent of its patients in Medicare and only 20 percent in Medicaid, the one that wasn't affected by the low Medicaid rates as tellingly as the other one was.

So you'd want to design some kind of DSH payment or some other mechanism for addressing this problem.

MS. RAPHAEL: The only factual point here that I do think needs to be modified is our assertion that the need for capital is close to zero through 2010. In my experience while maybe there aren't going to be new construction endeavors, there is a lot of renovation and modification

going on in the industry, partly because some of the nursing homes now have to compete with assisted looking in their regions, et cetera.

So I think we just need to modify that part.

MR. HACKBARTH: I think that's a good comment.

Okay, let's turn to what we do. Again, the context for this recommendation is, as I see it, we're in a very similar place as to where we were last year. With regard to freestanding SNFs, the margins are projected to be about the same, if anything a little bit higher. Last year our recommendation in that context was no update because there was more than enough money available for the freestandings and again this year, that's the recommendation, no update in that context.

The tact is a little bit different with regard to the hospital-based SNFs. We reiterate that we think that there is an issue with regard to the payment classifications and underpinning for certain types of patients as opposed to just a categorical increase in the rates for hospital-based SNFs. We're advocating instead that the dollars follow the patient type, wherever they end up, whether it's freestanding or hospital-based which I think is consistent

with our general philosophy in the past.

The issue that's been raised there is can it be executed quickly enough, and Nick raised that.

So as I see it overall we're in very much the same place as last year, just a little bit different approach on hospital-based.

I've heard three proposals for change. One, Nick's proposal that we add some language recognizing the possibility that the reallocation of the dollars may not happen quickly and we need to say that this is an urgent matter and address the possibility that it doesn't happen fast enough.

Second, we had David's proposal that the language about reallocation, drop the as appropriate qualification which seems to water it down a bit, I think was the gist of David's concern.

And then third, we have Dave Durenberger's proposal that we have some small increase, not a zero update, for the freestanding facilities.

What I'd like to do is go through each of those proposed changes one by one, beginning with Nick's proposal.

There are two ways, Nick, that we could address

this issue. One is to alter the language of the recommendation and make it still longer. It's already very long, uncharacteristically long for our recommendations. The second alternative would be to really pound on this nail in the text and say that we do think that this is an urgent matter and if, for whatever reason, this approach can't be done quickly we need to address the needs of the hospital-based SNFs where we think that there is a systematic classification problem.

Would you feel comfortable with a paragraph in the text on that issue? And obviously you'd have a chance to review the text, as would all the commissioners.

DR. WOLTER: I'd be comfortable with either approach.

MR. HACKBARTH: I sense that there's a consensus on this issue, that this is an urgent budget matter and important. I personally think it's the sort of thing dealt with more readily in the text, as opposed to expanding already long recommendations.

MS. BURKE: Glenn, I just want to make sure that I understand the import of what we're saying. Are we, in fact, saying that in the absence of an ability to respond to

the recommendation of reallocating the 6.7 that we recommend an increase in increase in the update for hospital-based? Are we, in fact, saying that?

MR. HACKBARTH: That's what we would be saying.

MS. BURKE: Then we ought to say that.

MS. DePARLE: I agree. I think it should be in the recommendation, not in the text. Because the text is already very strong on the impact on hospital-based. So if that's what we think, we should say it in the recommendation, even if it makes it an extra few sentences.

MR. HACKBARTH: The reservation I -- go ahead, Bob.

DR. REISCHAUER: Maybe I'm misunderstanding it, but one is budget neutral and the other isn't. Am I right? And so we should be aware that.

MR. HACKBARTH: That is a material difference.

Part of my reservation about changing the recommendation is I do think the best approach is to have the dollars follow the patients and do the reallocation on a budget neutral basis. And I don't want to make it more convenient to say oh, we're not going to do that difficult reallocative work, we'll just take the other part of the

recommendation that we like, which is add new money.

I think that this should be dealt with as a reallocation issue.

MS. DePARLE: I agree, but I think we have to be realistic about what is possible. It will take a change in law to even allow the secretary to do this, and then I think -- Mark or someone else here, won't it take a rulemaking process, at the very least, in addition to some analytic work? So I think the likelihood that this can be accomplished within 12 months is low. Sheila? Am I being too strong?

MS. BURKE: That's my concern. But that's the reality.

MS. DePARLE: So if that's what we're really saying, I mean I agree, Glenn, from a policy perspective. But just looking at this coming down the road, I don't think it's realistic to think that it can get done in a year, given that it requires a change in law and administrative process.

MS. BURKE: Simply that. I don't think we disagree with the policy direction you're taking at all. And if there's a way to say that clearly, that that is our

strong policy preference. But hell, they can't even organize the committees yet, let alone pass statute.

So I worry about the timeliness of this and being able to actually deal with the issue that's been raised, which is the treatment of particular facilities. But I think anyway we can say what you're saying in the strongest possible terms, this is in fact, what we believe is the right policy, is fine. I just worry about the timing.

MR. HACKBARTH: Could I just ask for a show of hands on this and see how many commissioners would like to see this addressed in the text of the recommendation as opposed to the body of the report?

So was I clear? I'm sorry if I garbled that.

So in the recommendation language, as opposed to in the body of the report. It looks like a majority would like that.

To have the actual language. I'd prefer not to try to wing it and give staff a little opportunity to work on appropriate language. And so I'll ask that that be brought back as quickly as possible. I'll let you work out with Mark, Sally, whether it's tomorrow or later today.

MR. SMITH: Just a quick thought about how to do

it.

Perhaps we could deal with the length problem by making this is a second recommendation that should Congress fail to give the secretary authority or should the secretary fail to accomplish the work, an update -- and we could probably use the word temporary and tie it to the reallocation getting done, but an update for hospital-based SNFs should take effect on October 1.

MR. HACKBARTH: The third outstanding proposal was Dave's, that -- I'm sorry, I did skip over as appropriate.

David Smith had suggested that the language in the recommendation about reallocation drop as appropriate. Could you put that one up, Susanne?

So in the second bullet point there, the as appropriate at the beginning would be deleted. Is there a sense that that makes sense to do? I think that's good.

I see an lot of nodding heads. We don't need a show of hands on that one.

And then last was Dave Durenberger's suggestion of a small overall increase.

MR. DURENBERGER: Let me just say before that, the issue that both Carol and I spoke to, which is the way in

which the demand for capital is portrayed in the text. This isn't part of our recommendation. But the idea that lack of demand indicates a lack of need, I don't think is realistic.

MR. HACKBARTH: I think that's a good suggestion. We need to rework the language.

MR. DURENBERGER: There are at least two of those quotations in the text that I'd like to see changed.

MR. HACKBARTH: So we will rework the language on the need for capital.

On the proposal for -- I think your term was a small increase, Dave, do you want to say anything?

MR. DURENBERGER: 2.1 percent, whatever it is, marketbasket minus productivity.

MR. HACKBARTH: Could somebody on the staff help me what that number would be? What's the projected increase in the marketbasket

DR. SEAGRAVE: The current projected increase in the marketbasket for 2004 is 2.9 percent and I believe that we how, from overall multifactor productivity in the economy is .9 percent.

MR. HACKBARTH: So it would be a net increase of 2 percent.

So the next question on that's, under your proposal Dave, an across the board increase for all SNFs, and then there would be, in addition to that, the reallocation proposal that we reallocate the dollars for the certain types of patients. Is that correct? Is that what you intend?

MR. DURENBERGER: Yes.

MR. HACKBARTH: So why don't you put draft recommendation one up there, Susanne. That one would be amended to read marketbasket minus productivity, which turns out to be a net effect of 2.0 percent.

Could I ask for a show of hands on that? Who's in favor of that change in recommendation one?

I think we've dealt with all the proposed changes. Should we now proceed, we can vote on draft recommendation one. And two, we'll need to come back with some amendments, right? So why don't we vote on one?

All those opposed to draft recommendation one as worded on the screen?

All in favor?

Abstain?

And then we'll bring back two.

DR. SEAGRAVE: There's a third.

MR. HACKBARTH: That's right, we do need to do number three which is -- would you put that up on the screen please? This is the recommendation for the continuation of the access studies.

All opposed to number three?

All in favor?

Abstain?

Okay, and we look forward to seeing the revised language on two.

MS. BURKE: Glenn, just to underscore, it's not in the recommendations but it essentially links a third, which is the nursing issue, to make sure that we make some note in the text about our desire to look carefully at this shift to non-RNs and impacts on quality.

DR. STOWERS: Glenn, is two going to change and be modified or are we going to have a separate recommendation?

MR. HACKBARTH: I'm certainly open to a separate recommendation. What I'd suggest is let's just let the staff look at it and see what is the clearest way to present it, whether it's in a revised single recommendation or a separate new one.

Next on the agenda is home health services. Sharon, whatever you're ready.

MS. CHENG: This presentation is the last in a series of three in applying our payment adequacy framework and making update recommendations for the home health services.

At this meeting, I will percent an estimate of the current Medicare margins for home health agencies. I'll discuss a new indicator of quality, discuss changes in the use of the benefit, and also review very briefly some market factors that we've discussed at previous meetings.

Finally, I'll present proposed recommendations for your discussion and vote.

Again, this slide, to just get us oriented, the home health sector represented $10 billion in Medicare spending in the year 2001. There were about 2.2 million users of the benefit in that year, and there were about 7,000 home health agencies.

This bar graph represents the trends in home health spending over the last 10 years. About 10 years ago, home health spending started a period of growth. Between 1990 and 1996 there was an average annual increase in

spending of 33 percent. It reached its high point in '96-'97, and from 1997 to 1999 fell about 50 percent. You can see it's about level between 1999 and 2000. And in 2001 spending started to grow again.

The Congressional Budget Office has projected the spending on this benefit will continue to grow over the next five years. Last March that estimate was 17 percent average annual growth over the next five years. However, CBO has indicated since then that they will revise that estimate downward. The new estimate of growth, along with their underlying assumptions, will be included in CBO's report out in March.

Like spending, use of the benefit has been up and down over the past 10 years. Changes in eligibility for the benefit, enforcement of program integrity standards, and the structure and incentives of the payments system have accompanied those changes.

Use of the benefit grew 85 percent from 1990 to 1996. The factors that preceded that growth were a loosening in the eligibility for the benefit, a legal decision that made enforcement a bit more difficult for HCFA, and the incentives of the payment system to maximize

the number of visits delivered.

Under the IPS, use of the home health benefit fell by about 1 million users. Again, the changes that preceded that trend was a slight tightening in eligibility, the implementation and the effects of Operation Restore Trust, which was not limited to the home health benefit but was a factor in the home health benefit, and it prompted several hundred involuntary closures of agencies over that period.

And also the incentives of the payment system changed again so that there was an incentive to maintain a relatively short stay and low cost patient mix.

Since PPS, spending has begun to grow once more but the number of users continues to decline, albeit it at a slower rate. With the implementation of the PPS, again there was a very slight loosening of the eligibility of the benefit. There is still medical review and there still are some involuntary closures of agencies.

But the structure of the PPS is very different again from the IPS. The PPS features case-mix weights so that the payment is adjusted to reflect the clinical severity and the functional limitations of the patients being cared for. Also, patients can receive multiple

episodes, so long as they remain eligible for the benefit. And there is an outlier policy that removes some of the risk for very costly patients, although it has been noted that the outlier policy is underutilized.

Looking at the underlying structure of the PPS, along with our analysis of the relationship between cost and payments, it does not appear that the structure of the PPS nor the current level of costs and payments are the sole barriers to increasing growth and utilization.

Those trends in spending and use provide important context as we move into the payment adequacy framework and its next phases. One important part of our adequacy framework is the assessment of the relationship of current payments and costs. We have three different analyses that we're going to take together: GAO's analysis, Medicare's financial margins, and the payment-to-charge ratio.

As you recall, GAO found that the average episode incurred reimbursement of $2,700 and incurred costs of $2,000. That different represents a payment 35 percent greater than the cost on an average episode. The Medicare financial margins, I'll go into more detail in just a moment.

The payment-to-charge ratio, we have discussed before, but in response to some of your questions we've disaggregated it to use that to look a little bit more closely at the financial status of rural home health.

These margins are for Medicare freestanding home health agencies. They're based cost reports from 10 percent of the agencies in the program. That is to say those with post-PPS cost report data. It is a non-random sample. However, it is roughly proportionate to the nation in terms of the mix of voluntary, private, and other types of home health agencies and the urban and rural mix. It is not geographically representative.

The overall margin that we estimated for 2003 takes into consideration the impact of the so-called 15 percent cut and completely phases out the add-on for services provided to beneficiaries who live in rural areas, even though that add-on will expire halfway through 2003.

The overall margin that we arrive at is 23.3. That's slightly different that the number in your handout.

There is some variation within our sample. Private home health agencies have a slightly higher margin than voluntary. And rural, reflecting the impact of the

phase-out of the add-on, have slightly lower margin that urban agencies.

As would be anticipated in any new payment system, there are some distributional and structural issues that may require adjustment. CMS does have plans to refine the PPS has data becomes available.

Our estimates of the margins for hospital-based home health agencies are lower than those for freestanding home-health agencies. When the hospital-based home health agencies are included, therefore, the average for home health in the sector would be somewhat lower.

The estimate for hospital-based home health margins may tend to understate their current margins for two reasons. They include pre-PPS data in the base year and the freestanding home health agency margins do not include pre-PPS data in the base year.

Secondly, there are issues with cost allocation within a hospital that would tend to affect all non-inpatient lines of service at the hospital. Including those somewhat lower hospital-based home health agency margins would decrease the all agencies 2003 margin to about 17 and would decrease the rural margin specifically to about 9.

The second piece of evidence that we have regarding the relationship of payments to costs is the payment-to-charge ratio. We've looked at the all episodes numbers before but we've gotten some commence on this and I'd like to elaborate on it a little bit.

Before PPS, Medicare paid by the visit the lesser of cost or charges. And given that incentive, we can assume that costs were lower than charges.

In 1994, the ratio of payments to charges was .74, and in 1997 was .73. Though we switched the unit of payment under the PPS, when an episode contains four or fewer visits, it's paid by the visit just like it was under the previous payment system. And that's a LUPA episode. As you can see, the payment-to-charge ratio for LUPA episodes of .75 is about the same as it was in 1994 and 1997. This is evidence that the charges have kept pace with changes under the new payment system.

We took advantage of the somewhat larger sample that we have in this payment-to-charge ratio to disaggregate by urban and rural. Here we are able to disaggregate it by the location of the beneficiary, which is how the add-on is calculated. We think this gives us a somewhat better look

at the rural situation.

That analysis provides evidence that both rural services in the aggregate and subgroups within rural areas are being paid adequately as all rural groups had a payment-to-charge ratio greater than one. This evidence, along with the margins that we've just discussed in GAO's analysis, suggests that payments are currently more than adequate for this sector.

When analyzing a sector that has had as large a product change as we've discussed at past meetings, we would like some evidence that despite this product change, quality has not declined. So we've taken a look at the quality of care and what we know about it since the PPS. CMS was aware of the incentives of the new payment system and implemented quality measurement and improvement along with the changes that it made in the payment system.

Home health agencies are required to collect outcome assessment information at the start of care and the discharge of care. This is the OASIS dataset. From that, CMS develops outcome reports, case-mix and adverse event reports which are fed back to the agencies, so that they can implement their own process level quality improvement.

CMS also plans soon to implement a reporting system that would allow consumers to use this quality information to choose high quality home health care providers.

One trial conducted by CMS of this process of collecting outcome measures and providing reports back to the agencies decreased hospitalization statistically significantly compared to a control group and increased improvement in clinical and functional outcomes, again statistically significantly more often than the control group.

We've also taken a look at an index of quality outcome measures that has been collected. This index includes decline, stabilization or improvement in patient clinical severity or functional limitations and was measured at the beginning and the end of the first full year of the PPS. This index has remained relatively stable and has shown no decline in quality over the first full year of the PPS.

The index was developed by researchers at Outcome Concept Systems which is a private firm that collects data from about 700 Medicare certified home health agencies. The

index itself was based upon 350,000 patient episodes of home health care. Participating agencies in this benchmarking agency's private sample include a cross-section of the sector geographically and by type of control.

The stability of this quality index provides some evidence that quality has not declined under PPS despite the decline in volume of visits and the change in the product. This provides evidence that productivity has improved and that costs, as we see them now, are appropriate.

As a final step in the first phase of the payment adequacy framework, we've also included other market factors. We've looked at these before to just briefly touch on them, the home health product has been changing. We've seen declining visits per episode, declining length of stay, fewer home health aide visits as a proportion of all visits and a greater proportion of therapy visit.

Entry and exit of providers has been stable over the past three years. We do know that about 200 agencies exited last year and about 300 entered. So not only has the total remained relatively stable but the amount of churning under that total is relatively small.

The number of agencies is not, nor has it ever

been, a measure of the ability of the system to care for home health users because it fails to capture any meaningful information about capacity. For an industry without much investment in bricks and mortar, capacity would best be measured by an index of personnel available. When one home health agency closes, its personnel may be able to easily move to another agency. So though it would register as a closure, there may be effectively very little or no impact on the capacity to care for Medicare beneficiaries in that area.

Our third market factor is beneficiary access to care. We used our hospital discharge planner panel and the OIG survey, and both of these concluded that beneficiary access is generally good. MedPAC is developing additional resources to provide more information on access to care. Our episode database will be able to track patterns and changes in home health use by beneficiaries referred from the hospital as well as beneficiaries referred from the community or from a skilled nursing facility.

The OIG's work, or a study similar to it in methodology and sample size, however, will continue to be an important adjunct to the work that we can do in our

understanding of beneficiary access to this benefit.

I'd like to touch on one final issue in this portion of the payment adequacy framework, and that's IPS repayments. Under the interim payment system many home health agencies received greater payments than they were due under the limits of the system, thus generating debts to Medicare for the difference. When the amount to be repaid was large, the program extended repayment plans and some of those repayments are still being made today.

Agencies were overpaid because they did not know what the limits would apply to their payment until they closed their books for the year, the costs were analyzed, and the limits were retrospectively determined. Overpayment was prevalent. In the last full year of IPS, about half of all freestanding agencies had some overpayment from the Medicare program.

Since then some home health agencies have left the program and some have repaid their debts. However, we've been asked to look at this issue because for some agencies, IPS repayments continue to be an important factor in their financial stability.

CMS has taken some steps to reduce the stress of

IPS overpayments. They have extended the repayment schedule and they have lowered the interest rate for repayment of this debt.

With that, I'd like to move to the second phase of the framework, which is anticipating cost changes over the coming year. Staff conducted an analysis to determine the impact of declining visit volume on costs. The results of that analysis determined that costs per episode fell from 1999 to 2001 by 16 percent. The decline over the course of 2001 was 5 percent.

Taking into account then the steep decline that preceded the PPS as well as evidence that the decline continued at a slower pace under the PPS, our evidence suggests that costs will continue to decline.

To apply our framework then, we bring this anticipated cost change together with our assessment of payment adequacy to make our recommendation for the update.

Before proposing our update recommendations, I'd also like to respond to some questions that we've received regarding rural home health, just to make sure that I've addressed the concerns that we've heard. Staff believes that costs per patient could be higher in rural areas than

in urban because many rural agencies have a very small scale of operation. The distances to travel upon rural clients could be great and there are differences that we've observed in the use of therapy between urban and rural providers.

At this point in time, our analysis of margins cannot determine the cause of the difference in Medicare margins between urban and rural agencies further than the factors that we believe to exist. This leaves us, on the one hand though variations among margins for some rural agencies and the observations of some of the members of our discharge planner panel may lead us to conclude that continued special payments for services provided to rural beneficiaries are appropriate.

On the other hand, evidence from our analysis of the payment-to-charge ratio, which has a larger sample than our margins and is somewhat more recent data, tends to contradict this conclusion.

Thus, the need for continuing the add-on for rural payment is not precisely clear. In current law the add-on will expire April 1st, 2003. The commissioners may consider taking no action, thus they would allow the add-on to sunset. Alternatively, commissioners may choose to phase

out additional payments and a possible phase out is one of the proposed recommendations that I've brought for our consideration this morning.

Draft recommendation one addresses the update. Congress should eliminate the update to payment rate for home health services for fiscal year 2004. Our analysis has included the impact of the 15 percent cut and the phase-out of the rural add-on. With these two factors included, we've analyzed claims data from the PPS system and cost report data to find the current relationship between payments and costs.

This analysis, again taken together with the GAO evidence, suggests that payments are more than adequate. Looking at anticipated cost changes, we believe that costs will be declining over the coming year and market factors are generally positive.

The budget implications of this recommendation, since current law provides a full marketbasket update for the base payment home health services, would decrease spending relative to current law in the category of between $200 million and $600 million for fiscal year 2004 and between $1 billion and $5 billion over five years.

Draft recommendation two addresses the rural add-on. This proposed recommendation states that Congress should extend for one year add-on payments for home health services provided to Medicare beneficiaries who live in rural areas at a lower rate, for example 5 percent. The current add-on is 10 percent and is scheduled to expire on April 1st. This recommendation, we would propose to extend the add-on one year from April 1st.

At 5 percent, which is the suggestion in the proposal, this would increase spending compared to current law in the category of between $50 million and $200 million for fiscal year 2004 and less than $1 billion over five years.

Finally, our draft recommendation three addresses the series of nationally representative samples of Medicare beneficiaries' post-hospital discharge access to home health services. This is in parallel to the recommendation that we made earlier for the SNF, the two series are parallel. The budget implication, we believe, would have no benefit spending impact.

That's the package of recommendations. At this time I invite your discussion.

DR. STOWERS: Sharon, it's a good chapter. I just had a couple of questions.

When you talk about the charge-to-payment ratio for rural being 1.16 or whatever, and therefore adequate, does that take into account the volume problem? I know once the nurse gets out to the rural site for that visit, the charge-to-payment ratio is appropriate. But would it account for the fact that because of distance they could only see two or three patients that day, as opposed to five or six or seven?

MS. CHENG: That payment-to-charge ratio does address the issue at the claims level. So we're looking at episode by episode how does the payment relate to the charge and presumably to the cost. It cannot address what could be a difference in productivity between an urban-based nurse and a rural-based nurse.

DR. STOWERS: And there's no reflection in costs for mileage driven or time, the productivity things.

MR. HACKBARTH: The assumption would be that the charge structure reflects that.

DR. REISCHAUER: That shouldn't be an issue.

MS. CHENG: The same assumption that we make for

the overall analysis would hold. We assume that each agency has set its charges above its costs. So if the rural agency had a higher cost, then it would have a higher charge, right.

DR. MILLER: Could I add just one thing to this, just before we get off it? In the margin analysis, you are taking account of the volume changes and the change in the product. That's why we're trying to present both pieces of information.

MS. CHENG: Right, we're sort of trying to triangulate there.

DR. STOWERS: That makes me feel a lot more comfortable about that.

My second thing is the use of the term total phase-out. I'm not so sure I'm uncomfortable with let's say going from 10 to 5 percent or whatever, but I think there's some permanent environmental things like distance and that kind of thing that may remain over a long term in the rural world that may not change in a year or two. So I'm not sure we're ready yet, as a commission, to say phase it out all together. I can see trying to find a more appropriate level for it. Just an editorial comment a little bit on that.

DR. REISCHAUER: I thought what we were hoping was that new data would come in and reveal whether these cost differences are real and are significant. And if they are, then we as a commission would make an appropriate recommendation that there be some kind of differential payment.

Sharon, am I right that on the material that you represent and in the chapter here, the 2003 estimate assumes that the rural add-on for the margins disappears completely? And so, if we were to maintain the 5 percent add-on for 2004 the margins for urban and rural would be more or less similar?

MS. CHENG: That's right. The estimate in 2003 phases it out entirely. So you're seeing, hopefully, an estimate of the full impact of no add-on. So you can look at that and get a sense of what 10 percent higher payments might be.

DR. REISCHAUER: Or 5 percent if we went with our recommendation and it would then wash it out.

MR. HACKBARTH: Let me just try to nail down this point about the rural recommendation. Could you put it up there, Sharon?

Actually, to my eye at least, this does not look like a recommendation of a phase-out, but more in line with what Ray was describing that we don't have the basis for eliminating it. And right now we're recommending a one year extension at a lower-level until we get additional information.

If you really meant to say phase-out, you would say we plan to phase this out over such and such a period and that means a reduction of this amount. So I think this language is actually consistent with Ray's objective.

DR. STOWERS: I'm okay with the language.

MS. RAPHAEL: First of all, I want to thank the staff because I think they've tried to be very responsive to some of the concerns we've raised last time, trying to see where we might have some information on quality and outcomes in a field of now very limited data. I think they've really fished every pool available here.

I have a couple of comments to make. I would urge caution in this area because I think that we still do have limited data and knowledge. And while we're talking about averages, I think the effects and the results do vary very understandably by location, by size, mix of patients. And

we don't really happen very, very good information about the variation.

We know that visits per episode continue to vary dramatically geographically from 13 on average in Washington to still Louisiana being number one with 58 visits per episode. We also know that the industry is comprised of public agencies, 13 percent are public agencies that often are very much influenced by what's happening in their counties. 38 percent are hospital-based agencies, and there are many caveats there but the margins there are very shaky. And certain 14 percent are not-for-profit and I know among some subset they really handle 50 percent of the dually eligible and a large part of whatever uninsured and charitable care is provided to the home care population.

And unlike the nursing home sector, the home health sector is more like hospitals. I think about 28 to 38 percent of their revenues derives from Medicare. In some cases, for some agencies, it's up to 70 percent of their Medicare. So what we do here can be very influential.

I see a number of warning signals that I just feel we need to pay attention to. The first is the drop in beneficiaries which has been just substantial, 1 million

beneficiaries dropping out. And even, as Sharon pointed out, in the last year I think there was under PPS another 300,000 beneficiaries dropped out. The decline continues, albeit it at a slower level.

I'd like to put this decline in some context. First of all, every other sector of Medicare that we're looking at as a commission shows increase in volume and use. I went through our entire report here and did a little chart for myself to look at what's happening with physician utilization, what's happening with nursing home utilization, to see what's happening with hospitals. And interestingly enough, hospital discharges are growing up in the range of 3 to 4 percent per year and home health care -- I mean, I think in the chapter on transfer payments we say about 30 percent of hospital cases go to post-acute and about 9.7 percent go to home health care.

So everything here should be leading us to have more beneficiaries because we know more are coming from nursing homes to home, more are being referred by physicians, and more coming from or should be coming from hospitals as their discharges go up.

In our chapter three, which I thought was a very

good chapter, we conclude in terms of demographics that the population over 85 has grown in the last decade by 47 percent and we say that seniors over 85 use a significant amount of home health and SNF services. And at a much faster rate we expect growth in those two areas than we do in fact in the future in physician and hospital services.

We talk about the minority population growing. African Americans over 65 have increased in the last decade by 18 percent. Over 85 African-American population has increased by 43 percent. We say, and I quote, "two services are of particular importance to the current minority population, emergency departments and home health use."

I won't go into all the issues on the prevalence of chronic illness and what has happened in that realm, what's happening in medical practice. Nonetheless, all of the demographic and health status indicators should lead to more beneficiaries using home health care. Put aside the payment system, I'm putting that aside for right now. So this is very, very puzzling.

The other comment I want to make here is I feel very powerfully that there isn't a world of pre-'97 and post-'97. People are the same, they have chronic illnesses

with acute exacerbations. And then it subsides. While we might have changed how we're interpreting the benefit, people generally have the same needs today that they had pre-'97.

So I don't think it's as if we have kind of really changed the population. I think there are people who have short-term kind of very intense needs, and there are people who have longer-term sort of more attenuated supportive needs today as existed in the pre-'97 population.

The thing that I just cannot understand is why there aren't more admissions because the whole prospective payment system should lead you to increase your admissions. That's the incentive that we have set up. We see that one of the incentives is working, which we had expected, that visits have decreased. But the other incentives are not working. Why don't we have more admissions? The LUPA incentive, as we had predicted, has not come to pass. We thought there would be very few LUPAs and a real impulse to move toward that episode. That hasn't happened.

Outliers, we had thought would be at 5 percent, they're at 3 percent. There aren't as many second episodes as we might have predicted. So something to me indicates

that something is happening here that needs attention and that we should be mindful of going forward.

In fact, and I recognize that growth patterns, like home health care has the most astonishing changes in patterns here. But if you look from '91, 6.5 percent of the beneficiaries use the fee-for-service home health care benefit. In 2001, 5.5 percent are using the home health care benefit. So just trying to take out all of the volatility, we have less people today using the home health benefit than did 10 years ago and I'm trying to understand why this is.

And then the other point that I did want to make and, of course, I find this hard to reconcile with a 17 percent growth rate which you said that CBO is going to modify. I do believe and I can't prove this, but I do believe there are some access issues. I do believe there are two things happening out in the marketplace.

As you said, Sharon, the operative thing here is not the number of agencies but you said we need a personnel index. And I do believe capacity here is people. And most agencies have a 15 percent nursing vacancy rate. And that means that they can't admit people because the whole OASIS

system is based upon, at the gate, a nurse being able to do an assessment. And that really is your day-to-day capacity.

So I think there is a lack of capacity to meet the need for services here and that's one of the things that's causing a shrinkage.

Secondly, I do believe there is more selectivity. We don't know the distribution of cases. We don't know the wound care cases, we don't really know how many are what I would call complex care cases. I do believe that patients who are incontinent, have cognitive impairments, don't have a caregiver, are more of a burden, are the ones who are being selected out of the system. I can't prove it, I don't have the empirical evidence, I'm putting together an amalgam from my own expense. I think that is what is going on.

And I don't think that augers well for the future because what I would like to try to think through with the other commissioners is what are we setting in motion here for the future? Because home health care organizations can't really substitute lower cost services for higher cost services, to a large extent. You can't use LPNs -- this is my experience -- I can't substitute LPNs for nurses. In fact, I need more skilled nurses today than I ever did

before, given the complexities that we're facing.

The mix of services is interesting, because you saw that the lower cost services, aide services, in fact have dropped and it's the higher cost services, the professional services, that are composing more of the mix. It is hard. I have been a great proponent of the prospective payment system. I really believed it was very important but it has been hard to achieve some of the productivity we had hoped for because visits are taking longer for a variety of reasons.

So where does this leave us in the future? My worry is as we take dollars out, and I recognize what you're showing on the margins and the GAO report compared to our Medicare margin report and all that you have constructed here shows that we are paying more for an episode of care than it is costing providers to deliver it. So I recognize that.

However, where are we going? Because if we drop what we pay, what will agencies do? I think they will begin to do two things. They will bring visits down even more and they will be even more selective in terms of the types of patients that they take. I'm just worried, are we setting

in motion here a spiral which will end up hurting access for some of the most needy and frail Medicare beneficiaries?

So that kind of leads me to think I'd like to just discuss this a little bit and think through some other recommendations that we might make here that could help at least to address what I consider the worrisome issues that are at least keeping me awake at night.

So thank you.

MR. HACKBARTH: Carol, could I ask a question?

You've raised some I think widely held concerns or at least questions about what's happening to the number of users and clearly we can't answer those questions definitively. But what I'd like to focus on for a second is what is the appropriate policy response in the face of the uncertainty.

The thing that I have problems with is that when you look at the average margins, look at the data that we get from the payment-to-charge ratios, look at the GAO analysis, it looks like there's money in the system. Maybe because this is a new system, it hasn't been refined enough to get to all of the right places exactly and I'm sure we do need some more work on that. That's always been part of

implementing a new PPS system. There's a period of refinement so that you get the dollars to the right places.

But to say that in the face of 20 percent average margins, which are true pretty much across the board, we're not seeing a lot of variation in that, that the appropriate policy response to the uncertainty about the reduction in users is still more money into the system.

Why will that work? Why will that help with the decline in users? There's plenty of money in the aggregate there. If we just put more money in, what's the guarantee that it's going to solve the missing users problem if, in fact, there is a problem?

MS. RAPHAEL: I have been struggling with this whole issue of figuring out is there a way to refine the system or target so that you get to where you want to go in this system. I think you are raising a very legitimate policy issue.

But I don't think that if you put more money in you guarantee that you're going -- that this group of beneficiaries who have dropped out are more likely to come back.

On the other hand, we had 5 percent drop to the

base in October. We don't know the impact of that 5 percent drop. You're taking 3.3 percent out now when labor costs are going up 5 to 6 percent. And for rurals, we could conceivably pull another 10 percent out. The cumulative effect in a two year period for some agencies could be over 18 percent. So the flip side of that is by doing that, do you then just continue what we are seeing now or just intensify it?

MR. HACKBARTH: Just to be clear though, the projected margins here include the so-called 15 percent cut, include the effect of eliminating the rural add-in. So that's baked into the cake. This is saying even after those the average margins are quite high.

And when you compare these margins to other Medicare providers, a lot of people would say they've put a lot of money into this system to ease the transition. The payments are very high relative to costs. What more can be done at this point other than work to refine the system, not just throw more money at it.

DR. REISCHAUER: But there's a fundamental question which is whether the nature of the service is so squishy that it's inappropriate to apply a PPS system of the

sort that we have for payments.

MR. HACKBARTH: That is an important issue in home health, more so than with regard to other services. But again it begs the question, would throwing more money into the pot solve the problem? I just don't see how that's an appropriate policy response.

DR. REISCHAUER: I think you're right on that, but Carol's response is will cutting back further not create more of a problem? At some point we'll get down to average number of visits is one over the lower limit and the people who are being sent out are the least skilled people we can find and Carol will come back and say that the numbers of people being served has shrunk by 85 percent and we don't know who they are, who have left the system.

DR. WAKEFIELD: It's not on Carol topic. It's actually onto draft recommendations two. Do you want me to go there, or is there more that anyone wants to say about Carol's comments?

DR. NEWHOUSE: I want to echo what was just said, both the point that what we've seen reflects the incentives of this systems and there are some puzzles about why we're not seeing more. But I agree with Carol that the incentives

are to keep cutting the volume and selecting. I also agree with Glenn that tinkering with the update doesn't fix this issue. We really need a different architecture here entirely, but that's not an issue for this meeting. That's an issue for next year.

The other suggestion I have, which is also really not a -- I think at this meeting it's too late. But I think it would be helpful at some point to look at the distribution of these margins by agency, at the agency level.

You, Glenn, said that you see these high margins across the board. That's true for the means by subgroups. I'm not sure it's so true by agency. It could be that we have some agencies that are really trying to make out like bandits and we have some agencies that are the traditional non-profit ethos of carrying out, doing as much as you can with what you're given. And that may show up in a distribution at the agency level that I haven't really seen.

But that all being said, what we're doing today is acting within the constraints of the architecture of the system and, given these margins, it's I would say even somewhat generous to conclude that there should be no

update.

DR. WAKEFIELD: I want to speak to supporting draft recommendation two. I think, Sharon, it would be before your time but there was a song in the '60s that starts out -- I can't remember the singer. The opening line is something like something's happening here, what it is ain't exactly -- thank you, Crosby Stills. He's dating himself. Something's happening here, what it is ain't exactly clear.

I think we're still not exactly clear about what might be going on, at least in some of the rural health agencies.

The data that you broke down, and I should have commented on the SNF data as well, giving at least for me information about subgroups like rural versus urban and other even finer detail is extremely helpful. I know that probably takes you guys a lot of time to do. But it makes me even more comfortable with this recommendation as opposed to a 10 percent continuation and so on.

So A, I just want to say thanks so much for doing those additional cuts and giving us more clarity.

Having said that, I'd say as you pointed out, we

do have discharge planners comments on this. We do have concerns around access in some rural areas. We do know that the types of services that rural beneficiaries get is not at the same level of therapy even though their severity of condition is the same as their urban counterparts. So there's enough going on with that population that it still makes me a little bit concerned. And until we get more clarity on that data, I would be in support of that recommendation.

MR. HACKBARTH: On this the particular recommendation, the inclusion of the e.g., the for example, seems sort of wishy-washy. If we want to recommend that they go to 5 percent, I think we ought to just say it and drop the e.g.

DR. MILLER: That was just for this meeting, to give you some place to start off from.

DR. REISCHAUER: After extensive statistical analysis, we've come up with 5 percent.

[Laughter.]

MR. SMITH: I want to come back to the colloquy that you and Carol had and ask Sharon to get back into it. Carol began by urging caution and I think that's right.

Perhaps I don't know whether it was Stills or Nash who wrote it -- I think it was Grant Nash who wrote the song.

It's not at all clear, and Sharon said early in the presentation, and it focused what I thought as I read the materials, that we don't know what accounts for decreased utilization but the PPS doesn't account for it. And Carol suggests that, as well.

If we are concerned, as several folks have expressed, about the decrease in utilization, this chapter doesn't say it. And I think we ought to say that. And we ought to point to a concern about the structure, the architecture, some of the questions that Joe raises, as a concern that requires some urgent analysis. We don't believe that we know enough to fix it by fixing the payment levels.

On the other hand, Carol strongly suggests that we might make it worse by reducing the payment levels. I don't know how I feel about that or what we might do in terms of a recommendation. It's awfully hard to argue that these margins don't meet an adequacy test, but there are a million people missing so something's inadequate.

It sounds like we think what's inadequate is the

structure of the benefit, and we ought say that. We ought not to have this chapter conclude that the payment system is adequate without raising in a very explicit way the concerns about the inadequacy that the evidence of decreased utilization points to.

MR. HACKBARTH: Sharon, could you remind us about the trends in the number of users? My recollection, and it's admittedly not as clear as I would like it be, that we've had an ongoing decline in the number of users over a period of time, only a part of which has happened post-PPS. There was a substantial decline, in fact, my recollection is most of it occurred pre-PPS and was concurrent with things like --

DR. NEWHOUSE: No.

MR. HACKBARTH: I would like to hear what the data are on that. There was some decline that was associated with Operation Restore Trust and all that. So could you just sketch that out for us, please?

MS. CHENG: At the high point of utilization, which was 1997, the number of users was about 3.5 million. And that had fallen to 2.5 million before the implementation of the PPS. There was a substantial decline during the

interim payment system in the number of users.

The decline has continued since the PPS but it hasn't been as steep as it was before the implementation of the PPS.

DR. REISCHAUER: But there were other things going on. There was a moratorium on new agencies and there was a crackdown on fraud and all of that occurred in the years before PPS.

DR. NEWHOUSE: Can I jump in? Because I wanted to make that comment on Carol's point about pre- and post-'97 people were the same, which I agreed with. But they also were presumably about the same in '93 and '97 and this utilization was going up like a rocket ship. And some of this decline we do think it's attributable to reduction in fraud, which makes it very hard I think to interpret these numbers.

DR. REISCHAUER: But I think the most interesting number actually was Carol's number that the smaller fraction of Medicare participants access home health now than in 1991 and that's a little hard to understand.

MR. DURENBERGER: There's a section on page seven under incentives. It's at the top of the page, the first

paragraph. The structure of the PPS should not represent a barrier to an increase in the number of home health users. It seems to me that somewhere right there a sentence or two could be added which would reflect this discussion so that it would come out as a warning signal about the value of the current structure.

DR. MILLER: Maybe I'll just interject for one second. As you can imagine, we've been discussing this quite extensively both within the staff and talking to people outside in the industry and in the agency itself.

Through those conversations this conversation occurred in so many words and also there were discussions between MedPAC and CMS. There's a lot of work going on at CMS right now on looking at refining the actual weights, looking at the outlier policy, and also looking at the first and second episode issue, which I think Carol referred to.

We have contemplated for purposes of this meeting bringing up the idea that maybe there was a stronger set of supporting language that could go in underneath the recommendation that says this is the recommendation. We recognize some of the variation on some of the issues here, put that, and urge that this work that is going on at CMS

come out as soon as it can so that some of these issues can begin to be addresses.

MS. BURKE: I was just going to say that in addition to the actual decline in numbers, which is obviously confusing all of us, I continue to be struck by all the other stuff we don't know. And throughout this very nicely done chapter there is a continual reference to there's a change in the demand, there's a change in the nature of the service, there's a change in the mix of the things that are being sought, there's a change in the length of stay.

It's a continuum of what we don't really truly appreciate and I think Carol points out, and I think we have a responsibility to say not only in the context of the recommendations but specifically in the context of the chapter, that work needs to be done only on the issue of why are there not more number of people, but also what fundamentally is changing in the nature of this benefit?

It is a function of technology, it's a whole host of things. But it is fundamentally a different benefit than we knew it to be and I think we don't yet fully appreciate, nor can we accommodate in whatever we ultimately do in the

design of the payment system, what that is.

And I think we also ought to comment on, as we go forward, additional information not only on the numbers but on who and what and why and how they're being served is going to be critical to us. Because it really isn't the same thing as it was in the '80s or the '90s. It's just different.

DR. NEWHOUSE: It may be helpful in the text also to say something about the nature to which this should be a purely post-acute benefit because that seems to me to be one thing that's happened. It's clear in the decline of the eight visit users, it seems to me policy has somewhat shifted there from trying to accommodate what was basically some portion of chronic long term care through the mid-'90s to then this system which tries to shift back to something that really is truly post-acute.

I don't know if one can explicit direction here but it seems to me trying to frame that issue in the text could be helpful.

MR. FEEZOR: On Joe's point, I think on page 13 there sort of a reference to it about it's changing from a maintenance of consistently ill and disabled over time to

that of acute illness recovery. And that raises the question, earlier this morning there was some question in terms of whether that was a deliberate policy change or not. And if so, we ought to make that very explicitly and underscore that in the text somehow.

DR. NELSON: Glenn, what I was going to say and didn't, Sheila started getting into it, but it has to do with the qualitative changes in the product, not just the quantitative changes. And that a company that's faced with the prospect of going out of business because of inadequate payments may very well change the qualitative aspects of the product in a way that isn't picked up in the quality assurance monitoring, by eliminating certain services that are labor intensive, by eliminating from their menu of services diabetes education, for example.

I think that recommendation three provides for monitoring of this. But I agree with Sheila that it's different now than it was 10 years ago and payment policy should not force it to become different in a way that's perverse, that's qualitatively perverse.

MR. HACKBARTH: As Joe correctly pointed out we're looking at average margins here and ideally we'll have in

the future more information about the distribution of margins. To the extent that there are a large number of agencies losing money, and the averages is at 20 percent, that implies that are a whole lot at the other end of the distribution that are offsetting those, which is both an interesting and troubling thought.

I keep coming back to yes, there's uncertainty; yes, undoubtedly refinement is required. But will putting more money into the system when we have such high average margins be an effective response in the short run? Or is it simply necessary to do the detailed work to improve this system over time?

To me that's what's different than when we had this conversation last year. Last year we recommended a marketbasket increase for home health agencies and we were quite explicit in saying that we make that recommendation because we do not have any evidence on costs and margins. And we don't have evidence about the rate of growth in costs relative to input prices.

We do have evidence today. Not perfect evidence but we have substantial evidence today of high, very high average margins. So I think we're in a different place than

we were a year ago.

My personal conclusion is that that supports the recommendation of no update, but that we ought to state with some force and urgency the need to get on with the refinement of the system.

As I see it, that's where we are.

In the interest of keeping on time or some semblance to on time, I think we need to get to the question of the recommendations. Carol, you have the last word.

MS. RAPHAEL: I'm going to support the rural continuation even though I've seen the margin information and one could argue that the differences are very minor between urban and rural area. But my own experience is that we do have rural counties where we have one or two organizations really embedded in that community, fragile for a whole variety of reasons.

And I think we need to really try to preserve those agencies to the extent that we can because they're not interchangeable parts. If they go over the cliff there's isn't going to be a company that's going to swiftly go into that are and try to pick up to that capacity. So I'm supporting that.

I would like a recommendation on moving toward refinement in line with what Mark was saying.

And thirdly, I have problems with the last recommendation which speaks to trying to restore the surveys of post-hospital discharge planners, because to me that's sort of George Orwellian old think. We're still defining this benefit only in terms of being attached to the hospital and discharge when we know that 50 percent of the people come in from the community, from physicians, from nursing homes.

When we looked at what's happening with physicians, we did surveys of positions. I think there should be some way to do surveys of agencies or surveys of consumers and their families. I'm not saying this is easy and I know there have been problems with previous attempts at this.

But I know when you speak to agencies they will tell you what they are doing, whether they are accepting all new Medicare beneficiaries, whether they're only accepting some. I think there should be some better way to get at this access issue.

MR. HACKBARTH: So on the third recommendation,

Carol, you would propose deleting the specific reference to post-hospital discharge and ask that it be reworded so that we need studies on access to home health service.

MS. RAPHAEL: Right.

MR. HACKBARTH: Do people agreement with that?

DR. REISCHAUER: I think we have to change the wording so it doesn't say continuous series.

MR. HACKBARTH: Right. Do people feel comfortable with that modification in number three?

How would you like to handle that, Sharon and Mark? Would you like to actually draft up language? That's probably the best thing for you to do, is draft it up and bring it back on number three, and we'll look at the exact language.

DR. MILLER: May I make just one suggestion? Can you put that recommendation up there, the one that we're discussing?

I realize what you're saying and we can always put text in this. Would it be sufficient for the purposes of the recommendation and just moving on to strike post-hospital discharge and say studies of beneficiary access to home service and then we'll put in supporting text that says

we would like the surveys to reach to other sites or other sources of information along those lines.

DR. NELSON: Yes, and include within that the kinds of services because anecdotally some organizations are substantially changing the menu of services they provide. They still have the number of visits but they aren't doing ventilation services, they aren't doing diabetes teaching. They're doing that in order to prevent losses and that needs to be examined, as well.

MR. HACKBARTH: Since we're on recommendation three, why don't we go ahead and vote on that? Do people feel comfortable voting with the description that Mark just gave?

So all in favor of recommendation three as modified by Mark?

Opposed?

Abstain?

Let's go back to recommendation number one. All those in favor of recommendation number one?

Opposed?

Abstain?

Okay, recommendation number two. This would be

modified to strike the e.g., so it's an explicit recommendation to do 5 percent.

DR. NEWHOUSE: Probably the whole thing needs to be somewhat reworded, not just strike the e.g.

MR. HACKBARTH: Okay, but substantively, the change is dropping for example and making an explicit recommendation of a 5 percent rural add-on.

DR. MILLER: We can just say at a lower rate of 5 percent.

MR. HACKBARTH: All in favor of number two as modified?

Opposed?

Abstain?

Okay, thank you, Sharon.

MR. HACKBARTH: We are well behind schedule, an hour, but I think it was important to spend the time on each of those areas.

Physician services, Kevin, I think we can afford to move through more quickly. We've been over this numerous times. So in view of the fact that we've covered this train pretty carefully and we're making a recommendation that's very consistent with where we've been in the past, I'm going

to ask you to move quickly through your presentation. I'd like to do this quickly.

My goal, and I may or may not achieve this, but my goal would be to get to the public comment period between 12:30 and 12:45. I apologize to people in the audience who will be delayed as a result, but that's what I'm going to try to accomplish. So, Kevin, would you lead the way?

DR. HAYES: Sure. We went over this issue, as you said, at the December meeting and the staff's perception was that there was general agreement about our findings on payment adequacy and general agreement with the recommendation. There were a few questions, though, about some related issues and I just wanted to spend a second or two on those, the first one having to do with participation agreements.

Your concern was that we might see a drop-off in physician participation in Medicare in 2003 given the scheduled 4.4 percent reduction in the fee schedule's conversion factor. Indeed, if there is a drop-off, that would be a distinct break from the trend. As you can see here, participation rates has been climbing steadily. This is a trend that's been going on since the late '80s. But

just in this most recent experience the participation rate has gone up from about 80 percent to close to 90 percent.

As to what we know about participation in 2003, it's really too early to tell. The rates for 2003 were not published until December 31st. Enrollment materials were sent out to physicians starting on January 2nd, so we're talking now about two weeks ago.

Given the level of concern about this issue however, I did call a few of the carriers and track down the enrollment coordinators with them and they confirmed that yes, indeed, it's just too early. In the case of Northern California, they had received enrollment materials from five physicians, I think. In Pennsylvania it was 11, similar experiences.

So all we can say at this point is that physicians have not flooded the carriers with enrollment materials indicating that they are no longer going to accept assignment. That didn't happen right away, which is kind of a nightmare scenario, but that's all we can say at this point.

I was going to say a few things about professional liability insurance premiums and how they've changed over

time in response to questions that came up at the last meeting, but I don't have anything to say here that was not in the paper that was sent out. So if you've got questions about this we can come back to it but I won't spend any time on it now.

And then we can just move on to the recommendation which is what we presented at the December meeting, which is that the Congress should update payment for physician services by the projected change in input prices, less an adjustment for productivity growth, currently estimated at 0.9 percent. The current estimate on the change in input prices is 3.4 percent for 2004, so the net update would be 2.5 percent.

This would be greater than current law. The current law update for physician services for 2004 is an update of minus 5.1 percent. So we are certainly talking about an increase in spending here. We estimate that that would be in the category of greater than $1.5 billion in that year, 2004. That's it.

MR. HACKBARTH: Comments?

DR. NELSON: Thank you, Kevin, for some of the additional material that was included in here, including the

further description about the participation process. And also a good discussion on the behavioral offset. I appreciate that.

Glenn, is it possible to -- are we restricted to one sentence recommendations? Because if we are not --

[Laughter.].

MR. HACKBARTH: If we are, we violated earlier this morning.

DR. NELSON: If we are not, I'd be much more comfortable -- if indeed our recommendation included an additional sentence which is on page one, it's the last sentence in the pull-out paragraph. It says if the Congress does not change current law higher update may be necessary in 2004 to offset the negative update in 2003.

Now I'm happy with it being in the pull-out but it's such an important consideration and played such an important role in our earlier discussion, that I'd be more comfortable if that caveat were included with the recommendation.

MS. BURKE: I don't disagree substantively with what you're saying, Alan, but I worry about putting it as part of a recommendation which is a specific action. And

this is sort of well, if you don't, X will occur.

I wonder if there isn't a way to make that statement a much more direct one and a forceful one in the context of the text rather than literally as part of the recommendation. I don't disagree with where you want to go, I'm just not sure I understand how it fits into a recommendation.

DR. NEWHOUSE: Additional recommendation.

MS. BURKE: Well, is it?

MR. HACKBARTH: If you don't do it now, then do it in 2004.

MS. BURKE: That's not what he said. What he said was -- what I understand Alan to be -- well, then that's different than what I heard. Then I misheard you.

If we were specifically saying this update is what we recommend, if you don't do this update then we're recommending X update next year. That's different from what I heard.

MS. DePARLE: I think that's what you meant to say.

DR. NELSON: I think that's what I meant to say, Joe, and I'm happy if it's a second recommendation. And it

may be that it's not necessarily but I think that it is, at present, in a very conspicuous part of the text. It's not that we're burying it. But a lot of times members of Congress just read the recommendation and they will read the recommendation as though that's just fine, and it's not just fine if there's a negative update this year. It's far from fine.

MS. BURKE: It's an interesting question in scoring. Just as a side note -- and Bob, maybe you'll have some sense of this. If we literally -- I mean, we are looking at what the implications would be. We know it will increase spending by such amount. Were we to say do it now, if you don't do it now, we're doing it double time next time. I assume they start tracking -- I mean, it's an odd convenience to sort of do two year's worth of recommendations in a year's recommendations.

MR. HACKBARTH: The reason that I prefer, Alan, doing it in the text is, number one, we made the 2003 recommendation once. This is a package of 2004 recommendations.

All indications are that Congress is grappling with the 2003 issue. I don't think we need to take out a

megaphone and yell at them about it. They understand that this is an issue that at least they need to deliberate on. How they will end up, I don't know.

So I would prefer to, consistent with every other chapter in this book, focus on the recommendation, but clearly at a prominent place establish the context for that. And it's in the context of our 2003 recommendation.

DR. NELSON: I bow to your wisdom.

MR. HACKBARTH: Thank you. Any other comments on this?

MR. DURENBERGER: I just want to compliment the analysts for introducing the subject of volume growth, which in my mind relates to the intensity and some of these kinds of issues, and the lead up to it in various subspecialties and in radiology and so forth, which strikes me as being a very important reality that we can't quite put our heads around. And very appropriately it says MedPAC is currently conducting research on this issue, which I think is a very, very important piece of work and I compliment them on doing it.

MR. HACKBARTH: As I recall, our objective is have some of that work for the June report; is that right?

Any other comments on this?

DR. WOLTER: Yes, just for clarification. Is the recommendation that we're looking now predicated on the possibility that last year's recommendation would possibly occur as Congress readdresses this? Because that could happen, there could be an elimination of the cut but a freeze at current rates. Or nothing could happen. And although the language here does generally talk about some compensating change, it's a little bit unclear to me what that might mean.

MR. HACKBARTH: I think you're touching on the same concern that Alan had. As you'll recall, last year -- actually, Nick, you wouldn't recall because you weren't on the commission last year. Our recommendation last year had two parts basically for physician services. One was repeal of the SGR system. And then the second was to replace it with an update based on a revised MEI minus a productivity factor.

To this point all indications are that Congress has not embraced repeal of SGR, but they are looking at options for modifying the result of the SGR system for fiscal year 2003, namely the 4.4 percent cut.

Again, how that turns out, I don't think there's anybody that knows at this point. Whether it's a 2.5 percent update or a freeze is really anybody's guess.

That is why we wanted to go on record in the text as saying we're recommending this in 2004 and we think at least a modest increase in fees would have been appropriate for 2003, and trying to remove that ambiguity. But for the reasons I just gave Alan my preference would be to have the bold-faced recommendation focused just on 2004 and have the other matter dealt with in the text.

I had one question about the language, Kevin. It says less an adjustment for productivity growth, currently estimated at 0.9 percent. For physician services and all other services, we're using the long-term trend in multifactor productivity in the economy in general. We're not trying to measure physician productivity. I think MedPAC, at one point, used to use the term -- it was like a policy adjustment factor or something like that, as opposed to an estimate of actual productivity.

Some people might construe the language here as we're trying to estimate the change in physician productivity. So what I would suggest is just say less an

adjustment for productivity growth of 0.9 percent to avoid that confusion.

Did that come through clearly and do people agree with that?

Okay, are we ready to vote on the revised recommendation then? All those in favor?

Opposed?

Abstain?

Thanks, Kevin. Next up is outpatient dialysis. Nancy, again, I'd appreciate your help in trying to move through this as quickly as possible.

MS. RAY: I'll do what I can.

This is the last in the series of three presentations that you've seen on assessing payment adequacy and updating payments for outpatient dialysis services. I'll focus on any new information, as well as any changes from my presentation last month.

Moving right along, staff used 2001 cost report data as the first step in estimating current costs for 2003. As we've done for the last several years, we consider separately billable drugs as well as composite rate services. However, for the first time this year our

analysis does account for the fact that the most current year that we have the data, 2001, that that data has not yet been audited. MedPAC's analysis of providers cost is based on Medicare allowable costs.

Our analysis of the most recent year for which cost report data are available, that's 1996, shows that allowable cost per treatment for composite rate services for freestanding facilities averaged about 95.7 percent of the reported treatment costs. Therefore, taking that into effect, the average payment-to-cost ratio across freestanding facilities, including separately billable drugs and composite rate services is 1.04. Considering just composite rate services, the payment-to-cost ratio is 0.97.

Then to estimate current payments and costs for 2003, how we did this is in your briefing materials and we went into this in greater depth last month. So our protection shows that for 2003, the payment-to-cost ratio would decline by no more than 3 percentage points lower than the 2001 level. Again, this assumes current law, provides for no change in the composite rate payment for 2002, 2003 or 2004.

We looked at market factors, and again those are

described at great length in your briefing materials, and they suggest payments are at least adequate. The information on the next three slides is what you've seen before, in terms of the growth and the capacity to furnish dialysis, in terms of the increasing number of freestanding dialysis facilities, as well as the increase in the number of for-profit facilities.

So we now go to our second step in MedPAC's framework where we project increases in providers' costs in the next payment year. Based on MedPAC's dialysis marketbasket index, we estimate that input prices will rise by 2.5 percent between 2003 and 2004. This number did change from what you saw last month, which was 2.7 percent because we got in the latest information from CMS in the interim. So MedPAC's dialysis marketbasket index projects input prices will rise 2.5 percent between 2003 and 2004.

MedPAC's framework does consider other factors that affect providers' cost in the next payment year. Staff conclude that most medical advances will be accounted for through the payments for separately billable drugs and for productivity improvements we again use the multifactor productivity standard that the other provider groups are

using which is 0.9 percent.

Therefore, staff have drafted this recommendation based on the conclusion that staff judge that payments are at least adequate, that the dialysis marketbasket as developed by MedPAC shows that costs will increase by 2.5 percent and the draft recommendation reads for calendar year 2004 the Congress should update the composite rate by the projected change in input prices less 0.9 percent. The budget implication for that, relative to current law, we estimate that for one year it will be in the category of $50 million to $200 million and in the category of $250 million to $1 billion over five years.

MR. HACKBARTH: Comments? This is unprecedented.

DR. REISCHAUER: Jack Rowe isn't here.

MR. HACKBARTH: We're ready to vote, I guess. All in favor of the recommendation?

Opposed?

Abstain?

Thanks, Nancy

The last item before lunch is ambulatory surgical facilities.

MR. WINTER: Good morning. First, I will present

a new draft recommendation related to the collection of ASC cost data. I will then briefly review our assessment of payment adequacy for ASC services, and our draft recommendation for updating ASC payment rates. Next, I'll discuss our analysis of the mix of patients who receive procedures in ASCs and hospital outpatient departments. Finally, I'll review our draft recommendation to limit ASC payment rates to hospital outpatient rates and discuss the impacts of this recommendation.

Current ASC payment rates are based on a 1986 survey of ASC costs and charges. The secretary is required to conduct a new survey of ASC costs and charges every five years. In 1998, CMS proposed restructuring the ASC payment system based on data from the 1994 cost survey. This proposal would have reduced payment rates for high volume procedures, such as cataract-related surgeries and colonoscopies. However, the Congress required CMS to delay the new payment system and to base new rates on cost survey data from 1999 or later.

To our knowledge, CMS has not conducted a new survey since 1994. Thus, we propose recommending that the secretary expedite the collection of ASC charge and cost

data for the purpose of analyzing and revising the ASC payment system. Once it is collected, recent cost data also would be used for our assessment of the adequacy of ASC payments. This recommendation would have no impact on spending on Medicare benefits.

Because we lack recent data on ASC costs, we look at market factors in judging payment adequacy. Here is a quick review of those factors which we discussed in more detail last month. In the interest of time, I won't go through them in more detail but you can ask me about them if you have questions.

Briefly, though, we looked at rapid growth in the number of ASCs. We also observed rapid growth in the volume of procedures they provide to Medicare beneficiaries. We also note that there is strong access to capital for ASC facilities. These market factors lead staff to conclude that current Medicare payments to ASCs are more than adequate.

We also considered expected increases in ASC's costs in the coming year, and concluded that current payments are at least adequate to cover this increase in costs.

Thus, we propose recommending that the Congress eliminate the update to payment rates for ASC services for fiscal year 2004. Under current law, payments would be updated by the increase in the CPIU, which is currently projected to be 2.7 percent for 2004. We estimate that this recommendation would reduce spending in the category of less than $50 million in fiscal year 2004 and in the category of less than $250 million between fiscal years 2004 and 2008.

At the last few meetings, we've also discussed the issue of ASC payment rates that exceed outpatient hospital rates for the same procedure. This table compares rates in each setting for the five procedures with the highest share of Medicare payments to ASCs. We've been through this before so I'm not going to go through this in more detail right now.

The commission has expressed concern that payment variations by setting that are unrelated to cost differences could create financial incentives to shift services from one setting to another. We lack evidence that ASC costs are higher than outpatient department costs, which would justify higher ASC rates.

One factor that would affect costs in each setting

is regulatory requirements and outpatient departments face more requirements than ASC. For example, hospitals are subject to the Emergency Medical Treatment and Labor Act, which requires outpatient departments to stabilize and transfer patients who believe they are experiencing a medical emergency, regardless of their ability to pay. This law does not apply to ASCs.

We have also hypothesized that, compared to ASCs, outpatient departments serve beneficiaries who are more medically complex and thus likely more costly to treat. To test this hypothesis, we used Medicare claims data to compare the characteristics of beneficiaries who use ASC services versus those who use outpatient department services. First, we compared the average risk scores of fee-for-service beneficiaries who received surgical services in each setting. The risk scores were derived from the hierarchical condition category risk adjustment model. They predict beneficiaries' expected service use in 1999 given their health status relative to that of the average beneficiary. Expected use is based on the beneficiary's age, sex, and diagnoses from inpatient, outpatient and physician visits during 1998.

This table compares average risk scores for beneficiaries who received similar types of procedures in an ASC or outpatient department. The five procedure categories shown here represent the highest volume ASC categories. Each category consists of several related procedures, whereas the procedures listed on slide five, two slides earlier, are at the individual level. It is important to control for procedure type because the mix of surgical procedures differs between ASCs and outpatient departments and higher risk patients are associated with certain procedures.

Keeping in mind that the average beneficiary in Medicare has a risk score of one, you'll notice that beneficiaries in both settings had higher risk scores than the average Medicare beneficiary, and were thus more medically complex. Across these categories, risk scores were uniformly higher for beneficiaries who received care in outpatient departments than those who were treated in ASCs. The percent difference between outpatient and ASC risk scores ranges from 3 percent for patients who received cataract removal to 10 percent for patients who had upper GI endoscopy. This indicates that outpatient department

patients were more medically complex than patients in ASCs, which probably means they were more costly to treat.

Since these numbers were calculated, we have been reviewing our methodology and have revised it to better account for part-year Medicare enrollees. We do not yet have results for the new methods. However, we believe that the new method will affect the results in two ways. It will move the risk scores closer together for the first four procedure categories shown here which account for 71 percent of ASC volume, but the outpatient scores will still be higher and the difference will still be statistically significant.

For the last category, which accounts for 13 percent of volume, and that's ambulatory procedures other, the risk scores should move closer together but may no longer be different in a statistically significant way.

Next, we compared total Medicare payments for all services in 1999, for fee-for-service beneficiaries who receive procedures in an ASC or outpatient department. Total payments represent spending on all the services used by the beneficiary, including ambulatory care, inpatient care, and post-acute care. Total spending could reflect

beneficiaries' health status. We'd expect utilization to increase as health status declines. However, other factors could also affect total payments, such as supplemental coverage and local practice patterns. Thus, these are a less direct measure of health status than the risk scores.

This table compares total payments, average total payments for beneficiaries in ASCs and outpatient departments who receive similar types of procedures. And just to walk you through this a little bit, the top row, cataract removal, the number there represents total spending by Medicare on patients who received that procedure in an ASC versus an outpatient department.

Across these categories, beneficiaries who received care in outpatient departments had higher average total spending than beneficiaries who received care in ASCs. The percent difference between outpatient and ASC total spending ranged from 13 percent for colonoscopy to 30 percent for ambulatory procedures, other. The methodology used to calculate these numbers already fully accounts for part-year Medicare enrollees and thus will not be revised.

In summary, patients and outpatient departments had both higher risk scores and higher total spending on

average than patients in ASC's who received similar procedures. This indicates that outpatient departments serve patients who are more medically complex.

DR. MILLER: Ariel, can I just ask you one thing? I'm sorry to interrupt.

The last table, where you had the total expenditures there, that includes everything that goes to that patient. So it would include things like separate billings for radiological procedures or prosthetics or that kind of thing; is that correct?

MR. WINTER: That's right, as well as any other services they received besides ASC or outpatient services.

MR. HACKBARTH: This is their total utilization, on average, for the year.

MR. WINTER: That's correct.

MR. HACKBARTH: So it's another way of getting at the relative risk of the ASC versus outpatient department patients.

DR. NELSON: Does it include the copayment, as well? Does it include the patient contributions?

MR. WINTER: I believe it just includes the Medicare portion of the patient.

DR. REISCHAUER: Not to complicate this any further or make this into a real research job, but the geographic distribution of ASCs was very skewed. Is this at national prices? Or is this at --

MR. WINTER: This is at nationally standardized prices, yes. That's a good point.

This is the same recommendation you saw last month with a slight revision. We've added the clause in the beginning that until the secretary implements a revised ASC payment system -- and the rest of it is the same as what you saw last time -- Congress should ensure that payment rates for ASC procedures do not exceed hospital outpatient PPS rates for those procedures.

The reason we added this is because we believe that once the ASC payment system is revised, based on updated cost data, the disparities between ASC and outpatient hospital rates should be minimized.

We estimate that this recommendation would reduce spending in the category of between $50 million and $200 million in fiscal year 2000 and in the category of between $250 million to $1 billion between 2004 and 2008.

There are several concerns that have been raised

about this recommendation, which I'll try to briefly address. The first is that outpatient departments receive additional payments, such as outlier and pass-through payments, that ASCs do not.

We would like to look into the issue of what types of procedures receive outlier payments, which represent about 2 percent of the total payments.

On the question of pass-through payments, most pass-through items have been incorporated into the base rates for 2003 so we believe this will be less of an issue going forward.

A second concern is that outpatient departments may be billing separately for radiology services that are provided ancillary to surgical procedures which ASCs cannot do. This is another issue we're looking into. We would note that we have learned that ASCs can bill separately for prosthetic devices which outpatient departments cannot do, they cannot bill for them separately. They're currently bundled into the outpatient rate. So some of the unbundling also occurs on the ASC side.

A third concern is that outpatient rates may not cover costs as the procedural level and thus it would be

inappropriate to apply them to ASC services. We believe that the 2003 outpatient PPS rates are the most accurate that can be calculated using current data. This year is the first time that the rates are based on the costs of hospitals operating under the outpatient PPS. In addition, they are more accurate than previous rates because most of the pass-through items have been folded into the base rates. If there are anomalies where outpatient rates do not cover costs, the secretary could deal with this during the rulemaking process that would follow a legislative change. For example, in anomalous situations he could decide to phase in payment reductions over time.

A fourth concern is that outpatient rates have been fluctuating from year to year. We expect that with incorporation of most pass-through items into the base rates, the rates should stabilize.

We estimated the impact of this recommendation using a model based on 2003 ASC and outpatient payment rates and 2001 volume of ASC services. Based on this model, we estimate that this recommendation would lower payment rates for half of the volume of ASC procedures accounting for 35 percent of Medicare payments. For these affected procedures

the average payment reduction would be 20 percent. Overall, ASC payments would be reduced by about 7 percent and beneficiary coinsurance would also be reduced on average by about 7 percent.

This table shows the impact of the recommendation by procedure category for the categories with the highest share of Medicare payments to ASCs in 2001. Cataract removal, which accounts for half of the payments to ASCs, would be unaffected because ASC rates are currently lower than outpatient rates for these procedures.

The impact individual ASCs would vary by the services they offer and the share of their revenues accounted for by Medicare. About half of ASCs offer ophthalmology services and 40 percent offer gastroenterology services. About half of ASCs are single specialty and the other half offer multiple specialties.

The largest ASC chains report that Medicare accounts for 20 to 30 percent of their revenue. We don't have Medicare revenue data by specialty type across the entire industry but a large ASC firm has reported that Medicare accounts for 60 percent of its revenue for after cataract laser surgery, which is in the other eye procedures

category on the table, and 30 percent of its revenues for colonoscopy and upper GI endoscopy, which also shown on the table there.

This concludes my presentation and I welcome your comments, questions, and look forward to your discussion.

MR. HACKBARTH: Could I just explore recommendation three for just a second to make sure I understand the intent?

Sometimes we make recommendations that are basically formulaic, take this marketbasket index and subtract that number and you get a very specific result. Here, on draft recommendation three, the tone seems to me to be a little bit different. By that I mean we're not necessary suggesting to the secretary take this number from the hospital outpatient schedule, compare it to this number from the ASC, and go to this. We're recognizing that some adjustment, some degree of judgment, may be necessary to get a true apples-to-apples comparison.

So this is really a statement of policy direction that the commission is concerned about having different payment levels for the same service in different settings for fear that that will inappropriately influence the

clinical decision-making process, as opposed to this is the right formula to do it.

MR. WINTER: That's correct. That's our intention here.

MS. DePARLE: That's not how I read it, Glenn.

DR. NEWHOUSE: That's not how I read it. This is a formula, pay the lesser of the two rates.

MR. WINTER: I think what we're --

DR. REISCHAUER: To ASCs, not to outpatients.

MS. DePARLE: ASC rates shall not exceed hospital outpatient rates. That's how I read it.

DR. MILLER: I think to describe where we are in the conversation, both from last month to this month and here, is our policy statement was that ASC payment rates should not exceed outpatient. And I think that is where we generally are.

There have been concerns expressed throughout our conversations about ourselves and from the outside world. And I think what we're trying to reach for here is that in implementing something like this, the secretary -- there can either be a flat statement in the law that says you will pay no more, or you could construct the law in a way -- and I

realize this is a little bit more difficult and I'm not sure I have the words to say, this is what the payment rate should be, but the secretary should exercise some discretion in reaching that.

So for example, if the Secretary found for a given procedure some evidence that cost was unaccounted for because the bundles are not completely defined, the secretary might take that into account or take the policy in steps. I think that's what we're trying to say here. Is that about right?

MR. WINTER: Yes, that's right.

MS. BURKE: That's not what that says. Only to the extent that if it is your -- I mean, there are a variety of ways you could do this. One would be to say that on average, they shall not -- I mean, there are a number of things you could do in constructing what the rate looks like.

But if you're intention is to literally leave it discretionary to the secretary to determine where it is and is not an absolute, that is it shall be no higher. You're suggesting that there be circumstances where it would be higher. Then this doesn't achieve that end, I don't

believe.

MR. HACKBARTH: Let's try to agree on the intent first and then we can deal with the language, and maybe that will require coming back with some revised language.

The new issue for me, this discussion as opposed to last time, is that the bundles are not exactly the same. And my intent would not be to say well, you've got to treat them as though they're the same and just do a simple comparison of this number and that number.

The point that I think is important is that we strive to make an apples-to-apples comparison which will require some judgment on the part of the secretary. But once we have that apples-to-apples comparison the policy principle ought to be they we not pay more for the service rendered in an ASC than we would in the hospital outpatient department.

So that's what personally I would strive for. Do people agree with that or disagree?

MR. SMITH: Glenn, I think I agree with that although it would follow from that that it ought to work in reverse. If we get the bundles precisely calibrated so that we're doing apples-to-apples, then that we should pay

whichever rate is lower in whatever setting it's delivered.

[Simultaneous discussion.]

DR. REISCHAUER: One aspect is the bundles. The other is the acuity or the severity of the outpatient. A third is the regulatory burden and other costs that we impose on one. And we have pretty good evidence that all of those go to the disadvantage of the outpatient hospital.

DR. NEWHOUSE: The other is which bundle do you standardize to? Do you standardize to the old outpatient bundle, or to the old ASC bundle.

MS. BURKE: Isn't this essentially what he's supposed to be doing? My concern is not where you want to go but this is where we ought to be getting, and they haven't gotten there yet. So it's not clear to me how this would get you where you want to get before you get there.

[Laughter.]

DR. REISCHAUER: The question is does it move us in the right direction?

MS. BURKE: I'm sure that's what I meant. I'm sure of it.

[Laughter.]

MS. BURKE: My concern is that with that kind of

specificity, that is what is supposed to occur in the context of building a payment system which they have not done. So are we again putting forward a proposal which from a policy perspective makes absolute sense, practically is the job that's supposed to have been done. And this suggests that in the absence of a revision of a system, do this.

My concern is this is what they ought to be doing to get to the system. So it's not clear to me how this happens before the work that has to be done in order to get to were ultimately we need to be. That would be my practical concern.

MR. HACKBARTH: I think there are two parts to what we're recommending here. The first recommendation is that we think this system needs to be revamped and we need to get on with it, and I think we have said or should say that the amount we pay for the same service in these two different settings needs to be synchronized in a way that it currently, as we speak, is not.

So recommendation one is we need to get on with the task of an overall rehaul and synchronization of the payment system.

Then stepped two is what do we do in the interim? What we're suggesting is that the secretary, as quickly as possible, move to assure that we're not paying more for a comparable bundle of services in the hospital outpatient department than we would in the ASC.

DR. NEWHOUSE: I suggest that we add to the end of this, after accounting for the differences in the bundle of services covered. I think that fixes what I heard was the problem.

MS. DePARLE: I just think, if I can go back to we've discussed this extensively at the last two meetings and the staff have spent a lot of time talking to me about it, which I appreciate, and they've tried to be responsible. But I think your point, Joe, and what we're discussing right now gets to the place where they can't be responsive, which is that we don't have the data.

Unlike other areas we've been looking at Medicare costs and Medicare margins and we don't have that here. And that's going to be hard work and the agency does need to get going on it, starting with collecting the data. But to say that they can just go immediately to this and start changing bundles around, that doesn't work.

And so that's been my concern about this whole thing, is that, as opposed other areas, we just don't have the data. As I said, I think the staff have done a tremendous job of trying to collect proxies for things about adequacy, but we don't have it.

MR. HACKBARTH: The difference, Nancy, I think may be in one case we're talking about cost data which is a difficult process, requires time.

What we're suggesting here is they not look at cost data but payment data, which is easier to collect. It doesn't require industry surveys. They simply need to look at what Medicare is paying, what they are paying. And as an interim step strive to not pay more for the same service in an ASC.

MS. DePARLE: But that presumes that you've made a judgment about cost being adequate.

MR. HACKBARTH: Just to be clear, I am not presuming anything about costs. I'm saying that we ought not pay more for the same service delivered in ASCs as opposed to hospital outpatient departments, especially in view of the evidence that we have about the complexity of the patients served.

DR. NEWHOUSE: In other words, is what you're proposing that we would just the numbers we saw on the screen by a payment rate for radiological services and prosthetic devices until we've made those numbers cover the same bundle and then we would compare?

MR. HACKBARTH: Right.

DR. NEWHOUSE: That seems, to me, fine.

DR. REISCHAUER: I can't imagine why the data isn't available for that.

DR. NEWHOUSE: We'd have to use it for one system or the other, where we have a separate payment rate for that service, and add it to the bundle where it doesn't exist.

MS. DePARLE: I don't know, and I don't think any of us knows -- Mark, you may know -- how difficult it will be to unbundle and rebundle and make those comparisons about what's in the payment rates.

But I guess I don't quite follow, Glenn, what you're saying because I still think it does -- implicit in this discussion is some decision about a policy choice about adequacy of payments. I agree and have always agreed that we should not, through our payment methodology, favor one site of service over another for the same service unless

there is some independent policy choice being made based on safety, efficacy, some other thing. But I just think we're fooling ourselves if we think this is going to get there.

DR. NELSON: This all presupposes that they are the same service. You might do an operation, the same operation, at two different sites and they may be totally different services. And we're trying to graft one payment system on another, and we're doing it arbitrarily by lopping the top of the other one.

It seems to made that we have always said that we should pay the legitimate costs of an efficient provider. For this service, we then need the data before we can do that. And we have all of these other confounding variables that we're ignoring to make an arbitrary decision to remove a portion of payments if they're high, but not bring up any if they're low.

My point on this is that it seems to me that beneficiaries benefit from having a choice. They benefit by having a lower copay in many instances if they go into an ambulatory surgical center. That they are not exactly the same services. And until we have data, I'm reluctant to make a recommendation that just sort of well, we'll peel off

the top if they're paying higher. They're different services in many cases.

DR. REISCHAUER: But there's a perception...

MR. MULLER: I thought Ariel's presentation was quite convincing, in terms of both the complexity of care, in terms of the patients being more complex. He had at least two measures of that. And secondly, the regulatory burden, whether it's MTAL or other things one wants to cite.

So the argument, as I understand it, is that both the complexity is greater -- maybe not on every last received, but the complexity is greater on average in the outpatient setting. And the regulatory burden is greater in the outpatient setting. So there wouldn't be much reason for there to be a higher payment in the ASC setting. And that's why, I think, the recommendation as written is well stated.

I think for the reasons that Nancy and Joe and others discussed once we start getting into exactly what kind of bundled services, I think that takes a more complex calculation to do. So I'm not as convinced of adding on the bundling language because I'm not sure we know what we're bundling vis-a-vis each other.

But certainly on the procedures, we have no reason to think that the ASC costs should be higher, and therefore are worthy of a higher payment.

DR. NELSON: We don't know.

MR. MULLER: We do know that the complexity is greater based on the information that Ariel presented. And we do know the regulatory burden is greater. That we do know.

MR. HACKBARTH: Any other comments on this? Why don't we go ahead and vote then. Recommendation one, do you want to put that up, Ariel?

All in favor of recommendation one?

Opposed?

Abstain?

Recommendation two. All in favor?

Opposed?

Abstain?

And recommendation number three, All in favor?

DR. REISCHAUER: With the modification?

MR. HACKBARTH: Good question. Actually, maybe the thing to do is ask, Ariel, for you to come back with a revision of the language so that we don't muddle around with

it right now. Can you do that?

MR. WINTER: [Nodding affirmatively.]

MR. HACKBARTH: Do you have any questions about the intent?

MR. WINTER: I was going to use Joe's suggestion.

MS. RAPHAEL: Could you just read it for us?

MR. WINTER: Sure. It would read, under Joe's modification, until the secretary implements a revised ASC payment system, the Congress should ensure that payment rates for ASC procedures do not exceed hospital outpatient PPS rates for those procedures after accounting for differences in the bundle of services covered.

MR. HACKBARTH: Are people prepared to vote right now on that? All in favor?

Opposed?

Abstain?

Okay, thanks, Ariel.

That completes the morning presentations. We will have a 10-minute public comment period.

As usual, I'd ask people to keep their comments as brief as possible. And if one of the people in front of you in line has made your point, please just say I agree with

that and you don't need to make it again. That will allow us to get as many people in front of the microphone as possible. Thank you.

MR. WARDWELL: Thank you. I'm Bob Wardwell and I'd like to speak to you for just a minute or two about the home health recommendations from the perspective of the community non-profit home health agencies.

I think at the outset before I really start, if you want a clue as to where to look for these missing people, and why they aren't in home health, a good place to look is the nursing shortage. We have a 21 percent turnover rate in nurses right now in VNAs. There's a bidding war and the fuel for home health is nurses. Often under the PPS system, you don't know you have revenue in time to bid for them.

I think that this margin discussion is somewhat illuminating. I know the staff and you have to work with the best data available. I had to work with the best data available for a long time as a regulator. Sometimes the best data available isn't really good data. I hope this is good data that you made your judgments on. I think there are some flaws in it and I think there are some

incompletenesses in it.

Getting to the margins themselves, even if it's true we'll say for the sake of argument that margins by some standards are relatively high, we really didn't hear the data today to penetrate below that level to illustrate what that impact is on those agencies that are at the other end of that continuum of margins. I think a lot of them are VNAs, I've heard from a lot of them. And to them it has catastrophic consequences.

I think the primary issue here in the PPS system is a distributional issue and it has to be cured through a distributional fix, not through an across the board activity that hurts the best along with the worst.

I just wanted to go through 10 quick facts I came up with, one sentence apiece to keep it short. Those VNAs that I know of that I have spoken to that have made positive margins haven't pocketed the money. They've turned it right around, as soon as they knew they had it, into services to reach out to those most at risk, to try to hire the nurses so that they can take patients that are more complex.

Looking at last year's financial statements from VNAs, the average VNA barely broke even. They only got into

the black through charitable contributions.

Talking since the last meeting to VNAs, I said what about your charges? Haven't they kept pace with cost? They basically said, in large part, since charges are now moot, we're largely Medicare/Medicaid, we've been negligent in really keeping our charges up with cost, which makes the charge analysis somewhat useless.

The only cost report you can possibly have right now -- I didn't hear from what year it was, but it has to be the first year. Those are the only ones that have been submitted. That's an extremely atypical year. Those of us that experienced it know how atypical that year has been. I also know that there can't be any cost reports in it from the entire New England region. They haven't been submitted in time. That's where the majority of VNAs provide home health care.

Because of all the retrospective adjustments in the PPS system there are a lot of agencies who really don't even know for sure what any year's revenues are in order to book them.

I'd have to say that at least anecdotally from our VNAs, access problems do exist. They don't exist

everywhere, but they certainly exist in places are the provider of last resort. They see patients coming to them that aren't profitable.

We've already shown what happens to these high cost patients under the current outlier of system. We've presented that data to MedPAC staff. You take a loss on every outlier. How many of those losses can you afford to take?

I think the access are masked by this kind of inadequate system we have of measuring access in home health. Discharge planners have a very disproportionate narrow view of what access is.

Frankly, the distributional shortcomings of the PPS system were known right from the outset. They were supposed to be fixed as quickly as they could be fixed. They haven't been fixed yet. I think that's the real solution, not an across the board cut.

Distributional shortcomings don't get solved with an across the board cut. What it does do is it perpetuates the problem and it discourages access to care, which is what I think we've talked a lot about today.

In conclusion, I think the stakes here are very

high. When I was a regulator, even though I'm not a physician, I took the position that above all, do no harm. At least once I was a mature regulator.

I think at best there was a lot of conjecture about what this cut in home health means. I would urge anybody to think, above all, do no harm.

MR. PYLES: I'm Jim Pyles on behalf of the American Association for Home Care. I won't repeat some of the things that Bob said, which I do agree with.

One of the things I think is a pity is that you did not recall the rest of the song that you were talking about in the home health debate because when it ain't exactly clear what's going on here, you got to beware. And it's a shame that you didn't do that.

I would also urge in the future that the public comment period perhaps come before the vote so that you can arm yourself with the relevant facts.

These are the facts. Under the interim payment system, we lost one million Medicare home health beneficiaries from the home health benefit. Under PPS we've lost 300,000 so far, that we know about. It is likely to be continuing.

Now why is that? The answer is in your discussion, and Commissioner Newhouse I think put his finger on it, and the staff has acknowledged it. You converted the benefit. By changing the reimbursement you converted the benefit to a short-term acute care benefit.

Everyone mentions that and thinks that's just fine. The statutory coverage criteria have not changed materially since 1980. That means that under your own analysis we have eliminated access to many of the patients who have a lawful right to receive the benefit. We're not covering it, we're not paying for it.

That means that your payment policy is inconsistent with your coverage policy. That then leads, of course, to a lot of stress for home health agencies and patients and physicians who don't know what's covered or what will be paid for.

I would think that is a fundamental error, a fundamental problem, that this commission should address.

We know that if it has been converted to a short-term acute care benefit, as I agree it has, then the one million we eliminated and the 300,000 we eliminated were the sickest, most chronically ill. These were not the marginal

patients. These were the patients who really needed the benefit.

And we know that happened when you had across the board cuts under IPS, under PPS, the 15 percent cut. We know that's what across the board cuts generates, is it always hits the higher cost patients first because it's undifferentiated. And yet we recommend further across the board cuts.

I would suggest that may not be a wise direction to move in.

Total payments for home health are down to 1993 levels by the chart staff gave you. Payments per patient and down, I think as Commissioner Raphael said. This is not occurring in any other benefit.

At the same time health care costs are increasing. Could there be a connection here? Interesting possibility.

Will more money make a difference? Well, instability is what is causing the problem right now. More money probably will make a difference if agencies can understand that they can rely on it. A 20 percent profit margin, if it's accurate and I would wonder if it is, but if there is a profit margin out there, instability breeds

caution. And you can't turn on a dime. You're not going to go out and hire staff unless you understand you can rely on those payments.

And a 52 percent cut under IPS, another 15 percent cut under PPS, another 10 percent cut or 5 percent under the rural add-on, another cut under the marketbasket update, we're undermining the stability that PPS should bring to the home health benefit. You will never have the data to make the adjustments you need to make reliably as long as we keep making across the board cuts.

I think as Commissioner Raphael indicated, we are in a downward spiral with home health. Elimination of higher cost patients is caused by across the board cuts. It always discriminates against the higher cost patients who present the highest financial risk. And that results in more across the board cuts. Eliminate those patient, you just cut more.

So we are on a downward spiral and I would just urge you to break out of that and let this benefit stabilize so that you can get accurate data to do your jobs.

Thank you.

MR. LANE: Larry Lane, Genesis Health Ventures,

also speaking for American Health Care Association.

Four quick points. I want to pick up on Sheila's point on what we don't know is important. That applies to SNFs. Over the last seven years there has been a 68 percent increase in utilization, a 76 percent change in individuals discharged to the home without any further care, 191 percent change in discharge to home care. There's a lot happening here that nobody seems to be curious about and we need to look at it.

The second point actually goes to Carol Raphael's comment on the metric that she used. That is an extremely important metric and it probably applies to all the post-acute services. We're all of a sudden seeing a change in the demographics, we're seeing a change in service patterns, we're seeing changes in payment, and yet we are seeing fewer beneficiaries who need this service as a percentage of total beneficiary claims. Why?

That's inquisitive issue. Several years ago, I guess almost a decade ago, ProPAC did a very good report on post-acute services. Just data, just facts, not conclusions, not recommendations, but data so that we could actually begin to look at that. I would urge the commission

to dust off that report, come up with some new numbers, and work with us. Let's look at what is happening.

Third, heartfelt thanks for Dave Durenberger for raising the update concern. The total margins issue in the SNF sector is very important. You can't just look at the silo that is Medicare and the data that is 10 percent or such. That seems like an old number. Actually, it accounts for 26 or 27 percent of revenues and it's nearer to 14 or 15 percent. But more than that, for a company like my own, nine out of 10 of our admissions are post-hospital Medicare admissions. The total destabilization of the skilled nursing sector is being caused by Medicare policy and you can't just walk away from that impact. We're living with a wimp W. You don't know what your business number is going to be so you can't clinically plan for your coming year.

Fourth, just a point, there's a consequence of rising costs, underfunded Medicaid, rising acuity and less resources. We plan on continuing to work with the commissioners. We have sent some materials recently. We will be sending out a report, two reports, that the Lewin Group are finishing, one on early warning. What's happening with that 10 percent cut that we just took? And I think

it's an excellent statement of what at least we're observing and we're going to try to quantify that during the year so we can actually see what the payment impact is.

The second is we will have a report out within the next week or two on the predictability of the RUG system relative to the home care, relative to the hospital, relative to the long-stay hospital, relative to the rehab hospital, and what you're going to find is the RUG system has no predictability of any significant measurable part. So that we're, in fact, playing with the allocation of dollars on a system that does not reflect the care and services.

Thank you for your time and I'll continue to be coming to your meetings.

MR. FENEGER: Randy Feneger for the Federated Ambulatory Surgery Association. Let me echo the comment, first, that was made that perhaps it would be helpful to your deliberations to hear some public reaction to the staff presentations prior to the time you have to vote. We would urge you to consider that as a procedural option for the future.

Let me touch on the recommendations that you

considered. Recommendation number one is essential and we congratulate you on supporting that. We wish you would stop there. The recommendation underlies what has been discussed now at three meetings. There is no data on the cost of providing these services in this setting. Had the Medicare program done the job of collecting the information that it is statutorily required to do, probably none of us would be here today having this discussion. We believe that it is critical that this data be collected, that the apples get compared to applies across the various settings where these services are provided, that then policy judgments and debates can that place at the time.

For many of these procedures there are three ways of calculating the costs. One is the way you calculate them for the ASC. One is the way you calculate the cost for the APCs in the outpatient department. Some of these procedures are also paid for in the physician office. We have yet a third way of calculating those costs. All three are different. All three start with different data sets. It should come as no surprise that we have different answers using those three systems.

Recommendation two, that there should be no update. In the absence of data on these costs, we have decided to use the proxy of access to Wall Street. What I think has not been proven, based on a survey of our own members, is that is Wall Street reacting to the 30 percent Medicare revenue, which is the average Medicare revenue of FASA member, or are they reacting to the 70 percent revenue from the private sector? And that perhaps Medicare rates had very little to do with what is going on in the marketplace and, in fact, those rates may indeed be subsidized by private pay. I think that bears a much harder look than seems to have been taken if you're going to make a recommendation that there be no update.

I remind you that as a result of the Balanced Budget Act of 1997, there has been only one full update for ambulatory surgery centers since the enactment of that law, and t hat was the one that went into effect October 1st, 2002.

Finally, on recommendation three, that no payment in an ASC should exceed the payment in hospital outpatient department. I can certainly stand here and accept the logic of the argument, but I would go back to the point that we

have two completely different payment systems enacted by Congress to calculate rates in different ways. Again, we should not be surprised that there are differences.

I would also point out that the APC values are a moving target. If you look at many of those values, they increased in the last year, the 2003 rates are higher than they were in 2002. In many cases, for those 300 procedures identified as having a higher rate in the ASC compared to the APC, the difference has closed.

My point is the outpatient department system is still a moving target. It may someday be a basis of reasonable comparison of these rates. I would simply caution that perhaps you, as a commission, should wait a little bit longer to allow CMS the opportunity to further revise and refine the data that it has. I think you can make a comparison that might have greater weight and credibility and strength.

MS. COWAN: Hi, I'm Joyce Cowan from the law firm of Epstein, Becker and Green. We represent AmSurg, a national operator, in partnership with physicians, over 100 ASCs nationwide.

Randy, for the trade association, has just

highlighted most of the main points I wanted to make to the committee, so I'll just go to the additional ones, as I agreed with his comments.

One, we strongly want to commend the staff and the commission for adding recommendation one. We have urged this for some time, get data. CMS is not gotten the data that they were supposed to get which put the commission in the awkward position it's been in in discussing recommendations two and three. You do not have data on the payment adequacy for ambulatory surgery centers.

Again, I echo Randy's comments earlier but I want to make just two extra points. What you've gone to with your recommendation three, and I would urge you to revisit it, is not a statement of policy preference that CMS should be setting neutral as to how physicians make their decisions, how beneficiaries make their decisions about where they want to get care. I think you'll find the industry extremely supportive on that core concept and we have said that in comments in the past.

That is not what you've done. Instead, you've done a crosswalk, as Randy highlighted, of a brand new system that has a lot of flaws still. The hospital

outpatient department system, and I think you would hear this from hospitals, as well, has many flaws and is not geared, and is still not geared at a CPT code level basis. So we don't know if the hospital figured that you've just set as a cap, we don't even know if it's adequate for the hospital. And we also don't know if it's adequate for the ASC. We would argue, in many cases, it did not be adequate for the hospital costs.

Finally, copay issue. In the staff's recommendation supporting recommendation three there was a note that beneficiary copays would go down as a result of recommendation three. I would suggest to you that if ambulatory surgery centers make a decision at the extreme that they cannot afford to continue to give a procedure with a 20 percent cut -- and unlike a hospital outpatient department it might be one of only a handful of procedures they're doing to begin with -- if they can't provide that service any longer, the beneficiary will be at the hospital outpatient department which has, in many instances, significantly higher copays.

The commission may or may not be aware of this, but there's a 20 percent set on the copays for all ASC

services across the board. We're still in the process of bringing down the copay level on the hospital outpatient department.

With all that in mind, I know the commission has a lot of work that they're moving forward on in this area, and we stand ready, willing, and able to continue to work with the commission in this area.

MR. DOMBY: Good afternoon, my name is Bill Domby. I'm with the National Association for Home Care. Rather than echo the comments of Bob and Jim, I wanted to add a few separate ones.

When look at the data that we've seen so far, and first I'd like to thank the MedPAC staff for their accessibility and their openmindedness in gathering information and trying to bring some light into a very dark tunnel that we've been in in home care for the last five years. But we've been gathering some data on our own, it's very preliminary information.

The one thing that stands out is that the variation in costs, the variation in revenues, the variation in utilization is quite wide. Our preliminary information indicates t hat in the first year of PPS, about 5 to 10

percent of the providers of services were in the red with their payment rates from the Medicare program. Since October 1st, when the 7 percent, or so-called 15 percent cut, took effect it's risen to between 25 and 35 percent, a major difference in just a short period of time.

But even within those two years, we've seen such a wide range in profits that's explainable only because of the infancy with which the PPS system is in existence. It has an extraordinarily weak case-mix adjustment. It explains no more than 30 percent of the cases that are incorporated within it. And that's in the context of a delivery system which continues to change greatly as time moves on.

Beyond that, in terms of the variation, the variation costs we see are also incredible. But the costs are going up in ways that are not measured by the marketbasket index. As you see a decrease in the volume of visits, you see an increase in your unit costs simply because the fixed costs necessary to comply with Medicare conditions of participation and the like remain and have to be spread out over a smaller number of visits.

But beyond that, just as many other health care providers, home care has had just tremendous regulatory

changes in the short-term. We all know what HIPAA costs are coming. HIPAA costs to home care are now rather than earlier because they were coping with new PPS costs. I don't think there's been a provider of service that has had to have as many changes in operations in such a short period of time as they have seen in the Medicare home health benefit since 1998.

We also see something else which we would look at and we'd say home care is essentially a chaotic system right now. I sat back and contemplated and say what does home care really need? I think what we need is some sort of a health policy psychologist to try to understand what is the behavior that should come from a home health agency when these changes occur?

If we were to employ someone from say the Congressional Budget Office, I think we would be misled. In 1997 they expected home health utilization to continue to rise despite the reduction in reimbursement, increasing the number of users from 3.5 million to nearly 5 million users. Yet today, as staff pointed out, we're half of what we were expected to be in terms of users. If we were to examine the psychology of health care generally and see that everyone is

trying to move people towards a non-institutional care setting -- we have the new Freedom Initiative from the Bush Administration, for example. Yet we see less and less users of home care services under the Medicare home health benefit.

Home care just doesn't behave as everyone predicted. BBA expected that there would be a reduction of $16.2 billion in five years in Medicare expenditures for home health services. It turned out to be $70 billion. When PPS was coming in, CBO continued to project, as well as the HCFA/CMS Office of the Actuary, an increased number of users of home health services, an increased number of episodes per patient. We see less episodes per patient, shorter length of stays, and fewer patients served overall.

So we need help because we don't understand how our delivery system is behaving in relation to the incentives. But when we look at the incentives that are there and the disincentive, we do see one thing that is within the control of the home health agencies that has been exercised of late. Unlike many other providers of health services, and particular physicians, home health agencies are not in a position to simply turn up the gas and increase

the number of users. They don't just open up the doors and say we now have space for you. We now have an ability to serve. We can't refer to ourselves. The only thing we can do is say no. And that's just what the home health agencies are currently doing, saying no, no to admission of patients to home health services.

MR. HACKBARTH: We need to move on here.

MR. DOMBY: I was about to say thank you for your time.

MR. HACKBARTH: I know this seems like a short period of time. What I would underline for everybody is that for each of these issues we've come back multiple times. There have been multiple public comment periods.

But more important than that, I know in talking to the other commissioners they have been quite diligent in reading the stack of letters and suggestions and comments that we get. So I hope people realize that the public input to this process isn't limited to this 15 minute comment period. There is an ongoing dialogue that I think is quite useful. I know it's helped me on a lot of issue.

We do only have a certain amount of meeting time as commissioners. It's a very scarce resource and I can't

afford to allow it to be used up with excessive long comments. So we'll have two more comments, one minute each and pardon me if I need to interrupt you at the end.

MR. ZIMMERMAN : With that admonition, I'll be very brief. My name is Eric Zimmerman. I represent several trade associations of ambulatory surgical centers and medical professional societies with interests in ASCs.

Many of the points that I'd like to make have already been addressed by some of the other trade associations so I'll just really address a couple of quick ones.

I understand what you're saying about the time limitation. Nonetheless, you do allow public comment and I have to echo a point made earlier that I think it really would be to the benefit of everybody if the public comment could come at a point before the recommendations are voted on.

MR. HACKBARTH: It has. We've had repeated public comment periods and repeated opportunities for people to send letters and what-not, which commissioners have diligently read. And the staff has met constantly with people. So I just reject the premise. You're using your

time beating a dead horse.

MR. ZIMMERMAN: I'll move on.

Hopefully, my comment right now will have some effect on the actual language that goes into the report. I think the recommendations don't always speak for themselves, and some of the language that precedes the recommendations hopefully will explain some of the deliberations that went on here.

One thing that I would like to see hopefully reflected in the report is that regards recommendation one regarding a CPI update. It was pointed out that ASCs have not received much of an inflation update over the last 10 years, since BBA of '97, it's averaged only about 1 percent.

The recommendation voted on today was based on proxies, largely based on proxies, of the number of ASCs opening up. We've tried to point out to the commission that there are a lot of other explanations for why ASCs are entering the marketplace. I haven't heard those addressed by staff, regrettably, during the presentations and I would hope that they would be listed in the report.

MR. HACKBARTH: They will be. Thank you.

MR. ZIMMERMAN: Thank you.

MS. MILMAN: Hi, my name is Diane Milman and I represent the National Coalition for Quality Diagnostic Imaging Services which consists of about 250 imaging centers throughout the county.

We commend the commission for its attention to the utilization issue in diagnostic imaging and we look forward to working with staff to study the causes of that further. We would just hope that the commissioners would keep in mind that growth and utilization does not necessarily mean misuse or fraud or any other negative implication and that we believe that this is worthy of study. Thank you.

MR. HACKBARTH: We are adjourned until two o'clock. We do need to use this room for the commissioner lunch. So if you choose to leave anything in here, you will not have access to it until two o'clock.

[Whereupon, at 1:13 p.m., the meeting was adjourned to reconvene at 2:00 p.m., this same day.]

AFTERNOON SESSION [2:13 p.m.]

MR. HACKBARTH: Next up on our agenda is a series of presentations and discussions and ultimately votes about hospital payments. We have one piece of carryover business from the morning. We need to take a final vote on amended language on one of the skilled nursing facility recommendations. I was going to do that right now but we're missing Carol Raphael, so I'm going to hold off doing that vote until after the hospital -- oh, there she is.

So what we need to do is take our final vote on a revised recommendation on the skilled nursing. Mark, would you read the draft language, please?

DR. MILLER: If necessary action does not occur within a timely manner, the Congress should provide for a marketbasket less productivity update for hospital-based skilled nursing facilities to be effective October 1, '03.

MR. HACKBARTH: All in favor of the revised recommendation?

Opposed?

Abstain?

Okay, thank you.

So Jack is going to introduce the hospital payment

issues. Jack?

MR. ASHBY: I'm going to begin by changing the order of the presentations that we're going to do in the hospital sector this afternoon over what appeared on the agenda. We're going to begin with a brief discussion of margin concepts and then Tim will follow immediately with the actual margins data. That will segue into our discussion of payment adequacy for the hospital as the whole, which in turn supports all five of the policy decisions that appear here as items three through eight in our discussion.

This approach with the payment adequacy proceeding both the distributional issues and the update is how we laid out our chapter, by the way.

Just a very brief moment on the concept of margin. We define margin as the share of an organization's revenue that it gets to keep and the formula is, very simply, revenue minus costs divided by revenue.

For hospital analyses we do indeed use several different margins but each has its own purpose. In short, different questions call for different margins. So while the pattern may not always be evident, we use the various

margins in a consistent way, or at least we try to do so. So this afternoon I'm going to first identify the margins at issue of this slide and then go through and try to explain how each of them is used.

All of the margin measures you see here use the same formula. They differ only in the services and the payers that they cover. The total margin includes all services and all payers, and that even includes non-paying patients and also covers non-patient revenue where there is essentially no service involved. Investment income and donations are examples of revenues where there's essentially no associated service.

Then the overall Medicare margin is intended to cover all of fee-for-service Medicare, but in fact it does omit a handful of small services like hospice and ambulance. Then we have the five component margins that come together to form the overall Medicare margin. We have the Medicare inpatient that covers inpatient services within the PPS; the Medicare outpatient; the PPS-exempt. That encompasses inpatient, psychiatric and rehab units. And then finally, the margins for hospital-based SNF and home health.

Moving to the uses, our policy basically on the

total margin is that there is no direct role for the total margin in Medicare payment policy decisions. But the total margin does provide us with useful context information so we do track the trend in total margin for the industry.

We have three different data sources for our total margin. Unfortunately, the three sources do sometimes produce different values, but that's not because they're measuring anything different but because of differences in the samples and also differences in the years. What we define as 2000 differs from source to source.

The primary source that we use is the Medicare cost report of course, and we have data through fiscal year 2000. Then we also have a value from the American Hospital Association annual survey, and that's more recent. It's a 2001 value. Then finally we have our National Hospital Indicator Survey. CMS and MedPAC sponsor this survey together and it's conducted by the AHA. In theory, this should be the most useful of the three calculations because it's the most recent. We actually have data for three quarters of 2002. But we also have to note that it has the smallest sample so it presumably has the largest margin of error around values.

Generally we use the overall Medicare margin to track how Medicare's payment relate to the allowable costs of treating Medicare beneficiaries. Then more specifically, we use it to assess Medicare payment adequacy for the hospital as a whole. As we've talked about before, this is necessary because of bias in the allocation of cost among components.

I want to emphasize that we wouldn't use this approach. We would probably want to assess payment adequacy for each component with its own margin if we thought that each component margin would give us an accurate reflection of how payments and costs relate in the absolute. But in fact we can't do that because all evidence points to the fact that the inpatient margin is biased upward and all four of the other margins are biased downward.

Some observers have expressed concern that we're more likely to note the downward bias in the outpatient margin. That may be just human nature when we see those big negatives, but in fact it is equally important that we note that there is bias in both directions among the components.

Given that allocation bias, that leads to an important question, why use the component margins at all?

We think there are three situations where the inpatient or the outpatient margin offers more useful information than we would get from the overall Medicare margin alone.

First, the component margins allow us to track changes in the mix of payments. If the inpatient margin were going up and the outpatient down, or vice versa, the changes might very well offset each other and be masked by the change in the overall margin. That's not just a theoretical possibility. That in fact is what happened in our latest round of data as Tim will be showing you shortly. It's only by looking at the change in the component margins that we even become aware of this very important shift in revenues.

Second, the inpatient or outpatient margin allows us a more focused comparison of hospital groups when we're considering a distributional policy change. The key word here is distributional. We use the overall Medicare margin for questions of payment adequacy. That's when we're looking at the amount of money in the system overall. We use the component margins when we're looking at distributional issues where a comparison among groups or individual hospitals is the important issue.

Seeing the benefit of that is easiest when you think about what would be involved in an outpatient policy change. The change in the overall Medicare margin might appear minuscule when in fact the policy change is having a major effect in the outpatient sector.

Then the third reason, which is probably the least important of the three, is that the inpatient margin documents the trend prior to 1996 when, unfortunately, the overall Medicare margin was not available to us. If we had historical information on the overall, that's clearly what we would show in the context of payment adequacy.

Actually before I turn to that next slide I wanted to make a sidebar note here that on the inpatient margin we do have a special calculation that you've seen several times of the inpatient margin excluding disproportionate share payments and the portion of the IME above the cost of teaching. Just as the costs and payments of other sectors confound our comparison of groups when we're looking at the inpatient margin, the DSH and above-cost IME payments also confound the comparison when we're looking at an issue that has to do with the inpatient base rates.

The best example of that is our proposal to

eliminate the differential in the base rates. It was only when we took the DSH and the above-cost IME payments and put them out to the side that we could even see that there is in fact a substantial difference in the inpatient margin between large urban, other urban, and rural hospitals. Without that separation, it was so confounded by IME and DSH that just basically the information was useless.

We also have used this margin, excluding DSH and above-cost IME, we've also used it in our transfer policy analysis that is coming up where again the scenario here is that the DSH and the IME are essentially just not relevant to the analysis, so we put them aside so that we can focus on a measurement that will not be confounded by these other revenues.

Then our last slide here deals with one last issue, and that is projecting margins. Our model for assessing payment adequacy, as you've heard this morning in the other sectors, calls for an estimate of current payments and costs. So we project the overall margin to 2003 for this purpose. We did not project the individual component margins. First of all, it's not needed for our assessment of payment adequacy. But secondly, it would not be accurate

given our projection approach. We end up projecting costs for the hospital as a whole and not by service line.

So that the concepts. If there's any questions on that we might wonder to address questions, and otherwise we'll move on to the actual data.

MR. GREENE: Good afternoon. Today I will be reviewing MedPAC's analysis of hospital financial performance in general and for services provided to Medicare beneficiaries. I will then review our work on the adequacy of Medicare payment for all services provided by hospitals paid under the inpatient PPS. After my presentation you'll hear discussions of the IME, the expanded transfer policy and MedPAC's rural recommendations. I'll then return and present draft recommendations for the payment update for inpatient services. Chantal will come after me and discuss payment update recommendations for outpatient.

The general financial health of hospitals is not an indicator of the adequacy of Medicare payments for services provided to beneficiaries. However, it is an important piece of background information in considering the context of the Commission's update recommendation. In analyzing it we consider the impact of policies of all

private and public payers.

Total margin reached a high of 6.1 percent in fiscal 1996 and averaged 4.6 percent for the full decade from 1990 through 2000. In fiscal 2000 it feel to 3.4 percent , a low for the decade.

MedPAC examined data from the American Hospital Association on developments since 2000. The decline in the total margin appears to have halted in fiscal 2000. We examined data from the AHA annual survey, which collects information from approximately 5,100 community hospitals. The annual survey indicates that the total margin fell in 2001 from 4.6 percent to 4.2 percent.

We then looked at the National Hospital Indicator Survey. The NHIS is a quarterly survey of approximately 700 hospitals conducted by AHA with support from CMS and MedPAC. NHIS data are the most current information on hospital financial performance. We used the NHIS data for the first three quarters of fiscal year 2002 to identify the direction of change in the total margin. We seasonally adjusted the data and estimate the total margin for fiscal 2002. Our estimate is that the total margin will equal 4.5 percent for full fiscal year 2002 which is equal to the value for 2001.

Let me note that these analyses so far are based entirely on actual data. The real data as collected and imputations by the survey questions.

DR. NEWHOUSE: Tim, can I ask you a question? Do you know if the cost data that you're using in the margin accounts for changes in reserves from year to year?

MR. GREENE: I'm not sure.

DR. ROWE: This is P&L, right?

DR. NEWHOUSE: No, it's revenue but it's costs.

MR. ASHBY: It has to be a current year expense.

MS. ROSENBLATT: Change hits the P&L.

MR. MULLER: If there's an operating loss that would show as a P&L negative, but it depends on how that is funded and so forth.

MS. ROSENBLATT: You're asking about changes in accruals, right? Changes in accruals would hit the cost --

DR. ROWE: No, I thought he was talking about reserves. This isn't an insurance company. This is a hospital.

[Laughter.]

MS. ROSENBLATT: That's why I changed the word to accrual.

DR. NEWHOUSE: No, she's got what I'm talking about.

MR. GREENE: We next looked at information from the fiscal year 2000 Medicare cost reports to examine Medicare financial performance. We analyzed margins for the major components of short-term hospitals. Hospital inpatient margins declined and outpatient margins increased from fiscal year 1999 to fiscal year 2000. This was accompanied by increases in the PPS-exempt and home health margins and decreases in the skilled nursing facility margins. There was a modest decline in the overall Medicare margin.

These measures are based on the most recently available cost reports with imputation of data for non-reporting hospitals. They're for hospital-based services only and differ from the results for freestanding skilled nursing facilities and home health agencies which you heard earlier.

Information on the Medicare inpatient margin is available from 1984 on. As Jack was describing, the overall margin is not available because of data limitations before fiscal year 1996. Because inpatient payments account for

approximately three-quarters of total Medicare payments to PPS hospitals, the inpatient and overall margins followed very similar trends. The inpatient margin increased steadily from 1991 to 1996. Both inpatient and overall margins then increased further in 1997 then began a decline to 2000. Inpatient margin reach a high of 10.4 percent in 1997 and the overall margin high of 16.5 percent.

The overall Medicare margin was 5.1 percent in 1999 and 5.0 percent in 2000. The fell in rural and other urban areas. Overall margins for major teaching hospitals improved while those of other teaching and non-teaching hospitals declined. I'll note that the numbers differ slightly from the information in your briefing material. As we said, this updated information reflects imputations of data that were not available at the time we prepared the mailing material.

We estimate that the overall Medicare margin will be 3.I percent in 2003. Rural margins improve in 2003 while other hospitals see declines. These results reflect policy changes taking effect in 2003 and scheduled for 2004, the year for which we're considering an update decision. Major changes include the reduction in the IME adjustment and the

end of transitional corridor payments under the outpatient PPS.

These results differ from the ones you saw in December. The results last month used fiscal year 1999 data to model fiscal year 2000 results. We're now using the new 2000 cost reports, the most recent available, to model 2003. And as indicated, now we're imputing data from missing hospitals. We've also taken account of changes we had not reflected in our December analysis. That study incorporated information on updates in law and most policy changes from 2001 through 2004. These changes had not been reflected in the 2000 cost report data and for that reason we need to take them into account for the purpose of projecting the 2003 results.

We now model other policies that we didn't consider in December. These include the end of transition payments in the outpatient PPS, as I indicated, the phase-in of the SNF and home health prospective payment systems, and the impact of closures of hospital-based SNFs on Medicare payments and costs. Some of these changes increase overall margins and others decrease them.

Now I'm turning to several elements of our payment

adequacy framework which I'll go through quickly.

Hospital cost growth is accelerated with both Medicare cost per case and cost per adjusted admission starting to grow rapidly in 1999. AHA data indicate the cost per adjusted admission increased 16 percent over the decade of the '90s, fell about 4 percent in the middle of the decade, 1996 to 1998, and then increased steadily through 2000. New AHA data indicates that cost grew 4.7 percent in 2002 alone. NHIS data suggests that the cost increase continued in fiscal 2002. Medicare cost per case growth was modest in the mid-'80s, but once again, accelerated at the end to 3 percent per year in '99 and 2.9 percent in 2000, the most recent year for which we have cost report data.

Increasing cost per adjusted admission and Medicare cost per case were moderated in the '90s by length of stay decline. We discussed this a bit last time. We now see the length of stay decline we were observing through much of the '90s appears to have moderated. Both overall and Medicare length of stay continued to decline but at a slower and less reliable rate. For example, stay for all patients declined 1.8 percent in 2000, 1.3 present the next

year, and may be stabilizing in fiscal 2002. The Medicare length of stay decline continued but may also have flattened out in fiscal 2002.

Wages are the largest component of the hospital marketbasket. As a result, wage growth has contributed significantly to higher overall cost growth. This has been accompanied by shortages of occupations such as nurses, pharmacists, therapists, and other health care occupations. Hospital industry wages rose more rapidly than wages in the general economy in 2001 and 2002, in very strong contrast to a trend that had prevailed through most of the 1990s. The employment cost index, or ECI, for wages and salaries of hospital workers is our best measure of hospital wages and it's now used in the CMS marketbasket. This measure increased 5.4 percent in 2001 and 4.4 percent in 2002. However, it's predicted to increase but increase at a steadily declining rate of 4 percent in 2004.

An additional factor affecting hospital cost is reflected in the market for hospital services. Increased revenue pressure from private payers through the 1990s helped produce low hospital cost growth. More recently, relaxed pressure has permitted hospitals to increase prices

and costs. We believe this partially explains current cost developments.

In 1998 and 1999, both private payer and Medicare payment to cost ratios fell, encouraging hospitals to control costs in those years. This turned around in 2000 when private payments increased relative to cost. The decline in Medicare payment to cost ratio slowed in 2002 as well. This increase in the private sector payment to cost ratio reflects more aggressive negotiations by providers as well as shifts by payers and consumers to less intrusive forms of managed care. These changes have weakened the bargaining position of insurers in dealings with providers in general and hospitals in particular, which is conducive to more rapid cost growth.

I'll go briefly over some of the other factors we consider in our payment adequacy analysis. We discussed this last time. I'm refreshing you on it, but it's a secondary consideration.

First, hospital volume has been increasing at a steady pace after slow growth in the 1990s. Admissions increased a little over 2 percent in 2001 and Medicare discharges about 3 percent. Our study of entry and exit of

the industry shows that hospital closures have been continuing at a steady pace at pretty much the rate we observed in the 1990s which is continuous and minor. It's not having a great deal of effect. It's affecting mainly low occupancy hospitals and small facilities.

We also considered access to capital as an indicator of adequacy of Medicare payment. We presented some results last time and we heard some concerns. We've re-examined the findings we discussed last time and we've concluded based on more recent information that our conclusions were correct. We indicated then that based on developments in the bond markets and our observations of the stock market that the financial condition of the industry was judged to be healthy by Wall Street and that the hospital industry had adequate access to capital.

DR. ROWE: That's for profit?

MR. GREENE: On the stock market, of course, for-profit, but we're making a statement more broadly applying to the bond market and the capital access of non-profit facilities as well.

According to a new report by the credit rating agency Fitch, in 2002 there were fewer downgrades of

hospital bond for every upgrade than in 2001. We examined information from Standard & Poor's last month and presented it. The Fitch report suggests that developments are not as positive as they were indicated to be by Standard & Poor's but the same general pattern prevails. 2000 is looking like a better year for non-profit hospitals seeking financing than 2001. More downgrades than upgrades, but nowhere near as bad as one would fear.

MR. HACKBARTH: Tim, on that issue, I recall reading in the text that if you just take a raw count of upgrades versus downgrades there would be more downgrades than upgrades, but if you look at the dollar volume there are more upgrades than downgrades. Did I understand that correctly?

MR. GREENE: I believe so.

DR. ROWE: The real issue is what proportion of the institutions are investment-grade and can access -- I mean, you could be a AAA-rated hospital and get a downgrade to AA and that's not nearly as important as a hospital that loses its investment-grade rating and doesn't have access.

MR. HACKBARTH: I think that's an important point. I recall also seeing some numbers on what proportion are

investment grade, although I can't remember the number off the top of my head. Do you have that in front of your, Tim?

MS. WILLIAMS: About 90 percent.

MR. HACKBARTH: About 90 percent are investment-grade. Maybe you can nail down that number for us. Why don't you go ahead, Tim?

MR. GREENE: Our second new piece of information is a report from Merrill Lynch. Merrill Lynch provides an overview of the hospital market, and in particular, the for-profit health care sector. Merrill Lynch sees the prospects for the for-profit sector as very good, and very bright in a variety of dimensions. It anticipates modest Medicare payment increase, but most strikingly, sees no slowing in private payment growth in the foreseeable future. They anticipate changes eventually but emphasize that in the foreseeable future we'll see continuing increased private payments, which is what we've seen in the last two years in the results we were reporting a moment ago.

In general, based on this information, and most importantly, on the overall margin information we discussed earlier we conclude that Medicare payments to hospitals are at least adequate.

Thank you. I'll be turning it over to Craig and coming back with an update recommendation later.

MR. HACKBARTH: While that's happening let me just try to set the stage for the process. There are a number of different recommendations under the general heading of hospitals, and as we've discussed at previous meetings, in a lot of ways they've related. We've talked to them as a package as opposed to just discrete units. So what we're going to do is have each of the presenters go through and describe the recommendations relevant for their piece, but we will not vote on recommendations until all of the hospital issues have been presented. Then we will have a series of votes both on each of the recommendations just one after another.

Again, one of the things that I want to underline here is that, certainly I individually conceive of these as a package. Although I think it's important for individual commissioners to have the opportunity to vote on each individual recommendation, I want everything on the table before we proceed to voting.

Craig?

MR. LISK: Good afternoon. This afternoon I'm

going to first discuss the IME adjustment and then Julian will accompany me and we'll discuss the expanded transfer policy.

In 2003, Medicare IME payments, indirect medical education payments will total about $5.1 billion according to the Congressional Budget Office, approximately 5 percent of Medicare inpatient payments. These payments go to about a quarter of Medicare PPS hospitals that train. Those are hospitals that train trade residents.

The IME adjustment is a percentage add-on to Medicare inpatient PPS rates. When the prospective payment system was established in 1983, the empirically derived estimate of IME was doubled. This doubling was achieved by reducing the base rates for all hospitals. The adjustment was doubled because preliminary analysis showed that teaching hospitals would perform poorly under the prospective payment system and doubling was a simple but arbitrary and quick way of dealing with this problem in terms of the analysis showing that teaching hospitals would not perform well. There was a lot of pressure at that point in time on Congress to pass the legislation implementing the PPS and this was the quick of dealing with that issue.

Some of the reasons for the poor performance though in that analysis is that teaching hospitals characteristically were poor reporters of case mix in terms of the early data. This is one reason. There was also some technical issues with how the empirical level was derived that may have also contributed to their poor financial performance in terms of the preliminary analysis.

However, once the prospective payment system was underway and implemented, teaching hospitals did not perform worse than other hospitals and performed -- actually had extraordinarily high margins in the early years of the prospective payment system.

Now the adjustment has been lowered over time and some key aspects of when it was lowered is it was first lowered with the implementation of the disproportionate share adjustment to help partially fund disproportionate share payments, and then again in the Balanced Budget Act. That proposal -- the Balanced Budget Act lowered the adjustment from 7.7 percent in 1997 to 5.5 percent in 2001.

Also it's important to note that the BBA provided IME payments for Medicare+Choice patients directly to the hospitals. So hospitals received directly those payments

whereas before they would have had to negotiate them with Medicare+Choice providers.

The BBRA and BIPA though stopped the phase-down from 7.7 percent to 6.5 percent and held the adjustment through fiscal year 2002 at 6.5 percent. In the current year we have just lowered the adjustment to 5.5 percent.

The IME adjustment is based on a formula which approximately raises Medicare payments for each case by about 5.5 percent for every 10 percent increment in the ratio of hospital's residents to beds. So a 400-bed hospital, for example, with 200 residents would get about a 25 percent increase in payments for each case above non-teaching hospitals, and a similar 400-bed hospital with 10 residents would get about a 5 percent increase in payments.

Now we have taken an analysis to measure what the empirical level of the indirect medical education adjustment would be. This is the measure of teaching hospitals' patient care costs relative to other hospitals and how much higher they might be. Our current estimate is the empirical level and we discussed it at the last meeting which, based on 1999 data, is 2.7 percent for every 10 percent increment in the resident-to-bed ratio. So the current payment is

more than double what our current estimate of the empirical level is.

This estimate of the empirical level, in terms of analyses, has decreased over time and we discussed some of the reasons for the empirical level going down in the chapter.

It's also important to note though, and some people have raised this, is that any significant change in payment policies could affect the empirical level of the adjustment. But I want to emphasize that the impacts of a lot of those policies would be relatively small. They would not be of a huge magnitude to make a difference of saying that the current empirical level would change to being 55. percent, for instance, to the current level. Most of those changes would be relatively small.

Under the empirical level, if we consider that, IME payments in 2002 if we paid at the empirical level would be about $2.5 billion instead of the current $5.1 billion we estimate. So this means that IME payments above the empirical level total about $2.6 billion in 2003.

This next chart then shows for different levels of teaching intensity based on the resident-to-bed ratio, what

the IME adjustment currently is and what it is at the empirical level. To give you an idea of what this might mean on a per-case payment, if we have a case, typical -- on average, a standardized amount base payment rate is about $5,000 for a typical hospital and a typical case mix for a case of 1.5, let's say, so $7,500 for a non-teaching hospital. A hospital with 400 beds and 200 residents with a resident-to-bed ratio of 0.5 would receive $1,853 more for that case than a comparable non-teaching hospital. $983 of that amount is over and above what we would say the empirical level would be.

If you talk about a smaller teaching hospital in terms of a hospital with fewer beds, those numbers are much smaller. So a hospital with 40 residents and 400 beds would receive $400 more, approximately, than in non-teaching hospital because of the IME adjustment.

This next graph then shows under the current payment system the frequency distribution of teaching hospitals by their percentage increase in payments per case under the current IME adjustment. Almost half of teaching hospitals receive less than a 5 percent add-on to their per-case payment rates. That's the combination of the first two

bars on the chart. About 10 percent of teaching hospitals receive more than a 25 percent adjustment add-on to their base rate. That's the hospitals with an IRB of greater than 0.5. For the extreme end, when we talk about at the very high end, 2 percent of hospitals receive an IME adjustment of over 35 percent. These hospitals have more than 75 residents per 100 beds.

I'm now going to show you two sets of margins, the Medicare inpatient margin and the overall margin to show the relative financial performance under Medicare for teaching hospitals. Again, as Jack had mentioned, there are the cost allocation issues when we present the inpatient margins; the inpatient margins are somewhat overstated relatively for all hospitals.

Major teaching hospitals are, in this graph, are hospitals with a resident-to-bed ratio of 0.25 or higher and they account for about one-quarter of teaching hospitals. Teaching hospitals do better with and without the IME payments above cost as we can see in this overhead. The first column shows what the margin would be if the IME adjustment was set in 2002 at 5.5 percent, we see that major teaching hospitals have an inpatient margin that would be

five times what that is for non-teaching hospitals. If we were paying at the empirical level the margin, of course, would drop for major teaching hospitals down to 13.8 percent, still substantially above the level for non-teaching hospitals.

As I said, this table provides the overall Medicare margin in providing the same context of the data for the overall Medicare margin, and again we see major teaching hospitals continue to have substantially higher margins that non-teaching hospitals, both with the current payment level and then if payments above the cost relationship were removed and we paid at the empirical level based on 2000 data.

So I want to next go to what the draft recommendation is. I'm going to present a little bit more information after presenting the draft recommendation here. The recommendation reads that the Congress should reduce the indirect medical education adjustment from 5.5 percent to 5 percent in fiscal year 2004 and gradually reduce the adjustment by 0.5 percentage points per year to the empirical relationship between teaching intensity and hospital costs per case.

In terms of the categories that we have for what the spending impact would be, it would decrease spending by $200 million to $600 million in the first year and it would be in the category of $5 billion to $10 billion over five years from 2004 to 2008.

So what would be the impact of reducing the IME adjustment from 5.5 percent to 5 percent on hospitals payments? Overall for major teaching hospitals, reducing the adjustment from 5.5 to 5 would reduce their payments by about 1.3 percent, inpatient payments by 1.3 percent and other teaching hospitals by 0.3 percent. You also see the impact on rural hospitals is very small, less than 0.05 percent.

Now some of the issues that have come up though with regard to issues of reducing the IME adjustment are that teaching hospitals have experienced a recent reduction in payments starting in fiscal year 2003. But keep in mind that we still show, even after accounting for those reductions we still show that teaching hospitals have substantially higher margins than other hospitals.

DR. ROWE: In 2003?

MR. LISK: Based on the 2000 data adjusted to

reflect the IME reduction.

Another factor that has been brought up is the total financial condition of teaching hospitals and at the last meeting we did show you that the total margins for major teaching hospitals were lower than for other hospitals. But as Jack had mentioned before, is that Medicare payment policies should not be driven by what is happening in terms of the total hospital margins.

So the issue is whether Medicare should consider what other payers do here, and generally it's been the policy of Medicare that Medicare pays for Medicare services. But we do have other missions is the other issue that comes up, and we have teaching hospitals that have research, uncompensated care and standby capacity are other missions that teaching hospitals have and that these revenues might be used for some of these other missions.

But to note that on research is we have NIH funding that is targeted towards that. On teaching, Medicare payments do pay for the higher cost of teaching hospitals and reflecting that in our payments for Medicare's share of those costs. On uncompensated care, I'll come to some information after that. And on standby capacity, if

they have higher costs, we would be reflecting that in the IME adjustment -- that would be one of the factors that would be reflected in the IME adjustment, but also to reflect that certain standby costs are in certain DRGs and those DRG weights would reflect those higher costs.

So moving on to the uncompensated care. IME payments do not target uncompensated care burdens well. As we can see in this chart, we show uncompensated care costs as a percent of total hospital costs. This is AHA data for fiscal year 2000. We see that public major teaching hospitals have a substantial uncompensated care burden in terms of accounting for 20 percent of their cost. But private major teaching hospitals, which account for three-quarters of the major teaching hospitals, that share is just a little over 5 percent; a substantial difference. In fact that is below -- is about at what the national average is across all hospitals.

It's also important to point here too that teaching hospitals, in terms that we have another program in terms of Medicare is Medicare DSH payments and that teaching hospitals receive two-thirds of Medicare DSH payments of approximately $3 billion. Major teaching hospitals receive

$3 billion out of that $5 billion in Medicare DSH payments.

This next chart is also AHA data and this shows the distribution of major teaching hospitals in terms of the number of hospitals and their uncompensated care burden. We can see that the major teaching hospitals with less 2 percent of their costs for uncompensated care is the same number of hospitals that have an uncompensated care burden of 20 percent or more. And a substantial number that have very low -- that have the 2 to 5 percent range; it's also below average.

MR. HACKBARTH: Craig, is this one a combination of both the public and private --

MR. LISK: This is a combination of both the public and private, so we would expect that the public is more to the right side of this distribution here, but there is a distribution and it's a fairly wide distribution.

So the implication is that -- and is this true for all these different types of other missions that teaching hospitals may have, that hospitals' roles vary. Certain hospitals provide a lot of uncompensated care and others don't. The same with the research and teaching and standby capacity missions, those roles vary across the hospitals.

So with that I'd be happy to address any questions you may have and after that we can move on to the next presentation.

MR. MULLER: The question of the Medicare program bearing costs that are appropriate to Medicare and how it affects the margins is one I've raised before and I want to raise again. Both the IME and DSH program have been public policy for quite a while now, 15 years or more, reflecting the fact that Congress made a decision to allow Medicare to pay some costs that are not costs to the Medicare program, per se.

For example, it's easiest to point out in DSH but also point out in IME as well. In DSH essentially we put the total DSH payments into the hospital margins, yet we only put in roughly half the costs attributed to that because some of them are for Medicaid beneficiaries -- that's what DSH is for -- and we, of course, don't put the Medicaid beneficiary cost into the Medicare costs margins.

The same thing with IME, IME was intended to not just reflect the role that Medicare should pay of teaching but the fact that the teaching programs had a broad effect on society and therefore Medicare would pay for these even

when some other payers weren't covering it. So in both cases, DSH and IME, we overstate the margins by putting in the full revenue but not putting in the full costs, because the costs are outside the Medicare cost report.

If I use one of your tables that shows on DSH basically -- if you take your IME above cost out, the major teaching margins go down by about nine points. I think something roughly would happen, the same thing would happen if you took DSH out -- if you took some DSH out as well, if you follow my argument.

So insofar as we keep putting this red flag up there of these inpatient margins, especially in the major teaching hospitals, an awful lot of that would go away if you took what you call IME above cost, or I can say IME for other purposes besides Medicare, or the DSH payments that are covered in the Medicaid program. So a lot of that -- we reflect the margin, understandably so, because they are payments inside the Medicare program, but they're for costs that are not shown on the Medicare cost reports. Therefore we overstate the Medicare margin considerably inside this report and therefore we always cause ourselves to say, there's these enormous margins for major teaching hospitals.

But if you take the DSH, let's say half the DSH payments out, and take the IME payments above cost out, then the margins of major teaching hospitals go below the margins just inside Medicare inpatient by themselves. So I think we keep -- and I've raised this with Craig and Jack and others, that we keep overstating the inpatient margin considerably based on how we do our accounting. And most of that margin goes away.

I'd like to see what your numbers on it are but just looking at the IME above cost, nine of those 20 points go away, and my guess another nine of the 20 would go away with DSH. So you may have inpatient major teaching margins in the 3, 4 percent range on inpatient without that. So I think we should remember that the way we do our cost accounting dramatically overstates the margins on the inpatient program just the way the accounting is done.

I think secondly, the philosophical argument that Medicare should only pay for Medicare costs has been, in some sense, rebutted by what I just said. DSH is one, IME is another where in fact there have been public policies enacted by the Congress that essentially say they're going to pay, Medicare is going to pay for some costs that are

outside the Medicare program.

I agree with the majority of the Commission as expressed over these months that the Medicare program can't be stretched in too many purposes like that, and we had a discussion about that around freestanding SNFs this morning. But here is one that's been going on for 20 years or more. Some people could argue it goes back to 1966 in Medicare on the precursor to IME.

But I think we have had a public policy statement there that is contrary to the statement that you made, and I just would like to have that reflected, that Congress has reflected over the years that there are some costs the Medicare program will bear that go beyond the cost of Medicare beneficiaries. So by just saying as our paradigm that we'll only pay the costs that are in the Medicare cost report I do think we do misstate the public policy, and it's been there for a long time.

I'll get later into, I think why it's not appropriate to make these reductions at this time. You made some of the points in terms of the broader missions that the hospital is being asked to play, and the margins are going down. This is probably one place in which looking at total

margins is somewhat relevant, and the total margins of teaching hospitals are well below the margins of other hospitals. Given the importance of the Medicare program to hospitals, looking at total margins as a way of helping to influence our understanding of the Medicare margin I think would be appropriate in this context.

But I do want to state, and I've tried to say this before that I think we consistently overstate these margins by the way in which we represent this data, by showing the full revenue but not showing the full cost. That therefore provides a red flag that causes people to want to say, margins are 20 percent -- high -- when in fact I think that consistently overstates those margins.

DR. REISCHAUER: Ralph, I can understand your logic with respect to DSH for which there is an explicit purpose, which is to provide resources for uncompensated care for the underpayment of Medicaid services or the extra cost that might be associated with treating low income or destitute populations. But I have a hard time understanding how the logic works with respect to excess payment for IME. Because there is no explicit purpose to which that money was directed. It was just like, we're very nervous that we

aren't going to pick the right number here so we're going to double it and then we work our way down.

MR. MULLER: No, one of the purposes of the original IME doubling, as Craig refers to it, if I can use that shorthand, was in fact to reflect this nervousness that the empirical calculation would not adequately capture the true cost of teaching hospitals. That's one of the reasons. That was not the sole reason.

Another reason was to look to have Medicare pay some of the cost of not being paid by the payers inside the program and to have that support inside the Medicare program. So we exclusively focus on one of those, but I think we should also acknowledge that there were other reasons for that.

MS. BURKE: At the risk of --

DR. REISCHAUER: Revealing how old you are?

[Laughter.]

MS. BURKE: Yes, revealing how old I am. Having sat at the table when this was all being discussed, it wasn't just a crap shoot. Admittedly, there was a great deal that we did at the time when we did the '83 bill and before that was not as refined as it might have been, but

there was a broader conversation about the value of the presence of teaching in hospitals, and the value that that was to society and specifically to Medicare patients. We were concerned about, one, the overall impact on teaching hospitals of this new payment system that we were not sure about, which Ralph is absolutely correct about, and Craig is as well in terms that there was a doubling to try and capture what we really didn't yet know because we hadn't experienced it.

But there was a broader commitment that there was value in the quality of care and the kind of activity that occurred in an institution where students were present. So it wasn't simply, we don't know what's going to happen, it was really an investment in that activity. So it wasn't just we're going to do it because we're going to do it, it was really a commitment to those activities and the value that accrued to the Medicare patient by the presence of those activities in the institution.

So I think it more than simply, we don't know what's going to happen. It was also a fundamental commitment to an activity and Medicare's responsibility to help finance that activity because of the ultimate benefit

to the patient that was Medicare's as well as, frankly, as it was broadly in society in terms of the presence of teaching.

DR. REISCHAUER: But the question is, does that extend beyond what the empirical estimate of the cost is? That all I'm arguing.

MS. BURKE: I think it is -- at the time we clearly didn't know what that cost was. I think there is probably some debate yet today as to what really the empirical cost of that is. But it's not clear to me at the time that we were prepared to limit it only to that very narrow cost; i.e., the cost of a resident per bed. That it was really the broader commitment and the implications for those institutions of all of the things that they would incur by the presence of students. I'm not sure we knew then and yet today know how to capture all of that, what that really involves.

MR. HACKBARTH: The history is important and I consider Sheila an authoritative source on the history, but to me it doesn't seem decisive. Circumstances change all the time and if we followed the logic, Congress enacted this once, therefore we cannot consider it, our workload would go

way down. I think the task that we're charged with is to take into account changing circumstances in the Medicare program and the health care system and make our best recommendations. Congress has the final say, of course. It feels too constrained to me to say, they intended this once and therefore we ought not take it up.

MR. MULLER: I don't think that's what I'm saying. What I'm saying is, however, narrowly defining the empirical level is the only thing that was ever intended and continues to be the only thing ever intended I think is too narrow an interpretation. Furthermore, as I've mentioned, putting the full revenues in and only put half the costs in, just by per se, makes the margins look a lot bigger. And as we've noted this morning and today, when the margins are up 10, 15, 20 percent, all of a sudden people say, that's a little bit too much. If these margins were two or three we wouldn't be talking about this.

I'm saying, if you took, as I have done, a number of those -- as least asterisk those margins, you would see those margins are nowhere near that. I think it's true on both DSH and IME. I referred to the IME for history and I fully agree that Sheila is the most authoritative source on

this, but it's been recognized over and over again by the fact that the payment has been well above the empirical level. So it wasn't just a one-time recognition.

DR. NEWHOUSE: I was going to make the same point Bob made, but let me amplify it in one way and raise another reason.

In terms of protecting the teaching hospital and how far back the policy went. The policy before the PPS paid costs which was, in this context, the empirical level. My recollection of that time was that there was no argument that teaching hospitals at that point needed additional protection. You were worried about what the PPS was going to do to the teaching hospitals. But that would suggest to me that there was possibly the intent was to protect the teaching hospitals to the degree they had been protected up to the point. That was point one.

Point two was the reason I asked about -- and I thank Alice for correcting me on accruals -- there's some work of Nancy Kane in a recent Brookings volume that suggests actually the margins are potentially quite misleading in that hospitals can -- and one should look at cash flow as a much more relevant indicator because -- the

difference being that hospitals can take cash into or out of their accruals. And that in fact in her look at teaching hospitals, teaching hospitals had a more robust cash flow than one would have inferred from their margins on a small sample of teaching hospitals.

So I put that out there as a caution of putting -- casting all of this discussion in terms of the margins.

DR. WOLTER: Just a couple things. One is, are we so certain that the regression analysis has gotten to the right empirical relationship? And in that regard, the recommendation is fairly specific to reduce the percentage by 5.5 annually, although you might read the recommendation to allow for the target to change if more work were done on the regression analysis and we came to a different understanding of where we should end up. So maybe we should clarify that.

And then secondly, Dave Durenberger raised this at the last meeting, the timing of this is so critical, because although there is some breadth to the uncompensated care issue in terms of which institutions are affected than others, if this recommendation is adopted and some other approach to uncompensated care is not dealt with at least

roughly parallel it could be devastating to a subsegment of some very important institutions. I wonder how we would want to address that issue.

MR. HACKBARTH: So on the first point, Nick, if I understand you correctly, you would propose language to the effect that we ought to move towards the empirical level in equal steps so that if the empirical level were to change at some point in the future then the reductions change, either increase or decrease.

DR. WOLTER: I'm no expert on this but I understand that one of the arguments that people worried about this have is there may be some noise in the current target that we're at and perhaps there needs to be a little work done on what really is the cost of providing teaching, and maybe 2.7 percent ultimately won't be the target that we get to.

DR. NEWHOUSE: Can you say what you think the problem is? As far as I understand it, this is the same method we've always used, so if the original number was the right number, this is the comparable number now.

DR. WOLTER: You probably know much more about this than I do, Joe, but I think there are many people

worried that this doesn't capture entirely the cost of teaching and the cost of educating post-medical graduates. I'm saying, we're making a recommendation now that spreads itself out over three or four years based on 1999 information. And that as more work is done on this, if there is some adjustment in the target, do we want to make sure that we have the flexibility in this recommendation to be sure that that's accommodated.

MR. SMITH: Both Nick and Ralph have raised questions about getting the numbers right. It seems to me it's important to get a third number right here. I'm struck, Craig, that we didn't come back to -- although you did in the text, but didn't come back with one of the dramatic charts to the total margin data for hospitals across the distribution.

If we're buying public goods, whatever those public goods are, IME, uncompensated care, support for the research establishment, we're buying public goods then the right thing to look at to assess the capacity of institutions to provide those public goods is total margin not Medicare margin. Medicare is contributing to it and there is a policy question that Congress has addressed with

the clear answer, if not always the right numbers but a clear answer that, yes, Medicare ought to be in the business of helping support the purchase of public goods.

We might not have invented this scheme if we'd sat down with an empty piece of paper, but it's the scheme we have. And we have chosen to use this payment system to contribute to the purchase of things that we believe have broad social value.

I think for those reasons alone, it seems to me, we ought to be very nervous about cutting into the capacity of a group of institutions that are especially capable of and especially burdened with the responsibility of providing those public goods. So we ought to remember when we looked at the total margin data for large teaching hospitals they were at the other end of the distribution, unlike when we simply look at the Medicare inpatient margin.

DR. ROWE: Thank you, Glenn. We've all been thinking about this issue for a long time, both together in this forum and other forums and I've recently come to a different view of how we should approach this which I have mentioned to a couple of my colleagues, some on the Commission and some not, and gotten encouraging responses.

I've not spoken with any of the organizations in the environments so I don't have the benefit of their input, although we may get that later.

But I'd like to take a minute and propose a different way of looking at this. I'll try not to repeat anything that's been said although I associate myself with many of the comments. The only thing I would repeat is Bob's comment about, a concern about no explicit purpose for the subsidy. I don't like it either. I'm offended by it. We're just throwing the money at the hospitals. They can use it for advertising, they can -- there are no costs that it's lined up against other than these general social goods, et cetera. I'm not against Medicare supporting it, but I think it would be better to have a more explicit purpose.

But I believe we should approach this by looking forward, not looking back. I think we are making this policy looking in our rearview mirror. I believe there are very, very substantial data to support the view that teaching hospitals are faced with very significant challenges to strengthen and modernize and reorient their clinical educational capacity. That this has to get done with significant investment in information systems, in new

curriculum, in preparing students for lifelong learning, and interdisciplinary approaches with physicians, nurses, and others being trained together in teams, et cetera.

They spend a lot of time in a variety of forums studying this. There are great needs and some institutions are doing it, but many aren't. To prepare themselves for the future demands of the health care system and the Medicare beneficiaries they need to do it.

I think that many of institutions we're talking about don't have the resources either in terms of access to capital or margins to do it. What I would favor is a proposal in which we take the excess over the empirical level and we identify that as funds to specifically be used to support the modernization and the information systems infrastructure, et cetera, of the medical education capacity of teaching hospitals, and we establish criteria for that and they demonstrate that they meet them in order to qualify for the funds. And if they don't meet them, they don't qualify for the funds.

And we use these funds not as a political hedge for the general social well-being but as a direct stimulus to help these institutions align themselves with the needs

of education of the modern medical workforce. So I would propose that rather than the proposal that we have, with all due respect to the staff, that I would propose that an approach to developing criteria over a very short period of time and requiring that hospitals meet it, and if they don't meet it within 24 months or show tangible progress then we go into this reproduction phase.

So that's an alternative strategy that I think looks forward rather than back. I'm interested, obviously, in my colleagues' response to this.

DR. STOWERS: I was going to get back more to what Nick was saying. I think if we are going to have a variable target in here, we ought to have some kind of a variable progression down to the empirical rate rather than just blocking off 0.5 a year times whatever, because it's not obviously going to come out even as we do that.

Then you talk to the five years. I can see the five years maybe being a time to allow the academic medical centers or whatever to adjust for the decreasing revenue over time, but I think another factor in there is how long is it going to take us or Medicare or Congress to correct the uncompensated issue which we see some of the academic

medical centers doing a great deal of and others not doing a lot.

So I think I still, and I've said it before, I think that we have to tie those two together. So if we're going to have a commitment to bring this down to the empirical level over a period of time then we need to have the uncompensated thing. So if that can be done on a five-year schedule then the five year thing makes more sense. But if that's going to take 10, whatever -- or maybe it will take less.

MR. HACKBARTH: I'd like to make just a quick comment on what Jack said. I'm with you on the premise. As you know, my concern about these payments has been that it's a lot of money at a time where we know that Medicare faces both immediate fiscal pressures and certainly long-term pressures, and I'm not sure that we can afford the luxury of paying such a large amount of money without very specific purposes in mind and being confident that we're getting value for our money, so to speak. So I start in much the same place as you, Jack.

I guess the questions that I have about your alternative are two. One, as you presented it it seems to

assume that we're still talking about Medicare trust fund dollars. And a second reservation that I've had about this policy is using trust fund dollars, the money raised by a payroll tax, for these broad public purposes. I'm not sure that that's the proper financing mechanism.

Now having said that, I understand the institutional reasons in Congress for that approach, but it does make me a little bit queasy to use payroll tax revenues for these broad social purposes.

The other question that I have is, if I understood you correctly, it sounds like only teaching hospitals would be eligible for these additional payments. There are a lot of hospitals that face critical issues, for example, with information systems, which I think is a really pressing problem for the health care system and an important impediment to improving the quality and safety of the care we provide. To say we're going to put aside $2.5 billion, and by the way, it's only teaching hospitals that are eligible, again, makes me a little bit uneasy.

DR. ROWE: I can respond to the second question. The first concern I think is an interesting policy issue we're probably not going to solve here today.

What I had in mind -- this is an idea and, again, I'm interested in other people's reactions -- was I was focusing on the E part of IME. I would expect, in fact predict, that such investments would improve the quality of care, and we could use some of that. It may even improve the efficiency of the care. But I was focusing on the E part as the essential thing that needed to be -- that the idea of these changes would be to improve the educational process, which I think is broken and becoming archaic in many institutions. These funds were initially identified for educational purposes so that was what I had in mind. So I'd give them to the teaching hospitals but I would predict benefits in quality of care, cost efficiency, et cetera.

MR. HACKBARTH: I have Joe, Allen, Bob, David, and then I think we need to move on. As important as this is, we've got a lot of ground to cover.

DR. NEWHOUSE: I originally wanted to respond to David but I also want to say something about Jack's epiphany.

[Laughter.]

DR. NEWHOUSE: I don't think of these payments as

buying a public good in the strict sense of a public good, meaning something that we all consumer like national defense, and one person's consumption doesn't reduce another's. I think of this, the extra payments to teaching hospitals as we're paying for the extra cost of patient care at the teaching hospitals. That's a product we've said we want to pay for, and I have no problem in paying for it, but that gets you to the empirical level.

Another way to say that is, had we not put these extra payments in, and had we paid the average cost per case across all hospitals, teaching hospitals would have taken it in the neck and would have gone out of business if everything had been Medicare and they hadn't been able to offset it in other ways, and so forth and so on.

So it's perfectly legitimate to have extra payments for teaching hospitals without going to what in my mind is an additional and probably wrong place to be of the saying that these extra payments are buying a public good. They're coming from the cost reports that teaching hospitals write down on their costs and those costs are basically buying, I think for the most part, a more intensive style of care for a given patient at that hospital. That's fine.

Then that also goes to the point the point that both Jack and Bob and others, and I've raised, that it's not necessarily paying for a medical education mission.

Now that being said, if we are going to have these payments I can see a good rationale for Jack's suggestion. One of the common complaints about traditional Medicare from lots of quarters is that we have a quality problem and traditional Medicare is a big part of the problem, and it doesn't really do anything to address quality of care even though the way this is set up it is limited to teaching hospitals. I sympathize with Glenn's objection here.

In effect, conditioning the subsidy on some measures like adopting information systems would have the effect of having Medicare get closer to the vanguard of trying to do something about the quality chasm. So if we're going to have this subsidy I think I'm in favor of conditioning it in the way Jack suggests.

MR. FEEZOR: Actually, Joe took some of my comments. I haven't had many epiphanies but I would strongly associate mine with Jack. In California we're trying -- we know we can't come up with any additional dollars so what we're trying to do is, can we get better

results and a different set of dynamics with the dollars we are spending? I think Joe is right on target. There are very few times that Medicare can do that. We seem to be, as you said, driving in our rearview mirror.

I think if those dollars are going to be spent, demanding accountability that would make some changes, that would emphasize both quality, effectiveness, and efficiency I think would be a very worthy cause, so I'd like for us to consider some language around those lines.

DR. REISCHAUER: Comments on comments. With respect to Nick's point, I think the recommendation says that we're just going to go to the level that the empirical evidence suggests. So you really don't have to worry that a change in that estimate because of better analysis, new data, whatever, is going to cause a problem.

The real question that's relevant, it strikes me is, is 0.5 in one year too big a fish to swallow? Should it be 0.3? Should it be 0.7? Who knows? But if there was a sudden surge of analysis that showed the appropriate payment level was really 4.8 percent rather than 2.7 we'd go down 0.5 in one year and 0.2 in the next year and then just stop. So I don't think that's something that we should be

concerned about.

With respect to David's point, taking Joe's amendment that these aren't publics, they're really social goods, and hospitals, many hospitals of all kind provide these. Teaching hospitals might provide more than others but it certainly has to be an extremely bizarre way to distribute money for providing social goods, to distribute it based on the ratio of residents to beds and the number of Medicare patients that you serve. You've got to ask yourself, what is it that they're doing and let's pay them for what they're doing.

With respect to Jack's point, I guess I can swallow hard and overlook the trust fund source of payment and focus on the education role. But I really think this is a huge issue and what we really should do is spend some time thinking about exactly what kind of leadership role do we want these institutions to provide. Somehow I think that this is a recommendation that is not going to be adopted by Congress within the next couple of weeks and we might be here next year having the same discussion, at which point we would have the time to think about a more careful definition of exactly what it is that this money should be devoted to

and how one would design the incentives and the procedures and the eligibility, whether it would extend beyond teaching hospitals or not.

DR. ROWE: More detailed. I was careful; just imprecise.

MR. HACKBARTH: Of course related to that is also, what is the right amount for this additional purpose? Is it, just by coincidence, $2.6 billion, or is it some other amount? I have David and then I'd really like to move ahead, Ralph, if we can.

MR. MULLER: I'll be very brief.

MR. HACKBARTH: Maybe even briefer than you realize.

[Laughter.]

MR. SMITH: To Joe and Bob, I thought I said social goods. You're absolutely right, these are things that we value. They aren't public goods the way economists think about them.

If I understand Jack right, and as usual Jack's epiphanies are provocative, what he's proposing, and I support it, is that we increase the empirical level. That we devote more resources to the teaching mission, that we

get more sophisticated, that we improve both the quality of the inputs and the share of resources that we devote to it. I think that's right. I don't know what the right number is, whether it's 2.8 or 3.5.

But the question that we're being asked to deal with in this recommendation is not whether or not the empirical level is right, but whether or not the subsidy, in addition to the empirical level, should be retained. I don't think Jack's question or Jack's proposal addresses that.

The arguments that Nick and Allen and I tried to make didn't speak to the question of whether we are appropriately investing in the educational mission. I'm quite sure Jack's right, and to the extent that he wants to propose increasing it I think we should take that very seriously.

But that's not an argument that says that we ought to arbitrarily -- and, Bob, you're right, it's a bizarre formula. But it is the formula that we have. We are where we at the moment and we are buying something that Congress has regularly considered that it wants us to purchase. Either the proposal before us or Jack's modification would

result in a recommendation from this commission that we stop buying those social goods. I think we shouldn't make such a recommendation and when the time comes I'll oppose it.

MR. MULLER: This goes to both Bob's and David's and other point, is we keep talking about the empirical level, and certain in these 19 years since PPS we have used the resident ration as a way of allocating the payments that are under the broad definition of IME. That, as I said earlier, and Sheila being present at the creation affirmed, that wasn't the only purpose for which the IME payments were intended.

We use the resident ratio -- I grant with Bob it's not -- it seems to be the measure that we have and have used for 19 years, and people have tried to come up with other ones. But it's not the only purpose for which IME was intended; the support of residents and just the indirect costs that come from having residents inside a hospital.

So I want to second David's point that the subsidy above this so-called empirical level is in fact something that we should support and have supported. The fact that we have only this resident ratio as the one by which we've been distributing these payments over these 20 years doesn't mean

that's the only purpose for which this payment is intended.

DR. NELSON: If I'm going to vote against the recommendation -- and I haven't spoken and I've been trying to get recognized -- I ought to have an opportunity --

MR. HACKBARTH: I'm truly sorry.

DR. NELSON: I ought to have an opportunity to say why I'm going to vote against the recommendation.

My concerns have to do with reducing the payments to the teaching hospitals from 6.5 to 5.5 percent, and reducing it further when we haven't seen the impact of the earlier reduction from 6.5 to 5.5 percent, with no understanding of within that very small Medicare margin, whether that's a bimodal curve with one population of major teaching hospitals that's doing very well and another population that may go belly up as a result of this cut.

So my concern is with making a further reduction in IME payments when we haven't seen the impact of the current reduction that we're only three months into, given the uncertain circumstances and my inability to know how big of a problem that's going to cause for how many large teaching institutions.

MR. HACKBARTH: I'm sorry, Alan, I didn't see your

hand. Have I missed anybody else? I really don't want to prematurely cut off, but I do feel like we need to move on here.

If there's nothing else, here's where I think we stand in terms of process. We have the draft recommendation on the table and I'd like to vote on that. Not right this minute but when we get to the end of the whole package. Then, Jack, I have a question for you on whether you want to offer, after that vote, the Rowe proposal? If so, I'm going to put the heat on you to come up with some specific language so that we've got something in front of us.

DR. ROWE: Given any encouragement, I'd be happy to do that.

MS. DePARLE: I hope you will. Some of use haven't spoken, but I like that proposal I'd like the chance to address it.

MS. RAPHAEL: One clarification. At the end of this we're going to integrate all of these and get the full impacts, aren't we, before we vote?

MR. HACKBARTH: Yes, there actually will be some impact analysis that shows you the effect of all of it together, which again will underline the fact that we've

talked about these as piece of a whole as opposed to discrete proposals. But we'll do that at the end, Carol.

So what I hear, Jack, is some interest in your putting pen to paper, so go ahead and start writing.

For the time being, we will move on from teaching to the expanded transfer policy.

MR. PETTENGILL: At the December meeting Craig presented information about the so-called expanded transfer policy in the hospital inpatient prospective payment system, and the rationale for and the effects of expanding that policy to additional DRGs.

In a subsequent discussion you raised some important concerns about the policy's impact on hospitals and patients, and just to refresh your memory I thought it would be useful to identify what those concerns were.

One was that extending the policy would undermine the averaging principle that is central to the prospective payment system. Another was that it would penalize hospitals that improve efficiency. A third was that it would create incentives to discharge patients to home without post-acute care or to extend their inpatient stays. Another was that it would disproportionately affect

hospitals located in regions that have relatively short length of stay patterns because they would be more likely to trigger the policy with short stay transfers to post-acute care.

Finally, some people argued that we don't really need to do this because most patients discharged to post-acute care have relatively long stays, and second, because Medicare has hardly switched its payment methods for most post-acute care providers from cost reimbursement to prospective payment, thereby presumably vitiating the incentives to transfer people.

In this session we're going to review the rationale for the policy quickly, and the evidence, and then present a draft recommendation. Along the way we'll try as best we can to address the concerns that were raised at the last meeting.

For the benefit of commissioners and members of the audience who were not here at the December meeting or missed that discussion I'd like to begin with a brief review of the origins of the transfer policy and a little bit about how it works, and then I'll talk about the rationale for extending it, and the flip side, which of course is, what

are the implications of not extending it?

Then Craig will present some data, which is mostly new, that we hope will help you to decide whether it would be desirable to extend the policy to additional DRGs, and if so, how rapidly that extension should occur.

So let's begin with the origins of the transfer policy. I want to start by saying that the transfer policy has always been a part of a larger design, as part of the payment system, for dealing appropriately with factors that might change the service content and the cost of care over time.

The initial DRG payment rates reflected the historical cost of the service bundles associated with the DRGs in the base year of the prospective payment system. But hospitals facing fixed price payment have very strong incentives to reduce their costs, and they can go about doing it in a number of different ways. One of them, for example, is to adopt process improvements and new technologies that improve productivity and reduce costs. Another is to shift services to another setting, either at the front end of the stay or at the tail end of the stay. A third is simply to stint on care and provide fewer services.

Now policymakers at the dawn of all this recognized that the prospective payment system would have to have policies to address these kinds of changes. The most obvious processes or policies in place are the annual processes we use to update the base payment rate and to recalibrate the DRG weights and the wage index, and so forth. Those policies are appropriate vehicles for dealing with changes in technology and practice patterns that affect the cost of care in a DRG, broadly within a DRG or across all DRGs and hospitals where you have essentially the same phenomenon, reductions in costs going on widely. In fact MedPAC, and ProPAC before it, and CMS have all had site of care substitution factors in their update frameworks for many years.

The site of care substitution component was intended to reduce the update when hospitals were decreasing their costs by discharging patients to post-acute care, thereby shortening their inpatient lengths of stay and providing fewer services then were implied by the DRG payment.

In addition, the prospective payment system has always had policies designed to reduce the financial rewards

that providers could earn by unbundling care to other settings. For example, the 72-hour rule says that if a hospital provides in the outpatient setting related services within three days prior to an admission, those services are part of the stay and can't be separately billed.

At the tail end -- and here the transfer policy applies, originally it applied only to discharges to other PPS hospitals after a short stay where, arguably, the transferring hospital was not furnishing the same product as for cases that were kept in the same DRG till discharge.

In the BBA, Congress extended the policy to cases discharged to post-acute settings after relatively short stays out of essentially the same concern, that providers were not furnishing the same product in these instances. This policy was implemented for the initial 10 DRGs beginning in 1999. The Secretary was authorized, but not required, to expand the policy to additional DRGs, and in the proposed rule for fiscal year 2003, this year, the Secretary considered expanding the policy to an additional 13 DRGs and to all DRGs. But facing substantial pressure from the industry, the Secretary was not prepared to go forward at this time without reviewing all of the concerns

that were raise in comments to the proposal.

Now a little bit about how the post-acute care policy works. First, it applies only for cases that are discharged to PPS-exempt hospitals such as rehabilitation hospitals and units, psychiatric hospitals and units, or long-term care hospitals, or to skilled nursing facilities. It also applies if a patient is discharged with a plan of care to related home health care that begins within three days after discharge.

Transfer cases are paid a per diem payment rate for each day up to the full DRG rate, and that per diem is simply the regular DRG payment rate for the case divided by the national geometric mean length of stay for the DRG. So a hospital in a DRG that has a payment rate of $5,000 and a geometric mean length of stay of five days, the per diem payment would be $1,000. The payment is a graduated payment. It's doubled for the first day, to reflect the fact that in almost all DRGs, the most expensive day is the first day, and that's followed by less expensive days as you go further out in the stay. So the hospital would receive $2,000 for the first day and $1,000 a day for each subsequent day up to the full DRG rate, which would be

achieved at day four. That is, one day below the geometric band length of stay.

As we noted in the mailing, in some surgical DRGs where you have very high costs in the first day, more than half the cost is incurred in the first day, there's a modified method in which the hospital receives half of the full DRG rate plus a per diem payment, and then half a per diem payment for each subsequent day. Of course, in this case they still reach the full DRG payment one day before the geometric mean length of stay.

I'd now like to turn to the rationale for extending the policy to additional DRGs.

MR. HACKBARTH: Julian, can I interrupt for just a second? I just want to make sure that we're using our time effectively. Do people feel like we're going over things that they're very familiar with in terms of the mechanics of it and the rationale? If so, maybe it would be good, Julian, to skip ahead a little bit in your presentation so that we can maximize the amount of time we have for discussion.

MR. PETTENGILL: Okay. All I was going to say here is that there are basically three reasons to do it.

One is that you want to recognize that hospitals, when they transfer patients to post-acute care, are not providing the same product. Now that may not be true 100 percent of time. There may be individual cases where they are in fact providing the same care that someone would get if they were discharged to home the same day. But it's true a portion of the time.

Another reason is to promote payment equity by targeting the reduction in payments to the cases where a different product is actually being provided, and not to all hospitals. A third reason is to create a better balance between the financial rewards of transferring patients and the clinical reasons for doing so.

You might well ask why the normal update process can't be used successfully. The answer to that is on the next slide, and it's basically that site of care substitution isn't uniform. It's concentrated in some DRGs much more than others, and it's concentrated across hospitals, as some data that Craig will show you, will demonstrate. The annual update and recalibration processes essentially treat all cases the same way, so they would reduce payments to all -- to the extent that transferring is

occurring, they would reduce payments for all cases.

In fact in DRGs where there's heavy use of post-acute care, it would reduce the DRG weights because the short-stay cases that are low cost cases are being counted as full cases just like any other and it brings the average down. So what you'd be doing, if you don't extend it, is underpaying cases that are not transferred relative to those that are.

Now Craig will present some data that we hope will help you to make a decision here.

MR. LISK: I'm going to start out with some evidence of substitution over the past decade. First, we have seen Medicare inpatient length of stay drop by 35 percent, which is greater than what has been experienced by the private sector. At the same time, the proportion of cases discharged to post-acute care increased substantially by -- increased 49 percent. In 2001, 30.5 percent of cases were discharged to post-acute care settings. The increase since the beginning of PPS is even much greater than these numbers imply.

We can interpret this data in two ways. One, all the growth in post-acute care was new care and the length of

stay declines observed would have happened anyway. Or some part of the increase in post-acute care use represents substitution from the inpatient setting and contributed to some of the declines in length of stay. The latter, we believe, seems more plausible. Some other information that corroborates that is some of the other supporting evidence includes greater length of stay declines in DRGs with high use of post-acute care compared to other DRGs, and greater length of stay declines for post-acute care users compared to non-users. There's evidence of that substitution.

This next slide shows the length of stay distribution for DRG 14 which is for strokes, one of the 10 current DRGs affected by the post-acute transfer policy. There are about 300,000 cases in this DRG with a little more than half the cases being discharged to post-acute care. Cases discharged to post-acute care with length of stay from one to three days would have payments reduced under the current transfer policy, and hospitals receive full payment at four days and longer.

We're showing you this and another chart, but we observed this pattern in terms of length of stay pattern is typical across DRGs of post-acute care users and non-users.

So what we observe is that transfer cases tend to have longer stays and fewer shorter stay cases. The shorter stay cases are generally less common.

So here we have the same information for DRG 79, which is for respiratory infections, one of the 13 DRGs that was being considered for expansion. Again in this DRG, cases staying one to five days would have their payments reduced under the transfer policy. Again, the picture is similar to the previous chart and is pretty consistent across DRGs.

I also wanted to bring up one other point. Some have argued that we do not need post-acute transfer policy because these cases have longer stays. But in fact some do have shorter stay, as we showed. Yes, they are less common than for non-transfer cases but there are many cases that do have -- that go on to post-acute care that do have shorter stays.

We would suspect that the distribution would shift somewhat to the right, if we asked the question of, what would happen to these cases if there was no post-acute care provided? We would suspect if there's some substitution going on that they would have stayed a little bit longer in

the hospital and the distribution would have shifted some to the right.

DR. MILLER: Craig, can I interrupt for just one second? We're looking ahead and also looking at the time. I notice that we have a lot of charts for different kinds of DRGs. Is there a way to move through this and to make your point with one DRG and move past --

MR. LISK: We're using just one DRG here. There's several slides that show the different relationship of payment to cost ratios and we can go through those pretty quickly.

This next slide we group hospitals by the percent of cases discharge to post-acute care, which is shown in the first column. The second column shows how they are distributed with 10 percent of hospitals discharged less than 10 percent and other Medicare cases going to post-acute care, and 4 percent at the bottom, discharging more than 50 percent of their cases.

As we can see, hospitals vary in their proportion of cases discharged to post-acute care. This is consistent across DRGs. Those with high rates of post-acute care use consistently have higher use rates across DRGs, and those

with low rates of post-acute care use consistently have lower use of post-acute across DRGs. These findings hold whether the DRG has a high rate of post-acute care use, like DRG 209, which is for hip replacements, or DRG 116, which is for pacemaker implants.

This next slide shows the payment to cost ratio for transfer cases before and after the transfer policy. The red line shows the ratio before the transfer policy and the green dotted line shows the payment to cost ratio for transfer cases under the policy. Now we're showing just one example but the findings are very similar across all DRGs that we have examined. We examined for all 13 DRGs considered under the expanded, and additional DRGs as well. But this relationship is very similar.

The chart shows the rewards for discharging patients early without post-acute care transfer policy is very large. But even after applying the policy we are still paying substantially above the cost of care, just the size of the reward for discharging early is diminished under the expanded transfer policy.

These very high payment to cost ratios may imply that the cases are not getting necessarily the full

complement of care implied by the average payment for the DRG.

This next slide shows how the distribution would change if we consider all other cases, and what we see is actually across the full length of stay and we see that the distribution drops just slightly. The basic averaging principles of the PPS though still hold. Now some have argued that the transfer policy violates the principles of PPS averaging. However, the old average implied by a full DRG payment is no longer the correct average if some of care has moved from the hospital to another setting. The transfer policy, rather than reducing payments across all cases, the policy reduces payments for cases where the substitution likely occurred. That is cases discharged to post-acute care with short stays.

Another interesting finding though that we find is this next slide that shows payment to cost ratios for post-acute care users and non-users. What we find in this slide, the red line is for post-acute care users is higher than for non-users. Meaning that the post-acute care users for the short stays have lower costs than other cases, meaning they may not be getting necessarily as many services as implied

by the full DRG rate. This is a consistent pattern across DRGs. This may also imply, again, substitution is going on for these cases.

DR. NEWHOUSE: I don't understand actual to expected length of stay. What does expected length of stay mean?

MR. LISK: Expected length of stay is, given your case mix, what you would -- if you stayed the average for the DRG, what your length of stay would be. So if you have an expected length of stay that is lower, you are staying less than average.

In this next slide we group cases by the proportion of cases discharged to post-acute care with short stays. In other words, the percent of Medicare cases that would be affected by the post-acute care transfer policy. The second column again shows the distribution of cases.

No motivation for this table was to show how hospital's financial performance might be related to the percentage of cases hospitals discharge to post-acute care after a shorter than average hospital stay. We find that hospitals with a larger proportion of short stay transfer cases have higher Medicare inpatient margins, and these

margins are without DSH and IME above cost, reflecting the margins for the base rates.

What contributes to this better financial performance? Hospitals that discharge a large proportion of cases to post-acute care with short stays have length of stays that are lower than expected given their mix of cases. The lower length of stay is a good thing and one factor that contributes to their better financial performance. They also discharge a greater proportion of cases to post-acute care as well, and the combination of these factors may be what's contributing to their lower length of stay and their better financial performance.

But this brings up another concern that was raised at the last Commission meeting, that the transfer policy might penalize hospitals and regions with short stays. As the table above shows, length of stays varies by regions, although the differences are not as great as they used to be.

If we compare average length of stay with the percent of cases discharged to post-acute care settings with short stays we do see an inverse relationship. Hospitals and regions with shorter average length of stays tend to

have a greater fraction of cases discharged to post-acute care with short stays, the second column in the table. That's post-acute care cases, how many are discharged with short stays.

But that one column does not drive what the effect of the impact of the transfer policy. The percentage of cases affected by the policy is a product of two components. First, what proportion of cases you discharge to post-acute care and then how many of those have short stays. So the net effect is not as great when you combine the two effects.

It's also important to remember that the PPS is a national payment system so we don't have policies that vary other than the wage index that vary by hospital's local circumstances. And the hospitals with shorter average stays benefit for all their other -- should benefit for all their other cases that have shorter than average lengths of stay.

DR. MILLER: So, Craig, the point here in this chart is that -- the specific question last time was a concern that length of stay varied across the country and that this policy would essentially be penalizing people just for having short lengths of stay.

MR. LISK: That's correct.

DR. MILLER: And what this shows is actually the intervening variable that is relevant here is what proportion of cases are sent to post-acute care, transfers, and then the relationship between regional length of stay and the impact of the policy is no longer clear. It's much more just a random --

MR. LISK: Yes, it's less clear.

DR. MILLER: That's what I think the point of the slide is.

MR. LISK: The next two slides I'll show will show the payment impacts of expanding the policy to all DRGs. As we see here, it's related to the percentage of cases discharged to post-acute care, with larger impacts on hospitals that discharge a greater proportion of their cases.

We show here both the impacts for the initial -- for the 13 DRGs and the impacts of expanding to all DRGs. The impact across hospital groups is fairly uniform. You have that table in your report so I'm not going to show you that here today.

Now these impacts are based on modeling of the 2001 claims data. You may see slightly different results

from Jack's presentation when we factor this into -- in terms of the total impact when you factor this into 2003 payment policies. The total impacts are a slight bit lower, 0.3 and 1.1 percent overall from going to a full expanded from those two numbers.

Then finally this next table shows really what is the undiluted impacts of the policy with the proportion of cases affected by the policy. We see that the impacts are much greater on hospitals that discharge a high proportion of cases to post-acute care with short sure stay. Under 13 DRGs, those that discharge more than 15 percent of their cases with short stays to post-acute care is -1.1 percent under 13 DRGs, and under all DRGs is -3.8 percent. This policy basically targets hospitals with the greatest amount of site of care substitution in terms of the focus.

So this leaves us with the recommendations. We have two options here. The first one is, that the Secretary should add 13 DRGs to the post-acute transfer policy in fiscal year 2004 as part of a three-year phase-in. It expands the policy to all DRGs.

In terms of the buckets that we have for the impacts, this would be in the category of $200 million to

$600 million over one year, and the five-year impact would be in the category of $1 billion to $5 billion.

The alternative recommendation B is that the Secretary should add 13 DRGs to the post-acute care policy in 2004 and then evaluate the impact before proposing further expansions.

The one-year impact of this policy would also be in the $200 million to $600 million category and the five-year impact would be in the $1 billion to $5 billion category as well, but at the lower end of that category compared to the first.

DR. STOWERS: Craig, obviously you were not talking about doing this budget neutral. This was originally presented to us to help better distribute funds between those hospitals across the country that may have availability of post-acute care and those that might not. That was the premise that we started on. If in fact we were really trying to fulfill that premise, wouldn't this be budget neutral rather than otherwise? I'm just asking that question on the budget neutrality because it's come up several times already.

MR. LISK: I think you have to think about that in

the context of all the recommendations you're considering today.

MR. HACKBARTH: Let me just pick up on that point. If you were to apply that concept here you would need to apply it, I think logically, in some other places in the package as well. For example, the change in the base rate, and going to a single base rate as opposed to a differential for the rural and other urban.

Unfortunately, I have a piece of paper that you don't have but you can piece it all together. But the bottom line is that if you applied this budget neutrality concept to transfer policy and the single standardized amount, basically they offset each other in terms of the net budget impact. And I think you'd have to do it for both of them, so you end up at zero. One is a plus 0.3 and the other is a -0.3. So in terms of our aggregate budgetary impact you end up at the same place.

DR. STOWERS: The package concept.

MR. HACKBARTH: Right.

DR. WOLTER: Is that if we expand the 13 DRGs or to all DRGs?

MR. HACKBARTH: That is the 13.

MR. DURENBERGER: Question about what information we have about what I'd call discharging up as opposed to discharging down. In other words, a lot of rural or smaller hospitals frequently on admission find complications that they can't handle in a patient and they will discharge to a tertiary care hospital in some larger community and so forth. Are there certain presumptions about all of this that are based on both kinds of discharges?

DR. NEWHOUSE: This is all independent of that. That just continues as it's always been.

DR. WOLTER: I want to thank both of you for trying to address many of the questions asked last time. I still have a few.

When you say that looking at how marginal costs are covered extends to DRGs to which the transfer policy would apply, that still remains a little bit vague and there's really no sources cited in the paper and that has been said several times; have we looked at all 500 DRGs? Have we looked at the additional 13? Have we looked at a random sampling of those beyond the 13?

MR. LISK: We have looked at all 13 DRGs that are included plus a random sampling of other DRGs that both have

high post-acute care use and actually low post-acute care use, and our findings are consistent across DRGs. Then you have the cases where you do have some cases where the payment to cost ratio is below one when you put in the transfer policy, the basic transfer policy, but when you do the modified payment that Julian described, their payment to cost ratio then goes well above one in those circumstances. But this is consistent across all the 13 DRGs we examined plus a random sample of other DRGs.

DR. WOLTER: I think this is an important question, at least for those of us in this business because I think we believe that there is a universe of DRGs where there's a pretty good margin and there's a universe of DRGs where almost always there's a negative margin. I think in particular their proposal to extend transfer policy to all DRGs has many of us questioning what that will do to margins.

I would also say that I didn't quite understand the argument that because there are still a number of short transfer cases that we shouldn't be concerned that, I think it's some 72 percent on average within a given DRG where there's a short stay transfer are actually transferred at

length of stays beyond the mean geometric length of stay. So I think a number of us are concerned about this will all work out over time, particularly with changes in the last few years where length of stays have certainly moderated in terms of their changes.

Also, I think there are a number of us concerned about the mix of a per diem philosophy with the DRG averaging philosophy. This is even complicated further by the fact that we now would have the DRG averaging philosophy, the transfer policy, and the modified transfer policy. It does become a bit complex in terms of the way that it affects incentives.

Also, there's a number of comments in the text about overpayment and paying twice. One of the concerns I have does have to do with some of the complex cases that are currently being transferred into hospital-based SNFs. I think it's the belief of some of us that even with what might be considered double payment, the combination of the two payments is probably not covering the total cost of care, particularly when you look on the SNF side at some of the negative margins and the fact that there are more patients going into those hospital-based SNFs that are of

the high acuity and complex non-rehab patients.

I'm also a little bit concerned about the statement that this will have a negligible effect on beneficiaries. I don't know what the effects might be, and certainly no one does, of extending this to all DRGs. But if we should see an acceleration of exiting of hospital-based SNFs, I think access to care on the part of those higher acuity, more complex patients could possibly be affected and I think we should be mindful of potential unintended consequences.

Then lastly, you showed a chart on the relationship of short stay transfers and margins which I noted is in our text and our handout as well. What strikes me there is that 58 percent of -- excuse me, it's about 74 percent of hospitals are discharging between 25 and 33 percent of their cases to post-acute care. That's a large number. That's the second and third lines on this chart. That's a large number of hospitals.

But this particular group actually has a ratio of actual to expected length of stays that are within the normal range. They also have Medicare inpatient margins, after your adjustments, that are not very healthy. I think

that we're targeting in this policy, it appears we're targeting the bottom two lines which represent somewhere between 3 percent and 15 percent of hospitals. I'm very concerned about the effects of expanding the transfer rule to all DRGs because it's going to hammer 75 percent of hospitals who are ill-prepared to accept it, even though if there is a rationale to it, it may be targeted to that 13 percent and 3 percent of hospitals that are on the lower two lines there. And if you look at the margins of rural and other urban hospitals, I think my concerns would be echoed there as well.

So I think there are some significant issues here that perhaps haven't been entirely worked out.

DR. NEWHOUSE: I'd like to make a couple points. One is in response to Nick's point that this somewhat mixes the averaging principle and the per diem principle, which I agree, and also somewhat in response to the points and the mail that we've all received that this undermines the averaging principle.

The point I want to make is, the averaging principle isn't necessarily a good thing. If you have cases that you make profits on and cases that you take losses on,

you have incentives to want to try to attract to your institution the cases you make profits on and shunt off to somebody else's institution the cases that you take losses on. So trying to cut down the variation within a DRG in what we pay for relative to cost -- that is, to cut down the absolute amounts of profits and losses seems to me a good thing. So to the degree that we're undermining the averaging principle by doing that, that seems to me a good policy.

The second point I wanted to make, and this is why I favor option A because I think this is basically good policy, but we have had, in terms of the difference between A and B, either way we add the 13 and the only issue is whether we stop or not. We've had this policy is for several years now; if I remember right, since '98. I think the BBA put it in, although I can't remember exactly when it was implemented.

MR. LISK: Fiscal year '99.

DR. NEWHOUSE: As far as I know, nothing terribly bad has happened in the 10 DRGs where this policy has applied. So I don't think there's a very good case for thinking that we would learn a lot that we don't already

know from evaluating what happens to 10 more DRGs.

Now the issue of, what about the overall budget impact I suggest we defer until next year, because for this year we're only going to consider these two options, adding the 13 DRGs. We can face next year what would happen in the update factor if we go beyond the 13 DRGs.

DR. WOLTER: Can I just respond to Joe's first point because I absolutely agree with it. I think we shouldn't probably have a system where incentives are to carve out certain DRGs, which by the way is going on all across the country right now. I'm just not sure this actually will have the effect of equalizing out where the bottom line is in certain DRGs versus others.

DR. NEWHOUSE: That wasn't my -- it's not the between-DRG variation, it's the within-DRG variation. So what the transfer does is it cuts down the profits I make on my short stays, and therefore my incentives to try cream off the short stays. Then depending on what happens in the base rate -- meaning the mean payment -- it doesn't do anything about the far right but it potentially shifts also right around the mean.

DR. WOLTER: I think that's the problem I'm

raising, is that we're focusing on the short stays but we may not have full information about how we're doing on the longer stays, and will we end up in a good place? When you look at 75 percent of hospitals, the we extend to all DRGs, having 1.3 percent of their payments taken out when they're already at inpatient margins with these adjustments of -0.9 to 1.8, I think that's a significant problem. At the very least it would argue for retaining the money in the system at least until we can see how the three-year reweighting of DRGs turns out.

DR. MILLER: But the point of that table -- I don't think you're incorrect, but the point is that those hospitals use post-acute care transfer significantly less than other hospitals. That is one point here.

DR. WOLTER: They use it 25 to 33 percent of their discharges, and yes, that is significantly less than those using it 43 to 50, but it's still a significant number of their cases that they're discharging to post-acute care.

MR. LISK: No, it's the first column. It's the first column in terms of the percent of cases that are affected by the policy.

DR. WOLTER: What's the third column then, Mark,

where it says percent of cases discharged to post-acute care?

DR. NEWHOUSE: It's all cases discharged to post-acute and the first column --

DR. ROWE: It's just the short stay that they're focusing on, Nick, so it's the left-hand column. It's a very small effect for those first couple hospitals.

MR. LISK: We're just showing that of those who have a lot of short stay transfers, they do have more cases that are discharged to post-acute care.

MR. HACKBARTH: Can we turn to the recommendation page for a second? Joe, you had a comment on the structure of the recommendations that wasn't sure that I followed.

So some other reactions on the two recommendations that are on the table? We can just wait and then vote sequentially on them, or if there's a clear consensus we can save ourselves some time later on. Any thoughts?

MR. MULLER: A brief question. Insofar as we think that these transfers are largely driven by financial rather than clinical considerations, if we change the financial incentives wouldn't we therefore logically assume that they'll change their behavior and then we don't save

any money on this?

MR. LISK: No. We're not implying that the first point that you're making is that this is perfect -- in terms of what hospitals are doing in terms of discharging these cases of short stays is likely perfectly clinically appropriate. What we are saying though is that because those cases needed to be discharged to post-acute care, that less services are being provided. If those cases weren't discharged to post-acute care they would have stayed in the hospital longer and had higher costs.

So what we're accounting for is site of care substitution that may have occurred for those short stay cases and reducing the DRG payment for those instances where that occurs.

MR. HACKBARTH: Any other pressing comments on this one?

MS. DePARLE: Just a question. In the letter that we got from the American Hospital Association, I think maybe in the comments that they made at the last session of public comment period, they suggest a concern that the recommendations we were considering at the last meeting did not suggest returning the savings from this policy or from

expansion of the transfer policy to the base DRG rates, which they say was a concept that MedPAC endorsed in June 2001. I wasn't here then. I just wondered if someone could comment on whether that's the case and what the thinking was then.

MR. PETTENGILL: That was discussed in the June 2001 report which was about health care in rural America and Medicare in rural America. The context was ways in which -- and actually it was a mistake, I think to put together the redistributive impact of the expanded transfer policy with the question of whether aggregate payments are adequate in the prospective payment system. They're two separate questions.

If you believe that the transfers result in less service to patients and therefore less cost to hospitals, and you shouldn't pay for something you're not getting, then you should take the money away. And if it turns out that you also believe that payments are not adequate in the aggregate, then you should do something about that. But it's a separate issue.

DR. WOLTER: I'll try one more time. If you look at the distributional impact of expanding transfer policy to

all DRGs, I think at least the point I was just trying to make at least partly holds, because even if you're transferring patients who are affected by the policy somewhere between 2 percent and 10 percent of the time, if the transfer policy extended to all DRGs it would reduce payment by 0.7 to 1.3 percent, if I'm reading this correctly. And that would be the group that always has inpatient margins with your adjustments of -0.9 to 1.8 and I think that's a concern.

MR. PETTENGILL: Nick, it's actually the group that has margins in that range after you exclude revenues from DSH and IME above cost.

DR. WOLTER: I understand that.

MR. PETTENGILL: Which isn't the same thing. If you wanted to know the answer to that you'd have to look at the inpatient margin, the full inpatient margin, to tell you where hospitals really are. We took the DSH and IME above cost revenues out because we didn't want them to distort the pattern that you can see in the margins on the base rate.

DR. WOLTER: I understand that, although if you look at other urban and rural margins, as you've just suggested, I think that the transfer policy, since it's

roughly going to affect them the same as other groups, the impact I'm talking about would exist.

MR. HACKBARTH: I sense a waning of our collective energy, or at least my individual energy, so I'm going to ask that we move ahead. Again, we will come back to vote on the recommendations at the end.

Next up is the previous MedPAC rural recommendations. Here I think we can move very quickly, if not at the speed of light, since these are -- we have considered these at length. They are recommendations that we have already made in other contexts. So if you could give us the one-minute version, Jack, that would be real helpful.

MR. ASHBY: All right, I will be unusually brief then, especially for me, I suppose.

This first slide I'll just pass right over. This speaks for itself. We have four previously made recommendations. To get right on to the first of them, implementing a low-volume adjustment. Just in short, the rationale was based on the fact that hospitals with low volume really do have higher costs, and they have lower margins. So with that I'm going to go right to the draft

recommendation.

The recommendation language is pretty clear; enact a low-volume adjustment. But we do have an issue here that we need to talk about that came up last time. That is that ideally we want to restrict the adjustment to hospitals that are playing a significant role in protecting access to care.

There are two ways that we can do that. One is the one that we raised last time, that we could restrict it to hospitals that are more than 15 miles away from another facility. But it was suggested that since the savings from doing so are very small -- and indeed, that is the case, they are very small -- perhaps we ought to just not bother with it and make the adjustment available to all low-volume hospitals.

But I did want to point out one potential problem with doing so, and that is that we have anecdotal evidence that suggests that some very small specialty hospitals have been built or in the process of being built in urban areas that might then qualify for the adjustment. Clearly, it seems that facilities of that type would not be in need of special assistance and to give them that, or to let them qualify might further unlevel the playing field for

specialty services.

So one simple way to get around that problem is to simply say that we restrict this adjustment to hospitals that are located in rural areas. But that's not airtight. It's conceivable we could have a specialty hospital in a rural area. Also conceivable you could have an isolated hospital that's in a nominally urban area. So we have to pick between these two.

MR. HACKBARTH: If I may I'd like to cut to the chase on this one. I recognize the dollar impact of the 15-mile limit is minuscule. To me it's more important as a conceptual point than a fiscal point. I don't think that we ought to be in the business of providing additional payments to low-volume hospitals that are low volume just because they're next door to another hospital. Just as a matter of principle that would bother me, even if the dollar effect were small. So I would strongly recommend that we stick with our original formulation which was option number one here.

MR. FEEZOR: I just think 15 is too small.

MR. HACKBARTH: That may be, but we could spend the next 45 minutes debating what the right number is and

I'd just as soon not do that. I think the point is made with recommendation number one.

Okay, Jack, next up?

MR. ASHBY: Next up is re-evaluating the labor share. In short, we have evidence that suggests that the labor share may be set too high but we have not yet done an analysis that is designed to isolate the "best" labor share for the hospital industry as a whole. So because of that we have worded the recommendation in this general way, that the Secretary should re-evaluate the labor share that is used --

DR. NEWHOUSE: Jack, why do we have to have one labor share for the industry as a whole if the labor shares importantly differ between urban and rural areas?

MR. ASHBY: I think the concern is that if we get into multiple labor shares then we set up a scenario where there may be an incentive to manipulate your labor share. And that's the last thing we need is to have one more opportunity for hospitals to do things to maximize their payments.

DR. NEWHOUSE: Wait a minute. You've still got hundreds of hospitals in each of those categories so if you manipulate your share you're still not doing anything to the

mean.

MR. ASHBY: That of course depends on how far you go in disaggregating it. But let me point out too that the research suggests that if we had a separate labor share for urban and for rural what we would actually end up with is the labor share would be higher in rural areas and not lower.

DR. NEWHOUSE: How much higher?

MR. ASHBY: That again gets back to the analytical thing. It's really hard to peg that down.

DR. NEWHOUSE: I was going to your issue that you were going to spend time analyzing the best single rate, and I'm not sure that's the best way for you to use your time, but I'll see what others have to say.

MR. HACKBARTH: Joe, I can see your conceptual point but it doesn't seem timely right now. We could have raised that issue sometime in 2001 when we first considered this recommendation. So if we want to at a later point open up that conceptual issue we can, but it's too late for this purpose.

DR. NEWHOUSE: It goes to how this draft recommendation is going to be implemented, what we mean by

it.

MR. HACKBARTH: This assumes a single labor share and that's what it's been since we first considered it two years ago. If at some point in the future, in the next cycle we want to say, maybe we ought to think about, okay. But we can't resolve that today. We're voting now, not opening up new issues.

MR. ASHBY: The budget implications of this one are none. This would be implemented budget neutrally.

The third recommendation has to do with eliminating the base rate differential. Here again the evidence is pretty clear that there is no rationale for a differential and the margins are in the same direction.

So the draft recommendation here reads, implementing this, phasing out the differential over two years. Here we do need to make note of the fact that there are budget implications here. The increase would be in the category of $200 million to $600 million in one year, and in the category of $1 billion to $5 billion over five years.

I did want to point out too that one of the concerns we received from industry here was that this should be structured with new monies and not with a differential

update, and as we can see that's what we are proposing to do in this case.

Then the last one has to do with raising the cap on DSH payments. We don't need to go through this again too but I did want to just remind everybody there is a larger major reform in the offing here and that this is an interim measure to get us through to the point where uncompensated care data will be available and we can then reform the entire system.

The recommendations is drafted as simply raise the cap from 5.25 to 10 percent. But we have an issue here left over from the last meeting and that is whether to phase this in over two years or five years, as we see on this next page. Both the Senate and the House proposed the five-year phase-in in their respective bills last summer. The two-year phase-in, on the other hand, would first speed relief, if you will, but also it in theory would allow us to be done with this phase-in by the time the uncompensated care are available to reform the system. Although I have to put in a major cautionary note that that's in theory. The odds of a complete DSH package being ready to implement two years from now are probably not very good, but in theory it could

happen.

MS. BURKE: Jack, could you just remind me in short form of what the intended newly, great revised DSH payment strategy is supposed to be?

MR. ASHBY: The larger reform?

MS. BURKE: Right.

MR. ASHBY: The larger reform would do two things. One is it would bring uncompensated care into the calculation of low income shares that are used to distribute the payments. So we would be allocating the payments more closely to the actual uncompensated care that hospitals have.

But the other objective of it was then to treat all hospitals equally. The thought was once we are using the correct allocation mechanism then why not have a single distribution formula for all hospitals?

This one again does have --

DR. WAKEFIELD: Can I ask a question?

MR. ASHBY: I was just going to do the budget implications but you can go ahead an ask a question if you like.

DR. WAKEFIELD: Go ahead with the budget --

MR. ASHBY: I did have to point out that this does have budget implications. It would increase payments in the category of less than $50 million if we go for the first year if we go with the five-year phase-in, and it bumps up to the $50 million to $200 million category if we go with the two-year phase-in. Under both phase-in approaches we end up in the less than $1 billion category over five years.

DR. WAKEFIELD: I just wanted to express support for phasing this in over two years. There's ample justification for raising the DSH cap. A year has already ticked by, at least, in the time since we first made our recommendation. While I understand that the issue here might be budget implications, I also think that there's some real inequity for rural hospitals until this cap gets raised. So I understand why we've got it phased in over five years, but I think that that's holding rural hospitals hostage in a way that our evidence would suggest is inappropriate. So I just wanted to speak to that.

MR. HACKBARTH: I agree with that. I too would like to see it two years. It seems a bit anomalous to me to say, this is a stopgap change in lieu of the overall reform but we're going to implement it over a five-year period. I

think the issue is a bit more urgent than that, both financially and in terms of equity, so I would like to see us do it in two years.

MR. ASHBY: All right, then on our speed-through technique we just have one more slide and that is the impact of these four rural recommendations. Let me go right to the -- first of all, let me point out that on the left we have the baseline margin here. This is kind of a new concept. This is the actual 2000 margin then adjusted for the 2001 increase in DSH payment and the 2003 cut in IME payment. It's a better indicator of our starting point going into these recommendations.

If you would go to the rural line you'll see that the impact is a one-year impact of an increase of 1.3 percent in their payments. That is with the two-year phase-in that we were just talking about. Notice also that despite this package being billed as improvements in rural hospital payments, there is also a 0.8 percent increase in payments for other urban hospitals. That's due to elimination of the base rate differential.

Finally, you'll notice that larger urban hospitals do lose 1/10th. That is due to the labor share issue. That

one is redistributive, done budget neutral. So these are the impacts, unless anybody has any questions.

MR. HACKBARTH: Thank you, Jack. I think we're ready to move on to the inpatient update. Are you doing that as well?

MR. ASHBY: No, Tim is.

MR. GREENE: As we discussed earlier you're considering the update for inpatient payment rates for fiscal year 2004. By current law the payment rates will be updated by the rate of increase in the marketbasket, unless Congress acts otherwise. $86 billion was spent on inpatient PPS payments in 2001. This is forecast to increase at a rate of 6.4 percent a year, reaching $103 billion in fiscal year 2004 according to CBO. Inpatient PPS payments affect care for almost 12 million Medicare discharges.

Now as we've discussed previously, the MedPAC update approach and the payment adequacy framework first looks at payment adequacy in the current year, which we've addressed, then turns to changes in costs of efficient providers anticipated in the payment year. In this context we consider changes in input prices and other factors. CMS measures input prices, as you know, with the hospital

marketbasket, the operating marketbasket in this case.

MR. HACKBARTH: Tim, I don't want you to feel left out. I'm going to harass you equally with everybody else. I'd really ask that we move to the bottom line here. We're familiar with the framework and all that. In this case I think people even know the bottom line pretty well.

MR. GREENE: Agreed. As you can see, marketbasket is growing but it's forecasted to grow more slowly, mostly notably 3, 4, and 5 percent in the payment year, considerably less than now, which parallels what I was describing earlier which is slowing growth in hospital wages. As you know, we take countertechnological change, or make an allowance for technological change. We estimate 0.5 percent in addition to hospital costs would be appropriate to take account of anticipated technology costs. We base that partly on the fact that CMS has approved only one new technology this year for payment under the inpatient technology pass-through program, which suggests that there's not that much with great expenses out there.

Finally, we make a productivity adjustment. We use a ten-year average of multifactor productivity measure that's been discussed several times. It's a measure the

Commission has used for some time and it shows steady grown over the last decade. So the numbers we're seeing here are considerably higher than they would be two, three, four years ago.

The draft recommendation states that the increase in PPS inpatient payment rate should be set increase in the hospital marketbasket less 0.4 percent. That reflects an allowance for science and technology of a half a percentage point, net of a 0.9 percent adjustment for anticipated productivity change.

Budget implications are a reduction in spending since current law would be increase in the marketbasket and the recommendation is increase in the marketbasket less than 0.4 percent. We expect a one-year savings between $200 million and $600 million in that budget category and a five-year savings of between $1 billion and $5 billion.

I'll take any questions or we can just -- do you want me to go on -- do you want to discuss it or continue --

DR. MILLER: Let's do the impacts.

MR. GREENE: This is a summary impact table that pulls together the marketbasket information and the update offset, the -0.4 percent and the distributional impact

information that you saw earlier. The distributional changes reflect the rural recommendations and the IME recommendation you've been discussing, and transfer.

MR. HACKBARTH: This is the whole --

MR. GREENE: This is the whole package, right.

MR. HACKBARTH: This is the net effect of everything in the inpatient package?

MR. GREENE: Yes. The DSH case we include is the two-year phase-in.

DR. MILLER: Though it has minor effects if you go the other way.

MR. GREENE: Yes, it makes some difference.

DR. MILLER: Overall. The way to absorb this table, moving from left to right is, the marketbasket increase in current law is currently estimated, the straight reduction off of the update, that recommendation, the -0.4, and then a set of distributional changes from IME, and transfers, and the rural policies, and then a net -- the actual increase in payments for the sets of hospitals after those changes. That's how you read that table from left to right.

MR. HACKBARTH: So looking at that first of row of

all, with the combination of the update offset and the distributional changes, we're talking about for the aggregate package a net effect of marketbasket -0.7. Am I reading it correctly, Mark?

DR. MILLER: That's right.

MR. ASHBY: I think the thing to remember is this is all 2004, so this is the first year in all cases. There's about five different recommendations that have a first-year impact and that's what we're capturing.

MR. HACKBARTH: Any questions about this? About this table in particular?

MS. RAPHAEL: No, about an earlier table.

DR. REISCHAUER: Just one reminder about this table which is that while columns one and two apply to every hospital, column four is the average for groups. So within the group there will be different hospitals coming out differently.

MS. RAPHAEL: I just had one quick question, Jack. On the chart that says accounting for cost change in the coming year, you have hospital marketbasket increases and forecast. The ones for '01 and '02 were the actual increases?

MR. ASHBY: Yes.

MS. RAPHAEL: Are there errors in what we forecast, and how are errors handled in the hospital update?

MR. GREENE: They're not reflected in the update. These numbers are actual historical numbers now, the 2001, 2002. '03 and '04 are forecasts. We don't make explicit adjustments for forecasts error.

DR. MILLER: But, Tim, when we forecast forward for purposes of calculating the margin, we use --

MR. GREENE: The actual historical --

DR. MILLER: If that data has been corrected, then we use the corrected data; is that right?

MR. GREENE: Yes.

DR. MILLER: So in that sense, for judging where they are -- and I don't want to say this wrong. We do use the accurate marketbasket.

MR. GREENE: Yes, certainly.

MR. HACKBARTH: We don't recommend each year that the policy -- the recommendation for the update go back and correct. We reflect it for underlying analysis of what's happening. We used to do that, but that's one of the things that we changed when we went to the new framework.

Anything else that you needed to present?

MR. GREENE: We just didn't go back to the margin chart. You saw this before. I'm putting it up again because it is of interest in the decision-making process. As you recall, our estimate of the overall Medicare margin for 2003 is 3.9 percentage points compared to 5 percent in 2000, with an increase in rural and decreases in other categories.

MR. HACKBARTH: Just to be clear, this is the original estimate of margins. This is not adjusted to reflect the policy recommendations.

MR. GREENE: Exactly.

MR. HACKBARTH: Okay. Are we ready to move on then to the outpatient update?

MR. ASHBY: Did you want to do the outpatient update first before we vote on the inpatient? I thought we would complete the inpatient first.

MR. HACKBARTH: Why don't we get it all out, Jack, and then come back to the recommendations? Thank you.

Chantal?

DR. WORZALA: Good afternoon. I'll try to be as brief as I can. I know it's getting very late.

This presentation looks remarkably like the one you saw in December so I'll only highlight what has changed. This is some information for you that gives background and context. We are doing an update for calendar year 2004. The current law update is marketbasket.

Tim previously went through payment adequacy for the hospital as a whole. These are the things that he looked at.

Here I'm present you some new information which gives you our outpatient margins for 1999 and 2000. I'm giving you the sector specific numbers primarily as a point of information for purposes of comparing across groups and to show the change from '99 to 2000. You'll recall that the outpatient PPS was implemented in August 2000 so these 2000 margins here do span the implementation of a new payment system. Since hospitals have different cost reporting periods, the margin calculation has a mix of pre-PPS experience and post-PPS experience.

Given this, we did calculate the margin for all outpatient services, not just outpatient PPS services. This also allows us to compare over time since we previously didn't have an outpatient PPS

The outpatient margins are negative. The average across all hospitals was -16.4 in 1999, increasing to -13.7 in 2000. We don't know the true outpatient margin. This is our estimate of what the cost reports tell us. We think that much of the large negative numbers here are attributable to the cost allocation issues that Tim described previously, where the inpatient margins tend to be overstated and the outpatient margins understated. The best estimate we have of the overstatement of outpatient costs is 15 to 20 percent.

The increase in the outpatient margin from '99 to 2000 is consistent with policies implemented under the outpatient PPS. PPS included hold harmless and transitional corridor payments that put new funds into the payment system. In addition, the pass-through payments were not implemented in a budget neutral manner until April 2002, so extra funds were put into the system through the pass-through payment.

In looking at urban versus rural hospitals, the margins are fairly similar although the improvement from '99 to 2000 is greater in urban hospitals. Of course the last two columns on this table show the overall Medicare margin

which we feel is the most appropriate for assessing payment adequacy, and it puts the outpatient margins in the context of a hospital as a whole.

The update factors that we considered are those that you've heard a few times today. The outpatient PPS is a bit unique in that technology costs are addressed specifically through two mechanisms, the new technology APCs which are not budget neutral payments so each service provided does result in additional payment. There about 75 services covered by new tech APCs in 2003. There are an additional five applications under review. An example of something covered under a new technology APC is a PET scan. Since these costs are dealt with directly and result in additional payment we don't see the need to factor that into the update calculation.

The pass-through payments, as we've discussed before --

MR. MULLER: We usually have 0.5 on technology. Is that worth 0.5?

DR. WORZALA: Are you saying, have the new technology APC payments equal to 0.5 percent of the total?

MR. MULLER: Yes.

DR. WORZALA: I think we would have to look for another year of experience. I haven't actually calculated but it would be slightly less than that, I think, in the 2001 experience. I wouldn't want to give you a number until I'd done the math but I would guess that it's closer to 0.025 rather than -- that's my quick math in my head.

MR. HACKBARTH: There are other instances where, because of the structure of the payment system, we take a productivity adjustment but do not add back anything for technology. For example, physician payment. There the logic is, we're talking about such small bundles that the way new technology is reflected there in higher expenditure is by new procedures being added and being used more frequently. So it's more or less self-correcting.

Here we're applying that argument plus the additional argument that we have the new service APCs as an automatic mechanism. So that's the reason for not using the policy factor of 0.5.

DR. WORZALA: That's right. Then for other kinds of technologies that are not new services we have the pass-through payments for things that are an input to a service such as a drug or a medical device, and those are covered

through the pass-through payments.

That is a budget neutral provision. However, it looks like in 2003 payments will equal the pool set aside for pass-through, so this isn't a place where we're seeing large pro rata reductions in the pass-through payments which might then need to be factored into the update calculation.

Looking forward, there are about two dozen drugs and five devices on the pass-through list in 2003. There are less than 10 applications for additional new technologies pending which suggests there's not a whole lot of action in this area.

Also, just on the pass-throughs, note that we did end up putting extra money into the system through the pass-through. In 2001, pass-through payments should have been limited to about 2.5 percent of total payments but they came out to be about 8 percent of total, payments. So there was excess spending of about $750 million on these items in 2001. For these reasons we've determined that technology costs do not need to be factored into the update for 2004. The final factor would be the productivity increase.

So putting these things together, we go to the following draft recommendation for your consideration. The

Congress should increase payment rates for the outpatient PPS by the rate of increase in the hospital marketbasket less 0.9 percent for calendar year 2004. This recommendation would decrease spending in comparison to current law. The one-year impact falls into the category of savings between $50 million and $200 million, and over five years the savings would be in the category of between $250 million and $1 billion.

That's it.

MR. HACKBARTH: Questions or comments?

Okay, I think we're ready now to turn to voting on the recommendations.

MS. ROSENBLATT: I just want to make a general comment on the recommendation that Glenn and I discussed but I wanted to get this out publicly. I've been quiet all day.

There was a comment that I think Tim made about less pressure from other payers, which I don't believe is true at all. Alan is laughing with me. There's been a lot of pressure from other payers, but I think that the situation is changing as evidenced by the decrease in the margin that we're seeing. I have an overall concern about the impact of the total package here. The modification I

would suggest before we vote is that even though Julian said it was not the right thing to do, theoretically when Nancy-Ann raised the point of putting the distributional effects back into the base my concern, given the trend line on these margins, is that we should put -- that our recommendation should be to put the distributional impact back into the base.

If I understand the numbers correctly, each 1 percent is worth about $1 billion, so 0.3 is about $300 million is my guess.

MR. HACKBARTH: Actually it wasn't Julian who said that that wasn't the right thing to do.

Let me just go through these one by one. I think the argument for doing it on a budget neutral basis has been most prominent around the transfer policy. A number of commissioners mentioned it in that context. There are clear arguments for doing it that way.

But I think if we start doing these distributional changes on a budget neutral basis we cannot single out that one and we've got to do it elsewhere. So next on the list I think would be going to a single standardized amount, and you would need to do that on a budget neutral basis. The

current recommendation is to do it with new money.

Now the net budgetary impact of going to a single standardized amount is to increase outlays by 0.3 percent. By coincidence, the net effect of the transfer policy, not on a budget neutral basis, is a -0.3 percent. So they're basically offsetting. So I think the net effect in terms of how much money goes into the pool of those two is the same whether you do them budget neutral or not, just because by coincidence they happen to be offsetting.

There are all other proposals in here like the IME proposal where, at least I personally, and other commissioners may disagree, feel like the Congress has clearly established that those changes are not budget neutral. The Congress, when it has changed the IME adjustment has taken savings for that, or when they've frozen already enacted reductions, that they've added costs for that. So for us to pretend like we can set one set of rules about budget neutrality independent of what the Congress has done I think is -- that's just an academic discussion.

Some of the other pieces like reducing labor share we've always talked about as being budget neutral

conceptually. So if you go through them one by one I think you end up in the same place in terms of the bottom line impact. The two big ones again are transfers and the standardized amount and they happen, just by coincidence, to be offsetting. So I think we could spend a lot of time talking about this only to end up at the same place in terms of the dollars going into the system. That's why I've tried to -- we have enough complicated issues ongoing and I just didn't think that that was a productive use of our collective time.

MS. ROSENBLATT: Let me also raise the issue -- Carol was very eloquent before about let me just give you a warning. I want to say the same thing. I am concerned about the impact of this package on commercial premiums due to the cost shift effect, which we've got historical evidence that whenever the hospitals feel pressure, it shifts out. We're already seeing double-digit increases. Would it be possible to modify the recommendation, because we're dealing with year 2000 data and updating it -- that if we see some kind of trigger -- and I don't know what that trigger is going to be -- that there may be time to change it. But I do have concerns and I think a warning is

necessary on this package.

MR. HACKBARTH: The normal global mechanism for dealing with changed circumstances, projections that turn out to be in error is, for better or for worse we do this every year. And Congress, if something happens in the next several months they can always take it into account, and in any event we'll all be back to it again next year.

Again, I'd like to try to establish some context for this. The aggregate impact of the whole hospital inpatient package is marketbasket by minus 0.7 percent, which certainly isn't out of the norm of what's happened recently through the legislative process if you look over the last 10 years or something. If you look at MedPAC's recommendation of last year, the aggregate impact was marketbasket.

The real difference when you boil it all down between where MedPAC was last year and this year is the transfer policy and the IME. Those are important policy changes and everybody's going to have their chance to vote on them in just a minute. But I don't think that either one represents a policy that came out of left field. They are ideas that this commission and others have debated for a

long time. So in that sense, I don't think that we've been hasty by any stretch on either of those issues. I think we've been quite deliberative.

So what I would ask is that we turn to the process of voting on the recommendations.

DR. WAKEFIELD: Glenn, are we going to hear Jack's recommendation before we vote on the IME, the first one? In other words are these at all mutually exclusive?

MR. HACKBARTH: I think that's a good point, Mary. What I would like to do is vote on the recommendation. This thing has been around. I think we need to vote up or down on the original staff recommendation, and then we will vote on Jack's. But I think all the commissioners ought to hear Jack's before the first vote so, Jack, do you want to go ahead?

DR. ROWE: Yes. Let me explain what I have in mind that's up there. Congress should phase out the portion of IME payments beyond the empirical costs of teaching over the course of four years, and during that time establish and implement a mechanism to broaden the definition of empirical costs of teaching to include explicit expenditures that enhance educational effective and innovation and increase

the quality of care.

Now what I had here, before we go on, is I don't what to go sideways for four years while we study it and then decide that we're going to start cutting it, and then we'll be here like we have been in the transfer and other things saying, four years wasn't enough and we need to study it longer, and just a couple more years, et cetera. So I want to have a trigger that this actually starts to decline as this thing has to get phased in, so somebody is going to have to start for doing something fairly soon.

Then it goes on, such funds should be allocated on the basis of measurable outcomes. Leave that ambiguous as to -- that's not quality of care necessarily. That may be process outcomes. They have to prove they did something. These expenditures might include information systems, development and implementation of new clinical curricula, and interdisciplinary clinical training programs.

The next recommendation that I write will be my second, so I don't have a great pride of authorship, so cut me some slack here, but this is, in general, what I think we discussed.

DR. NELSON: Jack, I can see how this could

involve a separate category of cost reporting that could be an enormous hassle, in addition to the current hassle. That's enough for me to worry about this and vote no just on that basis.

DR. ROWE: Then it goes away. That's the option, I think. I'm open to suggestions about how it could be done otherwise, but I don't think there's much appetite in Congress for just giving -- the idea here is to get rid of the subsidy and give money for something explicit. If that's the idea, then they have to report that they actually did the thing that we're paying for, and you can't do that without reporting. I think it's not realistic to think that Congress is going to just keep giving the subsidy and they can spend it for whatever. There's got to be some discipline, I think.

MR. SMITH: Jack makes the best case for supporting his substitute when he argues that the alternate is that the money goes away entirely. I don't know whether he's right about that or not. But I do know that if we support Jack's motion which encourages activity that we ought to want to encourage, and we do it in a way that requires that the funds actually be spent on that activity,

that hospitals will no longer be able to spend money on whatever they're now buying with the portion of IME above the empirical costs. We have evidence -- we don't know entirely what they're buying, but we have evidence that the hospitals that get the most of those resources are also the hospitals that do the most buying of something we all care about, which is the purchase of -- payment for uncompensated care.

The only reason about for -- if you are concerned about the staff recommendation for those reasons, the only reason to vote for the Rowe motion is because you believe that the alternative is that we get nothing. I think that's unwise as a matter of policy and certainly cloudy as a matter of prediction and I hope we'll forbear at this point and vote no on both opportunities. That we will vote no on the recommendation as presented originally had should -- we would then be asked to vote one way or another on Jack's substitute and I'd hope we'd also vote no, meaning we'd have no recommendation.

MR. MULLER: Glenn, if I understand your process, if we vote no on the staff recommendation then we can either decide to go to Jack's motion or not go to it.

MR. SMITH: Presumably we'd go to it.

MR. MULLER: So if we vote no on the staff recommendation, we can then decide whether we want another motion or not, if we vote no. So why don't we vote on that and then we see whether --

MR. HACKBARTH: I'm not 100 percent sure that I'm following implication.

DR. REISCHAUER: They're saying we don't have to have a debate about the merits of Jack's because if there's huge support for the staff recommendation, which I sense in the room, then Jack can just go home.

MR. HACKBARTH: If, I suppose, is the key word there. I'd like to just vote on both of them sequentially. Jack's would be in the nature of a substitute. So let's say, just for the sake of argument that there was a majority for yes on the first one, then you wouldn't be voting for Jack's. You'd vote no on Jack's.

MR. SMITH: Or yes. It seems to me, Glenn, that some of our colleagues are likely to be willing to vote no on the staff recommendation because they have an opportunity to vote yes on Jack's. So it seems to me you need to offer us the following option. Regardless of how we vote on the

staff recommendation, we then either get to vote on Jack's as a substitute or on Jack's as a freestanding resolution.

MR. HACKBARTH: That's what I contemplate is there will be two votes, right.

MS. BURKE: Just the following, prior to the vote. I would hope, not knowing what the outcome of the vote would be, but were the outcome of the vote that neither policy was agreed to, I would hope that that wouldn't prevent a conversation from occurring at some point that very much follows Jack's track, which is that we need to move to a policy that essentially explicitly pays for a particular activity if we in fact fundamentally believe in the activity.

And I would hope that if, for whatever reason, it remains an option for the future, even if we pass the staff recommendation, I think it is something well with discussing in some detail. I think there are some issues about how one does it that are a problem here, but I think philosophically it's something that ought to be discussed.

MR. HACKBARTH: So what I hear you saying is, some people might feel compelled to vote no because it's not quite formulated the right way, but that shouldn't foreclose

all future discussion of the concept.

DR. STOWERS: I wonder on Jack's if anyone would object to just limiting it to the first paragraph. It seems like to me that that gets too specific. I think what we're looking for is to redefine the empirical thing, and then we have those goals there, and the what Alan is saying. I think we'd be just better to stay with the very first --

DR. ROWE: It's a reflection of my naivete as a recommendation drafter.

DR. STOWERS: The other could go in the text .

MR. HACKBARTH: I agree with that, Ray. I think sometimes adding more isn't helpful and actually makes it worse.

DR. ROWE: If I had more time to draft it, it would have been shorter.

MR. HACKBARTH: Right. Thank you, Mr. Twain.

So on the particular issue, is there agreement that Jack's -- I guess it's up to Jack, isn't it, if he wants to just offer the first page, it's his choice.

DR. ROWE: Sure.

MR. HACKBARTH: So we're going to just do the first page on Jack's. All right.

DR. WAKEFIELD: Could we hear the first part of Jack's again please? Jack are you suggesting that those dollars for educational effective and innovation, and increasing quality of care, would be retained by teaching hospitals? That, is, the facilities that currently are receiving those IME payments? Or does this have any implication for, for example, residency training in primary care settings or other kinds of settings that speaks to innovation and increasing quality of care, et cetera? Where are those dollars going to go? Are they going to continue to drive into the facilities that are receiving these IME payments today or are we talking about the potential to enhance educational effectiveness even outside of the facility?

I also want to make the comment on interdisciplinary team training. I'm a big advocate of that, having served on the Quality Chasm committee report, been part of all of that. I also say that, frankly, if we're starting some of that at residency training or graduate nursing training or anyplace else, we're starting out way too late. That's the kind of thing that needs to be embedded in the first year of medical school as far as I'm

concerned, and the first year of nursing and so on. So those are important things to target that were on the second paragraph but I'm not sure that residency training is the vehicle for getting there.

The last thing I'd say is if we're concerned about quality of care and access to care, we've heard repeatedly -- and we're now talking about this for educational purposes -- we've heard repeatedly about the lack of access to nurses and implications for access to health care services for Medicare beneficiaries. While we don't want to go there either, I'd say if now we're going to refocus our attention on education for quality and education for access, we've seen data that show us clearly the linkage between numbers of nurses and facilities and poor patient outcomes, and we also have heard repeatedly from the different sectors of the industry about linkage between access to that part of the nursing workforce.

So that's just my 30 seconds on it, sort of a sidebar issue.

DR. ROWE: Let me respond, Mary. My intention was that the funds would go to support education. My focus is that we have been giving money to them under the rubric of

education but they can use it for anything. I'm concerned that clinical education is becoming archaic and we need to stimulate a rebirth of it. I'm interested in having the funds going to any institution which is doing clinical education. Anybody who's got a residency program or whatever, I don't care whether it's defined as a teaching hospital or not. But if it's a hospital that doesn't have any educational activities, I wouldn't put it there.

I don't mean to exclude having interdisciplinary training in the first year of med school, but we're talking about the Medicare program and clinical expenditures. So I threw the interdisciplinary training in there in order to try to get your vote.

[Laughter.]

MS. ROSENBLATT: Jack, given the brave new world that you described earlier, let's suppose there was an e-learning company. Would the money go only to providers or could it go to an e-learning company that was going to do terrific things, or a disease management company that was going to educate beneficiaries? I guess where I'm coming from is --

DR. ROWE: We're talking about payments to

hospitals.

MS. ROSENBLATT: I'm not sure that I want to throw additional money to hospitals because maybe in the brave new world there are ways to do education a lot better than through the hospitals. So I just don't think we've had enough discussion on this.

DR. ROWE: I'm not actually talking about additional money. My guess is it's about the same amount. But I was considering this to go to hospitals. I thought we were talking about -- the topic of the conversation was payments to hospitals. It doesn't mean we can't have another recommendation that there also be payments to e-learning companies, or disease management companies, but I was trying to address the question of what should we do about hospitals.

DR. WAKEFIELD: But it was payment to hospitals for enhancing educational effectiveness, so that's what stretches this out a little bit from my perspective. What's the goal you're trying to achieve? If it's the end of that sentence then you might be looking beyond hospitals.

MR. HACKBARTH: Let m pick up on Alice's comment and maybe also hearken back to what Sheila asked earlier.

There are things about this that I like, and basically what I like about it is it says that we need to be targeted and careful in how we spend Medicare dollars, and get specific tangible results and not just put a big box of money out there hoping we'll get good things. To me that's what this whole IME issue is about, so I really like that.

I am a little bit uneasy about designating the specific right purposes and implying certain types of recipients are going to get it, because I just don't think we've thought it through. Everybody is entitled, of course, to do what they want, but my inclination faced with this would be to say I like the basic premise and the direction but let's not go down the track too far specifying the purposes. Maybe just say something like, we need to phase this out. We need to direct it; there are unmet needs that are important in the care of Medicare beneficiaries and MedPAC and the Congress ought to look at what they are and develop a payment formula that's appropriate to those purposes, as opposed to starting to list them. That takes on a life of its own once you start to list them.

Is that similar to what you were thinking, Alice and Sheila? Does that make sense to people?

MS. ROSENBLATT: [Nodding affirmatively.]

MR. MULLER: I certainly value the effort to make more specific something that causes such debate as to what the purpose of the program is. I don't want to necessarily agree that what we call the empirical basis which is attached to a residency ratio is, as I said earlier, the only reason for which the IME purpose was intended. We've used it, as Bob knows and people have indicated, as a way of distributing the funds. That's not the only reason for which the IME purpose was intended. For those of us who feel it was intended for broader purposes, not to subsidize e-learning companies, therefore I think, like David, I'm against the staff recommendation because I think that's the best way to protect the broader purposes for which the IME was intended.

DR. REISCHAUER: Jack has my vote next year but I think what this discussion has proven is that this really isn't ready for prime time. MedPAC recommendations usually arise out of analysis; analysis of a problem, presentation of solutions. What we're having now is a recommendation in search of analysis and definition. I think I'm in favor of the staff recommendation. I suspect that I might be

standing alone or with my chairman on that one. But should it pass, I would argue that we include in the text some kind of paragraph saying that there is this larger problem and that these resources are the sort that they could be devoted to resolving it; look next year.

DR. NEWHOUSE: I think I'm with Bob, so you won't be alone anyway. I just wanted to respond to Ralph briefly. This payment is not only -- the residents are not only for the purpose of distribution, but it greatly affects the total size of the pot. When this started out it was, as I recall, it was in the 1-point-something billions and it grew to around the 6-point-something billions because the residents per bed rose virtually everywhere.

I, like Bob, have a hard time swallowing that the subsidy for these purposes should come from the payroll tax and the trust fund rather than general revenues. But as I said before, if there is going to be a subsidy I think we ought to consider this. I'm concerned also about how one would derive the empirical cost of teaching. What we've derived are the empirical costs of teaching hospitals in this formula, not the empirical cost of teaching.

MR. HACKBARTH: Okay, before us on the screen we

have the original staff recommendation. All in favor?

All opposed?

And then abstentions?

So what's the total on that? Why don't you read off what you've got so we can just verify? Who do you have as yes?

MS. ZAWISTOWICH: As yes I have Glenn Hackbarth, Bob Reischauer, Pete DeBusk, Dave Durenberger, and Alice Rosenblatt, and Joe Newhouse.

MR. HACKBARTH: So that was six yes.

MS. ZAWISTOWICH: Right.

MR. HACKBARTH: Then read off your noes.

MS. ZAWISTOWICH: My noes are Ray Stowers, David Smith, Carol Raphael, Alan Nelson, Ralph Muller, Allen Feezor, Nancy-Ann DeParle, and Sheila Burke, and Jack Rowe.

MR. HACKBARTH: So that should be nine noes and then to have abstentions for 17.

Jack, do you want to offer your alternative?

DR. ROWE: I'm very sympathetic to the fact that this is not the result of detailed analysis. I'm unapologetic about it. It came up in the concept of our discussion about these issues. I didn't come thinking we

were going to have a recommendation about it. I don't think we're going to accomplish anything by voting on this yes or no in terms of, is it ready for prime time and to be sent to the Hill. But since we spent so much of the Commission's valuable time discussing it I personally, and I think perhaps all of us would benefit from some assessment of whether people are supportive of the sense of this, and whether or not we should use this in an informal rather than a formal way as a stimulus for some additional analysis and conversation in the future.

I respect greatly everybody's input. I'm not trying to railroad this at all. But I'm not ready to wait till next year either to discuss it because I do have some sense that it is the proper way to go. So I would propose something along those lines if there is in fact in the methodology a way to do that.

MR. HACKBARTH: David, do you have a comment on this?

MR. DURENBERGER: Yes. As one who voted for the original recommendation and has had occasion to vote to cut IME after helping Sheila invent it and all the rest of that, I meant that vote.

By the same token, Jack's proposal accomplishes the same thing, plus it sends a message that might foster the reduction in the IME payment or the adoption of the staff recommendation by developing a value-based definition of empirical cost of teaching, which is kind of a newer added value. Now whether it can be measured or not measured can be debated for a long time.

But if the goal is to make the trust fund contribution to medical education actually produce medical education, then I think the first step in that process is to begin to reduce the amount of the trust fund that is not going into medical education. It's going to some other purpose that sustains teaching hospitals. If this is the vehicle, at least for this group to get on record with more than six people supporting a reduction in IME payments then my instinct is to support it.

DR. NEWHOUSE: I think we are actually on record, a former Commission as saying the empirical costs of teaching are borne by the residents and not by the Medicare program. That the additional costs of teaching hospitals go toward patient care. Everybody may not agree with that but it goes to -- I don't think there is any way empirically of

establishing the empirical cost of teaching. That's based on a fairly well-accepted set of theories in economics, what I just said. But as I say, I think we could be here forever trying to decide -- do a study of the empirical cost of teaching.

MR. HACKBARTH: Here's what I propose we do. I like the concept but I would feel compelled personally to vote no on the recommendation because I don't think we've thought it through. I think it dilutes our credibility to make hasty judgments about important issues. So what I'd suggest is that we not vote on this, but rather take it as an agenda item. And not one for the long-term but actually try to spend some time quickly to think it through a bit. If we think we've got something solid and promising, we've got vehicles other than the March report where we can say something to Congress. We can write a letter, if that's the case.

DR. ROWE: Glenn, if I can make a suggestion that I think is consistent with that and at the same time takes advantage of the fact that we've had all this discussion, and that is that I would be happy to try to revise this statement and offer it tomorrow in a way that's crafted more

toward the fact that we should study this and that we should look at this is a particularly important opportunity, or something like that, and see whether that is something that would give us something a little more specific than a letter or a paragraph in the narrative or something like that.

MR. HACKBARTH: Let's do it.

DR. ROWE: But isn't a replacement recommendation.

MR. HACKBARTH: Yes, it's worth a try to do that.

DR. REISCHAUER: I didn't know if we were going to recommend something to ourselves. Is that what you're suggesting?

DR. ROWE: I thought I'd have a glass of wine and think about it, Bob.

DR. REISCHAUER: Two glasses and it will help your heart.

[Laughter.]

MR. HACKBARTH: Okay, so we'll table this for now and perhaps come back to it in the morning if Jack has something that he would like to offer.

So we now need to move on to the transfer policy recommendation. I think what we can do here is just vote sequentially one the two alternatives here. So all in favor

of version A?

So the yeses that I see are myself, and Bob, and Joe, and Allen Feezor, Alan Nelson, and Jack.

Noes on option A?

I'll read them off to you. Sheila, Dave Durenberger, Ray, Mary, David Smith, and Ralph on this side, and then Nick, Alice, Nancy-Ann.

Any abstentions?

Pete, I'm sorry, I missed you. Which side were you on, yes or no?

MR. DeBUSK: No.

DR. MILLER: Can we do those one more time? Here's what I've got. On noes, Sheila, Nancy-Ann, Pete DeBusk, Dave Durenberger, Ralph Muller, Alice Rosenblatt, David Smith, Mary Wakefield, Nick Wolter. And I'm sorry, Carol.

MR. HACKBARTH: Any Ray Stowers. So what are totals?

DR. MILLER: Six yes, 11 noes. So that's everyone.

MR. HACKBARTH: So let's turn to variation B. We'll do option B, and I think it will be easier, as Sheila

suggested, if we just read off the names and do a roll call vote. So read down your list.

DR. MILLER: Glenn?

MR. HACKBARTH: Yes.

DR. MILLER: Bob?

DR. REISCHAUER: Yes.

DR. MILLER: Sheila?

MS. BURKE: Aye.

DR. MILLER: Nancy-Ann?

MS. DePARLE: Yes.

DR. MILLER: Pete?

MR. DeBUSK: Yes.

DR. MILLER: David Durenberger?

MR. DURENBERGER: Yes.

DR. MILLER: Allen Feezor?

MR. FEEZOR: Yes.

DR. MILLER: Ralph Muller:

MR. MULLER: Yes.

DR. MILLER: Alan Nelson?

DR. NELSON: Yes.

DR. MILLER: Joe Newhouse?

DR. NEWHOUSE: Yes.

DR. MILLER: Carol Raphael?
MS. RAPHAEL: Yes.
DR. MILLER: Alice Rosenblatt?
MS. ROSENBLATT: Yes.
DR. MILLER: Jack Rowe?
DR. ROWE: Yes.
DR. MILLER: David Smith?
MR. SMITH: Yes.
DR. MILLER: Ray Stowers?
DR. STOWERS: Yes.
DR. MILLER: Mary Wakefield?
DR. WAKEFIELD: Abstain.
DR. MILLER: Nick Wolter?
DR. WOLTER: No.
DR. MILLER: I think that's 15 yeses.
MR. HACKBARTH: So B it is.
Next is low volume. I think we resolved to include the 15-mile limit. So all in favor? I don't think we'll need the roll call on this. I hope not. All in favor of the low volume adjustment with the 15-mile limit. I think everybody's hand is up.
Next, labor share. All in favor of the

recommendation? All hands are up.

DR. NEWHOUSE: No, I'm abstaining.

MR. HACKBARTH: Just for the record, let me make sure I didn't miss anybody. Any noes on the labor share?

So we have 16 yeses and one abstention.

Nest, this is to go to a single base rate. All in favor?

Any opposed? Any noes?

Any abstentions? I don't see any. Do you want to put up the options, the two-year versus five-year? Increase the cap with a two-year transition. All in favor?

Opposed?

MS. DePARLE: That's the one where we were told that Congress, both houses had passed this as a five-year transition?

MR. ASHBY: No, one house had passed it as a five-year; one had only discussed.

DR. MILLER: But in both pieces of legislation, although one didn't pass, it was five years; is that correct?

MR. ASHBY: That's right.

MS. DePARLE: I vote know on the two-year.

MR. HACKBARTH: One no.

Any abstentions?

MS. RAPHAEL: I'd like to abstain.

MR. HACKBARTH: So we have 15 yeses, one no, and one abstention. Is that it for the rural package?

MR. ASHBY: For the rural package.

MR. HACKBARTH: Next is the inpatient update. All in favor of the recommendation on the inpatient update?

All opposed?

Abstentions?

Seventeen yes.

DR. MILLER: Is it correct we don't actually have a slide on -- or do we, on the outpatient one?

MR. HACKBARTH: On the outpatient update, all in favor of the recommendation?

Opposed?

Abstentions?

So seventeen 17 yes.

I think we are done with the voting and the recommendations. We do have one last discussion of paying for new technology. Where is Chantal?

Thank you, Jack, for your help on that.

MR. DeBUSK: Can we do it tomorrow?

DR. NEWHOUSE: Start at 8:30?

MR. HACKBARTH: Do people feel okay about that, started at 8:30?

DR. WORZALA: It will be very quick presentation if you want to get it out of the way. Otherwise we'll come back in the morning.

MR. HACKBARTH: What I'd like to do is go ahead and knock it off now. As I recall from reading the material, Chantal, there is, with maybe one exception, not a whole lot that's different from our previous discussions of this topic. But in the terms of the information presented, the substance of it, it should be familiar stuff to the commissioners at this point, so I'd ask that you move through it quickly, and then we do have some recommendations to deal with.

DR. WORZALA: Sure. The draft chapter is in Tab E. Also in that tab is a draft of an appendix on Medicare's coverage process. We're not presenting any of the coverage material but if you have any feedback on it we certainly welcome that.

This is the outline of the chapter of these four

areas. I'll discuss the first three. The last one I won't be discussing. We've discussed it previously. If you have any comments on it, please feel free to bring them up at this point.

This slide shows the basic argument of how prospective payment deals with new technology as a standard system. It's felt that since there is a fixed payment for a bundled service, there is an incentive to use cost-decreasing technology but not cost-increasing new technologies. There's a sense that the process of revising the classification systems and recalibrating the relative weights is a time-consuming process. This is of necessity due to the multiple actors involved and public comment. But it does seem to slow down incorporation of new technology and that argument has led to the implementation of new technology payment mechanisms in both the inpatient and outpatient PPSs.

This next slide shows the four new technology payment mechanisms that are discussed in the paper across four dimensions. These are the criteria used by CMS to determine which technologies will be paid, the way the payments are financed, the unit of payment, and how the

payment amount is set. I had planned to walk you through a couple of the ways in which these payment mechanisms vary, but in the interest of time I think I will stick with just the one thing that is the subject of a recommendation and that is the eligibility criteria.

The eligibility criteria are a key means for ensuring that additional payments are well targeted. Most observers agree that additional payments should be reserved for technologies that are truly new, costly and have a clear clinical benefit. When considering applications for the inpatient add-on payments and the outpatient pass-through payments for medical devices, CMS applies newness, cost, and clinical benefit criteria.

However, for pass-through drugs and biologicals under the outpatient PPS, CMS applies only newness and cost criteria. This leads to an inconsistency in the treatment of a drug or biological across the two payment systems as well as an inconsistency across types of technology within the outpatient pass-through payment mechanism.

This slide shows the clinical criteria for the inpatient add-on payments and medical devices under the outpatient pass-throughs. To be eligible, a new technology

must substantially improve relative to technologies previously available, the diagnosis or treatment of beneficiaries. CMS has provided examples of how these criteria might be met. They're listed on this slide and we did discuss them in December.

It's important to remember that the eligibility here is for additional payment, certainly not for coverage. Physicians are free to use a given technology whether or not it is eligible for additional payment, and there will be the base APC payment for a technology regardless of its pass-through eligibility status. So what we're really talking about here is applying clinical criteria when determining that a technology is eligible for additional payment beyond the base APC rate.

To address the inconsistent eligibility criteria, staff proposed the following recommendation for your consideration. The Secretary should introduce clinical criteria for eligibility of drugs and biologicals to receive pass-through payments under the outpatient PPS. This recommendation should have no impact on spending since the pass-through payments are implemented in a budget neutral fashion.

I'll stop there.

MR. HACKBARTH: Thank you. Any questions or comments?

Are we ready to vote on the recommendation? All in favor of the recommendation?

Opposed?

Abstain?

Thank you, Chantal.

All right we are finished for today and --

DR. REISCHAUER: No, public comment.

MR. HACKBARTH: That's right, we do have the public comment period. Forgive me. It's five minutes to 6:00. We will have a 10-minute public comment period. The usual ground rules applying.

DR. REISCHAUER: No more than 10-minute public comment period.

MR. HACKBARTH: No more than 10 minutes.

MS. HELLER: Hi, I'm Karen Heller with Greater New York Hospital Association. I just want to say on behalf of the more than 100 major teaching hospitals in our area I express are incredibly deep gratitude to the Commission for preserving the funding stream that we have, at least for

this year. I stand willing to help the Commission in any way, technically, to provide assistance on further identifying costs that could be construed as part of the empirical adjustment.

In addition, on the transfer policy, we talked a lot about within DRG-variation in cost. I would urge the Commission to put on its agenda the subject of recommending refined DRGs.

MR. MAY: Don May with the American Hospital Association. Want to thank the staff -- from what appears from the audience, there seemed to be a lot of staff work that went into addressing a lot of the questions that not only we raised but that you raised last month. I know from our prospective we appreciate the extra hard work that went into it, and the discussions that it spurred today. So wanted to just thank the staff for that and say that we were really pleased with the discussion around IME, as Karen mentioned, and SNF, where the hospital-based perspective came out.

Would still like to say that the cumulative impact of the transfer provision, the home health cut, the SNF cut if things aren't fixed, when you look at those hospital-

based SNF and home health margins, the rural provisions that went in, while we are happy with those rural provisions, we are still very concerned about rising costs in hospitals. Almost 60 percent, 57 percent of hospitals losing money on Medicare; a third of hospitals losing money. I heard a lot of that concern in the room with the transfer provision. I think given more conversation and more time to discuss that, and the option to look at that in a budget neutral way, the recommendation could have been very different.

I believe there were several commissioner who brought up budget neutrality. There's no reason why you can't do something like that in a budget neutral way while doing other things with new money. Congress makes those decisions all the time. You can look at doing the transfer provision in a budget neutral way; while we would recommend you don't do it at all, saying that.

But did want to also just make one last point. There are a lot of pressures out there. Hospitals are going through tremendous change. While I don't know how to react to Jack's comments, what you see in Jack's comments is tremendous pressure to innovate and bring new technologies and information systems. To think that hospitals don't need

a full update, both in the inpatient and outpatient settings to cover those new technologies, ways to improve quality, it's just missing at a time when there are so many pressures. Would just like to state that because we hear it all the time. Alice conveyed it. The private payers are feeling it. There is a lot of pressure out there and I just wanted to make those point.

Thank you.

MR. HACKBARTH: I think we're done and we reconvene tomorrow at 9:00. Thank you very much.

[Whereupon, at 5:58 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Thursday, January 16, 2003.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Thursday, January 16, 2003
9:14 a.m.

COMMISSIONERS PRESENT:

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

P R O C E E D I N G S

MR. HACKBARTH: Okay, let's get started.

Dr. Rowe wishes to be recognized.

DR. ROWE: We've had some discussion about now that we have voted against the staff's recommendation on IME, and everyone in the world knows about that, we do have a very nice piece of analytical work and we do feel that it is appropriate for us -- or I feel, let me not try to represent the chairman or the commission -- but it seems that rather than just present the analytics without any recommendation that there should be some policy oriented statement, even if it doesn't take the form of a recommendation that is in fact voted on and specifically formally offered to Congress.

There's also agreement, I think, that there is some disagreement on almost all aspects of this. There's hardly anything we can say from a policy point of view that there would be agreement on uniformly around the table. But there are some consensus items.

I've worked a little bit on trying to put the thoughts that I offered yesterday in the context of that and would like to offer a statement for consideration for

inclusion. I don't think this is something we need to vote on but we get a sense of whether this seems reasonable.

First, [inaudible] goals that hospitals may be engaged. There was a fair amount of concern about that. It doesn't say it shouldn't be there, but it certainly is not tied to anything they spend or anything they accomplish. It's just there.

That despite this there was not a consensus in this commission to reduce the IME to the empirical level at this time. That the commission will be examining this issue and calls for a robust and prompt assessment of the resources needed by hospitals to strengthen their educational programs, to keep pace with changes in health care delivery, and the evolving needs of the Medicare beneficiaries. There's also broad recognition of the need for hospitals to improve the quality of care.

Medicare support is appropriate for explicit expenditures that yield needed enhancements in medical education and quality of care. This is another way of saying that the empirical level may, in fact, be redefined to include these expenditures once they're identified.

And that the commission plans to revisit this

issue promptly, so that our lack of a specific recommendation should just be interpreted as the more we thought about it the more work we have to do on it.

That would be a sort of a general statement that I would propose be included in the report. Thank you, Glenn.

MR. HACKBARTH: What I'd like to do is, in particular, hear from commissioners who yesterday voted no on the staff and chairman's recommendation. What I don't want to do is be seen as trying to rework this issue and get around the majority of the commission. So if there are commissioners who yesterday voted no who would like to speak to Jack's comments, I'd like to hear from them first.

DR. ROWE: I voted no and I support this.

MR. HACKBARTH: Yes, I realize that. Alan Nelson, Nancy-Ann, David.

DR. NELSON: I think that's an excellent job, Jack, and I support it.

MS. DePARLE: I voted no yesterday and I appreciate the opportunity, Mr. Chairman, to discuss it a little bit more today.

I voted no because I wanted to vote yes on Jack's substitute motion which would have coupled the reduction in

IME above the empirical level to requiring in an accountable fashion the academic health centers and those who receive the IME payments to improve quality and to improve the quality of education and make sure that they're including interdisciplinary approaches, such as including nurses, in the training.

And so speaking just for myself, I would not want that vote against the staff recommendation, the chairman's mark, yesterday to be misinterpreted as support for what I view as a continued subsidy that is not targeted that I don't think we can -- that I cannot support. And I hope that we'll continue to work on this and be able to vote on something like Jack's motion in the future.

MR. SMITH: Thank you, Glenn.

Jack, I appreciate both the impulse and the work and the thrust of where I think you think we ought to head seems to me to be right. But I am concerned and in just my quick notes about your proposal about what I would guess would be the fourth point, where you argue that Medicare support is appropriate, I would like to make sure that in the drafting of that point it's cast rather widely, that it is not cast narrowly within -- so that it suggests that all

we're talking about here is perhaps an expansion of the activities that would fit in the empirical level of IME, but something more to the effect that Medicare support is appropriate for initiatives that because they promise widespread impacts on the health care system promise widespread benefits including those -- as the health system improves they promise benefits that flow to Medicare beneficiaries.

But I'd not like to prematurely -- and I think for many of the reasons that some of us voted against the staff's proposal yesterday -- I don't think we're ready and I don't think there's consensus around this table that IME means a narrowly construed definition of support for specifically identified traditional or new educational activities. The kinds of things that Alan and Nick and I and others, Sheila, talked about yesterday that IME supports poorly, Nancy -- and I agree, it supports them in a way where we don't have a good sense of what we're buying, we don't have a good handle on the quality of the product that we're buying. Those are concerns.

But I wouldn't like to suggest that those things that we are buying, however badly the current system both

purchases and accounts for them, we ought to stop buying.

So Jack, as we think about this language -- and I'm not sure I'm right about point four -- but if it is point four in your suggestion, I like to write that broadly rather than narrowly and then I think we might find something we could agree on.

MR. HACKBARTH: Just a word about the process, what I would envision is that we not try to wordsmith the language now, but after hearing the discussion we'll put together something that we'll circulate to all the commissioners and give people a chance to react to.

MR. FEEZOR: I, too, voted against the staff recommendation yesterday, not for lack of respect for a lot of the work and it was very consistent with what this body has been thinking, I think Nancy-Ann is right on target there. I, however, do feel and have made it expressed that we need to begin to change some dynamics in how health care is delivered, how professionals see themselves, and indeed how people access care both in the commercial and Medicare.

So I was particularly excited by Jack's epiphany yesterday. I think that we are wise in continuing to look at alternatives in terms of just how that might be

structured. And I guess I would reinforce I think what David's comments were, that if we are talking about trying to re-channel some of these monies that it, in fact, do be more broadly defined. The term quality, I know, is usually broadly defined. But I think in terms of effectiveness, maybe even efficiencies in the care and delivery, and also that if we're talking about education that we not be confined strictly to the education of a physician but there are other caregivers that we are in shortage areas now that we need to give some attention to, as well.

MR. MULLER: I think the appropriate concern for accountability is clearly one that we all share. I think the kind of contributions that teaching hospitals make to the American health system along the lines that have just been mentioned has been well recognized for years. And I think it's appropriate in each generation to kind of redefine what that contribution is to meet the kind of emerging needs of the nation so we're not just, as some people said yesterday, trying to lock ourselves into whatever the conception might have been in 1983.

So I share and support Jack's sense that it's appropriate now to redefine those accountabilities that

teaching hospitals take on for this payment.

I'm also concerned, as I said yesterday, that we have too narrow a definition at the empirical level. I tried to express my thoughts about that yesterday. We tie it to the number of residents in a hospital which is the means by which we distribute these IME payments. And then we get ourselves, I think, caught in the trap of saying that's all we support with IME and therefore it's a subsidy. I think we kind of get caught in that circular argument and then we say we have to get rid of the subsidy and I do reject that because I think all of us know, who have been around these teaching hospitals, it's not just the presence of residents. It's the presence of the faculty, of fellows, of nurses, of many skilled professionals that are brought together and make up these excellent medical centers that make the kind of contributions that have been supported by this program for many years.

So I'm hesitant to keep agreeing to say this is the empirical level and everything else about that is the subsidy. I think we therefore get ourselves caught into defending a subsidy that I think we too narrowly define. And then like all subsidies, they have to be justified and

we have to talk our way into a way of saying it's inappropriate.

So I'm not willing to agree that the empirical level is the correct specification. I'm quite willing to agree that that's what we pay for. We pay for residents right now and then we measure the role of residents in an equation.

I know that may be too narrow a point, but I think it leads us constantly to then feeling with have to justify or make that subsidy go away. And I do think it's a broader definition of the teaching hospitals beyond just the number of residents that there are in hospital.

I would then say, on top of that, I fully endorse the sense that with a broad concern that both the Congress, the commission, and other people have about the accountability of hospitals that we should, in fact, be looking at out that accountability can be redefined and justified going forward. So I'm in favor of a process that allows us to do that.

I'm very impressed by the level of attention that the staff and the rest of the commission has put into this, so I'm a little worried about trying to do something in a

day or two when this has been discussed for years, to think that we could deal with the complexity of this issue in a day or two or a meeting or two.

So I am both in favor of looking at this but hesitant to say that we should kind of figure this out today or tomorrow. But I am fully committed to working with the rest of you on having an appropriate rationale and understanding of what the contributions this IME adjustment makes to the health care system. And I think we should be working on that.

DR. STOWERS: I also, as you know, voted against it. I'm like Nancy, I would have voted for the other, second one, even though it would have continued to reduce it down eventually to the empiric value. My problem was that it be done in isolation. And I'm not going to repeat everything that's been said because I totally agree, is that I think this is a great opportunity for the commission to look at redirecting those funds. And I totally agree with the fact that the lack of direction that's there now is inappropriate for those dollars.

But as far as the education and the quality, and I think we even still need to deal with the uncompensated care

issue that some of these institutions deliver. Maybe it's not through these dollars but through some mechanism. That needs to be dealt with. So I agree also that we need to take the time and do this right if we're going to do it. Thank you.

MS. RAPHAEL: I voted no and, in general, there are certain principles in what Jack said that I very much support, among which is better targeting the dollars, trying to invest in the future, and rethink how we better prepare workforce and models for what we think that future will be.

But my only kind of concerns are what will this amount to in terms of better care for Medicare beneficiaries? We can kind of open up another industry here of people developing many different proposals that will basically represent improvements in quality, new systems et cetera.

But I think today everyone is working on quality. We're all struggling with how to deal with improving outcomes, how to produce better quality. And a lot of the issues are very complicated and they cross parts of the health care system. I mean, a lot of the breakdowns occur between different elements of the health care system.

So I really think that thought has to be given as to what we're going to target these dollars to and how we can avoid kind of setting in motion another situation where we end up in a decade or two -- when we won't all be here but others will -- kind of looking back and saying what have we wrought? And here once again we have a certain amount of dollars going and we're not clear what we have purchased and how we can demonstrate what we have purchased.

So that's the area that I still feel we really need to spend some time on thinking through because we have education, we have quality, we have uncompensated care, we have enhanced patient care. There's a lot brewing in this mix that I think we need to kind of put under the microscope.

MR. HACKBARTH: Are there any other commissioners that voted no yesterday that want to speak to this?

We do have a full agenda for this morning, so we need to move ahead. Joe, I know you were not on the no side, but you have the final word on this.

DR. NEWHOUSE: I was originally not going to say anything but I wanted to respond to Ralph and then I wanted to say something maybe that people could think about with

respect to what Jack was bringing up as we go downstream.

Ralph, I don't think it's fair to say that the extra costs of teaching hospitals that are somehow not associated with residents are not in this mix. I think the easiest way to see this is suppose we computed the costs of teaching hospitals by taking out the resident salaries as we do now and saying that's direct medical education.

And then we've got a cost per case for teaching hospitals and we've got a cost per case for non-teaching hospitals. And we'll just take the means. And those means will be different and we'll call that the extra cost of patient care of teaching hospitals.

That's a variant, in fact, of what we do now. Instead we have this continuous measure of residents that we say the cost -- instead of having two groups we have teaching hospitals that have a few residents, teaching hospitals that have lots of residents. The costs per case are different in each group and, in effect, we just have lots of groups of hospitals of varying intensity.

But all of the costs of patient care at those hospitals are in what we're computing. So at the end of the day the empirical level does include all of those costs. So

I think it's not fair to say there's not a subsidy there.

On Jack's thrust, I personally have some problems with Medicare support as appropriate, as I said yesterday. So I'm more in the if there is going to be the subsidy it should be conditional. But then I think my problems are somewhat like Carol's. If it's to strengthen education, I don't think we know how to do that very well and I think it opens up a whole raft -- particularly once you get beyond MDs.

What about training of pharmacists, for example? I think that goes on outside hospitals that now get these subsidies. How do we handle that? How do we decide how much money is in this pot? And how does it get distributed? I mean, we have the money distributed now by residents per bed, for better or for worse. It's not clear that that's the right mechanism to distribute the new thing. It sounds much more like, as Carol said, a kind of apply for grant program. But that makes Medicare funding, in some ways, even less appropriate. It sounds like something for general revenues to me.

I don't have answers to this, but I think that, in trying to put forward what I'll call a conditional subsidy -

- that is you get the subsidy if you meet certain conditions -- in thinking about this, we're going to have to solve the how do we think about how much money and how does it get distributed? And does it get distributed to hospitals that don't now have residence because they potentially qualify for some initiatives in this domain?

MR. HACKBARTH: We don't have time this morning to engage in the specifics of the debate. What I do hear is broad consensus among the commissioners on three basic points. One, there is not complete satisfaction with the status quo. That we ought to at least explore possibilities for improved targeting of the dollars to some new purposes. But three, the exact way to do that -- or even whether it can be done -- is not entirely clear right now.

And so that's where I would like to leave it for right now. We will draft some language for commissioners to review and in then we'll figure out a plan for how to come back and grapple with this issue.

Jack, thank you for the additional work you did on this last night. And how we need to move on to today's agenda.

DR. REISCHAUER: I just want say something while

Sally's setting up that really goes to the way we, as commissioners, discuss issues like this. Several times today and yesterday, and certainly those contributing to the public comments, have referred to the IME recommendation as the staff's recommendation. And I think we shouldn't use that term.

These recommendations come out of analysis which the staff does, our reaction over three or four meetings. These are the commission's draft recommendations or the chairman's mark, if you want. There isn't a gap between the staff and the commissioners, in any sense. They're our agents and doing a heck of a good job trying to condense our thinking about this.

And so I'd appreciate it if we referred to these as our draft recommendations rather than the staff's.

MR. HACKBARTH: Okay, today we begin with the PPS for psychiatric facilities. Sally.

DR. KAPLAN: Thank you. Good morning.

In this presentation I'll briefly present some information about psychiatric facilities and then I'll focus on the issues CMS needs to consider when developing the PPS. We raised these issues in our letter to the Congress which

will go to the Congress at the end of this month.

To review the chronology, the BBRA requires CMS to do two things about a PPS for inpatient psychiatric care. First, to design a PPS that would pay on a per diem basis, and to report on the PPS to the Congress.

MedPAC is required to evaluate the impact of the PPS on which CMS reports. In other words, we're required to report on their report.

CMS issued their report in August, 2002. Our report is due to the Congress March 1. However to be more useful to CMS and the Congress, we plan to submit a letter in January.

I want to make it clear that our letter is targeted or is based on the report that CMS made to the, Congress. The proposed rule, which is scheduled to come out probably in March or the end of March, may be different than what was described in this report and we don't know whether it is or it isn't but it may be. And our report to Congress is based on CMS's report. So I just want to clarify that.

When CMS actually publishes the regulation on the PPS, we'll comment on their proposal and I think we can be more helpful after we see what they're actually proposing.

Once the PPS is implemented, we'll suggest refinements as necessary as part of our regular work, as we do with all of the PPS'.

Some basic volume and spending figures for 2000 on the screen. You've seen these before. About 300,000 beneficiaries received care in 2000. The majority of these beneficiaries were disabled. Some had more than one discharge. Medicare spends about $3 billion a year on beneficiaries who use these facilities. There are about 2,000 psychiatric facilities that are Medicare certified and 75 percent of these are hospital-based units.

This is a map that you've seen before. The red dots represented the government-owned hospitals. The blue dots represent the other freestanding hospitals. And the green dots represent the hospital-based units.

Another way to look at the distribution of facilities is by region and by type of facility. The table on the screen gives you that distribution. We show census region by percentage of hospital-based units, government-owned freestanding facilities, and other freestanding facilities, and also the total by region.

Other questions you've had about the distribution

of facilities and the Medicare case load by facility type.

As you can see on the screen the majority of beneficiaries are treated in hospital-based psychiatric units. About 6 percent of patients are treated in government-owned hospitals.

To briefly review, the model described that was developed by The Economic and Outcomes Research Institute, or ThEORI, collaborating with the American Psychiatric Association -- we call this the APA model for simplification purposes. It uses regression coefficients from a model that relates per diem resource use for beneficiaries to the patient and facility characteristics available from CMS administrative data.

Examples of patients variables are principal diagnosis, secondary diagnoses, and age. Examples of facility variables are location in overall area or the extent of teaching activity. The regression model explains 20 percent of the variation in per diem resource use among beneficiaries.

During our analysis of the APA model we identified six major issues that break down into three broad categories of issues: determining appropriate payments, implementation

and administration, and system design and statistical methods.

To determine appropriate payments for inpatient psychiatric care, we believe CMS needs to do additional work. CMS found differences between hospital-based and freestanding psych facilities and they attributed the difference to patients transferred from acute care hospitals with still unresolved medical problems. However, only 21 percent of the patients treated in units have had an acute hospital stay in the previous month.

CMS will need to examine more fully the differences between hospital-based and freestanding facilities to determine how much of the difference in costs is related to cost allocation issues or to differences in patient complexity. Ideally, the payment will follow the patient and properly reimburse the facilities regardless of whether it is hospital-based or freestanding.

The other issue regarding determining appropriate payments has to do with government-owned hospitals. We prefer that the government-owned hospitals be included in the PPS. As you saw in the earlier slide, government-owned psychiatric hospitals treat only 6 percent of Medicare

beneficiaries but these hospitals function as safety nets, admitting patients other facilities will not admit. These hospitals have lower costs per day than other facilities but we don't know why.

CMS will need to explore further the differences among patients treated in different types of facilities and the cost of their care to determine appropriate payments. We also plan to do further work on this issue so that we can comment more fully on the proposed rule.

We identified two implementation and administration issues. The first is a little more complex than the second. The implementation issue has to do with the transition to the PPS. A gradual transition would allow facilities that have relatively generous payments under the current system time to adjust to the PPS. An option for facilities to move to 100 percent PPS payment before the transition is complete would allow facilities who have relatively low payments under the current system to benefit from the PPS immediately.

Ideally, having a slow transition coupled with an option for facilities to move to full PPS payments immediately protects the provider infrastructure. CMS will

need to estimate the number of facilities that are likely to take the 100 percent option because the base rate will still need to be budget neutral.

When considering the length of the transition and the effective of 100 percent option, CMS will need to balance these two policies to make sure that no group of facilities is overly penalized by the policy choices made.

The second issue has to do with updating payments. Currently it's silent on updating payments to psychiatric facilities. Providing the secretary with authority to update payments annually and adjust for case-mix creep is needed will ensure the most efficient implementation and administration of the new PPS.

Finally, we move to two relatively technical issues, one on structuring per diem payments and one on per diem costs. The APA model uses what is called declining block pricing for the PPS. This system sets per diem payment rates for blocks of days where payments decline as the stay gets longer. For example, facilities would be paid higher rates for the first two days of the stay. They would be paid 84 percent of that rate for day three through eight. The rates would continue to step down thereafter. Because

rate blocks create cliffs, we suggest that per diem payments decrease continuously, resulting in a smoother decline in rates. This avoids financial incentives associated with cliffs.

The second issue has to do with the fact that CMS has commonly transformed costs into logarithmic values in designing payment systems. New empirical evidence suggests that models using large samples of raw values produce more reliable estimates than transformed values. The database used to construct the psychiatric payment model has a very large sample, about 400,000 observations. Therefore we suggest that CMS explore both logged and unlogged cost variables.

That completes my presentation.

MR. HACKBARTH: Questions or comments?

DR. NEWHOUSE: So I'm right in remembering that the APA model left out government facilities?

DR. KAPLAN: The original APA model did and then when they added them in based on what was said in the report, and that showed that the government facilities got 18 percent payment, an increases 18 percent in payments, compared to the current system.

DR. NEWHOUSE: The question I was going to raise, has there been any thought given, to your knowledge, of the crowd out issue? That is if we give more to government facilities, the state and local governments will reduce support potentially?

DR. KAPLAN: I'm not sure but we can certainly raise that issue.

MR. HACKBARTH: Others?

DR. MILLER: I just want to mention a couple of things quickly. Two, I think, are just things I want to change a little bit in the tone of the letter. We said consistently throughout all of our meetings that we're commenting on this before the reg comes out in order to try and be helpful. We've been very clear about that. I think we just actually need a sentence or so in the letter saying that's what's going on.

A second thing, I think we characterized throughout the letter, this is CMS's model. And the same vein, they haven't proposed it yet in March. We know this is going to be the basis of it but we'll just refer to it a bit differently. I don't think this really makes a big difference.

The last point, which I just want to reinforce, is we're going to add a sentence or so based on something that Sally just said there. When the Secretary looks at the transition going to allowing people to move to 100 percent of PPS we just want to be sure that inside the budget neutral framework that's done in a way that doesn't create a lot of disparities between the facilities. She said that. I just want to be sure that that sentence gets in there.

DR. REISCHAUER: Sally are the government-owned facilities largely caring for Medicaid financed patients and very long-term patients?

DR. KAPLAN: I think what were going to be doing in part of our work is to really understand what's going on in the government hospitals. The work that CMS did showed that they have an average length of stay that's much longer but it isn't clear to us whether all patients or most patients in government hospitals have very long lengths of stay compared to the other facilities. And that's one of the things that we're going to be looking at. So I hope to be able to answer your question more fully when we comment on the proposed rule.

MS. DePARLE: I'm mulling this because I had

trouble hearing. At the beginning you said something about the new payment system explaining only 20 percent of the variation or something. Could you restate that?

DR. KAPLAN: Yes, it explains 20 percent of the variation in per diem costs per patient.

MR. HACKBARTH: Could you put that in context? How does that compare with some of the other PPS systems?

MS. DePARLE: That strikes me as little bit low.

DR. KAPLAN: But you're taking out the variation that's due to length of stay when you go to a per diem system. So it's not necessarily comparable to your hospital PPS where you're talking about a per case system.

MS. DePARLE: So in your view -- I mean, you've raised other concerns, but is that piece of it adequately predictive at this point?

DR. KAPLAN: We think that it is. We don't think this model is perfect or fabulous but we think that this may be the best that can be done with the information that's available at this time. And we do think that the current system that the hospitals are under, and have been under for 20 years, is a problem.

DR. MILLER: Can I just ask one more thing along

these lines? Has anyone looked at how it explains the variation at the hospital level? Because we're talking about the per diem level -- or the facility level. Because again, once you start aggregating, more of the variation might be explained. So that's something else we can try and look at.

DR. KAPLAN: We can add that to the agenda.

DR. STOWERS: Sally, I mentioned geri-psych last month. It's a little difficult to ask this question but you have the long-term psych patients that are there longer. And then you have the geri-psych that primarily come in, it's usually their first episode, it's usually a one-time stay, relatively short, a week or two, where you're trying to differentiate I would say a medical diagnosis versus a psych. So you may do the scans and medical workup, rule out diabetes and the other things. And then you stabilize on whatever medicine they need and then send them back to long-term care or home or whatever. But there's a significant medical component to those shorter, more intensive, stays in these older patients.

How is that medical part accounted for? Or do we use the medical PPS to add onto these? I'm just curious

because it's really not explained how that works.

DR. KAPLAN: There are two ways that that is taken into account. First of all, there's a variable for age, patients that are over 65, and the coefficient is higher for those people. In other words there's additional money put in for patients who are over 65.

In addition, CMS uses comorbidities. Now, in the proposed rule, they only talked about four comorbidities. But I think we need to see what the actual proposed rule -- I mean, in the report they only talked about four comorbidities, but in the proposed rule they may have changed that somewhat. And I think that's something we can weigh in on that.

DR. STOWERS: Usually what's happening here is you have the psychiatrist or their staff doing the psychological workup. And then you have the primary care physician or internist or whatever doing a complete medical work on the patient at the same time. I mean, that's the norm. So just be sure we're accounting for all of that medical workup that occurs in those people. If I'm making sense.

DR. NEWHOUSE: That would be Part B, on the physician side.

DR. STOWERS: I think I'm talking more about what they order because it's very common to do the scans, CTs, and that kind of thing to rule out tumors or other things.

DR. NEWHOUSE: It would still be Part B, wouldn't it?

DR. STOWERS: I'm not sure. It may be, even though they're in patients. I wasn't sure.

MR. HACKBARTH: Anybody else? Okay, thank you, Sally.

Next, Joan is going to talk to us about alternatives to AWP for Medicare covered drugs.

DR. SOKOLOVSKY: Good morning.

In the commission's October letter to CMS commenting on the proposed rule for the outpatient PPS, we stated that the current method by which Medicare pays for outpatient drugs covered under Part B leads to payments that far exceed provider costs. We noted that Congress and CMS have been considering ways of reforming the current system and that MedPAC would monitor the impact of any payment changes. Staff is also focusing its efforts on analyzing options for change.

Today, we plan to describe recent changes made by

CMS to the payment system, discuss payment methods used by other payers, and finally look at some new developments in the private market.

Although Medicare covers relatively few outpatient drugs, both utilization and spending for these covered drugs have been growing rapidly. In fact, by more than 20 percent a year for the last three years. In 2001, Medicare spent more than $6.5 billion on Part B drugs and this total does not include drugs dispensed in outpatient apartments or in dialysis clinics.

As I'm sure you remember, Medicare reimburses providers at the rate of 95 percent of the average wholesale price or AWP. Under Part B drugs are generally provided by physicians in their offices or pharmacy suppliers when the drugs are used with durable medical equipment. Physician-billed drugs account for more than 75 percent of total Medicare expenditures for covered drugs and it's primarily the physician-billed drugs that we're going to be focusing on today.

I want to discuss one change that CMS has already implemented and then a couple of other things that the agency is doing that have implications down the road for the

way in which Part B drugs will be paid for.

CMS recently implemented a change in the way payment rates will be calculated. Instead of having each carrier calculate AWPs, they have determined that there would be what they call a single national drug price or SDP. It will be determined for all carriers by one chosen carrier, Palmetto GBA. Medicare will still pay 95 percent of AWP and AWPs will still be calculated based on the same sources that all the carriers are currently using, red book and national databank, but it will be done by this one carrier with expertise in finding the AWP's and then all the carriers will use it.

CMS has estimated that this will save the program about $50 million annually. The policy will not affect drugs dispensed by outpatient departments or drugs purchased from pharmacy suppliers along with DME. The DME carriers have for awhile had one set of prices that all of the DME carriers use.

Establishment of the single drug price could create the infrastructure for further changes. In time the carrier -- and this is something that the CMS administrator discussed in congressional testimony in October. In time

the carrier could use a market survey to calculate AWPs based on what providers actually pay for the drugs. The agency has previously estimated that this approach could save about $500 million annually.

I want to briefly note, and these were not in your mailing materials, two other developments that could potentially have effects. Recently, on December 13th, CMS issued an interim final rule on inherent reasonableness. This establishes a process for changing prices if payment systems result in prices that are grossly deficient or excessive for an item or service covered under Part B and excludes physician services.

If the payment adjustment that would be required to make the payments more in accord with market prices exceeds $100 million per year, the change would have to go through a Federal Register process and there would be a public comment period of about 60 days.

Any changes would have to be made gradually over a course of a number of years depending on how much would be needed to get the price more in accord with market prices.

The second thing I wanted to call to your attention is something that happened in the outpatient rule.

CMS determined that a particular drug that had received pass-through status, they used clinical criteria and established that this drug, which was a new rather expensive drug was what they called -- and this is a new term of art for CMS . They determined it was functionally equivalent to another drug that already been approved and so they set the pass-through payment at zero and are paying for that drug at the same price in which they pay for the older drug. This does not affect payment under Part B where it would still be reimbursed at 95 percent of AWP. But this sets a precedent that potentially could be used in other situations.

MR. HACKBARTH: Joan, the first part of that, the December 13th notice, so basically that just established a process for determining or applying inherent reasonableness? It was not specific to these drugs?

DR. SOKOLOVSKY: No, but it does specifically say that it can be applied for drugs.

Next, I'd like to talk about what private payers are paying for physician-billed drugs. But before I do that I need to spend some time talking about the kinds of drugs that we're talking about. And in the private market these drugs are usually referred to as specialty drugs.

Specialty drugs are obviously not exactly the same as Part B drugs and, in fact, they're such a new idea that they have many definitions. In general they're physician-billed drugs and other high cost injectables and they are the most rapidly growing portion of both the private as well as the public pharmaceutical market.

An estimated $19 million were spent on specialty drugs in 2001 which represents an increase of 24 percent over 2000. At this point they represent 11 percent of the U.S. pharmaceutical market. So this is a really rapidly growing piece of the pharmaceutical market.

DR. ROWE: I'm sorry, but $19 million could not possibly be --

DR. SOKOLOVSKY: $19 billion.

DR. ROWE: Oh, okay.

DR. SOKOLOVSKY: These are the drugs that are used treat cancer, AIDS, hemophilia, hepatitis C, MS, and anemia. And as I said, they're high cost drugs. They range in price from $5,000 to $25,000 per patient per year. They also require a lot of special handling. Each unit those needs to be individually prepared based upon the weight of the patient and the doctor's particular dosage instructions.

They need to be refrigerated, many of them shipped quickly to prevent spoilage.

Because of the high cost many insurers require prior authorization before dispensing. And the drugs often have unpleasant side effects and patients need frequent monitoring to ensure both that the side effects don't require intervention and also to ensure that patients don't give up on lifesaving drugs because of the unpleasant side effects.

Why are these drugs growing so quickly? Well, partly because the number of people living with serious chronic conditions is rising and because of the development of new treatments for managing these diseases that didn't exist before. But the largest driving factor in increase in this particular kind of drug is the increase in the number of biotechnology drugs in the market.

80 biotechnology drugs have received FDA approval. There are many more in the pipeline. These are the kinds of breakthrough drugs that you read about, they actually fit into this category. Not only are they expensive initially but there is currently no FDA process for approving generic biologicals, so there is no reason to think that the price

will go down in at least the foreseeable future.

At the same time as Dyckman & Associates did their survey on what private plans were doing about physician fees, we asked them to also ask health plans about how they paid for physician-billed drugs. This was a survey of 32 large health plans with a combined enrollment of 45 million lives. We asked them again what formula they were currently using to pay for coverage of physician-billed drugs and whether they anticipated making any changes in the formula.

The survey found that payment systems for these drugs were in a state of flux. Most of the plans, or at least half of them, either had just made some changes, were about to make some changes, or were at least considering changes. All plans reported pricing based on AWP but 11 have developed or are developing different methods for not all drugs but at least categories of drugs. Most paid as much or more than Medicare for physician-billed drugs and the pricing method, again variation was by the kinds of drugs, therapeutic class of drugs, when the drugs did.

As I said before, these payment methods are very much in a state of flux. It's because of the rapid growth in the utilization and spending for these drugs. What was a

little piece of the health care pie is growing rapidly enough that plans are beginning to take more notice of them. And at the time of the survey about having half of the plans had changed, were changing, or were evaluating their payment methods for 2003.

Lots of different strategies were discussed by the plans. Some were simply lowering the percentage of AWP that they were paying for particular drugs. Some were asking physicians to submit invoices and paying acquisition costs. Some were setting up group purchasing organizations to buy drugs for their physicians and then reducing the reimbursement level for physicians who purchase drugs outside of the group purchasing organizations.

The most common change we found was that plans were working on selective contracting for some particular categories of drugs. Selective contracting is a relatively new method for paying for drugs that depends upon new entities in the health care system. It is this new and rapidly growing market for providing specialty drugs, which has led to the growth of specialty pharmacies.

Specialty pharmacies developed as niche providers for one or small number of serious medical conditions. They

tend to specialize in not a particular drug but a particular condition. Hemophilia was the first disease that specialty pharmacies got very much involved in. Currently about $7 billion or 30 percent of specialty drugs are dispensed through specialty pharmacies.

These are not just things that insurers use, they are things that physicians use to purchase drugs.

They have a great many differences with conventional pharmacies. First of all, they don't have to be buildings. They generally aren't brick and mortar pharmacies that you go into. Most of their work is done through mail order. These pharmacies have expertise in preparation, the management and the delivery of therapies associated with a particular disease. They have compliance programs to make sure that all of the kinds of prior authorizations and whatever forms are necessary are completed so that providers will be reimbursed for the cost of drugs and manufacturers will be paid for the drugs that they reimburse.

They have patient assistance programs. Some are developing disease management programs. Some of the specialty pharmacies have special relationships with

particular manufacturers.

One of the problems that's been discussed with specialty pharmacies is that because they focus on specific diseases they may not able to monitor interactions between drugs taken for different conditions. They know very well what you're doing about one particular condition but will not necessarily know, if you have comorbidities, what other kinds of drugs you're taking.

A second way in which specialty drugs are being dispensed is through the large PBMs. Most of the bit PBMs have either purchased specialty pharmacies or are developing their own specialty pharmacies. Because they link purchase of specialty drugs with all the other drugs that they're covering for a particular payer, they are better able to track drug utilization. They also try to bring the tools that they use to manage expenditures for drugs and other settings to use of drugs in this particular setting.

Some have worried that the use of PBMs to pay for these drugs could result in the kinds of formularies where a doctor's decision that a particular drug is needed for a particular disease may not been necessarily handled if there's a formulary that's set up that recommends a

different drug.

The third model that seems to be growing in the private marketplace is that some health plans are taking over the management of specialty drugs. Some of them set up networks with different specialty pharmacies that monitor different diseases and then they do the administration that links the interactions between different drugs.

Based on the survey results it seems likely that more health plans will be moving in the direction of somehow working with the specialty pharmacies or PBMs.

I think this look at the private market for specialty drugs has some implications for our analysis of payment options for Medicare. The first thing that I think has to be stressed is that utilization of physician-billed drugs is going to continue to rise and rise rapidly. We need to get the payment system right.

Secondly, I think it's important to recognize that this is not a simple system. The drugs aren't simple and the methods for paying for them are not simple. We should be careful about developing a policy that pre-empts innovations in a marketplace that's changing so rapidly.

Finally, payment reform should consider the

different categories of covered drugs and biologicals and consider when developing a policy whether different strategies may be appropriate for different categories of drugs.

I welcome your comments.

MR. HACKBARTH: Joan, this to me seems a bit reminiscent of our discussions of payment for new technology where we're troubled with the status quo and that outpatient pass-through system. But it's one things to be dissatisfied with the status quo. It's another thing to come up with an option that works for a program like Medicare.

I remember in our discussions of paying for technology we went out and surveyed private payers and delivery systems about what they did and then we had a discussion about how well or not well some of those methods would apply to a program like Medicare.

It seems like what we say here needs to be closely coordinated with that. Am I barking up to right tree here? Aren't a lot of issues the same?

DR. SOKOLOVSKY: Many of the issues are the same but I think because we are limiting it to a discussion of drugs and biologicals, we have concrete strategies out that

are being tested and we can look at them for that reason.

MR. HACKBARTH: Strategies used by private payers that we do think --

DR. SOKOLOVSKY: By private payers and public payers.

MR. HACKBARTH: That will work for Medicare?

DR. SOKOLOVSKY: Potentially. We have something to analyze, I think.

MR. HACKBARTH: Just one other question about the context. When we did the survey you said that we found that most were paying as much or more than Medicare?

DR. SOKOLOVSKY: Yes.

MR. HACKBARTH: That caught my ear because I had the impression from our previous discussions that we were sort of the lone cowboys, the last to figure out that this was a problem.

MS. DePARLE: We definitely had that discussion, Glenn. And in fact, I remember -- I could be misremembering, but I thought back in 2000 or so there were inspector general reports and maybe other reports that basically said that. So I was very surprised when Zachary's information showed they were using AWP.

DR. ROWE: I think before we thought you were the lone cowboys. Now the situation has changed to the point where you're the lone cowboys and you don't know it.

DR. SOKOLOVSKY: The difference here, I think, is that these are not what providers are paying for these drugs. Providers are paying less for these drugs. But just as in Medicare, most insurance plans that have not moved to these new systems are third-party payers. They reimburse on the basis of a formula which, as in Medicare, is irrelevant what the provider paid. And they don't get the discounts and the rebates that a provider may or may not get.

MS. DePARLE: You're right. I'm not sure that the IG reports actually went to the issue of what do other payers pay. That's what was interesting, new information out of the report that we commissioned, I thought.

DR. MILLER: If I could clarify, don't some of those reports address what other parts of the --

DR. SOKOLOVSKY: Yes.

DR. MILLER: For example, the VA.

DR. SOKOLOVSKY: When we look at Medicaid, we find that physician-billed drugs, Medicaid is not very different from Medicare. The Medicaid rebate does not apply for drugs

billed in physician offices.

These drugs really are different. When we look at the VA, it's a very different system because it's an integrated delivery system and they do have a method for tracking what's the lowest priced that any private payer is paying. By statute, they get that price. And then, because it is an integrated delivery system, they are also able to use competitive methods to develop some sorts of formularies in specific diseases categories, make the statement that two drugs are functionally equivalent as CMS has said and then go to the manufacturer and negotiate for a lower price. But they are the direct purchasers, so whatever discounts they can get, the get the benefit of.

DR. MILLER: I only bring that out because I'm sort of left with the reports were saying it's not what the provider pays and there are a couple of other payers, although not necessarily private payers, who can't get a lower price.

MS. DePARLE: I would be interested, if Joan understands, that she could just do a chart which show the various payers, because as I was listening to this it sounds like Medicaid -- Medicaid is entitled to the best price

given to a private purchaser, right?

DR. SOKOLOVSKY: The best price at a retail level. And so for pharmacy supplier drugs they get much better deals than Medicare under Part B.

MS. DePARLE: But the rebate does not apply to many of the drugs that Medicare also pays for because they're given in a physician's office.

DR. SOKOLOVSKY: And you don't buy them --

MS. DePARLE: So Medicaid also is paying more than some other private payers, probably. It's interesting. I don't know if it's possible to reduce this to a chart but I'd be interested in seeing it.

MR. MULLER: My questions are along the same lines that were just discussed by Mark and Glenn and Nancy-Ann, which is one looks at the comparisons of the VA or Medicaid or the big PPMs or even achieved the GPOs in terms of -- in some sense one has different tacks. One is one of just using purchasing volume to get a price, as you point out on the specialty drugs it may be less possible to get that.

Others, as you say, try to do more case management. That's one of the themes I would say certainly of the VA and it may be one of the themes of some of the big

private payers in terms of trying to have more disease management as a way of trying to control this.

So I think, in addition to Nancy-Ann's question about trying to get some rough comparison on a scale of 100 or something like that, what does the VA get versus the big GPOs versus Medicaid versus the PBMs, if we could also be looking at the various tactics in some kind of comparative way, are we likely to get more bang for our buck in terms of having some kind of competitive bidding or administered pricing-type mechanism to kind of look at the price of specific drugs? And what proportion of the drugs that are inside the Medicare program would be captured by such a mechanism? It may be you can only capture -- I'll just make up a number -- 50 percent. I don't know what the number is. And then you have to think about how you capture the other 50 percent, not to be wed to those numbers, versus what one can get out of case management.

I think there's a lot of interesting case management work going on around the country. My sense is that -- again, I'm making this number up -- if we push 25 percent of the drugs and case management -- I mean, if we're able to reach 25 percent of the drugs in case management I

would be very surprised because I think that's a field that may take many years to unfold.

So looking at the kind of strategies, I think that's covered in your chapter here, would also be helpful as we think about one might do three, four or five years out because certainly the curve on this, on drug costs -- and we discussed this over the last year -- it's not quite as steep as the cost of SNFs in the '90s but it's a very steep one.

So thinking about what one can do in learning from that comparative experience, I think looking at it tactically as well would make a lot of difference.

Thank you.

DR. ROWE: Just a couple of general comments. This is interesting.

I think when we first approached this issue there was some concern (outrage) on the part of some commissioners -- at least myself -- at the difference between what physicians were paying for the drugs and what they were being paid by Medicare, particularly in cases of some oncologists, some of the data that we were at least presented.

And I think that I certainly would not want us to

say well, it's okay because the private payers are doing it, too. I mean, I don't think that the message here is if there are these gross disparities, that paying $50 or getting paid $1,000, or whatever the numbers were, if others are paying at also, who also have other arrangements with those physicians and may be paying less for other services or whatever, we shouldn't say well, we should continue to pay these outrageous prices because, after all, others are.

I want to make sure we don't get into that.

MR. HACKBARTH: I agree with that.

DR. ROWE: There may be a little bit of that when we say oh, gee, we checked and everybody else is doing, it's okay, let's go on to the next thing. I think we need to focus on fixing that and finding out what the right price is and paying it and reducing it. And if we're leading the way, for a change, that wouldn't be so bad. And the health plans would be happy to follow. So I would like to see something like that.

The second is at this point I think probably every member of Congress has voted for one or another outpatient prescription drug benefit and it's likely, I guess, and most people think, that some outpatient prescription drug benefit

may become law, which I think would be a good thing. And I think it's really important that we make it clear that this is different and that whatever we're doing here isn't Medicare's approach to handling drugs. Now we're going to roll in all the rest of these drugs and oh well, we have an approach to handling drugs, here it is. And that this is really a different species and would be handled very differently, distributed differently, et cetera, et cetera. And there might be just a statement here saying this really doesn't inform any discussion about what system Medicare should set up, whatever that might be, for the usual and customary medications.

DR. NEWHOUSE: Four comments. I've been looking into the cancer drugs for other reasons and what I've been finding out is that it's not very simple to compare Medicare with the private side, that the private side differs by market, that in general if you have a single oncologist in town, he or she can command a higher price than if you have several. The private side just doesn't work the way Medicare does and say we pay 95 percent of something, take it or leave it. So it may not be easy to get a comparison there.

The second point that I'd like to just raise for us to consider is that talking to the oncologists, the oncologists complain that Medicare try to justify their markups in part because Medicare doesn't pay an administration fee. And I'm not sure -- there ought to be some deal here. The markups seem so high that at they're greater than the administrative fees the private side pays. I've been looking into what the private side pays for administration, too.

And I think if we're going to say something about this, we ought to think about administrative -- paying something for administration. But that would be part of a more general change in payment structure here.

The third point is I'd like to agree with Jack and even strengthen his point about not emulating what the private side is doing. If we do that, we invite distorting the private side because the manufacturer will take into account the fact that Medicare prices going with the private side. This is exactly what happened when Medicaid went in that direction and if Medicaid was to get the lowest available price, the lowest available price went up.

And the fourth thing is just a comment really on

Ralph. Bidding is great, and I agree with it, but it only really works if there's a good close substitute. And in a lot of these areas, I think there isn't a good close substitute. So bidding just isn't available. You're kind of stuck with saying this is what we're going to pay, I think. And I'm not sure that -- we've talked about there's not necessarily a very good way to do that. I'd be happy to be wrong on that and think that there was away for bidding to work, but I don't think so.

MS. ROSENBLATT: I think, Joe, the complaint that the oncologists have is not that there is no administration payment. There is one. It's the adequacy of it. And that has been what the debate has been and that is something that Congress has to change. There's been debate and hearings at which the oncologists have testified about that.

Secondly, I'm not quite sure I understand your point about the manufacturer incentives and what impact Medicare's changes might have on the commercial sector pricing. No doubt it may have an effect, but right now I think the point is the manufacturers are offering, in some cases, these drugs to physicians at much lower prices than they offer to others, it appears, to encourage them to

prescribe them.

MR. HACKBARTH: The effect may run the other way, that they say we can afford to offer these lower private rates because we know Medicare's going to pay a huge amount for the drugs.

DR. NEWHOUSE: My point was -- I wanted to speak against a policy that Medicare paid X percent above or below 100 of what the private sector paid. There was some effort to link Medicare pricing to what was observed in the private market.

MR. FEEZOR: Just a couple of things. First, Joan I think it's a good coverage of what's going on and certainly the issue of specialty pharmacies is something that, when we recently went out for consideration of a new PBM contractor, was one of the distinguishing characteristics that we looked at in terms of trying to manage our cost.

Two things I'd simply like put on our radar screen. I guess one is increasingly the prospect of genetically tailored pharmaceutical agents and what sort of reasonableness or how you cope with that. So I would just put that up as a question mark for the future.

The other thing, Joan, there is an effort -- and Glenn may speak more to it than I -- about 19 states are trying to put together a consortium in their drug purchasing, both in terms of their state employee programs and even possibly their Medicaid programs being led by a outgoing -- I guess he's now gone, Kitzhoffer in Oregon, some of his folks, growing out of their effort to do effectiveness comparisons and maybe some joint purchasing. And we probably ought to try to monitor that as well.

DR. NELSON: Joan, you mention drugs and biologicals as being separate, but it might be helpful somewhere to use the FDA or some other definition and define drugs and biological because there are some differences. You point out that biologicals are in a rapid growth position and certainly with monoclonal antibodies and things of that sort, I agree with that. I think that's true.

But this also has importance, I believe, because downstream probably we'll deal with this by more explicitly defining the work in administration and managing the patient around the administration of these products. I t may very well be that there's a different kind of work in managing biological administration than drugs. So that definition

and distinction would be useful looking forward to that, as well.

DR. WOLTER: I was just going to add -- and it's probably implicit in many of the comments that have already been made -- but an aspect of this has to do also with differential payment in different sites. And if our philosophy over time is to try to not have that -- and this one may be even more difficult than the ASC hospital outpatient discussion, but I think it is part of the analysis we may want to weave in.

MR. HACKBARTH: Anybody else? Okay, thank you, Joan. The last presentation will be made by Karen on using incentives to improve quality.

Karen, while I'm thinking of it, is part of your introduction to put this in historical context, if you will, in how we came to this subject? Actually, Dave and I had a conversation last week on the phone and, being a new commissioner, he wasn't quite clear on how we came to be in this conversation. So if you would spend a minute explaining how we got here, that would be helpful.

MS. MILGATE: I may have had a shorter version, so I'll lengthen it just a tad. I was going to start with the

retreat and not our discussions last year, but we could go there, too.

MR. HACKBARTH: Just briefly, I think it would be helpful to go back to last year and explain, very quickly, how we came to this.

MS. MILGATE: This discussion is really a follow-up to our panel discussion in October, most directly, and then also really it's been a progression from discussions we had last year in preparation for our report on applying quality improvement standards in the Medicare program, where we struggled with the concepts of how to apply standards across different types of plans and providers.

So through that discussion we basically, as a commission, came to the I guess conclusion that they needed to be applied differently but that left us in a situation where there was some unevenness in how those standards were applied. And one of the concepts that the commission felt strongly about is that there should be some way of actually rewarding those plans or providers who actually reached a high level performance or else put a lot of effort into improving their performance.

And so we got to the point of recommending that

there should be some type of reward for providers or plans, but didn't really get to the next step, which is what would those look like? So in many ways this discussion is kind of a further fleshing out of what would those look like and how would you address some of the issues that may be unique to Medicare and trying to put in place incentives to improve quality.

There was also further a discussion at the retreat about the importance of trying to align financial incentives in Medicare. And then we had the panel discussion in October where, I guess, the takeaway that I heard from the commission from that was it's very important to align incentives in Medicare to encourage quality and it's very difficult to figure how we would do so. I think daunting tasks was a couple of words that I heard coming out of that discussion.

So what we're hoping to do with this discussion today, over the next few months, and some analysis of current models of how private sector purchasers and payers, as well as public sector purchasers and payers, are using incentives is to shed some light on that daunting task to try to make a little bit less daunting, so we understand

some of the complications and perhaps have some idea about the best ways for Medicare to proceed.

So today this is a chance for you to give staff some feedback on an outline and some ideas about how to proceed with these concepts.

So first of all, it's important to define how to proceed? Improving quality is often rewarded through lower costs, through increased volume, so purchasing of better quality products, and sometimes through increased price.

However, in health care that's not exactly how it happens and while quality improvement takes resources and commitment, both staff commitment and executive level commitment to quality improvement as a task, there really at this point are few rewards for putting those efforts in place. Providers and plans certainly get personal and professional satisfaction, they meet regulatory or accreditation standards, but sometimes the entities that actually put in place the quality improvement don't even get any savings from them, if there are savings. And when there aren't savings, when it's a matter of simply investing money, often those improvements aren't well known by either the patients or the payers, or if they are known through

some type of public disclosure, often there is not necessarily a mechanism in place to steer patients or payers to better quality providers.

In addition, payment incentives are often neutral or negative. This is certainly true of the Medicare program where we basically pay the same regardless of quality, so that's a neutral incentive. And sometimes, in fact, when quality is worse we pay more. For example, when there are complications in procedures that may be due to the fault of an institution, sometimes the person will get kicked up into a higher DRG and so there's actually a higher payment for a worse quality product.

So why is it important for Medicare to engage in the discussion? In the Institute of Medicine report called Crossing the Quality Chasm, incentives were a big piece of the solution, as part of the national quality agenda that they laid out. And they suggested in that report that Medicare was a very important part of the solution, primarily because they were really the largest single purchaser. So without Medicare it would be difficult and it would be very important to them to take a lead role in trying to figure out the best way to put incentives in place

to encourage quality improvement.

And as I noted in my introductory comments, MedPAC also recommended the use of rewards to recognize improvement and performance in the January 2002 report on a applying quality improvement standards.

So how could incentives work? For better performing providers -- and I want to just note when I use the term better performing, it's used in two ways. One is to recognize those that are at a high level performance already? And the second is for those who may start at a low level and actually put some extraordinary effort into improving their performance. That was also a discussion that we had back in last year which is something that we need to be decided as Medicare goes forth in thinking through what to reward, but that's what I'm meaning, I'm capturing both those concepts.

So for better performing providers, incentives could -- and once again I want to stop to say in terms of incentives. there we're talking about both financial and non-financial. So the concept, at least that I'm presenting here, is that both non-financial and financial incentives could have some impact on the finances of the organization.

The first two bullets really talk about decreased costs and the second two bullets are ways to increase revenue through incentives. The first is shared savings models where you would try to recognize more explicitly the contribution that various providers within a health system make to improving quality. For example, if a primary care practice put in place protocols that kept some folks out of the hospital, would there be ways for those folks to capture some of the savings for the overall health system because they're putting in place the investment to actually improve the quality for their patients ever.

Number two is to decrease the cost of regulation which could decrease the cost to the provider -- I guess that's a fairly obvious one -- through perhaps more focused surveys. So regulators or accreditors could decide to focus more specifically on certain areas where providers were having problems rather than full-blown surveys. Or in one example, CMS in the M+C program has exempted M+C plans that are at a very high level of mammography rates from having to do a national project on mammography.

The second two bullets are basically examples of how incentives could increase revenue. The first is

increase volume and that would either be through public disclosure of information that consumers would use. They would then choose to go to the better performing providers. Or not leaving it necessarily to the will of the consumer totally, putting in place some types of financial incentives for consumers to go to better performing providers.

The second would be explicitly recognizing the efforts of the provider by perhaps paying a higher price to those who show better performance.

So clearly there are many design issues in trying to put incentives in place. There's what do we want to encourage, what information to use? Who would you actually try to encourage to do something? And how would you implement the incentives.

In terms of what we would want to encourage, we suggest in the outline that it would be useful to use the IOM framework which has explicit components of quality and that will give us a sense of, in some ways, what type of quality we're encouraging, rather than just using whatever information is out there on particular providers.

So we would suggest focusing on safety, clinical effectiveness, patient perception or patient-centered care -

- they're kind of used interchangeably in the report -- and timeliness. Once we decide what it is we want to encourage, then there are questions that I think I've hinted at, in terms of are you giving rewards for high performance in these areas? Or are you actually trying to get providers to improve so that you will then give them an incentive to improve what they're doing?

And then finally -- and this one depends a little bit upon, I guess, what's actually available -- are you going to measure improvement by looking at the structure, for example? Do you want to give an incentive for health providers to put in place information systems. Clearly, the discussion that began yesterday and continued today, I think from Jack's suggestion is kind of the kind of thing you'd work through there. Are there some kind of structural innovations that the Medicare program can encourage?

Processes are things like the QIO program is looking at, primarily in hospitals where we know that, for example, beta blockers after AMI are a good thing. And so you would measure those and then give rewards for high rates of those.

And outcomes could include things as varied as

mortality rates, functional improvement, for example for home health is something that's measured in home health. And one that's less talked about but comes under the rubric of patient perception is, for example, patient understanding of medication once they leave the hospital, is something that has been talked about in some circles.

What information to use? This is one of the most critical pieces and often most well debated in this area. How good are the measures? If you're to distinguish between individual providers and plans you need to make sure that those measures are really good measures and that they're measuring what you think they're measuring, and that you can actually compare across different facilities and providers.

We find, in just our preliminary look at things, and I guess we found this through our report last year that, in fact, measurement is better of some providers than others. So there may be different incentives depending upon who the provider is and how good the information is.

Who you want to incentive depends, I think, a lot on your goals. It depends upon who has the most ability to affect what you want to be affected. It could be at the physician level, hospital level, health system level. So

that's something that would need to be decided.

And then how? What is the most effective and simplest to implement? For example, in CMS currently there was article that came out yesterday in JAMA that talked about the successes of the QIO program, at least I would characterize it that way, in actually creating improvement on 20 of the 22 measures that they've worked on.

In that case there's not even public disclosure of the information. It's simply measuring how various institutions are doing on certain measures, feeding that information back to the institution. And I guess I wouldn't credit all of the improvement to the QIOs because there's been a lot of other efforts that have joined those QIO efforts, but I would say it's one model to use of measuring and feeding back information.

And I wanted to note something else here because I thought it was an interesting thing that I feel like we've already found through talking to private and public purchasers and payers. There seems to be a progression out there, in terms of payers and purchasers use incentives. It seems to be a progression of figuring out how to measure, what to measure, talking with providers so that there is a

good buy into what those measurements are. Then a feeding back to providers. And at that point then, payers start talking about maybe we should give this information out publicly or to our enrollees. And then they get to the more difficult but perhaps more effective incentives of financial incentives, either to providers or to beneficiaries.

So it's kind of an interesting thing to consider whether it's actually a continuum of effort, so you don't really plop yourself right up there at financial incentives without going through some of those other steps.

So what types of incentives are we thinking of considering? These are the six that we have identified through some initial analysis, so it was something that I would be looking for guidance on from you all, is if this sums up what you think is out there, if there are other types of incentives that we may have not found in what we've looked at so far.

DR. ROWE: Are these in priority order?

MS. MILGATE: No, they're not in priority order at all.

DR. ROWE: What order are they in? They're not in alphabetical order.

MS. MILGATE: I don't want to say they're in any particular order. I guess that in -- because I would say something that's not right. No, there's no particular order here except the first two are not financial and the last four are.

MS. DePARLE: The first two are things they're already doing. It isn't quite in terms of ease of implementation.

MS. MILGATE: It's not ease of implementation. That's w hat I was thinking but it's not really -- yes, cost differences for beneficiaries would be at the bottom, I think, in terms of ease of implementation. So no, there's no particular order except those are the distinctions, yes.

I wasn't that clever. I should have thought of something.

The first is public disclosure and that's fairly evident. That would either be where a plan would feed information about different types of providers to the enrollees for them to choose. Or the other way that is done, or reason that's done, is often just publicly disclosing the performance of providers for accountability purposes. So it's both for choice and accountability.

Flexible regulation, again, I gave you a couple of examples earlier of ways that you can decrease the costs for providers and plans through flexible regulation.

The third is payment differentials for providers and that would be basically gathering information that you would decide would be a good measure of provider performance on quality and then figuring out ways to actually pay the higher performing providers more.

Cost differences for beneficiaries could be done through cost sharing. Clearly, this is easier done in the private sector than the public sector, where in fact beneficiaries might pay higher amounts if they go to lower performing providers and less if they go to higher performing providers.

Shared savings is a strategy that's been used in some health systems to try to give incentives for different parts of the system, different providers, to actually work together to improve quality. So that the entity that may put the investment in improving quality gets some savings back to themselves, as well as any that may lose money because of quality improvements might be compensated for some of those losses. For example, lower hospitalizations

would save money for a health system but would cause the hospital some admissions. That's something that we could debate whether you'd would want to reward or not.

Then the last one is capitation/shared risk. There we're talking about an overall payment incentive that essentially encourages whoever gets those dollars to better coordinate care so that there if, for example, they do reduce hospitalizations for diabetics, that they would get those savings through the shared risk or the capitation that they receive.

So those are all general considerations. In looking at this may be applied to the Medicare program, many issues arise. This is really not intended to be an exclusive list at all. It's just some ideas about some of the more difficult issues that the Medicare program and thus the commission in this discussion would need to think through.

First, it would need to be done different in fee-for-service and the managed care side of the program. So we'd have to think explicitly through some of those issues. Some of the incentives are achievable through regulation. Others would need legislation to implement. So that would

need to be considered. And there may be unintended consequences of putting incentives in place. For example, if an institution gets designated as a high quality cancer care provider, they make get all the hard cancer cases. So that would need to be some risk adjustment there that would be adequate to capture those issues.

Access issues might arise. If there were incentives for beneficiaries to go to one provider over another, that could end up in making it difficult to access care in some communities if providers closed or there may be issues about equity, of whether some providers could actually afford to go to one or the other, or travel to go to one or the other.

The third, crowding out of quality innovation is a concern simply because Medicare is such a large purchaser that you would assume that the direction the Medicare program is going, in fact, could essentially become the direction that the nation goes in terms of quality innovation and that would need to be considered to make sure that didn't crowd out other efforts at innovating.

Implementation issues are many but the three that are listed here: one, budget neutrality. Would this be new

money for incentives, for the financial incentives, or would there be a taking away from some to give to others? Jack's idea, once again yesterday, about IME intrigued me because it was a mechanism for creating a pot of money that you would then need to define a product as to how you would then give it to various providers. And I think that discussion highlighted the difficulty of defining the product sometimes and that's clearly true in this area as well.

The availability of skills for a very complex task, trying to make distinctions between providers and beneficiaries isn't simple and Medicare is a large program involving many, many different parts. So it could be a difficult task to take on.

And then finally, the locus of control. We're talking about decisions that could drive the quality agenda for the nation. We're talking about issues about money moving between providers. So there's questions of whether Congress should decide some of these issues, whether CMS should have control, how would the public have input, and those kinds of issues would need to be discussed and decided.

That concludes my presentation, so I'd be

interested in your feedback and guidance on the direction of this discussion.

MR. FEEZOR: Karen, as always, your deep depth and interest in this area is quite recognized and I think you've laid out an excellent framework for us to consider.

Just a couple of observations, or a couple of things to track sort of as we look toward some examples of what has helped in terms of public disclosure besides those that Medicare may be involved in, I guess primarily on the SNF side, that we might look at, I guess, if some of the efforts like Pacific Business Group on Health and their efforts at the Leapfrog standards and those hospitals that participated in that might be interesting.

Many of you know or probably have seen that under the category that you had of type of incentives, payment for differential for providers, the six major payers in California will be, beginning this month, they pay for performance. And I noticed, I guess in the recent AMA News or something, that BlueCross and BlueShield of Massachusetts is trying to do similarly some sort of incentives for their specialists. And in addition, there are several of the larger medical groups in California that are trying to move

the pay for performance, not just at the primary care level but up to the specialist level.

Under the cost differentials for beneficiaries, a variety of tiered products coming on the line, both those that have sort of what I call more cliff-like behaviors, either you're in the network or not, and strong incentives. And then some that are sort of what I call sort of Zagart measures of four wisps or four dollar marks. And if I choose a four dollar mark hospital, it's going to cost me four times whatever my deductible would be per day of maybe $50 as a way of seeing if that makes any movement.

MS. MILGATE: Allen, have you put those in place?

MR. FEEZOR: We have not. The last one -- and I'm sorry that Alice is not here -- I think BlueCross of California is just putting that up year. Let's put them on our radar screen and try to get more information.

The one thing I did find on your list of six, I would add seven, though it may not pass the test of political feasibility but it's something that I think the current private payers are going to be revisiting. And that is exclusionary. That's a very perverse incentive. It's maybe a disincentive. Maybe stated more positively would be

raising the bar significantly on what minimum qualifications are for participation. Again that hits a political feasibility issue with us, which then, on your last slide, we may want to put -- I don't know whether we want to put it specifically but not far from my mind is considerations in terms of any of these that we might consider.

You said feasibility, I think there's also probably a political sniff test that has to be passed. And then one other sort of consideration for Medicare and for any payer is when I say measurability, we always get stuck in saying well, because we can't measure it perfectly, therefore we don't do it. I think if we think more in terms of accountability to make sure that what we are trying to evaluate does track to the provider of care, whether it's the system, would be a good standard that we need to include in terms of our considerations for Medicare.

MS. DePARLE: I agree with Allen, Karen, that was some very solid work and we appreciate it. And I'm excited about the possibility of MedPAC playing a roll in this debate about how Medicare can move forward more quickly with a quality agenda. As you noted, they're already doing some positive things and I just wanted to highlight one of them

and ask actually that you provide the commissioners with copies of the JAMA report, both -- the project that Karen referred to was started in either '98 or '99.

And what CMS did was develop quality indicators with a bunch of clinicians from around the country. And these are not things that are debatable. These are things that everyone agreed this is what should be happening. And then proceeded, I think for the first time in fee-for-service Medicare, to gather the data for each state. So on a state-by-state basis we have data now on what Medicare beneficiaries are getting and what they're not getting. Senator, as usual, Minnesota does very well.

MR. DURENBERGER: And Montana and North Dakota.

MS. DePARLE: It's also interesting when you match that up against payments from Medicare to the states on a per beneficiary basis. So we could have that debate, as well. It's very provocative, very interesting data.

But it was not an each easy project for the agency. It has not been an easy project and Dr. Jeff Kang and Dr. Steve Jenks led that effort. And the report that came out yesterday showed some improvement. I was pleased to see the reaction.

This was a bit of a yawn when it came out in September of 2000, the first report. But for example, I remember that it said that New Jersey ranked very, very, 45th or 46th among the states in achievement of these quality indicators. And the New Jersey Medical Society stood up and said this is unacceptable. We want to improve. And they did show some improvement.

So that, at least, made me hopeful and I think it's the kind of thing that the commission should encourage, as well as the other efforts that CMS is engaged in right now, to publicly disclose a lot of this information.

And I would even support disclosing what they have now, on a more granular basis. But that's a difficult thing. And we didn't do it while I was there, so it's easy for me now to say they should do it. I admit that.

DR. ROWE: Just four comments. We found it helpful in our quality initiatives in our company to focus on special populations rather than -- you know, there's more to quality than HEDIS. And two populations that I think Medicare might consider as part of the quality problem are care at the end of life and racial and ethnic minority disparities in care, which I see as not a civil rights issue

but a quality of care issue. And I think that there are a lot of data and there are a lot of disparities. There's a disparity behind every tree and under every rock. We don't have to do a lot of research to find more disparities but we should be able to target them specifically.

So I think there's an opportunity that Medicare has that I'd like to see. At least those are two populations.

Secondly, you made mention, Karen, early on of the fact that the people who make the investment aren't always the ones who gain. Don Berwick made that point when he joined us sometime ago and gave that presentation. I think that's true and its interesting, but you might make note of the fact that that's not necessarily relevant to the Medicare situation because the company invests in it and the health plan saves, or the health plan invests in it and the company saves because people have fewer days out of work and the company has to hire fewer temporary employees.

And some of those analyses that Dr. Berwick did aren't really relevant to what Medicare is doing and, in fact, we're paying both the hospital and a doctor and we're not counting work productivity as one of the outcomes et

cetera. So some of those analyses are not necessarily germane. Some are.

Third, is the issue of your list of approaches, you didn't include what to me is the most obvious one and maybe it's the most combustible one and therefore you didn't want to step on it and I don't blame you for that. But there is a simpler approach than trying to figure out whether you should pay certain providers more and that is, of course, not to pay some at all. And that is to restrict your network based on quality.

It's not easy to do but you know -- and there are areas in which there are limited number of physicians, et cetera, but just include them.

And then the last thing has to do with efforts, the co-variants, if you will, I guess, of efforts to improve quality and efforts to improve education, which was commented on in some of the discussion earlier today and yesterday. And it might just be noted that if Medicare does really decide that it's a proper utilization of these resources that we have for the program to improve certain underlying initiatives such as information systems, to get computerized order entry in all hospitals and stuff like

that, that that will also improve medical education and facilitate more effective training and stuff like that. So there might be some mention of the fact that there is some synergy with respect to well targeted education and quality initiatives. Thanks.

MR. DURENBERGER: I'm glad Nancy-Ann reminded us, because I wanted to begin by recognizing that without her, this initiative that got reported yesterday would not have happened and a whole lot of other things that people are doing voluntarily in the private sector to try to get a definition of quality would not have been encouraged because a lot of people knew what she had committed CMS to do. So I'm pleased that you explained it so that I could tell you how much your decision meant to those of us who have been working on this issue.

Second point, Karen, this is just a great outline, and particularly the three or four page outline that I worked with which was the design of the detailed outline. And I intend to respond to that in some detail, and I won't try to cover it in my remarks.

The first point I wanted to make is I think we should talk about this in the context of these other papers

we're doing, as well. We're doing papers on spending and the issue is spending on what? Just paying for providers or are we paying for something else? And it should be raised as an issue when we're talking about access which is access to what? And it should be raised when we talk about choice as a factor.

So it would behoove us, in everything that we do, to focus on the importance from a beneficiary standpoint of paying for what? Not just the prices that we're paying, but what are we buying with our money? Secondly, there's a comment in there somewhere about Medicare in the past not capturing savings and Nancy's already made the point that I would illustrate with a map that was in the Post yesterday. Medicare has captured a lot of the savings that came from the Northwest, the Upper Midwest, New England, and so forth because it kept driving down the payments in the fee-for-service system as back in the 1980s when we did the TEFRA risk contract.

As the behavior changed in heavy concentration of HMOs, the spillover effect on fee-for-service, in effect, took the whole part -- and there's a researcher up at Marshfield Clinic who's done a beautiful job on this map --

that the upper Midwest, for example North Dakota was one of the worst, was in the first or the upper quartile in terms of Medicare payments per beneficiary in the early 1980s. By the early 1990s, North Dakota was in the lowest quartile and in large part it was because of the impact on fee-for-service of the work that was done under both cost contracts and risk contracts. And I know there's some debate over cause and effect on that issue but his data from the early '90s shows all of the same areas that are black or high-quality here today are also the low pay areas today by comparison with 10 or 15 years earlier. So somebody made that money and it wasn't the HMOs and the providers. I think it was -- I think, at least in the early stages of it, it was the Medicare program. That's just a matter of my version of the record.

The second thing that I would hope you would build into the process, and that is looking at efficiencies in process as well as the results or the outcomes. I think in terms of empaneling people and bringing experts together you might be well advised to get the management experts, some economists, some people who have worked with the process of care design and delivering, as well as folks that might be -

- and you don't have to get just health economists or people that manage health organizations to do it -- but adding the dimension of efficiency to this effort to pay for performance and quality and so forth gives you a dimension that rewards the Billings Hospital or the whatever it is that is spending and investing the money in processes that support more appropriate care delivery as well.

The third one is sort of along that same line which is to evaluate not just -- I'm in section number three, which is the design issues -- to look at some processes and portions of processes to get to a particular end and to look at those as ways in which to reward the end that you want, not just looking at the end itself.

The last one is this, which is we have a tendency to look at a solution. Let's pick one of the six or something like that, and that will be the Medicare approach to it. But in many of our communities, the challenge is this, how can we equip consumers to make demands on providers even though they don't want to leave those, or they can't leave those providers. Let's say you're in so many communities represented here where you don't want to leave the provider and so yo don't have exit as one of your

options, you only have voice or demand or something like that as your option. How can we, on that kind of a level equip people to make demands on their providers? The point simply is there isn't one solution. There ought to be some smaller ways in which we might deal with it.

But as I said, I'm going to put this all together in a written document and send it to you, as well.

DR. NEWHOUSE: I know we don't usually have recommendations in the June report, but I'd like to suggest that where we might head is to encourage some kind of controlled experimentation in this area with the Medicare program. It's clear from what everybody has said and what Karen has written that Medicare is such a big piece of the action -- and many would say a big piece of the problem -- that it's important that Medicare do something here. It's also clear from Karen's last slide, there could be lots of unintended side effects that would make things worse, depending on how it's done.

In light of that, it seems to me the way to proceed is to try to learn something about what various things do. There's lots bubbling up in the private sector, has people have said, and we'll see how well that gets

evaluated. It may or may not be applicable to Medicare.

One other elaboration on Jack's point, it's clear that Medicare has some incentives to invest in, for example, preventive measures that don't apply on the private side. But where I think there is a problem with Medicare in the quality areas, among several other places, is in the hand-off coordination side of Medicare across sites. And I think our payment systems that are geared to site-specific payment just encourage that kind of problem. Or put the other way around, discourage trying to coordinate. The kind of obvious policy initiative in the Medicare area that would serve this area is M+C where the plan in principal could have incentives to coordinate. We may want to think about a link there, but given the anemic state of M+C, we also should think about ways to improve incentives for this in traditional Medicare.

DR. STOWERS: Again, Karen, great chapter.

I just wanted to -- we were talking about rewards, incentives and that kind of thing. And I think sometimes we need to step way back and put some kind of a reward or incentive or covering the cost or whatever of just collecting the data.

You know, we're putting together a national rural hospital database right now that includes financial incentives, patient and staff satisfaction numbers, and several evidence-based measures. And yet what we're finding is that these individual providers, hospitals, rural home health, that kind of thing, see tremendous value in just receiving benchmarking back of how they're comparing there and how they're doing. They actually have a very high incentive to improve the quality in their communities, but in many times they lack the resources to collect this data and so forth. And there is a cost associated with that.

And I think this could even be carried down to our individual physician offices that are on fee-for-service, where if there was some incentive in the Medicare program to provide this data and then where physicians could receive benchmarking back -- I know that's happened in certain health plans and that sort of thing, but we've never been able to reach the masses with that kind of feedback and data.

So I think somewhere along the way we're going to have to put a value on the data that is collected and some kind of an incentive for that to it occur, or at least cover

the cost of that occurring which does not happen under our current program.

So if you see incentives up there, I think just somehow covering the cost or whatever. I think as electronic medical records come in, we cover that kind of thing. We've developed some new systems. It's getting much simpler to extract out the data that you need to do that but there's some costs that some cannot cover to do that.

MS. MILGATE: I also hear you saying, in addition to covering the cost, that one type of incentive may simply be feeding back useful information to the provider and maybe that's another incentive we should also --

DR. STOWERS: I'm glad you picked up on that because I think that there is an underlying desire out there to improve the quality of care being delivered. I believe that. But I think what we fail to provide is that we collect all of this data and we do not get it back to the individual provider level, the individual physician, the individual small hospital, the individual agency.

So the umbrella data is fine but we have to get it back to the individual provider. And there is a value in that that I think we have to not lose track of. But we can

collect it until we're blue in the face, but if we don't get it back to the provider it's not going to create much change.

MR. HACKBARTH: Can I just pick up on that point? When you were talking about the report in JAMA you said that some of this effect may not be attributable only to the QIO effort and I think that's right. I think in some of these areas is that clinicians, providers are hearing from public and private payers, from the professional societies, that these are priority areas. So it's the fact that we're pushing in the same direction that helps.

I know when I was involved in Boston in a large medical group, the most frustrating thing was when everybody was pulling us in a different direction. Every different payer had a different set of priorities. We want to do ours now. And that's just maddening.

When people come together and say, at a professional level, here are well-defined clinical standards and they matter to a large group of different payers, boy that's a relief and you know what to focus on. At that point, the incentive issues and payment issues become a lot less because clinicians want to get better and they just

want to have a focus.

DR. STOWERS: I just want to throw one more pointed in. The other thing we've been trying to do is link accreditation requirements and those sort of things actually to the data that's been collected because that is a tremendous burden on both sides with the quality initiatives and then the accreditation process. And right now those two are sitting at absolute other ends of the pole.

So I think if we can somehow, as an incentive, link accreditation or standardization to the data that we're trying to correct, so that it has more than one purpose in the system.

MS. RAPHAEL: Very briefly, I wanted to second what Joe recommended, which is I think we should not be spending five years designing the perfect system here. I think we need a period of experimentation, recognizing that some of the approaches we try will not pan out or will need to be modified. But I do think we need to get going.

And I do think there is this issue about how to make this less overwhelming and really kind of give people the sense that you have the organizational capacity to take this on.

I think Jack's point on trying to deal with one population is a good one, because if you can do it for diabetics you get the sense that you can then take what you've learned and the whole methodology and move it on to another population.

I was also interested in your process because I do think there is a process here that's happening, which starts with getting information back, giving feedback, teams kind of using that to change what they're doing. And then that really kind of sets in motion a whole trajectory which could end with financial incentives. I don't know that it begins with financial incentives. So I think that's important.

I'd be interested, if there's any evaluation of CMS's public disclosure efforts in nursing homes, and I know they're moving to home health care. We've heard anectdotally that it's affecting providers much more than consumers, but I'd be interested in trying to get a better understanding of what effect that has had. Because I think one of the points you made is important. We often look at this from the provider end, clinical effectiveness, safety. But I think we should not lose sight of the consumer end.

I don't know what levers we have on the consumer

end. I know that the things that they value, responsiveness, timeliness, good support and information, are very different from the things that we as providers often focus on. And I'd just be interested in what we know about how to influence consumer behavior, if we really have any clear understandings in that realm.

DR. REISCHAUER: Karen, let me add my compliments to those of the other commissioners for a really nice job, and say I, like the other commissioners, think it's absolutely essential that Medicare play a leading role in the quality effort and that we should emphasize that very significantly.

I'd also urged that while it might not be a recommendation, we urge Congress to make some clear endorsement of CMS moving in this direction, because this is the kind of thing that unless Congress is on record saying something it will be undermined quite easily by individual members reflecting the interest of providers in their area.

I heard Joe, I guess, a little differently from how Carol heard him because I was a little distressed when he said well, some experimentation and demonstrations. I immediately thought that I will become eligible for

Medicare, benefit from the program, and die before anything happens here if that's the way we go. I think there's enough information, examples from the private sector, whatever, to move ahead in certain areas now while at the same time we try and beef up our knowledge base and go forward. And we shouldn't try and wait for some more comprehensive approach to this or something that's neat and all fits together in any kind of way. I want to see Medicare going forward.

With respect to some of your reservations along this line, I see them used as excuses for delay. And when I think about is this budget neutral, how do I go about this, I think every year we're sitting here providing a lot of updates. And the updates come with great precision, 3.4 percent, and we've subtracted .9 for multifactor productivity. We're really dealing with some pretty squishy stuff here and it would be quite reasonable to say we think the update should be 3.4 percent but .1 of a percent this year is going to be reserved for a quality fund. And over time, as our knowledge base and our ability to do this builds, this .1 of a percentage point each year will become real money. So I don't want to get hung up on the sort of

budgetary aspect of this.

Carol raised another point which I was going to emphasize, which had to do with your unintended consequences which also can be seen as a reason for delay. What we know, I think, from cardiac care and some other areas is that consumers are dumber that a stone when it comes to reacting to qualitative information that's put in front of them. You can say that you go to hospital A and your chance of dying is 10 times what it is if you go to hospital B and they all still go to A.

We should raise those issues but we shouldn't leave what evidence we have that suggests that they might not be huge factors not discussed.

Finally, I see there is a real problem here with respect to the geography of Medicare. We can go about this in some absolute sense or in a relative sense or a combination of the two. And I would argue for the combination of the two. If we had measures of quality of care for complex procedures, it might be that that the facilities capable of achieving the high quality exist only in certain parts of this country. And if you began rewarding that kind of behavior, you've created a problem

for people who represent geographic constituencies.

And so you can do a dual reward system which says we're measuring quality within this geographic area and giving bonuses to the most improvement within the area or the best level within the area and based on a national basis but you want to be very careful in how you do it considering the complex geography of our country.

MS. DePARLE: Karen pointed out, you can choose to do -- having high-performance and/or improvement. So surely, even if there are areas that start at a different place, they would show improvement.

DR. REISCHAUER: I have a problem, in a sense, with improvement because what you're doing is then maybe rewarding, in a sense, the biggest polluter. And it has to be for a very short period of time. There has to be expectations that everybody should reach a certain level.

MS. DePARLE: You've been away from Capitol Hill too long because I agree with you and this isn't where I would --

DR. REISCHAUER: There's no such thing as being away from Capitol Hill too long.

[Laughter.]

MS. DePARLE: Touche. But I think that we have to start somewhere, and for the very reason that you described it will be difficult to go down this road. But if this is a way to get started and to get everyone on the same page, and as Ray says, I believe clinicians and people who work in health care want to improve. If that's a way to get started and for the Senator's former colleagues to embrace this, let's go.

DR. WAKEFIELD: It sounded to me, Bob, like you might be talking about trading pollution credits, when you were talking about the clean air, that maybe the equivalent to that is trading quality credits instead of trading pollution credits.

Just a few quick comments. One is that I think, at least in my mind, it isn't -- in terms of where services get provide it isn't so much that everyone ought to be doing exactly the same set of services and so referral to large facilities and specialty facilities is wholly problematic. I don't think that is. I think the issue, for me, coming from a rural area is that what is done inside facilities, whatever it is, is done extremely well and it's not handicapped by lack of infrastructure or technology and so

on.

A thread that I think is going to run through a lot of this is availability of that infrastructure. The technology, therapeutic, sufficient information infrastructure, diagnostic technology, therapeutic technology, et cetera, to do whatever it is. If it's to take care of that 75-year-old that comes in with community acquired pneumonia or something else. But that we really keep a firm eye on what the basic infrastructure is and that we don't run into some of the problems that you might be getting at, Karen, with the question about will steering beneficiaries to one provider over another create access problems.

I think as long as we pay attention to access to that basic infrastructure and that if we're talking about community hospitals having a reimbursement that allows them to have an infrastructure not unlike teaching hospitals having a reimbursement that allows them to have infrastructure, as long as we're looking at reimbursement that allows that, the human and technology infrastructure resources to be there -- again, not so everyone is doing heart transplants but so whatever that care is that is being

provided across the board is high quality care.

Secondly, just in terms of reporting measures, think back 10 years ago. We're in a whole new field in terms of what's happening with access to reporting and how it might be incentivizing or not, where beneficiaries choose their care, or how providers perform.

It might be worth looking at, even though lots has been done in that area, whether or not there might be more incentives to reporting additional measures, recognizing that there are costs for gathering information, collecting it, and aggregating it and making it useful for consumption. But the question might be is there a more granular level that we ought to be reporting out? Or should we be casting the reporting net even wider thinking even more broadly than we are right now about what gets reported. So it might be a level of specificity or it might be greater breadth, not just depth.

Another comment is to really pay attention, thinking about the levers that we've got. I think that the notion of making major changes and demonstration project efforts are not mutually exclusive. So while we won't see a whole change necessarily tomorrow that we'll all benefit

from in terms of quality improvement efforts, we certainly ought to be pulling from the private sector what we can and using it where it makes sense.

We should also be pulling new information, I think, from the work that foundations and the others have supported. That may be relevant, I don't know, I haven't looked at it in this context. But like Pursuing Perfection, being financially supported through RWJ, and so on. What are private payers doing?

But in addition, what's coming out of some of these more targeted quality efforts that are supported by foundations? Anything there that we could learn to inform our thinking in the Medicare program?

And I would say let's look at demos, not to be timid but to say to the extent that CMS has demonstration authority, can we try and move that vehicle even more than it has been recently on the quality agenda?

I guess the last point I wanted to make is that when critical access hospitals, as that program has started to unfold in rural areas, it was wrapped around with incentives to focus heavily on quality and emergency care.

On the quality front, this program has been up and

running long enough now for a period of time, and spread to enough hospitals, that there might be something to be learned from what's been done with that quality agenda that was basically placed as an expectation on hospitals that were converting to CAH status. So in other words, I'd look there to see, in the tracking project that's been underway now for at least a couple of years, what is it if anything, we can learn?

Last point on the QIOs, I'm not sure -- when we think about small hospitals, that don't have a quality improvement and quality assurance infrastructure of a Beth Israel or a Mass General or whatever, but probably have to rely, if they're willing to, on the QIOs to help them with QI efforts. I'm not sure, and maybe it's for somebody else to decide, but I'm not sure about the extent to which we're adequately resourcing QIOs to do the work that I think clearly needs to be done in terms of assisting small providers. And I know there's been some expansion of that portfolio of late. But again, that's another lever that obviously Medicare has readily accessible. Is there anything else we should be thinking about, in terms of moving that lever?

MR. MULLER: I'll echo the previous congratulations on this very excellent report. Just as there's enormous variation of health care in this country, I think we're also seeing that there's enormous variation in that wonderful taxonomy that you provided of the quality initiatives.

In the spirit of both urging us to move forward on this, and focusing on it, I would suggest that our focus be on disease areas that are either high incidence or high cost, and specifically heart disease and diabetes and renal and mental illness.

I think some of the themes that have been discussed today, whether it's Joe's theme about looking at payment systems across sites of care, whether we look at systems of care versus just a focus on individual practitioners, whether it's the question of how to use evidenced-based medicine to best promote care. I urge us, as we look at both the June reported and beyond, to look at those disease categories because obviously in our role as a payment commission they are the ones where there are large costs. And I think there's now evidence, both around the country and around the world, that in these areas major

advances can be made by getting people to work on a more common set of protocols, not to try to drive out all variation in care -- I agree that's one of those combustible categories that Jack mentioned earlier -- but there's enormous advantage to be secured by having -- whether it's as simple an example as the beta blockers after AMI -- there's enough evidence now around the world and in our country to know that major advances can be made in that area.

So I would urge us to focus on our quality initiatives. This is the area I think we should focus on. And I think both an enormous advantage can be made in terms of quality and enormous advantage in terms of costs by taking the best evidence we now have, both in the literature and in practice, and using it inside the Medicare program. And using the kind of muscle of Medicare to move behind these large disease areas I think would be the most fruitful way to go.

DR. WOLTER: Very quickly, I think there are a number of people who have been thinking about this topic quite a bit. For example, I think the IOM has a subcommittee looking at barriers to creating the idea health

system of the future. I don't know if you've talked to those folks, Karen, but one of the specific barriers they've looked at is the incentive system currently in place and it might be worth visiting with them and seeing what they've put together.

Also, it's my perception that CMS really is playing a leadership role currently in this mess. And for an agency that is often under a great deal of criticism, I think in many ways they're way out front of Joint Commission and a number of other agencies, et cetera.

Also, I would say that they're doing things beyond the QIO. For example, they recently put out an RFP for large group practices to put together a program looking at care of Medicare beneficiaries over the course of a year or longer in which utilization cost data, and then also certain quality parameters, would be analyzed. And they built in some incentives such that, depending on your overall hospitalization rates and certain quality parameters, there could be a return of dollars even over and beyond what you might receive in terms of fee-for-service payment.

So somebody has put a lot of thought into this and we might be able to tap into that, in terms of how we build

on it.

And then, just lastly, I think the tone in the June report, as far as CMS goes, might be to somewhat congratulate them for the leadership they're providing and then urge Congress to continue to resource the good work that they've begun.

MR. HACKBARTH: Good points.

Okay, I think we are done. We have a brief public comment period.

Before we do that, though, I want to thank all of the commissioners for the extraordinary amount of work people put into preparing for this meeting, and likewise thank Mark and Lu and all of the staff for the same. I know special effort was made in the last week or so to provide some new formats for the commissioners to use and I really appreciate the work that the staff did in that regard.

So the microphone is open now for a public comment period that will be very brief. So set a good example, Jerry.

MR. CONLEY: Very brief, Glenn. Thank you very much.

I'm Jerry Conley. I'm an independent consultant

and I want to speak to you on behalf of two clients today and I'll be very brief.

One, following the quality initiative discussion and Joe's comments and Jack's comments and Carol's about some rapid experimentation in this area. In targeting some specific populations I would encourage you to also look at the rehabilitation sector. As you've heard me talk about earlier, there are initiatives, quality initiatives, there are functional measurement tools that are available. But in each sector of the rehabilitation -- at least the post-acute rehabilitation world, there's a different functional measurement tool for each sector, for each patient population.

Those have been developed through demonstration projects but again, they don't communicate to each other. And it may be a good opportunity, as you put together a post-acute database, to co-calibrate these functional measures and to target either feedback of information to providers, just to see how well and how this monitoring would provide improvement or if it doesn't provide improvement in the system. And then on the other end of the the spectrum, even use a pay for results or a value

purchasing option, in terms of basing that on the functional improvement measures.

Secondly, on behalf of the American Academy of Family Physicians, as you talked about the drugs and biologicals and the fact that there's a huge increase, a 24 percent increase, in the use of the physician-administered drugs and how you would revise or reform that particular sector of the Medicare program. I would encourage you once again to understand that this is not necessarily a pass-through in certain areas because remember that the drugs that are physician-administered in the outpatient arena, while not paid for under the Medicare physician fee schedule, are used as a calculation in calculating the expenditure target known as the sustainable growth rate.

So I would encourage you to go further, as you examine the options, to revise that program and to make a recommendation that again these physician-administered drugs ought not to be part of a calculation for a formula that is used to determine the payment rate for services that are not paid for under that program. Thank you.

MR. FENEGER: Randy Feneger with Sunstone Behavioral Health and Senior Health and a consortium of

about 60 rural hospitals that provide inpatient psychiatric care. I want to address the discussion earlier on the PPS.

Even though today's line is shorter, I assume from the chairman's comments that that does not entitle the speakers to more time to address the commission.

I would like to, on behalf of my client, thank the commission for its decision to submit a letter to Congress on the psychiatric PPS responding to the CMS report at this time rather than waiting for a proposed rule. We think you've identified some critical issues and we think there's great value to having Congress and CMS have your comments before them at an earlier stage when changes and adjustments could be made.

Our hospitals look upon the PPS with fear, I think is the best way to describe it, and that's based on their experience with the 1997 Budget Act which merged all the psychiatric payments into one great bucket. This is an issue the commission addressed in its 2001 report on rural health care and comment on the fact that one of the problems with the BBA was that it did not recognize sufficiently the differences among the hospitals.

That was spoken to, the differences among various

kinds of hospitals, this morning by Sally. I must thank her for her tolerance in dealing with every rural person I could find to bring to Washington to talk to her. She's been very good and very helpful in guiding us along this way.

Our request is simply that your letter to Congress address specifically the differences and concerns of these rural facilities, the geriatric psychiatric aspect of many of them, because of the predominance of Medicare patients, so that instead of being a refinement in a few years the rural facilities are, in fact, incorporated early on in the design and analysis of the rule that comes out. We would prefer not to be a refinement. We'd like to be in at the get go on this.

And so we would ask, if all possible, there be specific reference to the problems you previously identified in your 2001 report as they relate to the PPS and incorporate them in the letter. Thank you.

MS. CANTWELL: Hi, Kathleen Cantwell with ASHP, the American Society of Health System Pharmacists. We represent pharmacists who work in hospitals, long-term care, home care, any of the facets of the health system setting.

We wanted to just make a brief comment about any

adjustments to AWP. I know the focus has been on physician-dispensed drugs and the majority of the drugs are dispensed by physicians, but I just want to note one significant difference and why this could have a significant impact on pharmacy practice.

Pharmacist aren't currently recognized under the Medicare program as providers, so they can't bill for the services that they provide in conjunction with the Medicare-covered drugs. Any adjustment, it would definitely be appropriate for Medicare to be paying the appropriate amount for the covered drugs, but they should be also explicitly covering the cost of the service to get the drug to the patient in a safe and appropriate manner.

We'd be happy to work with the commission on just what the costs of pharmacist services are and revising that payment schedule also. Thank you.

MR. DURENBERGER: Mr. Chairman, I would say to my colleagues, I'm either going to go up to that mike to make this little set of comments or I'm going to stay right here but I think I'm the only member of the commission who has a statutory responsibility to reflect beneficiaries, and so I just want to make a couple of comments.

Right in the middle of health care reform, that whole debate, there was a story that came out that's just a delight about what happened to Claude Pepper when he died back in 1990 and went straight to heaven obviously, because he had done so much work on behalf of Medicare and Medicaid beneficiaries.

When he got there he insisted on seeing God the father, and he was admitted immediately. And he said I've been fighting for health reform in the United States all my life and I just need to know before I go to wherever my place is whether or not we're going to get health care reform in the United States. And God the father looked at him and stroked his beard and said I've got good news and bad news. The good news is yes. The bad news is not a my lifetime.

[Laughter.]

MR. DURENBERGER: I've got to tell you, I had that experience yesterday. I thought things were getting bad when I left the Senate in 1994 and what I saw yesterday is just a reflection of what your senators and your congressmen are experiencing today on the Hill, and I had that fortified for me last night and again this morning.

The common or the public ground, whatever we may call it, is occupied by the urgent demands of the special interests, of care providers, and to another degree to insurers, and there's no effective room at this mike or that mike -- there is at this mike, but not at that mike -- for anybody representing the best interests of today's beneficiaries or tomorrow's or the people that have to make decisions on their behalf like the senators and the congressmen and so forth, except this commission and its staff and its leadership.

I want to fortify that by way of my own personal commitment to this commission and to Glenn as a chairman and to the staff, because it was a tough experience. The whole month leading up to it, and then what happened to IME. And I'm not a great believer one way or the other, but it was sort of uh-oh, like what's going on.

But putting that aside, the main point is the one we all know, and that is there isn't room at that mike for the kind of people that the 40 million people are supposed to talk about except 17 mikes here and the staff out there and Mark.

The main criticism that I've heard, just in the

last couple of hours, is that we sort of like caved to certain of the House or Senate leadership in the overall. And that all came from the same folks that were lined up at the microphone. And I simply want to say thank God we did. I don't think it's caving. I think it was a very realistic piece of work, given all kinds of circumstances, but particularly focusing on the people we're elected or we're appointed to represent here, who are those Medicare beneficiaries.

It's really tough times. It's tough for providers. It's tough for a whole lot of people. But I think we did the right thing, the absolutely right thing yesterday. And I think we will continue to do that.

In one way or another, in conversations with people on the Hill, this is not -- and I had this conversation with Joe Newhouse -- this is not the ProPAC that I helped to create. This is not the PhysPRC that I helped to create. This is something else and it isn't your fault. in my view, that it's something else. It's a process that's evolved in this town over a long period of time.

It used to be a day when you wouldn't dare try to lobby, those of you who have been around a while. You

wouldn't dare try to lobby a ProPAC commissioner or even PhysPRC. It may have been permissible but it wasn't the thing to do.

I'm not saying that's an ideal and I spoke yesterday about the importance of having a public mike and public involvement. I'm simply saying I think our job is made much more difficult, just as the job of senators and congress is made more difficult by the realities of what's going on in this community and state capitals right now. And so it just demands more of us. And I, for one, am pledged to give it to you.

Thank you, Mr. Chairman.

MR. HACKBARTH: Thank you. And thank you all. Let's see, we meet again in March. See you all then.

[Whereupon, at 11:48 a.m., the meeting was adjourned.]