MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

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P R O C E E D I N G S

MR. HACKBARTH: Good morning. At this month's hearing we go into the various update recommendations on the various sectors of the Medicare program to be included in our March report so most, although not all, of the discussion over the next two days will have to do with update recommendations. We will have some other presentations like the first one we have this morning establishing context and then also a few policy related conversations as well.

The final votes on update recommendations will not occur until January so anybody who's here in anticipation of watching that exciting event is going to be disappointed. What that introduction, Anne.

MS. MUTTI: At tab B you will find a draft of the chapter entitled Setting the Context for Medicare Spending. This draft draws together some of the data and information that we have presented over the last few months and adds a couple of new pieces. The purpose of this chapter is to provide policymakers a context for assessing Medicare spending patterns and implications for changes. It is also part of MedPAC's assessment of whether payment met policy

supports the goal of the program which we have previously defined as ensuring that beneficiaries have access to medically necessary quality care without imposing undue financial burdens on beneficiaries and taxpayers.

In this presentation I will go over the outline of the chapter and summarize the main points. The chapter begins with a discussion of Medicare spending trends both in terms of the level and of growth. It then compares Medicare spending to overall health spending trends and those of other payers. Thirdly, to help policymakers assess the implications of Medicare spending growth, the chapter addresses various resource constraints that may affect policy choices concerning Medicare spending. And finally, given these trends and constraints the chapter discusses how MedPAC acknowledges and assesses the implications of its recommendations.

In terms of spending trends, we that after an anomalous few years aggregate Medicare spending has resumed its more typical growth rate of about 8 percent over the last two years and this is about 5.5 percent real growth. It is projected by CBO to grow at an annual rate of 6.8 percent over the 2003 to 2012 period or about 4.2 percent

real growth.

Among the fastest-growing service sectors over the last two years were home health and SNF, although a number of other sectors were also growing at double-digit rates including hospice, ASCs, and outpatient hospital services. Medicare spending is concentrated both in terms of service sector and by the number of beneficiaries served. Inpatient and physician services alone account for 56 percent of Medicare spending and as a result even though their growth rates over the last couple of years have been lower than some of other sectors they are major drivers of overall growth.

But perhaps more most noteworthy is the concentration of Medicare spending on a subset of beneficiaries. About 5 percent of beneficiaries account for 50 percent of Medicare dollars and many of these same people are in the top 5 percent from one year to the next. In contrast the least costly 50 percent of beneficiaries account for only about 2 percent of Medicare spending.

National health spending trends and those of other payers is the next section of the draft chapter. While these comparisons are intended to allow assessment of

whether Medicare is a prudent purchaser they must be viewed with caution given differences in covered benefits and population. In addition the comparison is compromised by the fact that private insurance spending also includes supplemental insurance spending for beneficiaries.

Nevertheless, we looked at three types of comparisons. First we looked at Medicare spending to compared to spending on personal health care services. This includes spending by other payers and out-of-pocket by individuals on health services and this doesn't include research spending or public health spending, other things like that. We find that until just recently Medicare was a growing share of that spending. It peaked at about 21 percent in 1997 and was 19 percent in 2000.

Second we looked at Medicare spending compared to private insurance spending. And over the long run it appears that the growth rates are similar. And if we take out drug spending for the private side the average growth rates are even closer.

Third, we looked at Medicare spending compared with premiums or spending growth other government purchasers including CalPERS, FEHBP, and Medicaid and found

that depending on the time period examined the rates can look similar or quite different. Some of the variation may reflect market dynamics unique to one payer in the time that we examined. But over the last 10 years or so the average rates of growth were relatively comparable.

In this comparative section we also discussed the factors driving the growth of both Medicare and private health spending. We noted that many of the same underlying factors are growing driving growth, including inflation, volume intensity mostly given by technology, and population. However because the benefit packages cover populations and payment methods differ some dynamics affect one sector differently than the other. For example prescription drug costs have been a big driver for private health spending but not so for Medicare since we don't cover most outpatient prescription drugs.

Similarly demographic changes will influence the two sectors differently. Coupled with increases in life expectancy the timing of the baby boom generation can be expected to influence Medicare spending more dramatically than private health spending.

The next section of the chapter discusses

resource constraints that affect Medicare spending or may influence policy decisions. The resource constraints discussed in this chapter are the federal budget, Medicare trust funds, growth in GDP, and the beneficiaries' ability to afford their care. Our findings include that Medicare is an increasingly large portion of the federal budget, the Medicare hospital insurance trust fund is estimated to be insolvent as early as 2018 under trustees high assumptions and 2030 under their intermediate assumptions. According to CBO, Medicare as a percent of GDP is expected to grow from 2.2 percent in 2000 to 5.4 percent in 2030, more than doubling in the time frame. When Medicare, Medicaid and Social Security are looked at as a whole they're expected to account for about 15 percent of GDP in 2030.

Between 1993 and 1999 beneficiary out-of-pocket spending for health care has increased somewhat faster that their growth in income and this trend is likely continue particularly if drug spending growth continues unabated.

In this slide and in the next I want to give you some more detailed information on the resource constraints of beneficiaries, this is sort of one of the new parts of the paper at the moment, and a sense of their health

spending patterns. Most elderly, 58 percent in 2000. have income below $20,000 and are spending an average of 25 percent of their income on health care. When looking at fee-for-service beneficiaries living in the community, Medicare's portion of total health spending has declined between '93 and '99 from 63 percent to 57 percent. This is probably coinciding with their out-of-pocket on prescription drugs growing, because when you look at all beneficiaries, including those who were institutionalized, the proportion has remained roughly constant over the time period at about 49 percent.

The biggest driver behind growth in out-of-pocket spending is spending on non-covered services such as prescription drugs. 57 Percent of the change between '93 and '99 was due to increased spending on non-covered services and 31 percent of the growth was due to increased costs associated with supplemental premiums.

This chart provides you with a sense of the distribution and composition of out-of-pocket spending. In this chapter we identified four components of out-of-pocket spending: the Part B premium, cost sharing for covered services, supplemental premiums, and non-covered services.

As you can see from this chart, those who have the highest out-of-pocket spending, those in the top quartile, spent nearly 50 percent of their total out-of-pocket spending on non-covered services. Again there is concentration in spending but not to the degree we saw with Medicare spending earlier. 5 Percent of all beneficiaries account for 20 percent of total out-of-pocket spending. Beneficiaries in the top quartile spent an average of about $5000 out-of-pocket while those in the bottom quartile spent less than $500.

Those who have high out-of-pocket spending tend to be older, use many services, have relatively high incomes, and are more likely to have supplemental coverage, primarily Medigap. Those with low out-of-pocket spending generally fit into one of two profiles. The first group includes relatively young and healthy beneficiaries as well as disabled beneficiaries with stable conditions who use few services. They may have either have Medicare only or additional coverage but they do not pay those premiums.

The second group includes people with comprehensive supplemental coverage including beneficiaries eligible for Medicaid and relatively high income people

comprehensive employer-sponsored coverage.

This chapter concludes that given these spending trends and various resource constraints, MedPAC's recommendations should be made and considered with an understanding of implications on program spending, beneficiaries, and providers. MedPAC will highlight these implications in the text of forthcoming reports and will include spending ranges for its recommendations.

That concludes the summary. I'd welcome your comments. Certainly there were some areas that we've been continuing to work on since the draft was sent to you but we welcome any suggestions you might have. And then also, I hope you will get another draft to look at in this form but before the next meeting you will have one in galley form. That's to encourage you to give me your comments sooner than later.

MS. ROSENBLATT: I think this report did a very good job of incorporating the comments we made at the last meeting and the only issue I had with it that was -- there's a comment in there about 2001 being a peak of spending for the commercial market and I don't think that -- I'd be real careful making that statement. I just don't

think that statement is accurate.

Two minor questions, on table 1-1, where it has Medicare spending by category like hospital, inpatient, physicians, and managed care shows up with an average rate for the '93 to '97 period as 29.5 percent, that I think is occurring because of the growth of managed care. And so I think this table would be better done on a per beneficiary basis as opposed to just raw increase in spending because it's kind of misleading.

And then on table 1-2, there are two identical time periods in the table-- there's probably just a typo in the table -- that have different percentages. So there's something where the years don't agree with the percentages.

MS. MUTTI: It was supposed to be '92 and 2002. I'll look. I don't see it right off.

MS. ROSENBLATT: Okay. That was it.

DR. NELSON: I also think this was very well done. I guess the only thing that I didn't see in it that I would like to is some reference to the fact that consumer expectations are probably changing, certainly from what they were when the program was first started. That there's more emphasis on health promotion and disease prevention,

that the Medicare population is assigning a higher value to retaining their health, and they don't have the expectation getting old means you get sick necessarily, and that the value that they assign makes it difficult to restrict spending because it's a powerful force that I believe increases demand and will continue to do, so the expectations and attitudes towards personal help that are different from what they were a decade or two ago.

MS. ROSENBLATT: Alan's comment earlier about what we were talking about led me to think, there should be some leading indicators about 2003. A lot of large employers have their January first renewals already. And so if we could put something, in my guess is there are surveys out there. You get into early 2002 but there's no mention of 2003 at all. If we could do that, that would be great.

DR. NEWHOUSE I would actually like to suggest some more work for you. We repeat the, number, which is very widespread, that 5 or 6 percent of the people account for half the dollars. And there's nothing wrong with that number, but people go on to draw some inferences from it. Like if we can only figure out who those people were in

advance, or if we can identify them in real time we can maybe prevent things, we can case managed things. I think there's some mileage to be had there but my point about the number is that it's an arbitrary number that depends on using a twelve-month period. It would be a much higher number if we looked at the percent of people that accounted for spending in a month. It would be a lower number if we looked over a multiyear period. 5 percent of the people would account for less of the spending over a multiyear period than they do in the annual period because you don't have a heart attack every year, mostly.

There's a further wrinkle, which is probably too much work for you, which is to account for lifetime spending. But if you could give some sense, the only numbers I've really seen on this are from Canada, they don't apply here. But you get some sense of how the number changed if you just accounted for even a two or a three year period, I think that would helpful. The annual numbers kind of get repeated and repeated and then people forget that this is kind of an artifact of how we're accounting for it.

MS. MUTTI: Joe, is your point that you want to

get at the persistence? Are they the same 5 percent?

DR. NEWHOUSE: They're not the same 5 percent. We know that. If we look at total spending for a group of beneficiaries, you take the decedents out if you want that's a problem in how you account for the decedents. But that's a problem even with the annual data. Or leave them in as you want. And the decedents do matter here.

But look over a three-year period and say what percentage of people, what do the top 5 percent account for? It's going to be a number that, my guess, is substantially than 50.

DR. ROWE: On this topic, I think there are a couple different ways to slice this. I do, by the way, think that predictive modeling techniques can identify people at risk. And there is of course a population, the population that Alice is most interested in as an actuary, which is the 25 percent of people that account for 1 percent of the expenditures at the other end of the spectrum.

MS. ROSENBLATT: Jack, I can't let that just lie. You know, I thought you were going to go the other way.

DR. ROWE: On the side of the spectrum that Joe

was thinking about, I would not agree entirely. I think there is a small subset of the population that are high expenditures during any given period of time, that the proportion will vary depending on what the epoch is, whether it's a day, an hour, a month, a year, a decade. But those are people with events. They have myocardial infarctions, hip fractures, major cancer operations, strokes, et cetera.

There's another subset that I think is even more interesting and might be more amenable to management for prediction, and that's the chronic disease group, which is the subset after that 5 percent, that may be 15 or 20 percent depending on how you count it once you get up into the Medicare age group that account for a very substantial proportion of the resources that are spent. So it's not just the 5 percent that have the catastrophic thing and it's hard to predict and they only have it once because they either die or they only have it once.

But it's that second group and they are rather identifiable because they utilize resources over time, frequent hospitalizations, multiple prescriptions, many diagnoses, frequent outpatient visits, procedures, et

cetera. You might think about that, stratifying along those lines.

MS. RAPHAEL: You make the statement in one of your slides here that over the last two years home health and SNF were among the fastest growing service. In your table you show from '98 to 2002 actually home care rate of growth is -6.3 percent so I don't think that's accurate, at least as I understand it.

MS. MUTTI: We've seen done the data breaking it into different time periods and the data I used in the presentation was just looking at the last two years, the one you're looking at. What we're planning to do for the chapter would be to break it into multiple things, so you'd see the dip and then you'd also see the increase, so that we'd give the whole picture.

MS. RAPHAEL: I remember something from the text something that I was very interested in which is that Medicaid is growing at a faster rate than Medicare. I was wondering if we know anything at all about what the impact of a growing number of dually eligibles has on Medicare expenditures?

MS. MUTTI: I would guess that it makes it more

expensive but I'll go back on that and get that for you.

MS. RAPHAEL: I don't whether we should conclude it makes it more expensive, I just would be interested in knowing that.

MR. FEEZOR: Ann, like Alice I thought you did a good job of trying to get a lot of the comments that we made the last time. There was still one that I urged. Throughout there's single line observations, 26 percent of beneficiaries with annual income say between $10,000 and $19,000 spend 22 percent, and it's sort of compared to what? Now that one you said there's more to come so I assume there would be. And for instance we talk about the in distribution of the high-risk cases and so forth, probably not dissimilar from the under-65 population. So I would again just urge, as you go back and read through it, to look and I think where it in fact parallels an under-65 it might be helpful to note that. Where it is significantly different then it may offer some other observations.

MS. BURKE: I just wanted to go back to Jack's comments for just a moment, in terms of the small percentage of individuals who use a large amount of the

resources. I double-checked the text to see if I remembered this correctly. There have historically been observations made that a great deal of this spending occurs within essentially the last six months of life. I mean, essentially it's for people who ultimately are, in fact, decedent.

I think in looking at what we know about this population, some understanding of how much of it is in fact, as Jack suggests, the single episode, how much of it is in fact the chronic users who are high end users, how much of it is in fact sort of end of life care, to sort of a further analysis of that but particularly that time frame issue which I don't recall Jack mentioning and I don't recall it being in the text. But at least historically it's been something that people often cite. So I think some further understanding of what that population looks like.

And to the extent that it is different or similar to the under-65s. I mean again, to Alan's point, that some sense of how this differs in terms of a pattern from the under-65s and the private set, I think would be helpful. Obviously the of the number of decedents perhaps alter but

not necessarily the episodes. It's an interesting question.

DR. ROWE: I'd like to comment on that. That's very interesting and I'm glad you brought that up, Sheila, because that has been a topic that I think, Congress, in many policy discussions, has had great magnetism for that issue. But I think there are some risks getting into that that we should if you get into that area. Since Ro Sitofsky, I remember at Stanford years ago, first came up with this idea of what proportion of resources is spent in the last year of life and the last six months of life.

Some people then, in government, said we've got to get rid of the last year of life. It's like they discovered that most of the fatalities in train accidents were in the last car of the train and so we should get rid of the last car of the train and it doesn't quite work that way.

I think that the issue is that the proportion of Medicare resources, as I understand it, that's spent in the last year of life really hasn't changed very much in a long time. It's rather stable and it's in the 20s or so percent.

My own view is that the amount of money that's being spent on the last year of life is not inappropriate, it's just being spent on the wrong things. We treat people at the end of life wrong. Our system is designed to give them proper treatments for care at the end of life. So they're in the hospital, they're getting aggressive advanced diagnostic treatments that are painful and costly and uncomfortable and they don't need them et cetera et cetera.

But I do think we want to avoid casting anything about this money is wasted because these people are going to die anyway. I think we want to make sure we don't fall into that trap.

MS. BURKE: Essentially what I want to try to do is avoid exactly the point that Jack has made, which is policymakers have glommed onto this sort of easily explained statistic and suggested that there are behavioral issues involved there, in terms of the payment system. And I think further looking at who in fact this population is and disabusing them of the fact it is suddenly all these people who are going to die within six months which is just not the case for Medicare's history. It has been

relatively stable. So I think to Jack's point, a further understanding of that will help avoid some of that kind of let's end the last year earlier.

DR. REISCHAUER: I'm tempted to get into this because of course there's another group that we don't talk about that are very expensive, and those are the ones that if we didn't dump a lot of money on them it would have been the last year of life. And if we didn't, we could average them with the ones that it was the last year of life and bring down the costs of the total group.

DR. ROWE: Another response that I once made, I think when I was giving testimony but I regret I made was well, Congressman what year of life would you expect the most expense to be? The middle year of life? I mean of course it's the last year of life.

DR. REISCHAUER: Ann's plural, I thought you did a really good job on this chapter and I just have a couple of nits on page 16 where we're talking about Medicare in the context of the economy. One is when you mention the 2.9 percent payroll tax you might refer to the fact that it's half paid by employers, half paid by employees in a nominal sense at least. But I was concerned about some of

the language where you said Medicare growth is deficit financed more capital would be invested in government debt and less would be available for private investment as opposed to absorbed by government debt.

And then later on you say if Medicare spending is financed by either raising taxes or increased beneficiary contributions there's less capital available for private investment. I think what you really mean is there's less disposal income which is available for either consumption or saving.

Besides that I thought it was a really good job.

MR. MULLER: Going back to Joe's initial point about the data, and I also feel this chapter is well done.

Given the increased visibility or the kind of glomming on, to use somebody else's, phrase of looking at disease management and case management as a way of saving substantial monies in the program, and also Jack's exchange in there between some of the acute episodes that people have, the MIs, versus people with chronic diseases. My sense is that people with a chronic disease -- for example the people in end stage kidney disease -- they also have a lot of acute episodes. So it's not as if you have this

kind of just undifferentiated stay in hospitals when you have chronic disease and other people have MIs and hip fractures and so forth. What in fact happens when you have chronic disease is you're prone to having these acute episodes.

So I would like to see if it's possible at all, as we look at some of these populations that have a lot of hospitalizations and so, forth, are there certain kind of diagnoses, are there certain kind of DRGs they fall into more than others? Because if in fact one of the theses that a lot of people, both at the Medicaid and Medicare, level, are looking at now in terms of controlling cost growth -- and I'm sure this is true on the private side as well because I've heard Alice and Jack speak to their efforts at disease management -- what does that population -- if they're using a lot of resources that we're trying to manage -- what kind of resources are they really using?

And if in fact, as a patient with chronic disease, they therefore have a lot of acute episodes over the course of 10, 20 years of their life, that's different than if they're subject to falls therefore and they may have multiple falls in that 20 year period. They could

have repeat heart attacks and so forth. That's different than just kind of having undifferentiated admissions to the hospital.

So if this is a series of acute episodes over a period of 10 or 20 years that would be interesting data to know, especially -- my sense is that it's much harder to do case manager than anybody thinks it is. That somehow just magically we're going to figure out how to treat these populations, as if people haven't thought about case management for 20 or 30 years. So I have some interesting in deciding just how much can really be done by better management of this, and perhaps looking at that, if you could.

How many acute episodes are there in the average chronic patient's years on Medicare, I think that would be helpful to look at that. Thank you.

MS. MUTTI: Just one comment, the 5 percent is from a CBO testimony on disease management, fairly recently that did follow patients over two years at least, so there was some persistence and survival in that. And we need to look at it further and all your points are well taken, but there are a lot in there. I think 47 percent had three or

more chronic illnesses. You need to read it in more detail to see exactly what they were but it was the whole testimony on disease management and whether or not that can really cut costs.

MR. MULLER: The hypothesis if you can keep people out of expensive institutional settings; e.g., hospitals or nursing homes, one will save more money for Medicare, Medicaid, Aetna, Wellpoint or somebody and then ultimately the employees and the employer. If in fact you really can't keep them out of hospitals because there are a series of acute things, then you have a different kind of conclusion as a result of the kind of interventions that you could make.

DR. WOLTER: I think another important area that might be noted is the tremendous variation regionally and provider to provider in how some of these services are provided and I think that's a very important topic. If indeed a huge percentage of resources are provided to a smaller number of beneficiaries and then, within that universe, there's tremendous variation from one part of the country or one institution to another there is something there that could be mined that would be helpful. And that

may not be our job per say but noting it as we look at these trends might be useful.

MR. HACKBARTH: Thank you, very much. Good job. Next up is fostering choice in the Medicare program. Whenever you're ready, Scott.

DR. HARRISON: Good morning. When the M+C program was created some policymakers had two goals in mind. One, to offer Medicare beneficiaries a wider choice of private plans. And two, to build a platform for a system of competition among private plans.

The draft chapter we are presenting today looks at these issues. We find that despite declining M+C enrollment over the last few years there are many other choices available to Medicare beneficiaries beyond the traditional fee-for-service and Medicare+Choice programs. We also find that the answer of how competition might work among these plans will depend one a number of issues, including specific national and local market conditions and the circumstances of individual beneficiaries.

Before I get into the chapter I want to give you a quick update on what we've learned about Medicare options for 2003 since the last time we talked. And then I will

summarize the three main sections of the March chapter draft, the first being the survey of options available to Medicare beneficiaries, the health insurance marketplace preferences of beneficiaries and plans, and supply and demand factors.

The last time we told you about the PPO demonstration program and promised to give you details about the benefits they will offer when we learned of them. We now have some details and I will give them to you in just a moment. Similarly, we reminded you about the existence of the Medicare HMOs operating under cost contracts and they are higher profile because of a plan transferring some of its members from its M+C plans to its cost contracts. Again we promised to bring you the benefit details and will do so momentarily.

Finally, the administration has proposed regulatory changes to a Medigap program that could have some effect on the supplemental market and I'm going to describe that now. The Medicare Select program began as a demonstration in the early '90s and was made permanent in 1998. Medicare Select policies are Medigap policies that cover more of the cost sharing when beneficiaries use

network providers.

From a beneficiaries point of view they are exactly the same as a Medigap policy when they use a network provider but they do not offer as good coverage as a comparable Medigap plan when they use non-network providers. In exchange for giving up some coverage for non-network providers, the Select policies usually have lower premiums than comparable Medigap policies. Insurers are able to offer these less expensive products because providers agree to accept lower than Medicare rates from the insurer in order to participate in the network. Because Medicare continues to pay its share on the claims from Select members, the reductions are really in the form of the provider waiving all or part of its beneficiary cost sharing.

Current Medicare regulations, however, has limited these cost sharing reductions to hospitals. The IG had ruled that Part B providers could not waive cost sharing without being in violation of anti-kickback rules. Studies of the Select program found that the program was limited because plans could not include physicians in their networks which kept them from any real possibility of

saving money through managing care.

The IG has now proposed regs that would allow physicians and suppliers to waive Part B cost sharing if they participate in a network. If physicians are willing to accept lower total Medicare payments to participate, then insurers might be able to pass along savings in the form of lower premiums. Network creation may also allow plans to pursue managed care objectives within their networks. In any event if the regulatory change allows insurers to lower premiums on Select plans they may become a stronger option for beneficiaries.

Let me take a quick look at the 2003 benefit and premium information for the plans designed to replace the Medicare fee-for-service benefit package. Starting with the Medicare+Choice coordinated care plans, here CCPs, almost 60 percent of beneficiaries have a CCP available in their county. This is down from over 70 percent a few years ago. Almost 30 percent of Medicare beneficiaries have a CCP available in their county that charges no premium. That percentage is down from over 60 percent four years ago. But now, due to a provision in BIPA, about 4 percent of beneficiaries will have access to a plan that

will in effect pay them to join. The actual transaction is a partial or full rebate on the Part B premium which all Medicare beneficiaries, traditional or Medicare+Choice, must pay in order to be eligible to receive the Part B benefits.

That's why the minus $58.70 on the table refers to a full rebate of the Part B premium. So that's the lowest premium that's charged by M+C plans.

The top of the premium range shows that some plans charge in excess of $200 per month. Of course premiums that high reflects that the plan is providing benefits in addition to the basic Medicare benefits.

As we've talked before, plans in the M+C program are not allowed to have cost sharing, which includes both premium and cost sharing on basic care benefits. That total cost sharing for the basic can't exceed the national average cost sharing of $102 per month. Of course, they can charge more in order to cover the extra benefits in the package.

Almost half of Medicare beneficiaries have an M+C CCP available that covers some prescription drugs. That is also down from four years ago when about 65 percent

of beneficiaries had such a plan available. The drug coverage that is offered has also been declining in generosity and some plans may offer generic coverage and that may only come with a monthly limit.

In addition to the drug coverage, we have started to examine a couple of other supplemental benefits that plans might offer, whether they cover all of cost sharing for inpatient hospital services and whether they cover all of the cost sharing for physician services.

We found that almost 30 percent of beneficiaries have a plan available that does not charge any cost sharing for inpatient hospital services. Total physician cost sharing was a little rarer with only 10 percent having a plan available.

Let's move a little quicker through the other types of plans. For 2003 the private fee-for-service plan -- there's really only one -- will charge a monthly premium of $88. The plan does not cover outpatient drugs. For inpatient hospital services the beneficiary has a copayment of $100 per day up to a maximum of $500 per stay. The beneficiary must notify the plan before a planned admission, otherwise there's an extra charge. For

physician services, the beneficiary has a copayment of $15 for each primary care visit and $30 for each specialist visit.

For cost plans premiums range up to $326 per month. Half of the cost plan offerings have monthly premiums between $72 and $116. Less than half of the low option plans include coverage for outpatient prescription drugs. Most of the ones that do not provide coverage do offer higher options choices that do include drug coverage.

Most of the plans charge no cost sharing for inpatient and hospital services in a plan hospital and about one-third do not charge cost sharing for visits to plan physicians.

On the PPO demos, all of the PPO demonstration plans charge premiums ranging from $32 to $184 per month. All but one of the PPOs will offer some coverage for outpatient prescription drugs and about one-fifth of those beneficiaries who have a plan available will have one available that charges no cost sharing for inpatient hospital services. However, total physician coverage is quite rare.

Apart from being able to choose from among these

insurance products intended to replace and sometimes supplement the fee-for-service benefit package, beneficiaries can choose from among packages that are designed to supplement the basic package. All aged beneficiaries have the choice to buy a Medigap plan when they first enroll in Medicare. Many beneficiaries also have the choice of buying a Medicare Select plan. Some beneficiaries may also be fortunate enough to have the choice to participate in an employer-sponsored retiree plan. Other beneficiaries may be eligible to receive supplemental benefits from state Medicaid programs and other programs designed to assist low income individuals.

At least when reviewed at the national level, the health insurance market for Medicare beneficiaries offers a number of choices. However there is tremendous variation in availability depending on, for example, each beneficiaries geographic location, work history and income.

It's also important to note that the available choices involve tradeoffs for beneficiaries. The dimensions of choice that are immediately apparent are affordability, flexibility and the scope of benefits. Beneficiaries may not be able to afford some of the health

insurance coverage that are available to them, especially options with the broadest scope of benefits. Beneficiaries' choices among coverage options are, however. not only constrained by the availability of the plans described above but also by factors such as underwriting restrictions on Medigap policies for some beneficiaries, financial resources, and incentives or requirements for participation in employer-sponsored supplemental programs.

Beneficiary preferences in health care needs may also affect the extent to which beneficiaries are interested in considering options or willing to change from one plan to another. So given the choices and limitations, the pie chart here illustrates what insurance beneficiaries carry.

What insurance do beneficiaries want? Judging from surveys and research surveys, we find that for the most part beneficiaries in both fee-for-service and Medicare plan alternatives are quite satisfied with their current health insurance.

Data from the MCBS and the recent data from the Consumer Assessment of Health Plan Surveys or CAHPS show that the ratings of plans and ratings of Medicare, in

general, are high. This is consistent with a lot of other survey data that show that most people rate health care well most of the time.

There are a few variations worth noting. People with more serious problems give somewhat lower ratings to both fee-for-service and Medicare+Choice, but those in Medicare+Choice report more or more serious problems. There are variations in satisfaction with M+C plans across regions. They tend to be rated higher in the Northeast and lower in the Pacific and Northwest regions.

Beneficiaries and advocate organizations have expressed a variety of frustrations with the existing systems of choices overall. The research suggests that beneficiaries want to be able to count on their plans being there over time and that they're upset by changes in plan benefits. Being able to stay with their own doctor and being able to choose providers is important to them. Beneficiaries find it very difficult to sort out what M+C plan offerings really are and what they will have to pay out-of-pocket. Finally, they are frustrated by what they see as an unfair system where beneficiaries in some areas get richer benefits for lower premiums than they may be

able to get.

What do plans want to participate? Plans believe that the M+C payments have not kept up with the cost of providing care in recent years. They also believe that Medicare regulations and reporting requirements are excessive and burdensome. Plans want to be able to compete with Medicare fee-for-service and other plan models on a level playing field. For example, federal law requires community rating and prohibits underwriting for Medicare+Choice plans but Medigap insurers can underwrite in most states. Plans also want more ability to create more varied products that can meet beneficiaries varied needs.

Clearly beneficiary and plan perspectives do not always align perfectly. Beneficiary advocates are concerned about instability and complexity. They point to the major problems that plagued the supplemental insurance market before plans were standardized in the OBRA '90 reforms. Product variations could also lead to bias selection, adverse selection in insurance products. Consumer protection and education may depend on some regulation and oversight.

To understand what Medicare can and should do to manage these tensions we need to look more closely at how markets are working now.

First, let's look at what CMS has been doing to address these tensions? They have been working hard. They have provided regulatory relief, particularly in marketing and data reporting requirements. They've unveiled extensive consumer education plans. They have facilitated plan marketing to employers and to unions. They have the demonstrations, the PPO demonstration, the latest of what they have been doing, although they have done smaller demonstrations. And they've continued work on risk adjustment which they feel is very important in order to make a competitive market.

The supply of alternative options to Medicare fee-for-service depends on several aspects of the marketplace. For HMOs and other network plans, a key question is if they can create networks. If there are monopoly providers in an area or resistance to managed care, they may not able to form networks. This is particularly a problem if payment levels are low relative to Medicare fee-for-service. State regulations such as

rating rules, guarantee issue rules, Medicaid and pharmacy assistance program policies may also affect competition in local markets.

On the demand side if, for example, beneficiaries have an option that subsidizes their expenses, such as employer-sponsored wrap-around supplemental insurance or Medicaid, their demand for HMO options may decrease. Affordability is a key determinant. In low income areas, the demand for pricier products may be low. Finally the local insurance culture may affect the personal preferences of beneficiaries. People who are used to being in HMOs may have a higher demand for managed care products. There are also larger scale dynamics at work.

What is offered and at what price is often affected by larger scale phenomenon. The underwriting cycle, for example, influences whether insurers are trying to increase market share or increase margins. We have been in the margin increasing phase for the last couple of years. Premiums have been increasing and insurers have been withdrawing from less profitable markets.

For network plans there has been a desire by enrollees for larger and more inclusive networks with less

utilization review and the response has carried over into the M+C market as well. Finally, providers have consolidated in some markets and pushed back against the managed care plans demanding higher payments. Again this has spilled over into the managed care market for Medicare as well.

Because these marketplace dynamics are so complex and because the decisions beneficiaries, providers and insurers make take place in local markets, we conclude that we need to study some local markets in depth. We plan to conduct in-depth studies in local markets and report these results back in June.

MR. SMITH: I found this very helpful and very clear. Two thoughts and a question.

We surely shouldn't be surprised that consumers want more stability and better benefits or that providers want more money and more flexibility. I thought we made relatively more of that than we should have, rather than the next section trying to talk about what's happening in the marketplace itself.

My question is every time we talk about what's happened to the shape of or the availability, the

distribution of M+C, we also note that the shape of benefits is changing and being more constrained. Do we have any way to size that, to sort of describe anything other than, of course, copays are going up, formularies are being tightened? And maybe it's back to an earlier conversation can we relate that to what's going on with out-of-pocket costs for folks who are finding either their Medigap benefits more constrained or their M+C availability more constrained?

DR. HARRISON: We have sort of the same problem that beneficiaries have, the benefit packages are so complex that it's really hard to quantify everything and figure out how they've changed We can pick a couple of measures and I've picked a couple to try to focus in on but past that it's hard to -- yes, we know that they're less generous but it's hard to quantify it.

The other problem is that we don't know who picks this which option. CMS, I believe, will be starting to report who picks which option within a plan. Like if a plan has a high and low option, we don't know whether they decided to buy the drug coverage or not. We've seen some early results that suggest that they do buy up most of the

time but we don't have anything that goes back in time for that data.

MR. SMITH: So taking a beneficiary who made a different choice as her plan changed its options or increased its premiums, we have no way of identifying that. Thanks.

MR. HACKBARTH: Aren't plans required to file statements with the actuarial value of their additional benefits? Can't you track that over time?

DR. HARRISON: They are. We could use the cost reports to get some sense of what the actuarial value they're claiming is.

DR. REISCHAUER: Is that just the free benefits or is this the benefits which they're charging the extra premium for?

DR. HARRISON: They're supposed to do it for all benefits. The problem is that they're usually based on guesses as to what's going to happen as supposed to the past. And since the benefit packages don't stay stable from year-to-year, when they do file past information it's hard to track with that was for.

MS. ROSENBLATT: Just on that last point if you

could do some plans with a lot of enrollment and get an actuarial consultant to value -- lets say a given health plan in a given area has three plans, plans one, two and three. And plan one, between 2002 and 2003, you could value it as of 2002 like $100 worth of value and in 2003 it might be $90 worth of value. So you might be able to do it for a sample and that might be a more accurate way of doing it than going back to the cost reports but that's a possibility.

But you won't pick up -- a plan that offers plan one, two, and three with plan three being the richest might stop the just stop offering that plan as opposed to reducing the benefits and you wouldn't pick that up.

I thought this chapter a lot of great stuff in it. I have a couple of comments. I have a reconciliation issue. Anne's chapter, that we just talked about, made a comment in it that 90 percent of beneficiaries have some form of supplemental coverage. And then this chapter talks about roughly one-third have Medigap, roughly a third have employer-sponsored coverage. And I had a hard time coming up with where's the rest of the 90 percent, even looking at the pie chart you had up there. Some of it's Medicaid but

I'm just not getting to 90 percent. So there's something that just doesn't quite gibe.

DR. HARRISON: We have 13 percent in this chart and there is a problem with these numbers. They come from the areas different surveys that don't always match. In fact, we're waiting to update this. We think we'll be getting data next week.

MS. ROSENBLATT: It might be helpful if we get that reconciled, to actually have like a little table where you could break down the 90 percent into its components. Because I don't know if it's just me but when I started reading Medigap is a third -- see I think of Medigap as both individual and employer. And I read the one-third and I went wait a minute, that's impossible. So it might be helpful to have an introduction laying out the components of the 90 percent or whatever that number is and to make sure it agrees with whatever Anne's got in her chapter.

My second comment is on the plan perspective section of this chapter, it really focused on the M+C program and I think there are other things that should be mentioned in the plan perspective. First of all, the comments you made about Medicare Select, that's not yet

happened; right?

DR. HARRISON: I think comments were due last month so it has not happened yet.

MS. ROSENBLATT: But I think most plans would be very supportive of that change Medicare Select, so that might be worth mentioning.

And then what was totally ignored would be the plan perspective on Medicare supplement plans. The standard plan issue that I always bring up, which I know beneficiaries get confused, but I always bring up the point that if you can get away from standard plans there's more chance for innovation and experimentation.

And then the unusual kind of comments about rating, underwriting, loss ratios and all that kind of stuff, that I'm not going to get into because Jack will make fun of me if I do.

DR. ROWE: I won't understand it, it's okay.

MS. ROSENBLATT: Also, the consumer satisfaction comments, there was a recent survey -- and I can't remember which research firm did it. It might have been Kaiser on the fact that the minority population was extremely satisfied with M+C. It's Kaiser? And it might be worth

including some quotes from there in here.

And then a couple of specific comments. Can explain, you've got something in here about if you assume beneficiaries enroll in PPOs, the value will be 109 percent. It's on page 11, Medicare payments for PPO demonstration plans.

DR. HARRISON: Okay. In the past what I simply did was I took the rates that would be paid to the PPO plans, took the fee-for-service spending in those counties, and weighted the counties by Medicare eligibles. So if PPOs attracted enrollment in proportion to general Medicare enrollment in the county, then we would end up paying 109 percent of what would be paid under fee-for-service for those people.

MS. ROSENBLATT: Because you're going to get higher weighted --

DR. HARRISON: Because they're higher rate counties.

MS. ROSENBLATT: It's a confusing number, at least it was to me. And I think it could be misinterpreted. So if there some other way of doing that or leaving that out, it just makes it sounds like how do

you get from 99 percent to 109 percent?

On page 18, there's a comment, policies for older beneficiaries and attained age-rate policies may cost considerably more than policies that use issue age or community rating. I think that sentence needs a balancing statement that says something like younger beneficiaries benefit from issue ag and community rating just make sure that people understand that it all washes out.

DR. HARRISON: Right, we weren't finished with all the rating stuff.

MS. ROSENBLATT: And then on the employer-sponsored supplement plans, I didn't see anywhere in here that mentioned one of the reasons that employers are cutting back is due to the FASB 106, as well as just increasing costs. And might be worth a mention.

DR. HARRISON: Okay.

DR. NEWHOUSE: I would like to comment on the conclusion and then couple of small points You wound up your talk with we need to understand what happens local markets, and that's kind of the last paragraph of what's in our book. But it comes across much stronger in the talk. And what I'd like o urge you do is actually go on to say

not only we to understand what happens but what we would do with it as policy. What I see it points toward is the geographic adjustments in M+C because other than that, in the traditional program architecture it's very hard to do anything about local markets. We have wage adjustment and that's about it, and then we have some kind of rifle shots in certain legislation but that's not really what you're talking about.

But we do have that policy of trying to reduce geographic variation on the M+C side and nothing on the traditional side, which we've certainly banged on that drum before. But it seems to me that's where this points.

What I would urge you to do is not just say we need to understand it but what we would do with that once we understand it, assuming we are capable of understanding it.

So maybe that can be a longer discussion there at the end.

My two nits are right away on page one you say policymakers are concerned that Medicare beneficiaries don't have the same choices of health care delivery systems that workers have. It's my belief that only about half of

workers have any choice of health care plans at the place of employment. So I wasn't sure exactly what you meant by that because obviously in traditional Medicare I can pretty much choose my provider. And we've given as a percentage of the number of beneficiaries that have choice of an M+C plan in addition to traditional. So I wasn't sure that that's factually correct.

DR. HARRISON: I think this was really supposed to point to the PPOs, that fact that workers have a choice of getting at a PPO.

DR. NEWHOUSE: They may not have a choice of a PPO. That's my point.

And then my other thing, and this was really something I didn't quite understand, was on page 22 you talked about more than one million new enrollees in the last five years in the VA, citing a Washington Post article. What does it mean to be enrolled in the VA? I thought you just showed up you were entitled or you didn't show up as your spirits moved to you, you didn't enroll.

DR. HARRISON: I think that's right.

DR. NEWHOUSE: Okay.

MS. DeParle: I just wanted to understand a

little bit better the information you provided us about premiums and benefits for 2003. And in particular, do you any more details about the coordinated care plans that are offering the minus $58.70? No premium, basically? How many of them are there? Where are they? How many beneficiaries have access?

DR. HARRISON: They're in Florida. There are some plans in New York who are offering $20 or $30 rebates but Florida is the only place where you can get the full rebate.

MS. DeParle: And they're not offering additional benefits then, it's just a bare bones plan? Or are they offering additional benefits, too?

DR. HARRISON: I looked at those plan and I believe they all offer higher options and so beneficiaries would definitely be trading off cash for better benefits.

MS. DeParle: So they have a higher option plan, as well as the one that's no premium at all?

DR. HARRISON: Right, as I recall, they were pretty bare bones but I think that they did offer some supplementation.

MS. DeParle: Are they all over Florida or are

they only in Miami?

DR. HARRISON: Miami and, I believe, Hillsborough County.

MR. FEEZOR: Just a follow-up on Alice's comment. If you reference the private sectors sort of retrenchment due to FASB, you may want to sort of give a heads up on the forthcoming GASB ruling on it, it might prompt similar response from public agencies.

And I think Joe's comments were that if you look at what really happened, a lot of large employers really never bought into the full managed competition theory and hence, did not offer a wide variety. And those that did have even further retrenched in the last few years to drop back in terms of the offering of plans. They've gotten rid of the Aetna's and the Cigna's and so forth. I just wanted to see if Jack was listening.

We've struggled with the issue of choice within my organization. And I guess I wonder if -- and I'm not trying to expand your horizon here a lot, but the attitude of really how important is choice and whether we want to do some sort of survey our opinion citing here.

When we looked behind it, we have clearly caused

a lot of angst among our members because we have dropped from our twelve plan offerings down to four. They said were losing choice. Well, the reality is they had one basic benefit design. When we do survey of our members their choice is, in fact, first and foremost, a choice of provider. And even in our plan elimination, we still have maintained the 90 to 92 percent physician match in each of those moves.

When you scratch a little further in the opinion that it is -- the choice I want is first in my provider, that's more of a freedom of as opposed to a lot of, I think.

And then the second really is it's not so much I want a choice of plans but somehow -- I think maybe Alice touched on it -- there's been this sort of dilution of value. And somehow I'm limited and I would like more value for the same amount of money, which may not be an economic reality. I mean the choice isn't there for that. And so when you really scratch away choice, to some degree, goes away as being a big issue except for the vendors and for the researchers.

MS. DeParle: But we may think that choice as

some value from an economic perspective. We believe in markets and --

MR. FEEZOR: That's what I'm saying, let's be clear about why we are pursuing it, why it is important.

MS. DeParle: This isn't a competitive pricing methodology right now but if it ever were presumably one would think there's a value to having more than one participant bidding.

MR. FEEZOR: I couldn't agree more, but I think -- well...

The final thing is that, I guess I was struck by some in there you talk about the fact that when all is said and done, this is a market that either out of ignorance or a lack of choice seems relatively happy with their coverage and in fact are rather static. They don't move a lot. You make that comment in here.

I guess I just wanted for us to focusing in on why we are pursuing choice. I think it may not be saving money. It is sort of the freedom that we sort of think that everybody wants it and we sort of flame that and when you scratch it, you really look below that, it may not the choice as we have thought of it in this model.

MS. WAKEFIELD: Scott, in your list of federal programs that provide coverage to retirees, what would the reason be that IHS wouldn't be listed there? Is there not any interface between IHS and Medicare? Or is there and it was just not listed for some other reason? Where you're listing Medicaid and DOD, et cetera.

DR. HARRISON: I think there is I mean, I think you can be eligible for both. I don't know.

MS. WAKEFIELD: If there is, and this is a chapter that's going to be included, could we just try and get a little bit of language in there about what that might be? Thanks.

DR. ROWE: Scott, just a couple of small things, really matters of emphasis. I think this is very well done.

From the point of view of the health plans, or at least one health plan, this is really much more about Medigap Reform than it is Medicare reform or change. You mention, under the section on health plans, you have an introductory sentence that says something about that, that health plans would like to see a level playing field where they could compete for Medigap programs.

But then you go in and all the rest is all about M+C changes and other kinds of changes within Medicare, as opposed to Medigap changes. And I think that it might be helpful to have a little more balance with respect to that, or throw in some of the other discussion about changes in the Medigap program or possibility of offering different kinds of programs.

The president, I think, came up with the suggestion of two additional Medigap plans, didn't he, President Bush a year or so ago? I don't know what happened to that, but he was going add K and L, wasn't he, at one point?

DR. HARRISON: Last year.

DR. ROWE: There might be some discussion about that and trying to get people more access, that was one approach to getting people access to outpatient prescription drugs, et cetera.

I just think if you lined up a bunch of health plan executives there's more interest in trying to compete in the Medigap and make those products more attractive and more responsive to people's needs.

The second thing has to do at the PPO, which I

think is misnamed. And you pointed out to us in the past that there were really two things going on here. One is it's a PPO rather than a more restricted network with access et cetera, and that's easier. But the other is they waive the cap.

So there are really are two experiments at once. Is the traction that it gets related to waiving the cap, or is it related to the network and certification issues? And I think that you mention that toward the end of the chapter, you that in a paragraph. But I think that that deserves to be seen with a little more sunshine on that because I think that that is, in fact, a pathway, independent of the network issues that might be something for CMS to consider. That would be something that would open things up a little bit.

So a little more emphasis on that. Unless you're among the cognoscenti or you're really reading this very carefully, you're going to miss that, sort of the second of three points that you make, the kind of inside baseball points about the PPO demonstration. And I think it might benefit from a little more emphasis. That certainly was part of what attracted us to it.

DR. REISCHAUER: Can I ask you how you'd like us to describe this, that this demonstration allows the plans to increase the costs on sick Medicare beneficiaries?

DR. ROWE: No, you could do that if you want and I would actually --.

DR. REISCHAUER: That is the description you want.

DR. ROWE: I would leave that up to the media, actually, which I think generally you're not a member of, but not always.

I guess what I was say is it provides Medicare beneficiaries with the choice of paying more for a broader set of benefits than they -- or different kind of structure than they would get in traditional Medicare. It's all about this is not mandatory, this is all voluntary. And it's about there are Medicare beneficiaries out there who instead of buying Medigap, might be more attracted to these other policies. That would be an alternative proposal.

But thank you very much for you suggestion.

MS. DeParle: On that point, do we have any data yet on how many folks have enrolled in the PPO demos?

DR. HARRISON: Enrollment opens January 1st, so

we won't -- if we were really lucky we might know by the end of January who signed up in January, at least, but I don't know how reliable that would be.

MS. BURKE: I know this isn't really the focus of this chapter, which I think was quite well done, there is a discussion on Medicaid that is contained in the section that discusses sort of other alternatives, along with the VA and some other things. You're left wondering at the end of the comment what it is that's not working because of the large number of individuals who are eligible who do not choose to participate.

There is also, following that one paragraph, a discussion under the heading Medicare beneficiaries that sort of raised some of the issues that you raised about the program, about some of the choices.

I think there is, in fact, something to be learned and, I think, some greater understanding of some of the challenges that are faced in terms of Medicaid because it is a safety net and, in fact, participates -- I mean, there's 17 percent of the population that are involved as it is, which is not an insignificant number. The fact that there are more 20 percent actually eligible choose not to,

I think, might bear at least some additional explanation.

You reference a particular study that notes the fact that people choose not to. There are lots of reasons that we've speculated on over the years as to why and I think we might at least add a small amount -- again, this is not the focus of this chapter, but I think it might enlighten folks in terms of looking at what some of these very low income beneficiaries confront in terms of their choices and sort of the limitations and what Medicaid offers or doesn't offer.

DR. REISCHAUER: Scott, I just thought, on the first page you should not make it sound like the first introduction of the choice of HMOs came about with the Balanced Budget Act of '97 but there was a program, the TEFRA thing, before.

MR. HACKBARTH: Scott, could you give us a quite update on the status of the risk adjustment system and implementation of it?

DR. HARRISON: I haven't heard much. I know Dan has been talking a little more with people.

DR. ZABINSKI: We don't know. Basically I think they just started collecting the data or are soon to

collect the data. So we really don't know a heck of a lot at this stage.

MR. HACKBARTH: My recollection was that January was when they actually start to file data reports with CMS?

DR. HARRISON: I believe they have started collecting -- I haven't had confirmation of that. I think actually it's October. But the dates I do know, in February there's going to be a public meeting where I believe they well -- CMS will discuss, I think they will discuss the final model. And then towards the end of March they actually have to put in the Federal Register the 45-day announcement on what their method will be for setting rates for 2004 and in that they will have to lay out the final model.

MR. HACKBARTH: Another question, Scott. Could you tell me how the rates paid by the private fee-for-service plan -- the rates paid to providers, compare with Medicare rates for providers?

DR. HARRISON: It's the same. If you were to apply to CMS to offer private fee-for-service product, you'd have to guarantee a network of providers who take your rates. The way this latest plan did it was they

simply said we'll pay Medicare rates, which should guarantee participation.

MR. HACKBARTH: If they're paying Medicare rates to providers and they're in floor counties which, by definition, increase the payment to the private plan above Medicare fee-for-service costs, remind me what happens to the increment, the difference? There should be money left over.

DR. HARRISON: I know they file either one or two cost reports for their entire service area. So they're not doing stuff county by county. And they're projecting total costs over their area, and they do offer something in the way of supplemental benefits. Some of the copays are lower.

DR. REISCHAUER: But they're also charging a premium.

DR. HARRISON: They're also a premium. Right now enrollment is over 20,000. It's been growing steadily but that's what they've gotten to so far.

MR. HACKBARTH: One last question. This goes back to something Jack said. The issue of the level playing field, as it were, between M+C plans and Medigap

plans, this is something, as you look at local markets and their dynamics, this is something that you will explore for the June report; is that right?

DR. HARRISON: Yes, it's going to be very complicated and I really think you'd need to do it market by market because the Medigap rates vary like crazy, the M+C availability varies quite a bit. So in order to sort this stuff out and see how the competition really lays out, I think you really have to get into local markets.

MR. HACKBARTH: Any other questions or comments on this chapter? Okay, thank you.

Next we turn to the subject of updates for fiscal 2004. We'll begin with a quick review of the update framework, and then proceed to talk about the updates for skilled nursing facilities and home health services.

MR. ASHBY: Over the course of the next two days we will have seven sessions on updating payments in Medicare fee-for-service, and they will cover the seven sectors that you see on this first overhead. As Glenn has said, we have devised a framework for developing our updates which with some customizing can be used in each of these sectors. So we thought we would start this first

update session by briefly reviewing that framework.

As you see in this first figure, our approach consists of two parts which asks two sequential questions, is the current base payment too high or too low? And then, how much will be efficient providers cost change in the next payment year? Each of these parts results in a percentage change factor and we simply sum the two factors to arrive at our update. Then as you see in the last step, we compare our update to current law. More about that in the moment.

The next figure elaborates on the first part of the process, assessing the adequacy of current payments. We see this as essentially determining whether we have the right amount of money in the system. Assessing payment adequacy has three steps, and they are shown in the three boxes going across the top. First is estimating our current payments and costs. That's essentially figuring out where we are now.

The second step is assessing the appropriateness first of our cost base, and then when we're comfortable with the cost base, assessing the relationship of payments to those costs. This is basically figuring out where we

want to be.

Then the third step is adjusting payments, figuring out how we're going to get to where we want to be. In the last step, the adjustment can be a straight percentage factor carried forward in the update, but it can also be combined with other policy changes that are intended primarily to affect the distribution of payments, but also affect the amount of money in the system. We'll be proposing in a couple of cases to do just that.

In the end, payment adequacy is a function of both the level and the distribution of the payments. That's the key thing to keep in mind here.

The bottom row of boxes in this figure lists a number of factors that we consider in assessing the adequacy of payments and costs. On the cost side -- that's the left-

most box -- we are, for the most part, restricted to examining the trend in cost per unit of output. We can then compare that trend to the change in the market basket, which essentially measures how much we would expect cost to rise if the volume of care and the inputs used were held constant.

But we also take a look, or we stay on the lookout for changes in product. The best examples of that are declining length to stay in hospital inpatient or SNF and the home health analog of a decline in the number of visits in an episode of care. When length of stay or visit intensity declines, we then expect that the cost increases will be less than the change in market basket.

On the payment side, that's the middle box, we list five factors that may provide us clues as to whether payments are too high or too low. Just one example, a large increase in the volume of care may indicate that payments are too generous or a large decline may indicate that payments are too low.

On the right-hand side we have one additional factor and that is the target relationship of payments to costs. When it comes to margins, in other words, how much is enough? We have concluded in discussing this in the past that we cannot specify a standard here. This will vary by sector, it will vary within sector depending on circumstances. So this is essentially a judgment that the Commission has to take on a case-by-case basis and we'll start that judgment process right this morning.

I wanted to point out just a couple of things about the first step in this process of assessing payment adequacy, that's estimating our current payments and costs. First, we just want to note that current refers here to fiscal year 2003, because we are developing updates for fiscal 2004. So we need to remind ourselves that we're only two months into 2003 so obviously we're not going to have actual data for that year. But that natural problem is compounded by the old data that we have available to us.

We had hoped to launch our process this year with complete 2000 data, but as has already been alluded to this morning, we have encountered problems with the 2000 data that are available to us from CMS particularly in the outpatient and the home health sectors. In both of these cases CMS, and therefore we, are still working through cost report changes that were brought about by the new PPS's. At this point we have some 2000 data that we'll be using and in some cases were back to the 1999 data. By January when we finalize our recommendations we will have more 2000 data. In fact if things go well we may at that point be able to put these 1999 data behind us for good.

But I wanted to emphasize that when we do our

modeling we know quite a bit. We know what the updates have been in the intervening years. We know what other policy changes have gone in and what providers they affect and in what proportions. In several cases we have other sources of data available to us on how costs have changed. So we're able to estimate current financial performance more accurately than you might think in most cases given the status of our cost reports.

Moving on to -- question?

DR. ROWE: I don't know if it's for you or for Mark, but notwithstanding the fact that you can make adjustments on the data that you have because you know what some of the changes have been, the data are still the data. Is it worth going ahead with '99? Isn't it worth just waiting a little longer till you have the 2000 data? What's the great rush?

DR. MILLER: Do you want me to start with this? I think a couple of things here. You want, particularly if a PPS has gone into place, you want to work with data that in a perfect world reflects the fact that the PPS is in place, and to the extent that the 2000 will get you closer to that or more of that, that's an argument

for doing it. I think we also have some of it. Some of it we have not had the same kinds of trouble in getting it.

What our feeling is here is, is to try and get you -- so that it's not such a blitz in January, to give you as much as we have and as much of a sense of where we think we're going to be in January so that when we have hopefully all of the 2000 data -- and I say that with some caution, that in January it's really just coming to the largely the same sets of conclusions based on more firm data. I don't know if Jack has anything to add to that.

MR. HACKBARTH: When by necessity we do need to project what's happened to cost using a year older data do you have an approach to doing? I remember reading in some of the papers, at least in some instances, there was a conscious effort to err on the side of making a conservative estimate. By conservative I mean that costs increased at a fairly rapid rate so that, if anything, we would be erring on the side of lower margins. Is that an accurate representation?

MR. ASHBY: Exactly. Where we don't know anything, which is where we were projecting costs generally at the rate of market basket. That's the official forecast

of what would happen, all else being equal. So I think that is --

DR. MILLER: But just if I could say one other thing. I think in a couple instance, or at least one instance that I'm pretty certain of, in an instance where we're working off of old data we did things like market basket but made no assumption for taking productivity growth and things like that out of it. So this is sort, as Glenn said, a fairly aggressive assumption about cost.

DR. ROWE: Since the freshness of the data are really important, particularly during a time in which the year over year changes in medical costs are not flat -- not that they wouldn't have even to be flat, the medical costs, but even a predictability of what the inflation rate would be. We're not in that situation.

Even 2000 seems a little old to me. If in our company we were making judgments based on 2000 for 2003, it wouldn't be very good. If 2000 isn't available, is their an option of taking 2001 instead of 1999? Could you just explain for us, maybe just for a second, why it is that it takes a long.

MR. ASHBY: It's a long story.

DR. MILLER: I can do at least the 10-second version. This question came up yesterday on the Hill, more than once. I'll just do the 10-second version and you should point out where it's wrong.

What you have is providers on different cycles, different years that they file their cost reports. They go through the development of the cost report and then that goes to intermediaries. There's work that's done there and then that goes to CMS. The other kinds of things that go on are things like auditing those cost reports to determine whether you have adjustments in them. And I think also there's another issue about how long you can get reimbursed on a claim, so you can do that for some period after the year in question as to when cost reports are all finalized at then brought forward and aggregated and put into standardized formats and audited, is what the delay is.

DR. ROWE: Alice is the actuary here. There is a point where you have a certain competence.

MS. ROSENBLATT: I was just going to say, health plans need to file reports within three months of the close of the current year, and get them audited in that timeframe. So it is possible to do things differently.

MR. HACKBARTH: This is distressing, and we regularly acknowledge how distressing it is, and in my view it needs to change, it must change. The causes are multiple. They're not going to be fixed in the next several months. To some extent they may require more resources for the people who process the claims, or CMS, but right now we've got to deal with what you've got and make the best of it that we can.

DR. NEWHOUSE: I can't remember what we did because I've brought this up before and I can't remember if it made it into a recommendation. But I've suggested that we pay some sample of hospitals to be on a fast track to help this problem. Did we make that as a formal recommendation? Because I agree, the demand is for fresh food and we're certainly not getting very fresh food here.

MR. DeBUSK: One comment on the cost report. I think part of the problem was, was it not, that CMS was a couple years getting some of this information back to the hospitals that they needed to complete the reports. And another thing, you look at the cost report, it's archaic. Certainly it looks to me like, going forward, that a gap or a modified gap would give us a lot more data here at MedPAC

that would actually be of value. I think it's a major issue.

MR. ASHBY: I'd just like to elaborate a little on the process here just to understand. The process, as Mark described it, if it were a normal year, would result in us looking at preliminary 2001 data right now. We're struggling with the 2000 . We should be looking at 2001 data right now. The reason we're not has to do with changes in the cost report brought about by these new PPS's and other issues. And there's a lot involved in a change here.

First of all, CMS felt obligated to give the hospitals additional time to fill out their cost reports because they were undergoing some fundamental processing changes just be able to comply with all the rules that come with the outpatient system. But on top of that, they have to redesign the cost report and then the Big 6 accounting firms have to redesign the package that they sell, the hospitals have to buy the packages and get used to how to use them, they have to fill them out. Then the FI's have to reprogram, and then CMS has to reprogram to receive the data.

So it's that process of accommodating change that has really brought about the problem that we have today.

MR. SMITH: Jack, in a normal world we would still be five quarters away from fresh data. We'd be looking at 2001 data in the first quarter of 2003, if the system were not being disrupted by changes in accommodations.

MR. ASHBY: Yes. It's all relative. We have a half full and half empty glass situation here.

MR. HACKBARTH: So it is a problem, and at the same time we must proceed. If we wish to take up a specific recommendation about a Band-Aid, namely a sample, we can do that at a later point. Personally, I'd like to see the more fundamental problems addressed as opposed to focus on instituting Band-Aids. But we need to move ahead right now, Jack, so please proceed.

MR. ASHBY: Just one more minute here. Moving on to the second phase of our process, that is accounting for providers' cost changes in the coming year. The most important factor here is expected change in input prices. This is input inflation as measured by a forecast of the market basket. But as you will hear, in virtually every

one of the sectors we also consider expected productivity gains and the cost of technological advances, and these two factors will at least partially offset each other.

Then one final note has to do with the last step where we will be explicitly considering current law. For each sector, in fact each recommendation within each sector, the analyst will first note what current law is so that you are aware of that going into deliberations and then indicate a range of impact that our draft recommendation would be expected to have relative to that current law.

That's it.

MR. HACKBARTH: Thank you, Jack.

MS. DePARLE: For the benefit of those who are new, it would be helpful if they would also indicate what MedPAC's recommendation was last year. Some people may remember that, but that's just helpful to keep in context.

MR. HACKBARTH: Nancy-Ann, help me remind people to do that. I believe skilled nursing facilities is first.

Suzanne and Sally, you can proceed whenever you're ready.

DR. SEAGRAVE: Good morning. Today I'm going to

walk you through the steps we used to determine our draft recommendations for skilled nursing facilities, and then present those draft recommendation, and then welcome direction from the Commission on where it would like to see us go for the final recommendations in January as well as for the March 2003 report chapter on skilled nursing facilities.

First I want to remind the Commission of the role that skilled nursing facilities play in the Medicare program. SNFs provide short-term skilled nursing and rehabilitation services to about 1.4 million Medicare beneficiaries per year. Prior to the implementation of the SNF prospective payment system in 1998, Medicare SNF spending grew rapidly. Average growth over the period 1992 to 2002 was about 13 percent per year. In 2001, Medicare SNF spending totaled about $15.3 billion or about 6.5 percent of total Medicare spending.

Also important to note is that Medicare's share of nursing home revenues is about 10 percent, and that its share of hospital revenues is about 2 percent. CBO projects that total Medicare payments to SNFs will grow an average of about 8 percent per year from 2002 to 2007,

although CBO has indicated that this number may be revised downward in its January baseline projection.

MedPAC goes through a multi-step process each in arriving at our update recommendation. We start by assessing current payment advocacy, as Jack has just described, and then we evaluate the appropriateness of current costs and estimate the relationship between current Medicare payments and SNF's costs for fiscal year 2003. Next we examine the evidence of anticipated changes in SNF costs for fiscal year 2004, and based on this information we determine appropriate payment update recommendations for fiscal year 2004.

I will briefly review the market factor evidence we discussed at November meeting. With regard to entry and exit of providers, we find that the total number of SNF facilities participating in the Medicare program remains relatively stable between 1998 and 2002, declining by less than 1 percent each year from 1998 to 2001, and then increasing by less than 1 percent from 2001 to 2002. The patterns of entry and exit vary among different types of SNFs with the number of freestanding SNFs, which represents about 90 percent of the market, increasing by 3 percent

from 1998 to 2002, and the number of hospital-based facilities decreasing by 26 percent over the same period.

It should be noted that over three-quarters of all counties in the U.S. experienced no net change in the number of SNF providers and of the other 25 percent of counties, more experienced a net increase in providers than experienced a net decrease.

Now turning to the volume in SNF services. 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 about approximately one day in the average length of stay. Although the total number of discharges declined slightly, the number of Medicare covered days in SNFs increased by about 4 percent.

Beneficiaries access to SNF services was generally good, with patients needing physical, occupational, or speech rehabilitation therapy generally having no delays in accessing SNF services. Patients with expensive non-rehabilitation therapy needs may had stayed in the acute care hospital setting longer, but it is not clear whether the acute care hospital or the SNF is the

most appropriate setting for this patient.

Finally SNF access to capital during this period is generally good. Hospital-based SNFs have access to capital through their parent hospital association, although this depends on the financial viability of hospital. Freestanding SNFs' access to capital may have diminished somewhat because of recent bankruptcies, payment uncertainties, and liability and insurance costs. However, this maybe outweighed by low demand for new capital to finance construction in the near term caused by over-investment prior to the SNF PPS.

Overall, the market factors we examined appeared to indicate that Medicare payments to SNFs are at least adequate.

Now we turn to evaluating the appropriateness of current SNF costs. Both the General Accounting Office and the Office of Inspector General reported that SNF costs were overstated prior to the SNF PPS. SNFs were paid based on their reported cost, with limits for routine operating costs such as room and board, but with no limits on costs for ancillary services such as physical therapy. Hospital-based facilities had higher cost limits than freestanding

facilities, and new facilities could apply for an exception from routine cost limits for up to their first four years of operation.

Under the SNF PPS however, SNFs are paid a case mix adjusted per diem amount to cover the routine ancillary and capital related cost of furnishing SNF services. This has provided SNFs with strong incentives to reduce the cost of caring for SNF patients, and evidence shows that SNFs have responded to these incentives accordingly. They have negotiated lower prices for contract therapy and pharmaceuticals, they have substituted lower cost for higher cost labor such as using therapy assistants for providing therapy instead of therapists, and using licensed nurses instead of respiratory therapists for providing respiratory therapy. They have also decreased the number of therapy staff they use, and recent evidence shows that they have decreased the number of minutes of therapy they provide to patient within each of the RUG groups, and I'll explain that in the next slide.

This graph is intended as a simplified illustration of the incentives SNF face for providing rehabilitation service under the SNF PPS. It shows the

Medicare reimbursement amount a SNF might receive in fiscal year 2003 for caring for a hypothetical SNF patient. As the graph shows, the Medicare payment SNFs receive for a given patient increase at intervals as SNFs provide the patient with increasing number of minutes per week of therapy.

For example, the SNF would receive $212 a day if the patient received between 45 and 149 minutes of therapy, and the payment amount jumps to $283 per week if the patient receives at least 150 minutes of therapy.

Recent evidence indicates that SNFs have responded to these incentives and others to economize on the number of minutes of therapy they provide and to lower the cost of caring for SNF patients. We have no evidence regarding the effects of these changes on the quality of care patients receive. However, to the extent that there are indicating that the incentives of the cost-based system prior to the SNF PPS were for SNFs to provide too much therapy, at least in some cases, the current reductions in therapy might mark an improvement in care.

DR. ROWE: This therapy is all individual therapy rather than group therapy?

DR. SEAGRAVE: It's supposed to be. There's an issue right now that --

DR. ROWE: But that's what this is supposed to be.

DR. SEAGRAVE: Yes. So you can see that SNFs have clearly responded to the SNF PPS in a number of ways, both by lowering the cost of certain inputs to providing care and by substituting lower-cost inputs for higher cost inputs. In other words they have increased productivity since the SNF PPS.

At the same time, however, SNFs have changed the product by economizing on the number of therapy minutes they provide to certain patients. We estimate that they are likely to continue improving productivity and changing the product over the near term in response to the continued strong incentives of the SNF PPS.

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. We find that Medicare margins for all freestanding SNFs, which are about 90 percent of all SNFs, average about 11 percent for fiscal year 2003. I apologize that we were

not yet able, for the reasons we discussed earlier, to provide you with hospital-based margins at this meeting. We really hope to be able to do that at the January meeting.

When we examined Medicare margins for freestanding SNFs by facility characteristics, we find almost no difference between margins for urban and rural facilities. If anything, margins for rural facilities appear to be slightly higher than those for urban facilities, although this averages out in the rounding process.

We do find vast differences according to whether facilities are associated with one of the top 10 nursing facility chains or not. With margins for facilities in one of top 10 chains averaging around 19 percent, while margins for other facilities average about 7 percent.

In January we will also bring you the overall margin for all SNF facilities, which we were unable to compute for this meeting without the hospital-based margins. To give you an idea, however, of what we expect to see, last year overall margins were estimated to be about 5 percent for fiscal year 2002, and we expect this

year's overall average margin to be at least as much because freestanding facilities are an even larger proportion of all facilities, and because margins for freestanding facilities are about two percentage points higher in 2003 that we estimated for 2002.

From this evidence then we conclude that overall Medicare payments to SNFs are more than adequate to cover SNFs' cost for caring for Medicare patients.

DR. ROWE: By top 10, you mean the largest.

DR. SEAGRAVE: Yes, the top 10 largest chains.

Now that we have assessed the adequacy of current Medicare SNF payments and determined that they are more than adequate for the industry overall, we turn our attention to what we expect to happen to the cost for caring for Medicare SNF patients over the next year.

MS. BURKE: I'm sorry, can I go back just one second to Jack's question? What do you mean by largest? Do you mean Medicare volume? Do you mean beds? Do you mean revenues? What's large, when you say top 10?

DR. SEAGRAVE: Number of facilities, I believe. I forgot to mention they're national chains.

First we looked for major quality enhancing new

technologies that will be expected to significantly raise costs over the course of the next year, and can find none in the SNF sector. In predicting cost growth over the next year we also looked for evidence of cost lowering increases in productivity or changes in the product, and as we mentioned before we find abundant evidence of both since the implementation of the SNF PPS. Thus, if anything, we expect SNF cost growth to be held down in continuing response to the SNF PPS over the next year.

Before I discuss our proposed draft recommendations for SNFs, I would like to remind the Commission that last year we recommended a differential update to SNF payments according to whether SNFs were freestanding or hospital-based. As we indicated in last year's March report, we did this to compensate hospital-based SNFs because we thought they might be caring for a different mix of patients, and because we suspected that they might be offering a different product.

Now we have updated information concerning the cost differential between hospital-based and freestanding SNFs and we find that this cost differential is largely due to two reasons. SNFs do have higher overhead and fixed

costs, some of which may be due to Medicare's cost accounting rules for hospitals.

In addition, the research lends stronger support to the fact that hospital-based SNFs care for a higher case mix of patients, often patients with the very types of resource needs, such as non-therapy ancillary services, that the SNF payment system does a poor job of recognizing. In fact the research finds, interestingly enough, that for some of these types of patients hospital-based SNFs can provide the care at lower marginal costs than freestanding facilities.

The conclusion of this research is that hospital-based SNFs may do best under the SNF PPS by specializing in caring for these types of patients. But we feel that the payment system does a poor job of supporting them in these efforts.

But because we estimate that with 11 percent average margins for the 90 percent of all SNFs that are located in nursing facilities, and at least 5 percent overall average margin for all SNFs, that the pool of money in the system is actually more than adequate currently.

So we recommend that the Congress eliminate the

update to payment rates for skilled nursing facility services for fiscal year 2004. The update in current law -- I just want to remind you -- is market basket minus 0.5, which market basket is currently projected for 2004 to be 3.0 percent. A zero update for SNFs would be expected to decrease Medicare spending in the range of between $200 million and $600 million over one year, or in the range of $1 billion to $5 billion over five years.

However, we realize that hospital-based SNFs are likely incurring higher costs from caring for a higher case mix of patients; costs which the SNF classification system is not adequately designed to recognize.

So our draft recommendation two, we propose a series of recommendations to help the money better follow the resource needs of the patient. So we continue to recommend, as in previous years, that the Secretary develop a new classification system for SNFs. Because we realize that this may take time to accomplish, we also propose recommending that the Secretary simultaneously draw on any new due and existing research to propose a restructuring of the current SNF payment rates to achieve a better balance between the rehabilitation and non-rehabilitation RUG

groups.

Finally, as a more immediate measure, we feel there needs to be an immediate fix to the distribution of money in the SNF payment system and 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 groups and reallocate some portion of the money to the non-rehabilitation RUG groups, as I said to immediately form a better balance of resources among all of the RUG groups.

We propose this reallocation for two reasons. One, the available evidence indicates that SNFs are already being overpaid for rehabilitation patients even before the 6.7 percent add-on. Second, the evidence also indicates that the SNF payment system does not appropriately recognize the resource needs of patients in the non-rehabilitation groups. This reallocation would immediately redistribute the resources in an appropriate way and presumably increase to facilities such as hospital-based facilities that tend to treat a disproportionate number of these patients. This reallocation of resources would be spending neutral.

Finally our final draft recommendation, we recommend that the Secretary continue an excellent series of annual studies on access to skilled nursing facility services. These studies provide reliable time series data to help us assess beneficiaries' access to these services; a critical piece of information without which it would be very difficult for us to appropriately evaluate the relationship of Medicare payments to cost.

The IOG has conducted these studies for the past several years but has not indicated any plans to continue with this series of studies. We urge the Secretary to reconsider. This recommendation would not affect Medicare spending.

This concludes my presentation. I encourage the Commission to discuss the draft recommendations I presented and provide guidance so that we can return with final language for the January meeting.

DR. REISCHAUER: Suzanne, in your description of the response of nursing homes to the PPS system you concluded that they had increased their productivity and they had shifted their product, and you described them hiring a lower-skilled group of people and reducing the

number of minutes in therapy and some of things like that. Somebody else might look at that and say they have degraded the quality of the service. I think in the chapter that we do we have to provide some evidence that that isn't the case, or to the extent that service might have deteriorated, it hasn't gone below some acceptable standards for the payment, just so we protect ourselves.

MR. SMITH: I won't belabor it -- Bob made almost exactly the point I wanted to make. One person's productivity improvement is another person's stinting. An awful lot of this has come about through staff reductions. There some evidence of lowering the quality of staff as well as lowering the number. It seems to me we need to at least raise the question of whether or not the product has been degraded, whether services are adequate, as a possibility. We may not have any data. We still don't have a lot of experience with the PPS, but we do know that less people are providing less services. That may be an efficiency measure. It may be a stinting measure.

MR. HACKBARTH: Has there been any research that sheds any light whatsoever on the quality issue?

DR. SEAGRAVE: I haven't seen any specifically

looking at the quality issue. We are planning a study that we're very excited about beginning basically immediately using the SNF episode database to try to look at some of those issues. We can get back to you.

MS. DePARLE: What about the MDS data?

DR. REISCHAUER: The information that they've put on the web for individual sites --

MS. DePARLE: Yes, the minimum data set.

DR. REISCHAUER: That gives some kind of feel, not over time, but certainly --

MR. MULLER: When the skill mix change occurred in hospitals about 10 years ago, a substitution of RNs -- substituting other aides for RNs -- there's now 10 years of history on that and studies and I think the evidence on that is that there was a diminution in quality. It had an upward effect on mortality rates. So that's a different setting and hospital RNs start at a higher skill mix than you would typically see in nursing homes. You don't have as high a number of -- proportion of RNs in nursing homes as in hospitals. But there was that effect on quality. Again it took seven, eight years to be shown by quantitative analysis.

DR. ROWE: I think with respect to the concern about quality, I think we should be mindful that quality problems occur in overuse as well as underuse, and that there may have been a financial incentive to deliver these minutes of rehabilitation treatment. We're up to a pretty exhausting number of minutes per week for an elderly Medicare beneficiary skilled nursing facility resident. We're up to how many minutes in that top plateau? What was it, 700?

DR. SEAGRAVE: Over 720 minutes.

DR. ROWE: Over 700 minutes a week of rehabilitation therapy. There was an incentive to provide a lot of rehabilitation and maybe that was a good thing because maybe it was needed, but also there may have been some overuse as well and we should be mindful of that.

MR. DeBUSK: I have two questions. One going back a ways. Where's CMS at with RUG reclassification reform?

DR. SEAGRAVE: They've been a little tight-lipped on this issue recently, but in the rule that they issued this past July they indicated that they had come close to recommending I guess you could say, an improvement to the

RUGS, but that they had pulled back because they needed to review and assess the implications of it. So they're required to provide a proposal on this January 1st, 2005, and we really don't know at this point if they're planning to do anything this year or if they're going to wait until 2005.

MR. DeBUSK: The second question, on draft sharp recommendation two it says remove some or all of the 6.7 percent add-on currently applied to rehabilitation RUG-III groups and reallocate some portion of the money to the non-rehabilitation RUG-III groups to achieve a better balance of resources, et cetera. You said this is spending neutral. Would that be giving it all back?

DR. SEAGRAVE: We would leave that up to the Secretary basically to propose the best way to reallocate the money. I guess our thinking was that they would probably not give it all to the non-rehab groups.

DR. MILLER: No, I think in the recommendation you have spending neutral because at this point we couldn't judge specifically how much and whether all of it should go. I think our presumption is, in the absence of other information, it all stays within the system. But I think

what Suzanne is trying to say, if for some reason through the process of whatever analysis the Secretary were to go through and reach some other judgment, that might be a different outcome, but we're not proposing that outcome.

Is that a fair assessment?

DR. SEAGRAVE: Yes, that's exactly right.

MR. HACKBARTH: So can I just add a word on this, Pete? So our long-standing position has been that there's some fundamental problems with the RUGs system, and it would be our recommendation that it be replaced. Recognizing, however, that development of a new system, implementation, is a very long-term project, here we're making a recommendation for a shorter, quicker fix, if you will, for one of the fundamental problems that we see. That the sickest patients maybe are getting too little money going with them and some of the others are getting maybe a little bit too much.

That would seem to me to be a budget neutral exercise. The purpose is not to withdraw those dollars from the system.

MR. DeBUSK: Suzanne, you mentioned January 2005 that by law we're required to have a new classification

system for the SNF piece. Wasn't that for some kind of a new system at that time across the post-acute as a unit?

DR. SEAGRAVE: Yes. It's both. They're supposed to propose both in January 1st, 2005.

MR. DeBUSK: That's confusing.

DR. SEAGRAVE: I agree.

DR. KAPLAN: The other mandate is not a new system. It's a new way of measuring health status and functional status, not just across post-acute care but across the entire continuum of health care, including hospitals. But the SNF is to test and report on alternative classification systems for the SNF PPS. So it's two reports that they're required to do.

MS. RAPHAEL: This may sound like the X, Y, Z affair from late 1790s but I remember a presentation, Sally, that you did which I think included X, Y, Z. You had recommended that we keep either -- it was either X, Y, or Z.

DR. KAPLAN: It was Z.

MS. RAPHAEL: So I'm not trying to correlate the X, Y, Z affair with current recommendation and I'd like you to first address that and then I have a few other comments.

DR. KAPLAN: It's was Z, purposefully chosen so that it would be the last add-on ever. Is Z add-on, we recommended it be kept, and it is, until CMS refines the RUGS. So it is still in effect and it will be in effect until CMS says the RUGS are refined.

MS. RAPHAEL: By statute.

DR. KAPLAN: That is by statute, that's correct.

MR. DURENBERGER: For the rest of us, what's X, Y, and Z?

DR. KAPLAN: X was a 4 percent increase across the board that expired on October 1, 2002. And Y was a 16.66 percent increase to the nursing component of the RUGS rate which expired on October 1, 2002. And Z was 20 percent add-on to the non-rehabilitation groups that are usually found in Medicare, and a 6.7 percent increase to the rehabilitation groups.

MR. DURENBERGER: I don't think I wanted to know that.

MR. HACKBARTH: Dave, one important thing to remember for this discussion is, the Z add-on related to refinement of the RUGS is still in place and we're suggesting a way to reallocate those dollars. The X and

add-ons expired as of the beginning of the fiscal year. So as we speak they no longer exist. And we do not recommend the restoration of those.

MS. BURKE: Do we not -- to Dave's point -- for someone who's reading the document -- not need to mention -- reflect on and that history?

DR. SEAGRAVE: Your mailing materials don't yet have the recommendations and the whole text around the recommendation --

MS. BURKE: So you'll reflect on what --

DR. SEAGRAVE: We certainly will discuss that.

MS. RAPHAEL: I believe we do need to have a recommendation that somehow captures the need to take a look at outcomes. I don't know that it needs to be new studies. There may be enough that we can draw on to get some preliminary sense of what's happening as a result of this substitutability. So I don't know quite how -o shape it, but I think that is an important area that needs to be explored. As important as the issue of access, where you do have as your last recommendation that we continue to study and really see what we can cull from the recent public disclosure and other measurement systems on the

outcome side.

DR. KAPLAN: ASBE actually has two studies that are going on. It's one study; it's a different point. One of which is being done with the University of Colorado as the lead on it, I believe. They are looking at quality indicators that are risk adjusted, preventable rehospitalization. And I believe they're looking at functional status increases, decreases, et cetera, as well. They are developing indicators also across post-acute care for SNF, home health, and rehab. It's just not there right now. We're a little bit behind.

MS. RAPHAEL: I'm trying to grapple with the extent to which a change in product is correlated with a change in population. I'm wondering if we know anything at all about how the population in nursing homes has changed. We're a making certain assumptions that the percentage of people who come just for rehab has increased. But do we have any data at all that would take a look at this?

DR. SEAGRAVE: We're starting to see some indications. This is all preliminary and anecdotal and that sort of thing, that SNFs are being more selective in the types of patients that their taking. From that

standpoint, we think that the population in SNFs is probably getting more selective. But I don't know that we'll have this data really in a quantifiable form for the March report.

DR. NELSON: Didn't that come from your discussions with the discharge planners?

DR. SEAGRAVE: [Nodding affirmatively.]

MS. RAPHAEL: But there's no way of looking at the MDS and seeing the characteristics of the population today versus several years ago?

DR. KAPLAN: We can only look at post-PPS. But we can look at the episode database that we're building for the June report, to start at least with the June report, will have back to 1996. With what's available in administrative data, we'll be able to compare populations. But we won't have MDS data back that far. So it's like we can look at how things have changed since PPS started. We can look at, with the variables that are available on the administrative data, which does not include functional status which is believed to be really crucial in the SNF area, pre-PPS said post-PPS. So it's a dilemma.

But we do have this matched data set that Suzanne

referred to which is called the DataPro, which does have the MDS, does have the claim, does have the cost -- I believe has cost report, or we can match cost reports, and has the OSCAR data, the survey and cert data attached to it. So it's going to be a rich data set, but only beginning with PPS.

DR. NEWHOUSE: First, I'm comfortable with our recommendations. The system, I think would be hard to explain to the men from Mars, but it seems to be one of those that on the whole is working tolerably well in practice even if it doesn't work in theory.

I would like to echo Bob and several of the others on productivity. We just can't say that we have no evidence on quality or outcomes and we also have imperfect case mix controls, as your functional status comment indicates, and then go on to say that we can say anything about productivity. Productivity is for a constant product. It's just a non sequitur.

The other small comment was a comment on the exchange between Jack and Bob on the overuse -- people in the top group and so forth. There presumably are some patients out there who would be in a rehab but are in fact

in a SNF because there isn't any convenient rehab nearby. Those people are supposed to get three hours a day if they were in a rehab, so that would certainly put them into a 700-and-more minute group.

DR. ROWE: Patients with spinal injury you who are past the acute phase of their rehab and get relocated from rehabilitation hospitals to SNFs with good rehab programs would be getting several hours a day of rehabilitation. I'm not suggesting those patients don't exist or benefit from it, but it's just worth thinking about the fact there may have been some overuse there.

DR. WAKEFIELD: Two quick questions. You went through it quickly so if you wouldn't mind restating it. The 26 percent of hospital-based SNFs that have exited the program, it seems to me you were suggesting that those were concentrated in a relatively -- if I understood you correctly -- a relatively small number of counties. So will you comment again on what constitutes, or what we know about that 26 percent of hospital-based SNFs that have exited?

Second question, of page 8 of the handout, on the relationship of Medicare SNFs payments to cost, you're

going to come back with, you indicated, with hospital-based margins for 2000 and '03 estimated. Is there anything that would drive differences across hospital-based SNFs that would make it worth cutting those data by rural versus urban or not?

DR. SEAGRAVE: I'll answer your second question first, really quickly. I think we were hoping to cut hospital-based SNF margins, if we can, by urban and rural. We just won't know until we are able to do the margin data for those, but we certainly wanted to look at that, if we can, at all possible.

The hospital-based SNFs that exited were largely in the Pacific region. They were largely on the West Coast. So from that there is sort of a regional component to that.

We are planning to look at that with rural and urban cuts, and freestanding versus hospital-based as much as we can possibly get into the data, and we'll definitely bring you as much as we can get with that back in January.

MR. HACKBARTH: I might just introduce a question or a comment upon the terminology that we use. I think in the paper, and maybe also in the presentation, we

characterized the access to capital as being good, including for hospital-based SNFs because they can get capital through the hospital. That's struck me as an odd thing to say when there are major withdrawals from the business. So the parents are taking capital out of the business and reallocating it to other purposes.

So I'm not arguing about the freestanding piece at all, but when you have a shrinking business, that doesn't sound like access to capital to me. It sounds like the capital base invested in it declining.

DR. REISCHAUER: Whether the decisionmaker, the hospital, can have access to capital to spend either wisely or foolishly, and since the full faith and credit or whatever of the hospital is at stake, it doesn't matter if --

MR. HACKBARTH: But apparently it represents a business judgment, if you look at the hospital as the potential supplier of capital, that this is not a good business to supply capital to.

DR. REISCHAUER: Presumably the hospital that is making a decision to expand its hospital-based SNF is facing different circumstances than the average here which

we're looking at.

DR. NEWHOUSE: The hospital has a better use for the capital than the freestanding. But that doesn't necessarily -- I think that's all it says. I'd also say on the urban and rural on the hospital side, that goes back to my accounting comment from before. I think the question really should be framed as, is there anything systematic in the payment system that differentiates urban and rural hospital-based versus urban and rural freestanding, since the margins are the same on urban and rural freestanding? I don't know of anything that there is, but there could be. If there isn't anything then I think the fact that they're the same on the urban and rural freestanding is a fairly compelling piece of evidence.

DR. SEAGRAVE: One other thing that -- I knew there was something that I forgot to mention regarding your question. The freestanding facilities tend to be much larger in terms of number of beds than the hospital-based. So that's one of the reasons for the finding of the 75 percent of counties and the 25 percent of counties. That's one reason for the finding.

MS. DePARLE: I was wondering if, in looking at

the decline in the number of hospital-based SNF beds if you had seen any correlation between that and the transfer policy for inpatient hospitals and the introduction of that?

DR. SEAGRAVE: I think we're interested in that issue. I'm not aware of anything that has been able to look at that specifically. We may look at that.

MS. DePARLE: Remembering back to the period that we were implementing that, it just stands to reason that that might have been one of the reasons why hospitals -- that plus the introduction of the PPS for SNFs, might have combined to cause that.

Secondly, to go to Carol's point, I agree with her that it's crucial that we begin to try to look at what the outcomes are here. But I also now am not clear about our recommendation, because the BIPA and BBRA increases were four 14 rehab groups by 6.7 percent and 12 complex care groups by 20 percent. So is the recommendation, does it encompass both the 6.7 percent and the 20 percent, or is it only the 6.7 percent?

DR. SEAGRAVE: No, we would be saying nothing about the 20 percent. In effect we would be leaving the 20

percent the same as it currently is.

MS. DePARLE: So the 6.7 percent, the recommendation would be that, not withstanding whatever happens on refinement of the RUGS, our recommendation is that remove some or all of that now to apply it to the non-rehab RUG-III groups, and as to the 20 percent, we have no recommendation on that?

DR. SEAGRAVE: Yes.

MR. FEEZOR: I just have a little bit of the same problem that I think the other Alan has in looking at the evidence presented. Part of it may be because we're a year or two lag. What I'm at least observing going on in the market in California, to the extent that -- and I guess I would simply like, as you narrow on the estimates of the margins for 2003, I'd like to see particularly drawn out what your conclusions are with respect to workers comp costs and malpractice costs. Those two components are really spiking, at least in the market that I'm a part of. That plus state Medicaid problems we have causes some problems at least locally. So if you could just make sure that you try to capture that spike.

DR. NEWHOUSE: Can I jump in and go back to

Nancy-Ann's question and ask why we're not including the 20 percent?

DR. MILLER: I think this is really just a semantic point, if I'm following this correctly. We're saying that there is a 6.7 percent for rehab. We're saying that we still feel that the RUG system distorts payments in the direction of rehab patients as opposed to extensive patients. There's the refinement piece that sits in the law, but for whatever sets of reasons the agency has not gotten up to the point of saying, I can declare this is how to recalibrate the RUGS.

So what we're saying is that while that continues to be thought about, reallocate some, or a portion, or all, whatever the case may be, of the 6.7 to the extensive patient RUGS. What we're talking about, our recommendation is on that 6.7 percent only. Implicitly we're saying, leave the 20 percent there. Is that the right characterization?

DR. SEAGRAVE: [Nodding affirmatively.].

MR. DURENBERGER: I apologize for being late but I couldn't come out until this morning and then the plane was delayed.

I have to begin my comments, because I have a couple of comments and then a question. I chair an organization for the last three years called Citizens for Long-term Care and it's a group of people that have lots to do with long-term care from insurance companies to providers of care. I just want to get my bona fides out.

The impression I have of what is going on in the SNF area, at least in the areas with which I am, Allen, anecdotally familiar, is that utilization of the SNFs, except for some of these specialized cases we talked about is flat and declining. In other words, it's just -- the capacity out there that existed when we could afford it, or they're weren't alternatives, is going unutilized. So there's a lot of capacity out there right now, and I'm going to get to that as it relates to capital a bit later.

The reality is that in many states one of the issues the state Medicaid folks are dealing with, and legislators, are the issues of how do we close or change beds, and/or freestanding facilities? In my own state of Minnesota in the last couple years under Governor Ventura they made a deliberate effort to use some Medicaid money to pay down some of these unused nursing homes in order to

keep the used part of an organization going. Evidently, they found it to be a wise investment of those kinds of money.

Many people have also found that hospitals, as we may or may not -- I guess we're aware of it -- are finding other things like hearts and orthopedics and a lot of other things more attractive in the current market. Not necessarily three years ago or nine years ago or whatever. But in the market they're finding other uses for those beds much more attractive than using them for SNFs. And at least some part of the 26 percent, I would suggest and I'd love to see this, is more than regional. That it is probably fairly widespread. It certainly includes my part of the country. That hospitals are just deciding they don't know how to run SNFS as well as some of the folks whose specialty it is, so they're getting out of the business.

So that conclusion that I draw from that, and I would love to see a reaction to that either now or in the final report, is that we are in the process of change. And that this change is going on probably to varying degrees all over the country. We're moving from a combination of a

hospital and a freestanding to something that is going to be very much the so-called freestanding. That's the first point.

The second one relates to Medicaid. Medicare appears to, and I believe Medicare does overpay for skilled nursing. So I don't disagree with that part of it. But I think we all know that Medicaid not only seriously underpays but it's getting a whale of a lot more serious.

So that if you look in parts of the country in which alternative access is not quite as available as we might like to see it, in this transition period in which we are living, I would like to argue, and I'll do that between now and January I suppose, that a little bit of overpayment, looked at from the standpoint of my mother or whoever else is benefiting from the system, that a little bit of overpayment in a time of transition by the Medicare program -- since we pay for lots of other things like overproduction of certain kinds of medical professionals perhaps, or whatever else the case may be -- that a little bit of overpayment, if in fact we are in a time of transition, given what's going on on the Medicaid side, is not necessarily a bad thing. It might even have been

anticipated by CMS when they did some of the add-ons. I do not know that for a fact.

The last thing I said does relate to the issue of capital. There's a reference to the National Investment Center study which I have not looked at. I know who they are; I've not looked at them -- says that there doesn't seem to be a great need.

My impression is different. My impression is, as reflected by the example in Minnesota of buying out nursing home beds, that the average nursing home -- not the new one, but the average nursing home in America is probably 30-plus years of age. For the owners, whether they're for-profit or not-for-profit, to redesign those facilities, particularly in areas where there isn't any other choice, is very costly.

But the only way to get capital these days is to be able, somehow or other, to combine your net income with your cash flow so that you can afford the debt service. I didn't see a discussion of that kind of relationship between the aging of the "SNF stock in America" and the ability or predictable ability, given what's going on in both the Medicare side, and the Medicaid's side, and

private pay side, to finance it. So I didn't think it was just an issue of capital markets but perhaps more an issue of not having the capacity to make the decision, which is part of the discussion I think the two of you were having.

I don't know the real answers to any of these questions. I'm simply raising them because these are the concerns that I've learned to have just in the last couple of years.

MR. HACKBARTH: Dave, can I pick up on the point about Medicare temporarily subsidizing Medicaid? That concept makes a me a little bit uneasy, particularly in these circumstances where Medicare represents 10 percent of the facilities' revenues. So we're talking about the Medicare program assuming responsibility for financial stability in an industry when its base of payment is quite small.

A second concern that I have is whether Medicare stepping up and subsidizing Medicaid aids transition to better Medicaid policy or inhibits it. I guess I spent enough time in HCFA to be worried that when Medicare pays more, if the states have an opportunity they'll say, good, Medicare has assumed responsibility for this, we'll pay

less. As opposed to saying, this gives us time to figure out how to step up to the plate and pay more. So I wonder whether in fact this subsidy would help a transition or impede it.

MR. DURENBERGER: Thank you. I don't know the answer to it but it suggests a discussion we had on Monday when the board of citizens was together. One of the members of the board is Bruce Vladeck, and Secretary Thompson was meeting with us and we were talking about the future of long term care. Number one, we don't lobby. We don't advocate various -- the only specific position we advocate is the whole system ought to move, in long-term care, from a Medicaid or welfare-basis system to an insurance system, combining social insurance arts and private insurance. That's our only shtick, so to speak.

But in this discussion, interestingly, Bruce pointed out this tension has always existed between Medicare and Medicaid, and you just articulated it very well. What he said to the Secretary, let's take something like the dual eligibles, the 5 million folks out there who are the victims, if you will, of this tension when state budgets are going down, and why don't we concentrate on

that population or on that group of people and see if there isn't a way, since we're dealing largely with public dollars on both sides, total federal funding in the Medicare program and majority federal funding on the Medicaid program, why don't we look at this from the eyes of the people that are involved and try to figure out why we can't do a better job of blurring that programmatic distinction? So it's in that spirit that I raise it, not that I'm advocating that one program subsidize the other. That probably doesn't look like good language.

I'm just trying to deal with the realities that exist in America today. So I just wanted to get it on the table so that between now and January I can be better informed about what we can say so I can be a better contributor to the solution. But that's where I'm going to come from, I think.

MR. HACKBARTH: These are important topics and we could easily spend much more time going over them. Unfortunately, we do have a lot of other important topics that we need to get to. If I may, I'd like to use the chairman's prerogative just to ask a couple additional questions.

The issue about whether the change in the mix of input, the mix of staff, for example, is hurting the quality provided I think is an important issue that's come up in this conversation. I'm not sure what we can do to answer that in the next month, but it is an important issue.

It leads me to a question. We do have an industry that because of the advent of PPS experienced a significant increase in payments. So we have the rise up. Did they use the additional money to add RNs and other staff? What's that side of the curve look like?

DR. SEAGRAVE: As you probably know there's all lot of controversy about that right now. GAO has come out with a report very recently that said that the additional money that they got from BIPA particularly, did not necessarily cause them to increase staff very much. However, the industry has come out with some evidence just very, very recently that they think shows that it has actually increased staff a lot more than particularly --

DR. MILLER: Isn't the point that the industry believes that the staff increase is larger than what GAO argued?

DR. KAPLAN: Yes. GAO said that they increased staff 1.2 minutes, I believe, per patient per day. And the industry claims that they increased it 2.8 minutes per patient per day.

MS. BURKE: Did the mix of the staff change? Did they in fact begin to replace the decline in the number of RNs as compared to staffing, or do we know?

DR. KAPLAN: I don't think we know that. I think they looked at total staff, total nursing staff.

MR. HACKBARTH: I hate to cut off discussion on this but we're -- the chairman is not doing a very good job keeping the trains running on time. So we really do need to turn to our next topic. Nick and anybody else that I'm cutting off, if you have questions, please feel free to talk directly to Suzanne, Sally, or use e-mail or alternative means. I apologize again for having to move on, but we do.

Thank you very much

Next up is home health services.

MS. CHENG: My presentation on payments for home health services this morning is the second in a series of three. Last month I gave you some background and examined

several market factors that provide evidence about the adequacy of payment. Today I've got three things I need to do. I'd like to review that background on the sector, and including in that review MedPAC's recommendations from the March 2002 report.

Second, I'd like to introduce two estimates that we have, and I'm going to have to choose my words carefully, recent payments and costs.

Third, I need similar input on my methods, conclusions, and the two draft recommendations that I'm going to present to you this morning. In January, we'll come back to this. We'll review the material as a whole and make final recommendations for a chapter of paying for home health for the March 2003 report.

By way of background on the home health sector, you'll recall we spent about $10 billion on home health services in 2001. There are 2.2 million users of the benefit in that year, and there are about 7,000 home health agencies. Recently, home health has had declining spending, however, current projections believe that that decline will stop and then actually turn around, and that action average increase in spending from 2002 to 2007 will

be about 17 percent per year.

The second bit of background are MedPAC's actions on home health. In our March 2002 report we made recommendations that were intended to promote stability in the face of uncertainty. We recommended that Congress eliminate the scheduled cut in payments, that they update payments by the full market basket, and that they extend for two years the add-on payment that is provided for services for rural beneficiaries.

At this time last year when we were developing those recommendations, the PPS system under which we're currently operating was still fairly new. We had no post-PPS claims. We had no cost data from the PPS. In fact we were still learning about the effects of the payment system that had preceded the PPS. The size of the scheduled recommendation at that time was still unknown, and response of providers to any kind of bottom line had yet to manifest.

Uncertainty on this sector has been diminished over the course of the past year. In June, CMS gave notice that the so-called 15 percent cut was to be a 7 percent reduction in payments. In August, the first full year of

post-PPS claims data became available, and in September CMS processed the first post-PPS cost reports.

Further reducing uncertainty is the passage of time. Two very important indicators, entry and exit, and access to care, have had time to be affected by providers who have had a chance to look at their bottom line from at least a year of PPS experience and to make decisions based on their current condition. We find currently that entry and exit is stable and that good access to care has persisted.

Finally, since March we've been able to use some of the data that's come in to make estimates of recent payments and costs, and these estimates suggest that payments may be more than adequate.

From that background I'd like to move on to the first part of the payment adequacy framework. As you recall, these are the market factors that we use to estimate the relationship of payments and costs. You'll see on the screen the list of the market factors that we're considering from the framework, and last month we discussed that entry and exit has been stable for three years. There continue to be about 7,000 agencies in the program. And

that access, according to our panel of hospital discharge planners, is generally good. I'll go into a little bit more detail on the final three market factors on this slide.

First, changes in product. This is just so essential to understanding what's going on in home health, because the product has been changing over the period that we've been examining it. Home health product has changed from the low intensity maintenance of consistently ill people over a longer period of time, to a higher intensity recovery, generally from an acute illness or injury. Now this change is a response that was anticipated in the BBA changes in 1997. Certainly the reduction in volume was an intended consequence, and the refocusing of home health on post-acute care.

The evidence that we have that the product has changed are the decline in the visits per episode. In 2001 there were 40 percent fewer visits per episode. The length of stay, which I calculate as the number of days between the home health admit day and the discharge day, has fallen 60 percent. And the mix of services has also changed dramatically. There's far less aide and a good deal more

therapy service in the average episode.

These changes in product, coupled with the decline in the number of users, has had a substantial impact on the total volume of services provided that fell from around 250 million visits delivered in 1997 to around 75 million in 2001. While we can put a number on that change in volume, what we don't know is whether or not it's had an impact that we can directly relate to volume on quality.

One of the key factors that keeps us from drawing that link and drawing that link strongly is the fact that the home health visit continues to be something of a black box. Although our data allows us to describe the visit according to who provided that visit, nurse, therapist, or aide, what we don't know is what happened within that visit. We know that a nurse provided a visit but we don't know if he or she changed a wound, made an evaluation of that patient's condition, or perhaps spent most of the time with a caregiver instructing them on how to best care for the patient. So without that knowledge linking quality and volume continues to be very illusive.

Though it is illusive, there is some good news on

that front as well. CMS and others had started to investigate using the OASIS which has come in, again, post-PPS, so we won't be able to look back very far. But we may be able to use OASIS outcomes data to try to see if we can establish any kind of link between volume of visits and the quality of the outcomes.

This last market factor I'd like to review, I'm especially referring to this market factor in response to several of your questions from the last meeting. At the last meeting I suggested that access to capital for this sector does not provide a great deal of evidence about the relationship of payments to costs. So I've spent some time looking into the capital needs for the sector.

When you look at the market basket for home health it's pretty clear that most of what home health agencies are purchasing to produce their services is labor. Fixed assets and equipment in fact are only 2.6 percent of their total basket. I also looked at the Polisher study. This was a study that was focused on the impact of PPS on the financial condition of home health agencies; especially on their financial condition. This study noted that OASIS data systems, computerized billing systems, and

administration were the significant capital needs for home health agencies. However, I'd like to note that HCFA added OASIS start-up costs in the IPS payment, and CMS added a one-time OASIS and continuing OASIS payments to the PPS episode payment.

The access to capital in this sector is more influenced but the relatively small size and low capitalization of a home health agency than it is by the relationship of Medicare's payments to costs. So I've returned to my initial suggestion that access to capital does not provide a great deal of evidence about relationship of Medicare's payments to costs.

In our framework for assessing payment adequacy we add estimates of current or recent cost and payments to the market factors that we have on had. This morning I'm going to present two estimates that I've made about the relationship of payments to costs.

My first estimate is based on a sample of claims. I used a standard 5 percent sample of home health beneficiaries. This yielded about 200,000 episodes. I included all types of episodes, even those that were adjusted for very low utilization or for high cost

outliers. The outcome of that research showed that the ratio of aggregate payments to aggregate charges for home health rose from 1.031 to 1.12 between January 2001 and June 2002. A ratio higher than one suggests that since 2001 Medicare has paid more ,in aggregate, for home health episodes than the charges for visits, drugs, and medical supplies.

Now from this analysis we can't get directly at the ratio of payments and costs because we don't know the ratio of charges to costs. Conclusions that we could draw from this analysis have to be based on two assumptions. First, that charges are higher than costs. And second, that the aggregate ratio of charges and costs does not vary wildly behind our period of observation.

The evidence that I have that assumption one might not be too far off the mark is that agencies were paid the lesser of costs or charges under the previous payment system so there was a pretty strong incentive to set charges that would at least cover your costs.

Second, that the aggregate of ratio of charges to costs has varied too much seems to be borne out by a look at some historical data, and comparing that to current

payments for LUPAs. This is when the Medicare program, instead of paying an episode payment, paid agencies per visit by visit type, much like it did before the PPS. When we look at the payments when it pays per visit by visit type, the payments to charge ratio is almost the same is the payment to charge ratio was in 1994 Kaiser study, and a 1997 study from HCFA's chart book. In both 1994 and 1997, the payment to charge ratio was about 0.74 and continues to be about 0.7 for those visits paid per visit by visit type.

MR. HACKBARTH: Sharon, just for the sake of clarity, this particular overhead or slide has nothing to do with cost even though it's labeled cost? We're using what is a different metric for us, payment to charge ratios because we don't have the cost information. And you're making some assumptions about the historical relationship between payments and costs?

MS. CHENG: That's right.

MR. HACKBARTH: You're assuming that they stay constant. Actually I'm not quibbling with that, just to be clear. But since we're using a different metric than the commissioners are used to seeing, I just wanted to highlight that we are and the reason is the absence of cost

report information.

MS. CHENG: That's right. We don't have any direct evidence about the relationship of payments to costs looking at the relationship of payments to charges. I've offered my two assumptions.

MR. HACKBARTH: I think they're very reasonable ones myself. So again, I want to emphasize I wasn't trying to quibble with you on that, but just trying to clarify things.

MS. CHENG: But I would like to suggest as we move from this slide, that I feel this is evidence that payments recently, at least adequate or more than adequate when we compare them to costs.

For my second estimate of payments and costs I looked at reported costs. This past summer GAO also examined reported costs. In their report they estimated that the average episode payment of $2,700 was $700 above the average episode cost in 2001. That would yield an overpayment of about 35 percent. GAO concluded in their report that the magnitude of the disparity between payments and estimated costs demonstrated that a reduction in payment rates would not harm the industry, and the

reduction that they had in mind was a so-called 15 percent cut.

For our estimate I also began with 1999 costs. I divided the total costs into fixed and variable, and inflated both by the market basket for 2000 and 2001. Next, I applied that estimate of market basket adjusted variable costs to the number of visits by type of visit in 2001 to account for the change from a more aide-oriented visit mix to a more therapy visit mix. And finally, added the fixed and variable costs to estimate total costs.

In making this estimate I also applied two assumptions, and the assumptions in this model that I applied, I hoped to find the largest likely increase in cost over this period. I assumed that fixed costs did not decline at all as volume decreased, but instead rose by the full rate of the market basket. I also assumed that variable costs per visit rose by the full rate of the market basket, and that productivity had no impact on the cost per visit.

Using my data and these two assumptions, my results indicated that costs from 1999 to 2001 fell by 16 percent. The primary driver behind that decrease in cost

was a decline in total volume as the visits fell 31 percent over the same period. Over that same period payments rose between 10 and 30 percent.

Several caveats are obviously warranted, and for this model particularly I can't account for changes in the visit itself. If the visit got longer, activities performed during the visit changed, or supplies used, that certainly could have had an impact on the cost per visit that I would not be able to capture in counting the number of visits.

I also can't include regional variations which very likely would change these results from area to area around the country. And I can't relate these results directly to margins for agencies because I don't know the case mix or the episode types by agency.

However, given those caveats, the data and the model, I feel that this estimate also suggests that payments are at least adequate or more than adequate.

Moving from the first to the second part of the framework, I'm going to look at changes in cost for the coming year. I believe that costs will increase, but not as rapidly as input prices. Visit volume will continue to

decline and will offset the shift from aide to therapy services. I based that estimate on the changing cost estimate that we just reviewed and I have no evidence to suggest that the trends that we've seen will not continue into the next year.

I also believe that any productivity gains would be partially offset by cost-increasing, quality-enhancing technology. The industry has been adopting some new technologies that we believe might be more costly but would enhance patient quality. Examples of these would be new wound vacs and other wound dressing technologies, and also telemonitoring equipment that has been adopted by the industry.

Now we'll combine parts one and two of the framework. Based on new data that has removed some uncertainty since last year, market factors that suggest at least adequate payments, and estimates that current payments and costs are more than adequate, we would move from Part 1 with a suggestion for a negative factor for the update. In Part 2, costs may rise but not as fast as the market basket, which would suggest a small positive factor for the update.

The draft recommendation that would flow from this application of the framework is that the Congress should eliminate the update to payment rates for home health services for fiscal year 2004. The current law update for 2004 would be the full market basket which was recently estimated at 3.2. We'll have the most current estimate of the market basket for you in January.

Compared to current law, the budget implication would be that this recommendation would decrease spending. Over one year it should produce savings between $200 million and $600 million, and over five years between $1 billion and $5 billion in savings.

My second draft recommendation is much like Suzanne's recommendation three. That the Secretary should continue an excellent series of studies on post hospital discharge access to home health services. This would not affect Medicare spending so the budget implication for this has been labeled as none.

Before I close I'd like to briefly comment that this package of draft recommendations does not revisit the recommendation that we made in 2002 about the extension of the add-on for rural payments. Right now we do not know

more about the relationship of current costs and payments for rural providers than we did at this time last year. We're still looking at recently received data and if we've got some data that we can apply to this question we'll certainly be bringing it to you as quickly as possible.

However, what we do know about current costs and payments for Medicare home health agencies suggests that payments are more than adequate for home health agencies generally. Rural agencies may not be doing as well under the PPS as urban ones because of size and issuance of travel, but if they're doing only half as well, it is likely that they are still at least adequately paid.

Evidence about post-PPS access suggests that rural beneficiaries are getting home health services. The OIG found that urban and rural discharge planners were able to place beneficiaries in home health at equal rates. Our discharge planners noted several special steps that hospitals have used to obtain home health care for rural beneficiaries. Much of the care delivered to rural beneficiaries comes from urban agencies, so the effect of some rural closures may be partially mitigated by the service area of urban agencies.

We have no evidence to suggest that rural home health agencies would be disproportionately affected by our recommendations. Thus we conclude that the need to extend the add-on for beneficiaries in rural areas is much less clear this year than it was in March 2002.

MR. HACKBARTH: Before we start the comments, let me just make an announcement for the people in the audience. Because we're running behind, I'm going to have to shift the public comment period to the end of the day. I apologize for that but we're going to need more time, obviously on home health, and then we have to allow a little time for the commissioners to have lunch and make phone calls. So there will be a public comment period for people to make comment on SNF and home health but it's going to occur at the end of the day, not at the end of the morning session.

DR. NEWHOUSE: I wind up thinking whatever we're going to do here it's going to be through a glass darkly.

Let me try to say what I take away from this at a very high level of generality. First, it seems to me the way you characterize this, it's very reminiscent of the initial implementation of the hospital PPS, where there was

the big fall in length of stay. In general we seem to be content with what the hospitals were doing after the fall in length of stay. Their margins went up with the fall in length of stay and we said, lower the updates, take the margins back.

Now that, of course, is predicated on that we were happy with the bundle of services that were being delivered after this. So my second reaction was that we were leaning awfully heavily on the access findings from the OIG and our own hospital discharge planners. I thought we were probably leaning too heavily on them because I think the access planners, or the discharge planners can tell us reasonably about placement, but they can tell us so much about what happens once you're placed.

The improvement in financial performance is largely what's going on after you're placed. It's the fall in the number of visits. So I wasn't that reassured.

And the second reason I wasn't that reassured was that -- I haven't seen any recent data. The last time I looked at these data some years back, about half of the visits were from people that were coming into the system without a hospital stay. Presumably, the hospital

discharge planners weren't telling us anything about that group, either getting them into the system in the first place, or what happened once they got there. So I think, at a minimum, if we're going to talk about access is good, we need to qualify that.

But then my third reaction was that this a system that strongly incentivizes the home health agencies to reduce the number of visits once you're over four, because you don't get anything for it and you incur costs.

So my third reaction was, even if we were unhappy with the number of visits, or the people getting in, if we gave an update, it wasn't going to change those incentives. So that given the system we're in, which I personally am not too fond of, I can actually rationalize my way to saying that payments are adequate now and I'll hold on -- because I haven't given as much thought to the update itself given where you are on Part 1. But it seems to me a lot of what's going on with the final recommendation drives off of what's happening with your Part 1, if payments are more than adequate.

MR. HACKBARTH: In this case, if these numbers are at all an accurate representation, any reduction in

what's going into the product is not financially the result of a lack of resources. It's due to the basic incentives in the system. So throwing more money into the system wouldn't yield more good things, whatever they might be.

MS. RAPHAEL: I have a couple of comments. First of all, I'm speaking from my own experience here. I have not done the yeoman task that Sharon has done in trying to reconstruct some semblance of a database here in the absence of cost information. But the average national visits now or 20 per episode. For my organization, our average visits are 32 per episode and 44 for dually eligibles. I must ask myself, how come, when all the incentives are directed otherwise?

We believe that the whole OASIS system very, very much measures the need for skilled service and inadequately measures functional impairment levels. It's very often functional impairment levels as well as the absence or presence of family that determines what you actually have to do here. So that what we're experiencing does not to resemble what Sharon is presenting here. So that's something that just really worries me.

Secondly, what doing we know about quality? We

benchmark ourselves, and 20 percent of -- I believe that 20 percent of home health care cases are readmitted to the hospital within -- I don't remember but I think it's within 30 days but I'm not sure. And a certain number, that I think is high, end up in ERs. If we're creating a system where people end up getting readmitted to hospitals at higher rates and going to the ER -- and I was very interested in the chapter that we have on patterns in the ER -- then I don't think that's a desirable outcome. I just don't feel that we're sure-footed enough in this area.

Thirdly, my labor costs are in the cost of about 80 percent, comparable I think to other home health agencies, and I don't have much substitutability. Unlike in the SNFs, which I'm very interested in, I really can't substitute lower-cost labor for higher cost labor. We do not use LPNs. We don't use much occupational therapy or physical therapy assistants. So my labor costs are not malleable. In fact my labor costs are going up by 6 to 8 percent a year because I have to deal with shortages, and I have to compete with hospitals which set the marketplace price for these services.

I currently have 90 vacancies nurses. I'm paying

a bonus of $6,000. Some of my competitors are paying $10,000, so I'm not even competitive in the bonus arena. So that's what I'm experiencing in terms of what's happening to my view of where I can go in the future. I'm trying to also correlate that with what we're going to be recommending in the update.

Then I have a problem with that last recommendation, I guess akin to what Joe was saying. Once again we're relying of the hospital discharge planner. The fact of the matter is that the whole mix of people coming into home care is changing. I have 20 percent of the people referred by physicians. I have more and more people coming from nursing homes. Now almost 10 percent of the people coming into home care come after a subacute short term rehab stay in a nursing home. So the whole continuum of care, if you want to use the word, is changing dramatically and we're still going back to hospital discharge planners to look at access. I just don't think that's the way we should be framing this whole issue.

I guess the last thing that I would just mention is, I have very, very high costs for biopreparedness and business continuity, and HIPAA. Right now I have people in

Atlanta working on administering the smallpox vaccine to our 68 hospitals because we're part of the bioterror preparedness group. I think that's true for community-based home care agencies in a number of areas. I'm sure this is true for other parts of the health-care system but I just wonder to what extent that we're at all taking a look at that area?

MS. CHENG: Carol, to respond to two of your points actually, that last recommendation by no means suggests that MedPAC would focus only on hospital discharge planners as a source of information. We learned from the OIG that they were not contemplating repeating their study on hospital discharge planners so we really wanted to bolster their work, the idea being that that would be in parallel with efforts that we're making with the episode database and others within our access framework, to look at all users of home health, those that are coming directly from the community, those that perhaps are coming from an outpatient facility, those that are coming from a SNF.

So MedPAC is going to be working a great deal on learning about access from different beneficiaries, but the second recommendation was to try to keep a good time series

on the hospital discharge planners going.

DR. NEWHOUSE: What are we going to learn about access that way? We weren't learn anything about who didn't use.

MS. CHENG: We anticipate in the episode database to capture all of our beneficiaries. So we'll be able to look at those that are coming from hospital and also from non-hospital settings and see what kind of post-acute care they used or didn't use. You're absolutely right, the group that we'll never be able to capture is the one that doesn't enter the system through a hospital or another setting and doesn't use home health. We won't be able to capture them.

DR. NEWHOUSE: How will we decide if it's good or bad if somebody does or doesn't go from the hospital, or some other place? From just a claim.

DR. MILLER: I think that's at least a question. If a patient can't get -- and this came up in the discharge planning, which I realize -- we tried to be very clear in previous meetings what it is when you're talking about a focus group. But one of the things that we drew out of that is people would say, I'm having a hard time placing a

patient, which means the patient may end up in the hospital for another day or so, or however long it is. It's not clear that that's necessarily, from the patient's outcome, a bad outcome.

This will be very hard. If they stay another day in a hospital or if they get moved to home health, it's still not 100 percent clear in that instance whether that outcome was bad for the patient. Certainly, the discharge planners were absolutely clear that the hospitals wanted them out. But whether it was the patient is, I think, a different question.

DR. WAKEFIELD: Just a couple of comments. Did you say that we would you get a look -- that you think we'll get a look at cost report data before we come back in January, or are we going to be working off of the proxy that you've just laid out for us?

MS. CHENG: I'd like to thank CMS, actually. Their Office of Information Systems has done a tremendous job in trying to get us cost reports. We've alluded to it over the course of the morning, but CMS did not give the statistical information that home health agencies need to file their cost reports to them on schedule this year.

That was delayed a great deal by PPS. So they didn't get the input that they needed until much later than normal. They needed time to learn a new cost report and respond to it, get that into CMS, and the first cost report that CMS processed from after the implementation of the PPS happened in September.

So we're trying our best to get what data is available and to take a look at it, and if we've got something, and we hope we will, we'll bring it to you in January.

DR. WAKEFIELD: Thank you. It just strikes me that this part of the industry has been so volatile that to the extent that we're making decisions based on something other than cost report data -- even though I'm pleased to hear my colleagues think that the assumptions they're based on are pretty solid, nevertheless it still makes me a little bit twitchy because I think this has been such a moving target in terms of this part of the industry.

The second comment that I wanted to make -- so I'll cross my fingers and hope we have something else to look at.

But with regard to the rural home health data, I

noticed that the discharge planners, the couple of common you cite from them is the notion that services are more difficult to access in rural areas, especially if therapy is needed. It seems to me when we did the rural report we were looking at data that suggested that the types of therapy that were available to rural beneficiaries was different. That is, there was less intensive services used by rural beneficiaries to treat the same equivalent health care problem, than their urban counterparts. This seems to be pretty consistent, if I'm interpreting it correctly, with what we had cited back then.

Secondly, are we still seeing longer lengths of stays on the inpatient side in rural hospitals compared to urban hospitals? You might recall that was also part of the discussion, I think, about whether or not there was adequate access to post-acute care services, if in fact rural hospitals didn't have a place to drop people into and instead were retaining them inside the facility.

The third comment I just want to -- may start being interested in to see if that has changed at all.

The last comment that I wanted to make was in terms of how we characterize in text the discharge planners

and the potential for over-representation on the panel, because you were getting some themes there seeming to indicate some issues with rural home health. To me, that struck me as a consistency in message across those individuals. It may well be that the answer to go ahead and have Medicare beneficiaries temporarily housed in apartments and then getting their therapy home health in an acute care -- in a metro area. Maybe that's the answer but I don't know that I'd characterize it that way.

So I don't know personally a lot of Medicare beneficiaries who would necessarily prefer that over getting just a little bit closer to home, at least in some circumstances.

But the length of stay issue I guess is the question. The others are really comments. The length of stay is a question for me because it at least informed our thinking one way a bit, seemed to suggest something to us the last time we looked at that data.

MS. CHENG: I'm going to have to defer to the hospital team on what the most current data is on length of stay urban versus rural, but I think we could get some data on that and see if there have been changes in that length

of stay.

DR. NELSON: Two brief questions, Sharon. Those agencies that have non-Medicare clients, how do the payments compare Medicare versus non-Medicare? And is the content of the service for comparable patients, such as diabetes or IV antibiotics, is the content of the service the same or roughly the same for the private sector as Medicare?

MS. CHENG: In home health, as it does all over the health care sector, Medicaid rates vary widely from state to state.

DR. NELSON: Excluding Medicaid. Private pay.

MS. CHENG: Medicare is certainly the primary purchaser of Medicare type home health, which is to say skilled nursing and therapy. There are many home health agencies that are Medicare only so we don't have a lot of comparable information on some of the other payers for a lot of this industry.

DR. NEWHOUSE: Does the commercial usually pay per visit, which would make it very non-comparable.

DR. NELSON: That was my point. Because some entities have substantial privately insured commercial

business. It seems to me that as we have with our other products, that some idea of comparability in payments to assure that Medicare patients aren't going to be disadvantaged, at least in some markets, would be worthwhile.

MR. HACKBARTH: Wouldn't these data suggest that the Medicare payments per visit, at least nationally, are soaring? Because the number of visits is declining. Again, there's potentially the geographic issues but --

DR. STOWERS: I just had a quick clarification. When we say that we're staying with the previous MedPAC recommendation, the so-called 7 percent decrease would go into effect?

MR. HACKBARTH: It is in effect.

DR. STOWERS: It already did. And we're recommending that stay, and the 10 percent rural stays?

MR. HACKBARTH: The recommendation on the table would not alter --

DR. STOWERS: Any of that.

MR. HACKBARTH: Yes. So the 7 percent cut went into effect in October and this recommendation would not alter that. This is the update after that's gone into

effect.

MR. SMITH: Very briefly, most of what I wanted to raise has been asked. Sharon, I wonder whether or not volume and quality is the right thing to look at. It seems to me that -- and Carol has talked about this in the past -- but volume isn't a proxy for much of anything. That outcome data ought to be what we're looking at here. We may explain some change in outcomes by changes in volume, but the discussion on page 12 about relating volume to quality seems to me to be looking for the wrong answer, or answer that doesn't tell us what we really ought to be trying to find out.

MS. CHENG: Certainly another piece that we could look at would be changes in outcomes, in quality of outcomes. There is a research outfit that has developed a weighted quality outcome that looks at the OASIS data that we've got and compares changes over time. The caveat to that obviously would be, you can't look at a period before OASIS, so we can't compare what's going on under the PPS to what used to happen. So we can certainly develop a baseline and look at changes in quality and outcomes going forward.

MR. HACKBARTH: Carol had mentioned looking at things like readmission to the hospital, which I guess in some ways are fairly insensitive and crude measures, but still may be some indication of whether the changes in the pattern of care here having adverse effects on patients. Is there any process for looking systematically at some things like that?

MS. CHENG: I think that the OASIS data could be fairly rich. Developing a baseline and looking forward, we can see over the course of treatment whether the severity has changed, whether there's been stabilization or improvement in functional ability. We can also look at some adverse events to see the rate of rehospitalization, developing UTI, developing bedsores. With all the caveats that you have to put on quality data, I think we could get some measures that will look at changes in outcome.

MR. HACKBARTH: Let me try to sum up what I think I've heard on this particular issue. We've got some questions, important questions, maybe not easily answered questions about whether these changes in the pattern of care represent reduced quality of care. There may be some ways that we can address that or try to address that in the

longer-term, at least I hope so.

We've got a question that Carol has raised about the well-known geographic differences in the patterns of care, and all of our discussion has been about the national average. If we could somehow get one layer deeper in some thinking about what this means geographically -- and not just urban and rural distinction, but more broadly, that would be helpful.

Our usual problem, in particular with this service, is that it's so ill-defined in terms of what's appropriate care. That one is going to plague us for awhile, but it's prominent in my mind here.

Last is the point that Joe made. We've seen significant changes in the pattern in terms of reduced services provided in an environment where money doesn't seem to be the problem, or a shortage of money. People are responding to the incentives.

So what would happen, even if you put more money into the system? Would it alter these patterns of care that we may or may not be concerned about? I think that's also an important observation.

Anything that I missed? In particular, let me

ask this, any piece of data that Sharon can bring to us possibly in January that would be really important for our thinking about this? We've identified lots of longer-term questions, but I think many of them cannot be answered in the next month.

MS. RAPHAEL: I think it would be useful just to reiterate the payer mix for home care agencies.

DR. STOWERS: One other piece of data might be to think about what happens if they can't find the home health care that they need, where would that service be going? A lot of time that's going to be a skilled nursing or a nursing home admission because they're unable to stay at home and get that service. So you wonder if there's a variability since PPS in the amount of alternative places they might have gone if they could not have received home health care.

DR. NEWHOUSE: This isn't a piece of data but one observation on Alan's question on how does Medicare compare. We know the answer for the marginal revenue. Marginal revenue for the Medicare visit is zero past four. So that's less.

MR. HACKBARTH: Okay, Sharon, thank you very

much.

We're going to take a half-hour for lunch. It's now five after 1:00, so we'll reconvene at 1:35.

[Whereupon, at 1:07 p.m., the meeting was recessed, to reconvene had 1:35 p.m. this same day.]

AFTERNOON SESSION [1:49 p.m.]

MR. HACKBARTH: We have a lot to cover this afternoon so I'd like to get started. I'm sure we'll have the rest of the commissioners join us very quickly.

The first item on the agenda for this afternoon is Medicare payments to physicians, and we're going to lead with reports on two pieces of research that have been conducted. Kevin, I'm sure, is going to introduce those in just a second.

For everybody this afternoon, not just Chris and Zack and Kevin, but all of our presenters, I hope people will keep in mind that we are short on time. We've got a lot of stuff to cover and not enough time to do it. So pardon me if sometimes I look impatient. It's not because I'm not listening. It's just because I want to get done before midnight. So, Kevin, would you lead the way?

DR. HAYES: [Off microphone] Our first presenter is Chris Hogan. You all know Chris. He presented a proposal on using claims data to analyze private sector payment rates and he's here today to present results of that analysis.

The one thing that came up at the September

meeting was your noting that we have claims data only through the year 2001, and you asked us to come up with a way to find out what's going on this year in 2002, given that Medicare's payment rates for physician services were cut in this year.

That brings us to our second presenter, Zack Dyckman. Zack has been working with his associate, Peggy Hess, to complete a project for us that includes interviews with over 30 health plan executives -- executives from over 30 health plans, I should say, and a collection of payment rate data from those plans. The goal there is to find out what happened between 2001 and 2002. So the goal here, as you can see then, is to look at trends in Medicare payment rates relative to the private sector starting in the early '90s and continuing right up through the present and even in some anticipation of what we expect to happen in 2003.

Before I turn things over let me just introduce Zack Dyckman. Zack has over 20 years of experience in health care consulting and research, most of it on physician payment methods. During our next session we'll be talking about the Medicare economic index. Zack developed the MEI.

DR. HOGAN: I've been told to keep this as brief as possible so I'll just plunge right into things. In my presentation today I'm going to tell you why I'm here, tell you roughly what I did, what the results were, give you a community projection of the ratio between Medicare fees and typical private fees through 2003, and offer a few conclusions.

You first heard about this topic at the September meeting this year. The task here is to compare Medicare's physician fees to fees paid by the average private insurer. When I say fee, I mean the total payment the physician should expect to get for a service including the payment from the beneficiaries. So I'm really trying to get an estimate of the total reimbursement of the physician.

We're looking at trends in pricing, not trends in price times quantity. So to the extent that the volume of service goes up and offsets some fee cuts, or volume of service goes down and offsets fee cuts, we're not interested in this. We're just looking at the price level.

The beauty of this analysis is that we can contrast the current situation to a historical analysis that I did for the Physician Payment Review Commission back

in the mid-1990s. It will be one piece of information to help you make your assessment of payment adequacy now.

Methods. Almost no one seems to care about methods. I'll go through this briefly. Two large private payers. Payers contribute the data on the basis of anonymity, construct a price index just the way you construct a price index for anything else. You take a basket of Medicare services, ask how much it costs for Medicare to purchase it, ask how much it would cost to purchase it if you paid private rates. The ratio of those two dollar numbers is the price index.

Weight the individual types of plans by their market share based on an estimate of enrollment that John Gable gets every year. Calculate a Medicare versus private price ratio, do a little sensitivity analysis -- in the paper but not here. Compare to historical estimates and then project them roughly into the future. Not an accurate projection of the future, but just some notion of what the future will look like through 2003.

There's the results. On this graph I've shown you the ratio of Medicare to typical private fees. A value of 1.0 would mean that Medicare fees are about the same

level as private fees. The fact that these numbers, these bars are all less than one means that I'm showing that the typical Medicare physician fee is less than the typical private physician fee.

A word of warning. I calculated Medicare versus private. Zack calculated private versus Medicare. My numbers are all less than one. His numbers are all greater than one. But we're saying the same thing. This proves that we did not collude and we got independent estimates.

[Laughter.]

DR. HOGAN: The bars to the left of the gap are the historical data. The three bars on the right are the modern analysis. The bunch of bars on the left are the historical analysis. And the conclusion here is that Medicare's rates are much closer to private rates now than they were in the early 1990s at the time of the introduction of the Medicare fee schedule.

Why? Is it because Medicare has become a more generous payer? I don't think so. Is it because private rates are held constant or declined? I think that's my answer. I'll show you two slides.

Medicare fees roughly kept pace with -- we can

argue about how closely Medicare fees kept pace with inflation over this particular period, but I think that's roughly right. You can't just read the actuaries' numbers. Kevin actually did some claims data to claims data comparisons from Medicare to do a true price index, including all of the changes in policy and the updates that occurred over this period. I've just run those against the MEI to show that from '94 to 2001, more or less, Medicare fees kept pace with the rate of inflation. If someone else did this line you might see the lines cross in a slightly difference place because of differences in how we've measured the fee update, but I think the conclusion is sound.

Private fees, on the other hand, I don't have a direct measure of what happened in private fees, but I'll show you what happened to enrollment and I think this is telling you the story. The blue bar at the bottom is indemnity insurance. This shows the composition of private insurance enrollment in 1993 and 2001 according to John Gable's data. The bar at the bottom is the good paying insurance, indemnity insurance that paid high rates. The yellowish bar, the greenish-yellow bars at the top are

HMOs, and the things in between are the payers that pay rates in between.

What has happened is, there's been a tremendous shift of enrollment out of high-paying plans and into low-paying plans. In the report I give you a table, Table 2, that shows you roughly the deflationary impact that this had. If nobody had changed their fees over this period, the simple shift in enrollment would have been worth about 12 percentage points worth of fee deflation over this period.

So that I think is the story, is that private fees have more or less come down. Not that any individual plan was particularly harsh to physicians, but that the shift of enrollment toward lower-paying insurers has brought the average private fee down. I don't think that should be news anyway. This is the managed care revolution in a nutshell.

I want to warn you that what I've shown you are national numbers, and there's lots and lots and lots of variation below the national numbers. I've just shown it to you here by type of service. Medicare pays quite well for visits. That's the medical category. That was

intentional. That's what the fee schedule is supposed to do. Medicare pays less well for other types of service, and the average is what I was showing you before. There's also substantial geographic variation that we're not prepared to show you at this time.

2003, that came up in the September meeting and I thought I'd just take a swag, I guess is the term here -- a scientific guess -- at what that might be for 2003, just to show you what the calculation would look like. So I've assumed that private rates went up an average of 2 percent per year. Had I read Zack's report, I would have assumed a higher number, but I've assumed 2 percent per year from 2001 to 2003. For Medicare I've just plugged in the actual 2002 and the HCFA actuaries projection of the 2003 increase, and I'll redo the charts.

You can see that even with the reductions that are proposed, it looks like the projected Medicare to private fee ratio will not be as low in 2003 as it was in 1992, '93, at the introduction of the Medicare fee schedule. But as a caveat you have to realize that if your standard of comparison is the underlying increase in physicians' costs, yes, you're going to see a pretty big

gap by the time you get to the end of this time series, where the physician cost number is the MEI projection through 2003 and the colored line there is the fee line.

Caveats. This is all based on claims data. Not every dollar gets put onto a claim. We're not exactly sure that the mix of insurers that we've used are exactly representative of the private market, but it looks like reasonably good. It seems to match other sources. This analysis is supposed to match the earlier analysis, but the world has changed and we had to make a few changes in methods, including how we weight up the individual payers to come up with a market aggregate. But other estimates seem to give us about the same numbers. Zack's number is quite close, when you do a little bit of adjustment between his analysis and mine.

I've recently completed an analysis for the Center for Studying Health Systems Change that used a completely different claims data set, MedStat market scan database, and come up with a number very close to the 0.8 to 0.83 that I've shown you here for the 2002 ratio of Medicare to private. So I'm reasonably comfortable that this is a fairly accurate analysis.

Conclusions. Yes, the gap between -- it's sort of a good news, bad news story. The gap between Medicare and private rates closed over this decade, but it closed because rates fell while Medicare rates more or less kept pace with the rate of inflation. You expect the gap to rise from 2001 to 2003, but even in 2003 it won't be as large as it was in the early 1990s.

MR. HACKBARTH: Thank you, Chris. That was a nice, concise presentation.

Zack?

MR. DYCKMAN: Good afternoon. I hope mine will be concise but not quite as precise as Chris'.

There were several primary objectives to the study. First, we wanted to get a good understanding of the dynamics in the physician services market, particularly the change in dynamics that may have occurred in the last couple of years and is occurring now, and the extent to which those changes could affect physician fees. We wanted to get a good current picture of physician payment methodologies. We hear that lots of people are using RBRVS. What does that been?

We want to get a good understanding of the

factors that influence private payers in terms of their physician fee decisions. Why do they change their fees and by how much? What factors are important, particularly the impact of Medicare physician fee changes, what role does that have?

In additional, we did a fee survey taking a look from a different perspective at some of the same things that Chris did. Ours is a bit more current. Doesn't use claims data. Uses fee schedule data. We compared current fees to Medicare fees and reviewed changed in fees between 2001 and 2002.

Overview of study methodology. I'll go through it pretty quickly. We invited more than 60 health plans to participate in the study. Virtually all the Blue Cross-Blue Shield plans plus about half a dozen of the largest managed care companies. We focused on health plans that had a significant share of the market. We didn't try to find the plans that had 2, 3 percent. We wanted to get a picture of the predominant payers' activities in each market. The Blues tend to have larger shares and the national companies have large shares in a number of areas.

As part of the arrangements with the plans and

the marketing effort to get them to participate, we assured them complete data confidentiality.

Thirty-four health plans agreed to participate in the project. There are a couple more that wanted to come in but it was a bit too late. We were under a tight time schedule. We interviewed executives and senior staff at 32 health plans. These health plans represent 45 million members.

When I say 45 million, for a few of the large managed care companies that participated we're not counting their full membership, we're just counting their membership in three markets where we focused our analysis in terms of analysis of fees and asked information about the environment. So it's truly 45 million for the plans that we looked at. And we analyzed 68 physician fee schedules from 33 health plans.

The 34 plans that participated in the study are well distributed regionally. You have that chart there. They're well distributed in terms of market share. They're pretty well distributed in terms of urban-rural mix, large urban areas, moderate size, and small areas.

Characteristics of the physician services

markets. We looked at the organization of physicians. how they organize themselves. It varies considerably by market area. In the majority of markets most practices are small, single specialty groups. In other market areas you have larger groups that dominated, sometimes faculty-based practices are important. But in the typical area, it most areas it's still what has been characterized as a cottage industry.

Where there are large physician groups, sole area providers, PHOs and IPAs, they frequently seek to negotiate higher than standard fees. Generally the smaller groups, unless they're in rural areas where they're sole area providers, don't seek to or don't feel they have the power to negotiate higher fees. But others do where there's some sense of market power.

We asked the health plans whether there were particular groups that were more aggressive than others. Often we didn't have to ask; they told us. Hospital-based physicians were singled out, particularly anesthesiologists and radiologists.

Recent changes in physician service markets. We see a trend in terms of physician consolidation, not

necessarily into IPAs or PHOs but into large single specialty groups, and more loosely structured organizations that the health plans maintained were set up primarily to try to negotiate higher fees. There's general agreement that there's increased pressure from physicians to negotiate special fee arrangements -- special meaning higher fees -- both as a result of the consolidation. But independent of that, groups that were not very aggressive before have become more aggressive.

A particular focus of the study was what impact do the Medicare fee reductions, the 2002 and perhaps the 2003 -- I don't think it's come out yet but it's projected to go down -- what impact that has on pressure to increase fees, and whether in fact they've done it. Two-thirds of the plans believe that the Medicare fee reduction in 2002 increased pressure on fees. The health plans didn't necessarily respond to that pressure but they're feeling that pressure.

We looked at physician payment system characteristics. All of the survey health plan fee schedules have, to some extent, been influenced by RBRVS. About 60 percent of them are RBRVS type fee schedules or

are RBRVS fee schedules. Very similar to or pretty close to what Medicare does; moderately close. About 40 percent of the fee schedules might be characterized as loosely inspired by, or influenced over time by RBRVS fees. These are health plans that moved fee relativities in the directions of RBRVS relativities over the years, but the fee schedule in no way is close to anything like the Medicare fee schedule.

We asked about frequency of fee schedule changes. About 60 percent of the plans update fees on an annual basis, about 10 percent, one-and-a-half to three years, and about 30 percent on an as-needed bases. There's some plans that haven't had any general fee increases for about four or five years. In most cases when fees are changed their not systemic. They don't cover all services by the same rates of increases, but they vary based on perceived need to increase fees.

We looked at anesthesia conversion factors. On average, this is for the average conversion factor for a 15-minute time and base unit definition of service, average for the plan varied from $31 to $52. A weighted average across the plans is about $43, which is approximately 160

percent above the Medicare rate of $16.60. Looking at from the other perspective, from reverse, Medicare is about 38, 39 percent of the average private payer fee or conversion factor.

What are the primary factors that influence physician fee decisions? The most important factors were perceived impact on claims cost and premiums. This, for I think everyone but one plan, was highly important.

The second most important factor is the impact on the plan's ability to maintain an adequate provider network; to satisfy their customer requirements, their member requirements in terms of access to care.

Third, and this is a bit further down, was to maintain parity or consistency with competitor fee levels. The plans don't want to be too far off from what their competitors are paying.

We asked them about at a desire to achieve a proportionate relationship to Medicare fees. None of the plans considered that very important, but about half of the plans considered Medicare fees and fee changes moderately important. It is one of the factors that they consider. They look at what Medicare does but it's certainly not

among the most important factors.

In terms of the impact of a 2002 or likely 2003 Medicare fee cuts, what impact has that had on their fee decisions? No plan indicated a strong direct impact on 2002 or 2003 fee decisions. In some cases decisions have already been made or were made before the announcement, or partly because for the most they don't consider what Medicare does as particularly important for them, at least not yet.

Approximately half indicated that it had a moderate impact on their fee decisions, where they allocate some of the fee increases, and to some extent, perhaps, how much of a fee increase. But there is a general concern among the plans about 2003 and future fee increases. The feel, one, there will be increased pressure, and, two, they will have to respond to that pressure and fees will actually increase as a result of that.

MR. HACKBARTH: Zack, can I just made sure that I've got this point, because it's a critical one in the policy discussion about this. People ask whether the Medicare cuts in fees will be followed by private sector payers. And what I hear you saying is, no, the

relationship, if any, is in the opposite direction. Rather than following Medicare down, what the private plans feel is pressure to respond to Medicare cuts with fee increases on the private side.

MR. DYCKMAN: To the extent that they respond to Medicare it's in that direction, yes. A couple of plans indicated, now they look better and perhaps the fee increase in 2003 will be little bit lower as a result of Medicare because they don't have to increase fees as much. But for the most part it's in the direction that you say.

DR. ROWE: And that's consistent with the history, kind of a mirror image; Medicare goes up --

MR. DYCKMAN: We conducted a fee survey. We collected fee schedules, 68 fee schedules from 32 health plans covering 31 million members. The fee data offered traditional PPO, HMO, and point-of-service plans. For the most part, most of the enrollment is in PPO type plans. We looked at 2001 and 2002 fees and fee changes for 64 fee schedules where they provided both 2001 and 2002 data.

Looking at physician fee changes, first, the median change among the 64 fee schedules was 4.5 percent; the weighted average is 3.8 percent fee increase. When we

weight the fee schedules by enrollment that's what the increase was.

A primary object of the fee analysis was to compare Medicare fees to private payer fees, or our focus is private payer compared to Medicare. We did it two ways. We looked at how they compared to Medicare carrier fees. That's the green lines for the locality of the market a plan is in, and also looked at how they compared to national Medicare fees.

Firstly, what we found for all services, that's the top bars, that private health plan fees 15 to 18 percent higher than Medicare fees. When we look at it by type of service category, private plans fees are much higher for the procedure-oriented services than for E&M services, for surgery it's in the mid to upper 120s, for assorted medical and diagnostic, cardiac, all kinds of non-surgical type testing, for those familiar with the code range, in the 90,000 range, it's about mid 120s, or 20 percent, 25 percent higher; radiology about 20 percent higher. For lad and path and for office visits, the differential is much less. It's about roughly 5 percent.

We see another interesting pattern, that in each

case the ratio private plans fees two Medicare fees is higher when the comparison is based on the national Medicare fees rather than Medicare carrier fees. What this tells me, and we'd like to do a little bit more analysis on this, is that the ratio is lower in the larger cities. The ratio to the Medicare carrier fees is lower in the larger cities where the GPCIs are higher than it is in smaller, rural areas.

One of the things I've noted over years and it was confirmed -- I've done a fair amount of physician payment methodology work but it was confirmed in the survey, is that in many areas fees are as high in small cities as in larger cities with the same carrier, and in some cases they're even higher, because the plans feel more of a need to keep the rural physicians happier because there are fewer of them in terms of there are more access issues.

Conclusions. There's been increased physician consolidation and increased pressure on health plans for higher fees, and the consolidation has been largely into larger single specialty groups. Medicare fee cuts, particularly if continued, could result in cost shifting

and increased pressure on health plan fees, but until now it has not been a significant factor in terms of health plan fee decisions. The primary factors influencing fee change decisions are impact on claims cost and premiums, and that has tended to hold fees down; and need to maintain an adequate provider network and in some places that has pushed fees up.

In terms of the fee comparison data, private health plan fees are 15 to 20 percent higher than Medicare fees. In terms of the way Chris has looked at it, the ratio of Medicare to private, Medicare fees are about 13 to 17 percent lower. The differential is less for office visits and higher for surgery and other procedure-oriented care. And health plan fees increased approximately 4 percent on average in 2002 over 2001.

Thank you.

DR. ROWE: A couple observations, Zack. Thank you very much. And Chris, thank you. It's always a pleasure to have you back here.

First, just to support one of your findings about the rural physician payments. They clearly are the highest despite the fact that the cost of practice is less, cost of

living is less in many rural areas, staff salaries are less, rent is less, the payments to the rural physicians are clearly higher, which tells you something about the margins there.

I think something you said about the methodology, and that is in order to protect the network, which is a very significant factor -- very significant. I think that something you said about your methodology suggests that the methodology may in fact underestimate the ratios of private payers to Medicare. Let me see if I heard you right.

You said that you interviewed health plans that were either local Blue Crosses, because they tended to have very high market shares, or large national plans in areas in which they have large market shares. Those of us in large national plans have large market shares in some areas and not in others.

If you're interviewing executives from areas in which they have large market shares, that is where they have the most leverage with the physicians and they are paying the least. From the point of the national plans, at least since they have to keep their networks intact for the national customers, such as a rural area and others, the

payments would be higher. So if that's the case, I think that that might introduce into the data set a bias that would make these estimates underestimates, or on the low side of the range of the relative payments of private payers to Medicare.

I'd be interested in your comment regarding that.

MR. DYCKMAN: I think that's correct. I don't think it's a large bias. I think it's a small bias. I have a lot of experience with the Blues, and this again was confirmed in this survey. Some of the Blues maintain or know that they're paying higher than other payers, but because of a variety of reasons -- they were formed by physicians, they like to maintain good relations with the provider community, in some markets they're higher.

In other markets, particularly competitive markets, they may be in the middle or at the lower end. So we see both. So in terms of the Blues, I'm not sure which way the bias goes. But in terms of the larger, the health plans with larger market share, they tend to use their clout to get better deals. An additional factor which was mentioned in the report but I didn't mention today, is that many plans, particularly the commercial plans, don't use

standard fee schedules for the larger groups. Those these schedules are higher and by and large we didn't capture those.

So the true ratio is probably a few percentages higher, which would bring me closer to Chris.

MS. ROSENBLATT: I too thought both of these studies were terrific; very, very interesting and well done. Chris, given that your data was a older, I thought the fact that you built some sensitivity in was a very good idea.

Now I was going to point out the numerator denominator issue that Chris has already pointed out, but I actually tried to compare the results of the two studies and that's where I ran into trouble. Chris had a table in there in which he used 3 percent to project from 2000 to 2002 and ended up with the ratio of 77 percent. Then I took Zack's results for 2002, which is based on the survey data for 2002, and nationally, reversing the numerator and denominator, it was 85 percent and local 87. So in my mind I've got a comparison of 77 versus a range of 85 to 87.

Now it's comforting that they're both under one. It's not comforting in that there's that big a gap. So I

was just wondering if either of you had done a similar comparison and if you have any ideas on it.

DR. HOGAN: We spent several minutes going back and forth as to why the numbers weren't exact. Aside from the obvious difference in methods, I put a little footnote in the paper, the choice of market basket matters a lot. It matters -- five percentage points could simple have been the choice of market basket. I took Medicare's mix of services, which is much more heavily weighted toward procedures, where Medicare pays poorly. Zack took the private mix, which is much more heavily weighted toward visits, where Medicare pays well. I didn't put that in the sensitivity analysis but I just have a footnote in the report.

Of that potential 10 percentage point difference, that's about half.

MS. ROSENBLATT: Could we get a comparable market basket just so we've done that analysis?

MR. DYCKMAN: Yes.

MS. ROSENBLATT: Given the 3.9 percent, I also don't know if rolling forward at 3 percent a year is sufficient, Chris. But my guess is if it was 3.9 from 2001

to 2002, I'm not sure it would have been that high for all three years -- for the two years that you'd be rolling it through. I don't know, maybe 3.5 or something.

DR. HOGAN: We only brought these together at the very end. As I say, if I had known Zack's numbers I would have used a higher inflation estimate. I must say, I had the exact opposite reaction. I was thrilled that the numbers were that close, given that that's a survey-based estimate and mine's a claims-based estimate. I was just --

MR. HACKBARTH: Chris, can I just repeat what I thought I heard you say? Could I just repeat it to make sure I got it right? So if there's like a 10 percentage point gap, you're saying that about half of that is due to different indices that you're using, and then the other half you think is different mix of services.

DR. HOGAN: Half of it we don't know what it is and half of it is the market basket, because Medicare pays so well for visits and if you take the private mix you have many more visits. So Medicare looks better with the private mix, and Zack's numbers show a smaller gap.

The other half, we aren't sure what it is.

MR. DYCKMAN: I think there's another factor also

but what Chris said is certainly correct. There's tremendous variability in fee levels across markets. The extent to which we used one type of sample and Chris's may have been narrower -- not to suggest that my sample is better, it's perhaps broader and more complex.

MS. ROSENBLATT: I think that's another point. My question again would be, could we do a follow-up where you're both using the same geographic weighting? Is that possible?

DR. HOGAN: I work by the hour. If you guys want to pay it, I'd be happy to do it.

DR. ROWE: Why do we need to? We've got two numbers. They're in the range. Why do we need to, just so you'll feel comfortable?

MS. ROSENBLATT: I think Chris's report in particular is drawing conclusions about the trend over time. I think if we could get them closer, I'd have more comfort that the trend over time is a true portrayal, because at the end point, 2002, we're there.

DR. NEWHOUSE: I thought these were two really helpful studies, among the most helpful that we've seen in recent times in terms of reaching decisions. I just had

one minor question/comment/reaction and that was on the interpretation of the near equality on E&M versus the difference on the procedure side which was attributed to, Medicare wanted to pay well for E&M, which was true I thought on the Medicare side, but I think there's another factor potentially also, which is on the -- I asked myself, there's a lot of pressure on the private side for choice. My first thought was that should push toward more bargaining power for the PCPs, because that's usually where choice gets manifested. At least in the Boston market almost every PCP is in every plan, but that's not the case with specialists.

I wondered if there isn't also an element here that there's differential market power, just because there's fewer specialists in any local markets. So that the specialists are able to achieve something that a lot of the hospitals and the rural physicians that you're talking about, the same kind of phenomenon, that the PCPs couldn't except for the demand from consumer/employers for very wide PCP networks.

MR. DYCKMAN: I think that could be partly true but I think we have to remember where we came from. I did

studies around 1990, 1991 and at that point in time surgery fees were about, on average -- and these were Blue plans -- about 70 to 80 percent higher than the Medicare fees, and office visits were at or sometimes below office visits. So what we've seen is the surgery come down and the office visits go up, but they haven't yet got to the same place yet.

Then in addition, I think your point about market power is a good one. Health plans to respond to pressure and they feel less pressure, and perhaps the PCPs have less leverage relative certainly to some specialists. But I think it's a combination of some things, that surgery has come down quite a bit, but not quite to the Medicare levels.

MS. ROSENBLATT: Joe, I'll just add, I agree with what Zack just said. I think the issue is when Medicare went to RBRVS it raised the E&M codes, if you will. and lowered the specialist codes. The carriers have been moving in that direction gradually. The carriers would not have wanted to decrease the specialist fees all in one jump like that, so there's been gradual movement toward --

DR. NEWHOUSE: Why not?

MS. ROSENBLATT: Maybe some did, but others didn't. So what you're seeing is exactly what Zack said, it's transition I think.

MR. DeBUSK: Zack, seems like I heard this two ways listening to Jack here about the rural physician. Is the rural physician paid more than the urban physician or less?

MR. DYCKMAN: I think on average, and I'm not certain of all but on average probably about the same. That's what I would think. But there are certainly lots of situations where rural physicians get more than large urban, and some reverse situations too. But you certainly don't see the pattern of a significantly higher fee in large urban areas, despite higher costs of living and medical -- expenses of running a practice, than in rural areas.

MR. DeBUSK: I believe Ray is taking exception.

DR. STOWERS: I think ratio-wise you may be talking okay but if you -- as you know, figuring in the geographic factor on the physician work, the ratio can go all the way from 0.78 up to 1.4. So I think the comparison with private payer and the differential is fine, but

there's even legislation that's been introduced to try to correct this problem of the difference in the much lower payments for the rural physicians than there is for the urban. So the gap may be closer, but the money in the pocket is much less for the rural physician for the same service in raw dollars.

DR. ROWE: I don't understand that. If we're paying them more why is the money in the pocket less?

DR. STOWERS: I think I'm having a little trouble understanding this too, because we just ran all the numbers for the legislation that's on the Hill and --

DR. MILLER: Can I interject for just one second? I just want to see if I can clarify it. The point that you were making was that private carriers when they set their fees for rural physicians tend to not set them lower even though cost of the practice is lower, in part to try and maintain the network.

MR. DYCKMAN: That's correct.

DR. MILLER: I think the exchange that's happening across the table, some people are referring to Medicare fees and some people are referring to private fees. Ray, I think you're referring to Medicare fees are

adjusted geographically for the cost of practice in rural areas. And I think Zack's initial point was at least referring to private carriers. Is that a fair summary of where we --

MR. DYCKMAN: Yes.

DR. STOWERS: I think what I was trying to say also and maybe you're saying the same thing, is I think they -- in looking at it aggregate across the country, my guess is there is a bigger differential between the Medicare payment in the rural area and the private because of the pressure that we're talking -- it's probably more than 4 percent or 5 percent in the rural. That may be what you were saying.

MR. DYCKMAN: I've would agree with that.

MR. HACKBARTH: But to the extent that Medicare is the only one geographically adjusting, if you will, then the gap would be larger in the rural -- fully adjusting, then the gap would be larger in the rural areas.

DR. HOGAN: If this is an important point, we can calculate the numbers --

MR. DeBUSK: On the private side, for clarification, how is that physician's assistant and that

nurse practitioner paid in the midst of all this, in the rural and urban area?

DR. ROWE: They're paid less in the rural.

MR. DYCKMAN: We didn't investigate that so I don't -- we didn't explicitly ask about payment for physician assistants and nurse practitioners.

DR. HOGAN: And I specifically screened them out.

DR. NELSON: I just had a minor quibble on the way Chris characterize the curves on page 7 in the handout. It was the slide that shows the MEI and the Medicare fee level. It's characterized as Medicare fees kept pace with inflation in those six years, and actually it is below the MEI for five of those six, and the difference between the curves is substantial. It does have relevance if it shows up to the text, particularly with the current flap over '03. Medicare fees lagged behind inflation.

DR. ROWE: So the question is, is the title right and the curves wrong, or is the title wrong and the curves right?

DR. HOGAN: The curves are right. The end point is right. But you're absolutely correct, I mischaracterized that. You're absolutely correct.

Medicare paid less money than it would have had it kept pace with inflation in every year. But they ended up at the same point they would have if they kept pace with inflation.

DR. REISCHAUER: Or in three of the six years it grew slower, and in three it grew faster.

MS. DePARLE: This is slightly off the current subject but it's a subject we've spent some time on. Zack, in your analysis you provided us with some information about how private plans pay for physician-administered drugs. I was really surprised to see so many of them paying AWP or above. That made my wonder, had I misread all those IG and GAO reports about Medicare paying more than other -- no one pays AWP. Actually, Jack, this is a pointed you spoke to at an earlier meeting. So I'm intrigued with where this data came from. Are they using a different definition of AWP than the red book?

MR. DYCKMAN: I don't think they're using a different definition. Sometimes there's a little bit of sloppiness in some cases in terms of their payment methodology. In some cases it's not very current. It may be six-months old. So it doesn't have the precision that

say an RBRVS fee schedule would have. But this is what the information shows.

It's important to realize that for private payers, physician-administered drugs is probably a less important share of their payout. Private plans tend to look where the money is going and don't necessarily worry very much about every different -- worry by category. So this is what the data show.

MR. HACKBARTH: If that's it, thank you very much. Good job.

So next Kevin and Joan will walk us through the payment adequacy analysis for physician services.

DR. SOKOLOVSKY: Good afternoon. Today, to help the Commission consider its recommendations for an update for physician payments we would like to summarize the evidence on the adequacy of the current payments. We will then account for expected cost changes in the coming year, present our draft recommendations for your consideration, and address the budget implications of our recommendations.

In 2001, total payments for physician services, that includes both program spending and beneficiary cost sharing, equaled about $56 billion, about 25 percent of

total Medicare spending. Payments have been increasing at an average annual rate of 4.9 percent since 1991.

Recommending a payment update for 2004 is complicated by the uncertainty of the update for 2003. Current law, as you all know, requires an update of minus 4.4 percent. In legislation passed by the House this summer, the reduction would have been replaced by a positive update of 2 percent. Congress could take up this issue again when it returns in January although we cannot predict what actions they might take. Kevin will speak more about this issue later.

As in our other update discussions we wanted to give you an estimate of projected expenditure growth. This slide displays the updates in payment rates required under current law from 2001 to 2006, as well as program expenditures for physician services as projected by the Office of the Actuary for this same time period.

On the right axis I want to note, one equals the 2001 rate and the updates for the following years are expressed as ratios of the 2001 rates. The left axis equals program spending as projected by the Office of the Actuary, which was about 2 percent. Note that OAC projects

a slower rate of expenditure growth than does CBO for the same period. As you can see despite the series of negative updates called for under current law, both the Office of the Actuary and CBO 50 -- -- and CBO have projected program spending to grow at an annual rate between 2 and 4 percent.

As we notes in the mailing materials, the available information presents a mixed picture of payment adequacy. The number of physicians billing Medicare has more than kept pace with growth in the number of beneficiaries. From 1995 to 2001, the number of physicians grew by 8.1 percent, while Medicare Part B enrollment grew by 5.7 percent. The differences in growth rates led to an increase in the number of physicians per 1,000 beneficiaries from 12.9 to 13.2.

Secondly, our MedPAC 2002 physician survey found that 96 percent of physicians who were accepting some new patients were accepting at least some new Medicare beneficiaries. This was a higher proportion than those physicians accepting new HMO or Medicaid patients.

However, the percentage of physicians accepting all new Medicare fee-for-service patients fell from 76 percent in 1999 to 70 percent in 2002. I want to add that

these results are consistent with the findings from the Health Systems Change survey but our results are more recent since our survey was 2002.

Although many physicians reported changes in their practices, the relationship between those changes and Medicare payment policy is unclear. Two-thirds of physicians said that they delayed or reduced capital expenditures. On the other hand, more than a third of physicians reported that they had increased the number of non-physician clinical staff and more than half increased billing and administrative staff. Three-quarters reported that they had increased their patient load in an effort to increase revenue.

Thirdly, as you've just hear, Medicare payment rates as a percentage of private payer rates increased from the late '90s through 2001. The 2002 payment rate reduction reversed this trend, but Medicare rates as a percentage of private payer rates remained at a higher rate than in the 1990s.

Lastly, last month we presented evidence on growth in the volume of physician services from 1999 to 2001. Overall volume growth was 2.7 percent, a rate

consistent with the trends in the 1990s following implementation of the physician fee schedule. By January we hope to be able to present 2002 data on growth in volume for specific services.

However, it should be emphasized, as we discussed last month, that much more analysis is required to understand the factors underlying volume growth and we're not going to be prepared to do that until the June report.

Nevertheless, the trend in volume increases, the data on entry and exit of providers, and the results of the studies presented to you earlier support the argument that the level of payments for physician services was at least adequate in 2001.

DR. HAYES: So Joan has covered what we know about the first element of our payment update framework, which is payment adequacy. I'd like to talk now about the second element, which is changes in costs that we anticipate for the year 2004.

Two factors are important here. First is input price inflation, and second is productivity growth. The preliminary information we have on input price inflation from CMS is that for 2004 they're projecting an increase in

input prices of 3.4 percent. That's the total. Within that, the two major categories that are considered are physician work and practice expense. Physician work expected to go up by 3.4 percent. That's weighted. It's roughly 55 percent of the price increase. And practice expense going up at a similar rate of 3.3 percent and weighted at the other 45 percent.

The practice expense component of this input price inflation is a broad category that includes a number of things like compensation for non-physician staff working in the office, rent, and so on. One of the categories of practice expense is professional liability insurance. This is, of course, the insurance coverage that physicians have to protect them in the even of a malpractice suit. That component of practice expense has the highest projected increase at 4.4 percent. It's worth noting, however, that that component has a pretty low weight, roughly equal to about 3 percent of physician revenues.

The other factor that we consider here is productivity growth. Our analysis of trends in multi-factor productivity suggests that the trend is an increase in productivity growth of 0.9 percent. We'll put these two

numbers together, the input price inflation and productivity growth numbers in just a moment.

So that brings us then to a draft recommendation for your consideration that would appear in next year's report but would be for the year 2004.

Before we get to that question let me just say a few things about the status of the update for 2003. As Joan indicated, the current law update for 2003 is minus 4.4 percent. There's pretty widespread agreement in the health policy community that such an update would be a problem. Unfortunately, there is no solution in place just yet. But as far as I know, the Commissions's position on this matter remains that a modest positive update would be appropriate for 2003.

So if we take that as our starting point than our task ahead is to try and come up with an update recommendation for 2004. An option for Commission to consider here, of course, is to adopt a recommendation like the one that was in our March 2002 report, and that would be the one that you see here, which is an update based on the projected change in input prices less an adjustment for productivity growth. Drawing on the numbers that were on

the previous slide, that would lead us to that update recommendation, based on the preliminary information that we have now, of 2.5 percent for 2004.

We should talk then about the budget implications of such a recommendation. Here we need to contrast this recommendation with current law, and for 2004 that is another decrease, this time of 5.1 percent. The resulting difference then between our recommendation and current law would put us in the category of a budget implication that would be greater than $1.5 billion dollars. I should point out though that there's a possibility that the budget impact would be less than that if, for example, there is some action like that that was in the House bill that was passed this summer which would have legislated a payment update and made other changes in the update formula for physician services that would have prevented these reductions.

The other possibility here is that there will be some action to correct errors in the current payment update formula. That too would prevent payment reductions.

Thinking further about these budget implications and what the five-year impact of our recommendation would

be, we have a dilemma there. The problem is first that under current law any increase of the type that would be recommended here would be taken away through the update formula that's in current law. Such an increase would be taken away in a subsequent year.

The other problem in making a longer-term projection is that it puts us in a position of having to make some -- use some rather controversial assumptions about behavioral offsets, about physician actions to offset payment reductions by increasing the volume of services.

Then the third thing, of course, is this possibility that there could be some action to change the payment update formula and prevent the payment reductions. So for that reason we don't feel that it's prudent to report a five-year budget implications for this recommendation.

That's it.

MR. HACKBARTH: Let me make something explicit that's been implicit in what Kevin presented. Last year you'll recall our recommendation had two parts basically. One was too repeal the SGR mechanism and then the second was to replace it with annual update that was based on the

MEI minus a productivity factor.

Here we're talking about in the first instance the MedPAC recommendation for 2004, but we all have the dangling question of what happens with the scheduled cut for 2003? So what I would propose and I'm eager to get your reactions to it, is that our approach be that we not go back to the SGR issue. We've made our views clear on that. Haven't been well-received in all quarters. I don't see any gain in going back to that issue.

What I would like us to address is what we think is the appropriate increase for 2004, and a statement about what we would have liked to have seen happen in 2003. Hence, there would be a recommendation that says -- I think the words that Kevin used in the paper were, MEI minus productivity for 2004. In the text we would say, in addition, we believe there should have been a modest increase in fees also for 2003. Again, no explicit reference to our SGR position.

So I'd solicit comments on that.

DR. NELSON: Just a clarification, Glenn. We would certainly not disavow our earlier recommendation with respect to the SGR.

MR. HACKBARTH: We would not.

DR. NELSON: We just wouldn't lay it out there front and center.

DR. REISCHAUER: But I think we would have to say that our 2004 recommendation is premised on the assumption that the 2003 recommendation, or something in that ballpark, is adopted.

MR. HACKBARTH: That's correct.

MS. BURKE: To that point, I just want to understand the implications of this. If in fact we come to January, the expectation at the moment is that the Labor bill, along with the other remaining bills, is going to be the first business at hand, which potentially could be the first week of the 7th. If in fact there is an attempt on the part of either the House or the Senate to go back and try and fix some of these things, I assume that part of what will happen here would ultimately be adjusting for what ultimately would occur, in anticipation of the March report.

To Bob's point, if this assumption is based on current law as a base or on the expectation that there'll be an adjustment to '03 -- I mean, if you assume that

you're proposing for '04 an increase that simply reflects the inputs now but doesn't correct the base, so it understates what in fact we think ought to occur, correct? Am I reading that correctly?

MR. HACKBARTH: Correct.

MS. BURKE: So that the statement would be that this adjustment presumes -- in order to be adequate under our test of what is adequate, presumes that there has been adjustment to the base that raises the base to a reasonable level and it is the adjustment to the base. In the absence of that, this is not an adequate adjustment.

MR. HACKBARTH: Exactly.

MS. BURKE: In some fashion that has to be described without getting in their face.

MR. HACKBARTH: Exactly. That's the challenge.

MR. SMITH: I would think though we'd want to say it using the words that we use in the framework. That we want to be explicit. That payments are not currently adequate unless. Therefore, we would have to take a two-step process in the 2004 update. We'd have to address the underlying inadequacy and then the update of MEI minus productivity. So we'd have a two-part recommendation.

Because we probably won't know, even if they take up the appropriation bills early, we're unlikely to know when we meet in January.

MR. HACKBARTH: I think that's true. It's unlikely that this will have been resolved.

DR. ROWE: Just a question on the data. As a member of the AMA I get a lot of material from the organization that talks about malpractice and the rates and how this is really one of the major concerns the AMA has currently. In addition, in my company we hear an awful lot, not only from the AMA but also from physicians around the country about malpractice rates and how the increases there require increases in the rates that we pay physicians for them to -- so that they can stay even, if you will.

I'm not surprised to see that malpractice or liability insurance is the most rapidly rising, but I am very surprised to see that it's only 3.2 percent of the expenditures, because even if it's rising at 4.4 percent per year, if it's only 3.2 percent of the expenditures why is there such a terrible furor about this? Are we sure about this number, that it's such a small portion of physicians' expenses?

DR. HAYES: That's the number that we have. It's based on a survey that the AMA conducted some years ago on spending for different inputs as a share of total revenues received. That percentage has moved around a bit over the years but it's always been, my recollection is that's always been under 5 percent anyway.

DR. REISCHAUER: It varies tremendously by type of practice.

DR. HAYES: Yes, it certainly does.

MR. HACKBARTH: Kevin, you said it's based originally on a survey that was done some years ago. Is the fact that it was done some years ago potentially an issue and a reason why this number may be off the mark?

DR. HAYES: It could be. The MEI, as the actuaries say, it is rebased periodically. The current MEI is based on 1996 weights. We can find out from CMS when they plan to rebase the MEI. It is possible to rebase it, I would think with newer information. There is a newer survey available.

DR. ROWE: I may be the only one that thinks it's off.

DR. NELSON: No, you're absolutely right.

MS. BURKE: But also to Bob's point, there are huge variations based on geography and practice, types of practice, the Ob/Gyns versus the anesthesiologists, versus the interns. At some point we ought --

DR. NELSON: They're all up this year, Sheila.

MS. BURKE: I'm assuming they're all up. But not only are they all up, but there are enormous variances. So that a statement of it's three or five or four, grossly understates some of the huge variance.

MR. HACKBARTH: I have no clue what the right number is. Like Jack, I guess I'm surprised to hear it's that small. Although if it's even close to that number, even large increases would not be having huge effects.

DR. ROWE: Why am I getting beat up about 4 percent increases?

MR. HACKBARTH: So even if it's perfect, and presumably it isn't perfect -- nothing that we do it, but even if it's 10 percent, it's not going to be the problem that the rhetoric would lead you to believe. There's a disconnect here between the passion and the numbers that we see.

MR. FEEZOR: Glenn, I' think take part of that is both the suddenness and the fact that there are no answers to go to when you have a major withdrawal from the market, so it's a real -- that's the reason there's a lot of passion on it.

DR. NELSON: And it comes out of your take-home. It isn't something you can pass along any more. You can't just raise your fees because your liability rates go up $50,000 a year. You eat it.

DR. ROWE: If it's 4 percent of 3 percent, it's a cup of coffee.

DR. NELSON: I'm talking about what premiums are going up.

DR. REISCHAUER: But the 4 percent is a projected increase for 2004 after we've had huge increases in 2002 and 2003. That's what they're howling about. So what this is saying to you, Jack, is just hang out, 2004 it will all die down.

DR. ROWE: I guess the question, and I think I've gotten the answer which is kind of a new experience here.

[Laughter.].

DR. ROWE: I was thinking that even after all

these huge and unprecedented increases -- and I'll be happy to wave the flag for tort reform. I'm on that side of the table, as you might imagine. I thought that even after those increases we were at 3.2 percent. It sounds like we were at 3.2 percent sometime in the past before all these increases. So we may be at a higher number, but still it's not going to be 20 percent.

DR. STOWERS: In the original formula, the PLI is not put in the other practice expense. We've kind of thrown that in here, and I'm wondering if it wouldn't be good if we went back to the original three parts of the formula and tracked it that way so that we can see what this PLI thing is doing, Kevin. Because the formula is actually broken down into physician work, practice expense, and PLI as the three parts, and it might be confusing people here to have that PLI factor thrown into the middle of the 3.2 that's the other practice expense.

DR. NELSON: It needs to be in both because it's establishing relativity.

DR. STOWERS: That's what I mean. But when we thrown it in the rest of all of the other practice expense it gets swallowed up in the numbers there.

DR. MILLER: Can I just make one point on this? Kevin, when we discussed this I also thought that there was some sense of a cycle here, an underwriting cycle that occurs. So in a sense, depending on how much inside the index you get, you're going to always be chasing, up and down, depending on where the underwriting cycle is.

DR. ROWE: I think, Mark, there are two cycles. We can turn this into a PLI discussion. I had the misfortune of, when I was running hospitals, having an offshore medical liability company. I'm sure Ralph had one too. One piece is the underwriting cycle. The other piece is the reduction in the value, and therefore the income from the assets that were underlying a lot of this, the reserves. So the stock market goes down, so that the premiums go up. I think that some people think that that's one of the very significant drivers recently, in addition to the size of awards and all the rest of it. But that's one of the more recent important -- so it's not just the cycle. You can see how that would have a direct impact.

MS. ROSENBLATT: I have a strange comment to make and please don't throw me out of the room. I know our charge is to come up with an overall update, given the

framework that we went through earlier today. But hearing the number that was just mentioned by Kevin got me very concerned. It's a big number.

MR. HACKBARTH: You mean the expenditure number of --

MS. ROSENBLATT: The budget implication. Is there any way for us to, instead of doing a general update for all types of physicians, is there any way instead to do -- when we were talking about the transition that carriers went through due to RBRVS where carriers didn't want to decrease specialists' rates and needed to increase the E&M rates, is there some in-between type of recommendation that looks at a finer level of detail? That's my question.

DR. NEWHOUSE: I can't resist putting in a couple, comments about the PLI. My recollection is I've never seen a number over 5 percent going back well into the '80s for the share of total practice expense. I think Bob's point is exactly right, that there were much bigger increases in 2001, 2002 although it's still -- you multiply it by a small share; it's not that big an increase. I would have said the passion you're seeing, this is not exactly a newfound passion and a lot of the passion

reflects the fact that many of the costs are not insurable. They're costs to your reputation, there's cost of your time to defend the suit. It's not the world's most pleasant experience being on the stand and I'm not surprised by that.

I think this discussion has appropriately focused on how do we frame what we're going to do in 2004 given what happened in 2003? But I wanted to raise another point that points also in a somewhat dovish direction to me. That is, I think we got -- in our normal update framework we want to try to account, however imperfectly, and it's pretty imperfectly, for productivity and technological change. Productivity comes in here as economy-wide productivity. That's a first order approximation, but it is an approximation. There is no reason that the physician sector should be exactly equal to economy-wide productivity. If you had to bet, at least I would probably bet that large parts of it were less, but some parts of it may be more.

Be that as it may, my main comment was I thought this got rid of the technological change factor too readily. That is, I'm mindful of a remark Jack made,

several years ago now, where he talked about the fact that -- this was in a somewhat different context, but that the 85-year-old person who you were trying to get onto the x-ray table took more time than the 67-year-old typically took.

You've noted -- this is a very helpful chart about what was increasing and what was not increasing so much by procedure type, and your remark there was that these were old technologies that were showing the big increases. My question was, so why were they showing the big increases?

My guess is they were showing big increases because as you send, actually the indications for them were changing, but I think the indications were changing because we were willing to do these things or the things they were going to lead to, on clinically riskier patients, meaning to a first approximation, the older-old. Those are precisely the people that may take more time. So I'm not quite so willing to get rid of technological change as not increasing costs here.

Now how much is it worth? I don't know. I don't know how we would ever figure it out but it would lead me

to tilt toward being somewhat more generous, or at least not doing a slavish adherence to an MEI minus economy-wide multifactor productivity.

DR. HAYES: If I may, one an option for us here is to pursue the project that we have in mind for the June report, which is to talk about volume growth in more detail and to look more closely at just this very question of whether the changes and indications for use of procedures are leading to different types of patients getting these technologies. So, yes, putting the number on it would be difficult to do, but if we do that further work we might get a little bit closer any way.

MR. HACKBARTH: Joe, to the extent that -- I think the initial thinking of why we didn't need a separate adjustment was that we've got very small bundles here. So as practices change, new technology is introduced and people use more complex services, it flows automatically through the fees that we pay.

I understand your point, but that still seems like a pretty good baseline assumption that we're getting the vast majority of the technology change just through the fee schedule payments. Yes, some of these may take a

little bit more time to deal with an older person for a particular procedure but we're getting --

DR. REISCHAUER: But isn't that picked up in the reweighting every couple of years? So that wouldn't make a difference, I don't think. I mean, there's a lag but when I look at this, the things that have increased most rapidly are all imaging of one sort or another. I don't know, but I'd be surprised if the age distribution of imaging has changed radically over the last five years of who is imaged.

DR. NEWHOUSE: I guess we'll find out in June.

DR. REISCHAUER: I can wait.

DR. NEWHOUSE: I'm willing to make a side bet, by the way.

DR. REISCHAUER: You're on. Let the audience be the witness.

[Laughter.]

MR. HACKBARTH: Let me just ask one other question about Joe's productivity comment. We have this placeholder, if you will, of 0.9 -- we have this uniform productivity factor of 0.9, and you're saying that you think for this particular segment that it might be a

significant overstatement?

DR. NEWHOUSE: No, I don't know how significant it is. I don't think we're ever going to know that. In my gut, 0.9 a year sounds a bit high, certainly for the E&M-based docs. Maybe the radiologists and the pathologists can make it. I don't know.

MR. HACKBARTH: Let me be real direct. We're at a point where we're getting very near to where we have to make recommendations, and even if things aren't quite right theoretically, this isn't a right number, I think what we have to do is disciplined ourselves to say, do we have really a compelling reason why we'd want to move this number for this segment? That's what I'm trying to push you for. It's almost certainly not exactly right, but I respect your judgment a lot, Joe, on whether you think it's likely to be so far off the mark that we ought to do something different.

DR. NEWHOUSE: No, the most I was thinking of was a few tenths of a percentage point and maybe the game isn't worth the candle for the combined effect of productivity and technological change. But I thought maybe just the text, if we're going to do this, would carry a discussion

of this could be off in either direction and some reasons why it might be.

By the way, the fact that these are old procedures -- to go back to the point -- actually makes I think where I'm coming from stronger. If there was a new procedure then I would think that costs might actually be falling in ways that this update factor wouldn't pick up right away. But I think the unit costs here for a given patient are probably pretty stable at this point.

DR. REISCHAUER: My guess is when you get into imaging you're getting economies of scale because you're running these machines 20 hours a day.

DR. NEWHOUSE: Yes, but some of them turn out to have fairly substantial marginal costs.

MR. DURENBERGER: Thank you, Mr. Chairman. First observation I have is that there's no way on God's green earth how I could argue with 2.4 or anything else and if at the end of March, like the rest of you I'm defending a number, I'm more likely to defend the process that we've gone through than I am to defend a specific number.

I guess the second part of that is, I have been instinct that tells me, regardless of what we say this year

there are other forces at work that are probably going to determine what that number and related numbers are likely to be.

But the third point is, for me personally as a member of this commission and as someone who represents MedPAC in that context after the numbers come out and so forth, it's what we say about what's going on in the practice of medicine I think is much more important, and that might be pointing to June or something like that.

There isn't a person on the Hill that when 2.4 percent comes out isn't going to hear from one of the 200 professional societies that are affected by this, and they'll tell them, this isn't adequate.

So there's nothing we can do here that's going to please anybody, but we might be able to tell somebody who's paying these bills and designing the structure for paying these bills, that there are things that we can observe as in the studies that preceded this testimony and what we hear here, there are things that we can observe now that will suggest to us -- and this is partly I think Alice's point -- suggest to us that there are some modifications in the way in which Part B reimbursement should take place

that might reflect certain of the ways in which, particularly on the subspecialty side, medicine is being practiced today in America.

The imaging part of it is probably the one that anecdotally will bother me the most because in November had I been wise. in this great group practice state of Minnesota with its lower costs and everything, I could have had a full body scan for only $300 had I wanted one.

DR. ROWE: It's not worth it.

MR. DURENBERGER: I know it isn't worth it. I know it's not worth it, but a whole lot of people don't know it's not worth it, which gets to the issue of, how can we begin to speak to the issues of appropriateness, and intensity, and some of those related issues that other people around here and people we know are talking about all of the time? That are some indication to the folks that have to take responsibility for paying those bills or raising the money, that there's something different --

MR. HACKBARTH: I agree, Dave. What we heard or what I heard was, frequently, about our SGR recommendation was that we were giving short shrift to an important problem for the Medicare program and for the budget;

namely, the potential for growth in the volume and intensity of services. So we were going back to an old world, or proposing that Medicare go back to an old world where we just pay for each unit of service, pay no attention to volume and intensity. The critics of our position said we can't afford that.

So I do believe that that, even if it's not a pressing issue as we speak, the volume and intensity is not growing rapidly by historical standards right now, it is a long term issue for the Medicare program. So I would like to pursue further the work that Kevin and others have begun, looking at where the volume increases are. Exactly where it leads, I'm not sure, in terms of policy prescriptions. But hopefully, if nothing else, we should be able to shed some light on the nature of the volume and intensity issue. But that is for June and perhaps beyond June as well.

DR. STOWERS: I won't take too long on this but I'm getting back to on assessing payment adequacy. We also have at the top of the list entry and exit of providers and we take that as some solid indicator of where we are. I wonder, Kevin, if this wouldn't be a place where we could

go a little deeper into that, because I think it's a very, very lagging indicator. To me, you've got those people that are not dependent on Medicare and what we're seeing is they're tending to stay in the program, so they're not one of those numbers that are going down as Medicare. They've got other sources of income. They can accommodate families and referrals and they stay in.

Then we've got those categories that are dependent but some of them have an option to do something else, so they can nix -- maybe in a more urban area they can switch the ratio of their practice, or they can go to new modalities, or they could discontinued altogether, but most of them don't. Then you've got those that have no options and we're already seeing difficulties with some of the physicians that know they're going into very Medicare-dependent practices, rural, innercity, whatever, that are just flat either leaving because they're fearing that point of not being able to make it or that we're having trouble recruiting them there in the first place.

So I think dependence on the practice and those options that they either have or do not have, but almost in all of these categories the enrollment numbers are pretty

well going to stay the same, whether they move their practice and leave underserved left out there.

So I think we put so much weight on that entry and exit that that bothers me a little bit. So I think we need to qualify that and just being right up front that, the survey says it went down 5 percent. I think when it goes down 5 percent or 10 percent, that's a lot bigger message being sent to us than just what the number would indicate. I think we have a chance here to explain that a little bit.

So I agree with your recommendation in your paper and all of that, but I worry about the weight that the general public out there might put on just rawly looking at those entry and exit numbers because they're way understated. Somewhere I think MedPAC ought to step up and say that.

DR. HAYES: Can I just ask a clarifying question? When you said the 5 percent drop you're referring to --

DR. STOWERS: I don't remember the exact number. In our survey that we did. I think that we all agreed that was a significant number, even if that raw number just meant that. But I think it means a lot more than that, and

could mean more in different situations of Medicare-dependent practices, geographic distribution. When we look at access to care I think we have to look overall, but we also have to look to specific geographic areas that may be affecting more than others. I just think we could get into that a little bit deeper, especially if we're going to keep it number one on the list, which every list that comes out has entry and exit as the number one thing.

DR. NELSON: My comments on PLI and productivity factor have been made thanks to others. I won't make those again.

But I would like to put on the record my concerns about the need to watch closely the participation rates and have a sentence or two about that, because I believe that with the cuts in payment a lot of physicians will examine their practice and make a decision about whether or not to no longer be participating physicians so that they can bill up to the limiting charge. That that will be an option that some may very well take advantage of.

Now what obviously that does is transfer that burden to the beneficiary, and that's a concern for me. But I believe that physicians in areas where there are

waiting lists of Medicare patients and waits to get in to see them, may very well decide that in order to keep their practice going the way they want, that they have do that. So it will be very important to watch participation.

MR. HACKBARTH: Yes, so the participation rate could be a leading indicator of, a more sensitive indicator than even access, as we're measuring it in the survey. So I think it's worth watching.

Based on the work that Chris did I want to pose a question, probably and unanswerable one, but what we have as described by Chris is a changing pattern on the relationship between Medicare fees and private fees. A significantly larger gap in the mid-'90s than exists today. Although recently we saw the gap between Medicare and private fees go down to less than 20 percent, and now with the 2002 cut it's begun to widen again, and certainly would widen some more if there's a 2003 cut.

The question, of course, that all that begs is, what does that mean for access? Does that mean if the 2003 cut goes into effect that there's going to be a direct effect on access? We can't answer that question, but I would hope maybe we can at least put the numbers in

context.

As I read the results, basically after the 2002 cut, the relationship between Medicare fees and private fees is about where it was in the late 1990s, at which time all of our surveys of access showed that there was good access. In fact we made explicit conclusions that access to care was adequate. So I think that's one specific point worth mentioning to our audience.

That, of course, begs the question, is there any reason to believe that on the way down that there would be a different response by physicians than there was in the 1990s? So it's the same ratio of Medicare fees to private fees but will they respond differently this time than they did before?

DR. REISCHAUER: I think it depends on the external environment and the extent to which there are other potential patients out there to fill up their excess supply. As the baby boom ages, one would expect the answer to that would be yes, because there's many people under the age of 65 who are increasingly high utilizers, for whom if they can control utilization or influence utilization, they might have a substitute, which was less true -- it is a

very gradual kind of demographic shift. So I would expect the impact to greater at an equal level of relative payments than it was before, unless they're losing their insurance. We have slightly higher insurance rates now than we did back then.

MR. HACKBARTH: By think the question that the data beg, and it's the question that the policymakers will want to know, so to the extent that we can shed even a little light on it I think that would be useful.

DR. STOWERS: There was a chart that we used on the hospital payments, or the Commission did a couple of years ago or whatever, that had the economic index and then it had what Medicare was paying and then imposed on that what the private payment was. I'm wondering if we couldn't translate that from the hospital world and do one of those on physicians, because it then would show when private pay was coming down. It would be taking part of what Chris told us today and part of what you're telling us and putting that together.

DR. NEWHOUSE: But the constancy of those -- in the numbers that Christ showed suggests there wasn't the big swing that there was on the hospital side.

DR. STOWERS: But there was a time when private was going down also. That's what really affects --

DR. NEWHOUSE: But those numbers didn't bounce around very much, Ray. They didn't bounce around anywhere near as much as the hospital numbers went around.

DR. STOWERS: It just would be interesting to see.

MR. HACKBARTH: I think that's it for now on physician payments.

Next up is outpatient dialysis. Okay, Nancy.

MS. RAY: Good afternoon. Switching topics, I will be discussing the adequacy of current dialysis payments and updating the composite rate payment for calendar year 2004.

Two questions that you should keep in mind during my presentation. One, do we believe that Medicare's current payments for all services provided by outpatient dialysis facilities are at least adequate? And two, what would be needed to account for anticipated increases in efficient providers' cost in 2004?

Just to briefly review their revenue streams that facilities are paid for furnishing provider Medicare

services. They're primarily two. The composite rate payment cover the outpatient dialysis session and this prospective payment system was implemented in 1983 and covers many of the services associated with the treatment including nursing supplies, equipment, and specific labs and drugs. On average, facilities receive about $130 per treatment and facilities are paid for furnishing up to three hemodialysis sessions per week. The other major stream of revenues that facilities are paid are for injectable drugs. Notably, the composite rate bundle does not include certain drugs that were not available in 1983. These drugs include erythropoietin to treat anemia, IV iron, and vitamin D analogs, to name a few.

What does Medicare pay for these drugs? For Epo, Congress sets the payment rate, and that is $10 per 1,000 units. All other separately billable drugs are 95 percent of AWP.

To review the services provided by freestanding dialysis facilities in 2001. In 2001, there were about 3,300 facilities and they treated roughly 220,000 beneficiaries. Estimated spending for dialysis services is about $3.3 billion and for injectable drugs was about $2.3

billion. CBO projects spending for outpatient dialysis services, and that includes the separately billable drugs, to grow at about 9 percent per year between 2004 to 2008.

At this point I'd like to again switch gears a little bit and go into our two-step model that assesses payment adequacy and updates payments. The first step in our model assesses payment adequacy. The way we do that is to estimate current -- that is 2003 -- payments. We compare that to providers' cost. We do that to evaluate whether current base payments are either too high or too low.

For the dialysis sector, we will do that using 2001 cost report data, which I just got at the end of November. Now before I start getting into those numbers, the 2001 payment to cost ratios and the 2003 projection I'd just like to take a step back at this point.

MedPAC's analysis of payments to cost is based on Medicare allowable costs. I raised this issue in the March 2002 report and I think staff has gone a little bit further in our analysis of the effect of CMS's audits of dialysis facilities' cost reports. think it's important for the commissioners to consider the effect on -- to consider the

relationship of current payments and costs when the costs are based on Medicare allowables.

The 2001 cost reports have not been audited. If history is any guide, a portion of the reported cost included will most likely be found to be non-allowable, when and if they are audited. The most recent year that we have audited data is 1996. Preliminary results of the audited 1996 cost reports show that allowable costs per treatment for composite rate services for freestanding facilities average about 95 percent of the reported treatment costs. So this would increase our composite rate payment to cost ration by about five percentage points, as well as our all service payment to cost ratio that includes both composite rate services and separately billable drugs.

Just to let you know that an older audit that was done back in 1998 found, for dialysis facilities, that allowable costs for treatment for facilities averaged about 88 percent of their reported costs for treatment. So our findings are not terribly unexpected.

The biggest reduction in the cost per treatment that we have found were for administrative costs. Those were reduced by about 70 percent. The other costs were

roughly in the 90 percent level for labor, capital, and other direct costs.

Now this graph displays a historical comparison of Medicare's payments to providers' cost. Again, these data have not been audited. The 2001 data point is not up there yet because I was still working on it. I'd like to caution commissioners that the 2001 data point is preliminary at this point and we are going back and triple-checking all of our data.

Our preliminary analysis on the all-service payment to cost ratio is that it is about 1.01, and that the composite rate payment to cost ratio is about 0.93. That's for 2001. That's not on this graph.

DR. ROWE: Am I getting this right, that's a significant reduction from where it was, and the other is 0.93?

MS. RAY: Right. In 2000, the all-service payment to cost ration was about 1.05. This is unaudited.

DR. ROWE: This is not for publication. So what you're saying is that there's a kind of parallel reduction in the two of them, the composite rate services and the all-services?

MS. RAY: That's correct.

DR. ROWE: Which I don't understand based on the material here, but I'll wait till she finishes.

MS. RAY: Let me keep going. If we would correct for the audit, then the all-service payment to cost ratio and the composite rate payment to cost ratio would go up. The all-service ratio would go up to about 1.06. If we decreased costs and made them 95 percent, which is what the audit result suggests, and the composite rate payment to cost ratio would increase from 0.93 to 0.98.

MR. HACKBARTH: Say again what the combined --

MS. RAY: The combined would go from 1.01 to 1.06.

MR. HACKBARTH: for 2001.

MS. RAY: For 2001. Again, I do want to just caution --

DR. ROWE: Which means that basically if you were to put it on this curve it would just go up a little bit; is that right?

MS. RAY: No. The results up there are also not audited. so the whole line would shift. We would shift up.

I'd like to make a couple of points about this

graph and about the 2001 findings. Just first off, and we've said this before, I think these findings continue to demonstrate that separately billable jobs cross-subsidizing the composite rate payment. Many have studied the fact that AWP on average significantly exceeds providers' costs. The OIG has looked at this matter specific with separately billable dialysis drugs other than Epo and also found that to be the case.

The OIG also looked at payments for erythropoietin a while back, back in 1997 and also found that those significantly -- that payments significantly exceeded providers' cost.

The next issue I'd like to discuss is the drop in the payment to cost ratio between 2000 and 2001. The drop occurred because of a spike in the cost growth in composite rate services between 2000 and 2001. For example, the average cost of composite rate services went up between -- and again, preliminary numbers -- it went up about 5.7 percent. By comparison, between 1997 and 2001 it went up about 2.1 percent.

Now within the cost categories of the composite rate cost the two components that spiked up were labor,

which is I think not terribly unexpected given from what we hear about providers and their having to compete with other health care providers like hospitals and SNFs for RNs and technicians.

The other area that spiked up was in administrative costs, the G&A category. Both of those, the 2000 to 2001 increase was much greater than the '97 to 2000 average annual increase.

The cost growth in the separately billable drugs, although it is greater than the composite rate services was generally constant between 200 to 2001 compared to the '97 to 2000 period. Whereas, the composite rate services are under a prospective payment bundle, the separately billable drugs are not. I think the reasons for the cost increase there are a little bit different. More has to do with the manufacture of erythropoietin raising the price of that drug in both 2000 and 2001, and the fact that newer drugs are increasingly being used in the later years, in 2000 and 2001.

The last point I'd like to make about this graph is that while it's the most comprehensive measure that MedPAC currently has, I'd just like for commissioners to be

aware that several national chains own laboratories and they receive payments for lab testes that are furnished to dialysis patients that are outside the composite rate bundle. In addition, some facilities are beginning to furnish the diabetes educational services that are now paid for by Medicare and staff will begin to look at that and the extent to which that's being furnished.

So now to project current payments and cost for 2003. Again we used our preliminary results from the 2001 cost report data. We projected costs for 2003 by assuming costs will grow at the dialysis market basket index. We also assumed continued productivity improvements on the part of providers.

We modeled payments for 2003 to reflect current law which does not change the composite rate in 2002, 2003, or 2004. So based on current law our model suggests that the payment to cost ratio would decline by about three percentage points lower than the 2001 level.

At this point I'd like to talk a little bit about market factors that we looked at. The first one --

DR. ROWE: Could you just say that again about the net effect? It's going to decline by how much?

MS. RAY: By about three percentage points lower than the 2001 level for the all-services.

DR. ROWE: Audited all services? Is it the 1.01 or the 1.06?

MS. RAY: The projection was based on the unaudited data, but it doesn't really make a difference because you're just talking about the level.

DR. ROWE: I understand. So it's 3 percent of the 1.06 not of the 0.98?

MS. RAY: That's correct.

MR. HACKBARTH: If we used the standard that we have used in the past which would be to look at audited costs, as we do for all providers, that's our benchmark if you will, then it would have declined from 1.06 to 1.03 is the projection for the combination of composite --

MS. RAY: That's correct.

DR. ROWE: In 2003.

MS. RAY: And current law did not update -- that takes into account no increase in the composite rate payment in 2002 or 2003.

DR. NELSON: Since 40 percent of the payments are for separately billable drugs and since the AWP is to be

replaced with a fee schedule established by CMS, and since there's no way to know where they're going to set that, how can we project what it's going to be?

MS. RAY: I think that you raise an excellent point. I projected based on the way our current law pays right now. So I did it based on the profitability of the AWP/

DR. NELSON: Understanding that that may be -- [Indicating.].

MS. RAY: It might, right.

MR. HACKBARTH: It's a significant wild-card in this.

MS. RAY: I think there's also the other issue about broadening the payment bundle. The Commission has gone on record recommending that the Congress instruct CMS to broaden the payment bundle. When the payment bundle is broadened, the separately billable drugs will no longer -- if the broadened payment bundle were to include these separately billable drugs than we would no longer be paying them AWP or on a per-unit basis like we're paying Epo. They would be included in the payment bundle and providers would have the same incentives to efficiently use those

services as they do now the composite rate services.

DR. ROWE: Can I comment? I think we're creating a problem for ourselves though a little bit. I know that we have a need to answer all questions that we are asked, particularly those that we are asked by Congress, who we respect greatly. But that does not mean that we have to be illogical. Everyone saw that paying 95 percent of AWP makes no sense at all. I'm not certain but I think my company gets an 80 percent discount off AWP. Something like that. I mean, a huge -- AWP is a made-up number. So everyone has agreed that we're not paying 95 percent of AWP any more, we're paying something else. And this is not only 40 percent of the total billable, or 33 percent of the total billable costs, but it's the largest growing, most rapidly growing piece of the cost.

So we have no idea what that number is going to be. For us to write something, or promulgate something that says that if all these things that we know are going to happen didn't happen, it would be 3 percent less is, I think misleading. We should just not file this, or we should stop this analysis at this point and say, because there's a whale going in the pool here and we don't know

how big the whale is, that we are not able to give meaningful estimates of what the rate will be until we know what this drug is going to cost. I would feel much more comfortable doing that than putting a number up there that we know is going to be wrong.

MR. HACKBARTH: This is a whale potentially. That assumes that something happens in the course of the next year, which I hope is true, but the AWP issue has been a well-known problem for a long period of time.

DR. NELSON: But the proposed rule has been published.

MS. DePARLE: No, the rule that was published was to say that CMS is going to use one carrier as the reference point for AWP. It did not say what the new rates were going to be, I don't think.

DR. MILLER: That's right.

MS. DePARLE: Now the administrator has talked about estimates but --

MR. HACKBARTH: Saying a whale is about to go into the pool, therefore we have no comment on renal services would not be my preferred choice. I think we can say, using the past payment rules, this is where we would

be, but a whale is about to go into the pool which means that all of this would be way off the mark.

MS. DePARLE: Can't you do it separately? I thought part of the reason why Nancy was giving us composite rate analysis and the other analysis was to enable us to distinguish somehow --

MR. HACKBARTH: Doing it separately I think gives you such a misleading picture of the industry's financial position.

DR. NEWHOUSE: And we've consistently recommended funding.

MR. HACKBARTH: Right. So this one ought to flash or something, we can have a picture of the whale.

DR. ROWE: We could put the whale on a dialysis machine and we could have a picture.

[Laughter.].

MR. HACKBARTH: We're joking here. Mark is reminding me that we need to be careful in what we say because we don't know how big this mammal is.

DR. ROWE: I think that Mark is expressing what I would interpret is a skeptical view that nothing changes, or it doesn't change much, or it takes a long time, et

cetera, and that the pressures on the other side will reduce the amount of reduction, et cetera. But the fact is that this has the potential to be very significant. Notwithstanding the general skepticism about the government in general, I don't know anything specific about this that would lead me to have great confidence that is going to be a small or a big effect. And given that we really shouldn't be promulgating numbers --

MR. HACKBARTH: We need to provide appropriate warnings. Nancy, I'm sorry for the interruption.

MS. RAY: I'd like to talk about several market factors at this point, the first one being the appropriateness of current cost. I've already pointed out to you the spiking of per unit composite rate cost. Again, there's the spiking of per unit cost, and then there's the level, whether or not the data is audited or not audited.

I'd like to now talk about changes in the product. In my review I would say that what I've done is I've looked at several parameters using 1997 data and 2001 data. I would conclude that the product has remained relatively constant. The length of the dialysis session has increased slightly -- and this is CMS numbers -- on

average from 210 minutes in 1997 to 215 minutes in 2001. I'm sorry, that was in 2000. The 1997 number was 210 minutes. The 2000 number was 215 minutes on average.

The ratio of technicians to other staff, and the other staff includes -- technicians to all staff, that would include RNs, dieticians, and social workers, has remained steady at 0.54 in both years. Sessions per station also remained steady in 1997 and 2001; on average roughly about 655. The patients to RN ratio has just slightly increased. Again, those are preliminary numbers going from 18 to 19 patients per RN, as well as the patient to technicians numbers. So I think just looking at those five parameters, my assessment is that the product has remained relatively constant.

Now to look at provider entry and exit and changes in the volume of services. I have a couple of graphs to show you. The first is the growth in the capacity to furnish dialysis has steadily increased between 1993 and 2001. On the left-hand side are the number of facilities; on the right-hand side are the total number of dialysis treatments. Treatments have gone up by roughly about 7 percent per year. I did look at what I call same-

store growth, the growth in the same facility. I looked at it for 1999 to 2000 and then 2000 to 2001. So the same-store growth increased by 4.7 percent in 2000 to 2001 compared to 4.5 percent between 1999 and 2000.

This graph shows the growth of for-profit facilities. This area seems to be attractive for for-profit facilities. They have increased to roughly 79 percent of all facilities from 61 percent in 1993. Furnishing dialysis services also is attractive to independent providers and I think this demonstrates that facilities can stand on its own, that they don't have to be part of the hospital system. Freestanding facilities increased to 83 percent of all facilities from 70 percent in 1993.

I did look at the characteristics of facilities that closed in 2001. Between 2000 and 2001 there was a net increase of about 156 facilities. Again, that's strictly by looking at the provider ID number. So if a facility just moved across the street that would be counted as a new facility. Facilities that closed were more likely to be small in terms of the number of patients they treated and total hemodialysis stations. They were also more likely to

be non-profit and hospital-based compared to those facilities that remained in business in 2001.

Some providers are contending that they are limiting their exposure to Medicare patients. I looked at the percentage of Medicare beneficiaries that were treated and it was roughly the same in facilities that did not operate in 2001 -- roughly 90 percent of patients were Medicare or Medicare entitled, and 91 percent for those that remained in business.

We also looked at quality of care, primarily by using the indicators collected by CMS in their clinical performance measure project. There was a table in your mailing materials that showed those data. Those showed continued improvements in adequacy of dialysis and anemia management.

Throughout the year we followed the literature and the press about looking at any systematic problems in beneficiaries' access to care and did not find any systematic problems in either 2001 or 2002.

Finally, we looked at access to capital which is necessary for dialysis facilities to improve their equipment and open new facilities, to accommodate the

growth in the number of patients requiring dialysis. Again, about 80 percent of the dialysis facilities are for-profit, and the four largest for-profit chains account for about two-thirds of all these facilities. These for-profit chains appear to have adequate access to capital as demonstrated by the growth in the number of clinics, the number of patients they treat, and their earnings.

So based on this evidence staff concluded that current Medicare payments are at least adequate in 2003.

Going to the next step of our framework is estimating increases in providers' costs in the next payment year. We still, unfortunately, don't have CMS's market basket index. That study is still being reviewed within the agency. However, if we do get it between now and the January meeting we will definitely incorporate it into our analysis. MedPAC's market basket for dialysis services actually uses information from price indices for PPS hospitals, SNFs, and home health agencies, and the market basket that we estimate is that providers' costs between 2003 and 2004 will rise 2.7 percent. We will have the most current MedPAC market basket number for you in January.

Other factors affecting providers' costs in the next payment year. Our update framework does consider scientific and technological advances. This factor is designed to include only those new technologies that are quality-enhancing, costly, and have progressed beyond the initial stage of use but are not yet fully diffused into medical practice. Based on staff's review of the literature we believe that the cost of most medical advances will primarily be accounted for through the payments for separately billable drugs.

Finally, as Kevin discussed, MedPAC's update framework reflects the expectation that in the aggregate providers should be able to reduce the quantity of inputs required to produce a unit of service while maintaining service quality. We here also use the 10-year moving average of multi-factor productivity in the economy as a whole, which is 0.9 percent.

Therefore, putting both staff's framework together, our recommendation reflects the increase in the projection to account for providers' costs, the market basket less an adjustment for the growth in multi-factor productivity which is 0.9 percent. So the draft

recommendation for you to consider would be that the Congress should update the composite rate by market basket minus 0.9 which is 1.8 percent for calendar year 2004.

Finally, the budget implication. Now this recommendation increases spending. Current law does not provide for an increase in the composite rate payment. It increases spending. The one year would be the category of $50 to $200 million and our five-year estimate, it would fall into the $250 million to $1 billion estimate.

MR. HACKBARTH: Can I ask you to do one piece of research for January? As I understand it, the rate for Epo is set by statute. Could you look into whether that would be affected by the AWP reform as currently constituted, proposed, since it isn't on the AWP system. There was an effort already to separate from that for this particular drug, and this particular drug is 40 percent of the separately billable, something like that?

DR. ROWE: Maybe more.

MR. HACKBARTH: Maybe more. So that's an important piece of information we need for next time.

MS. RAY: I will go ahead and do that.

DR. ROWE: I want to make a general comment and

try to see if the commissioners agree with me on this. First of all, I think this is excellent work. We've become accustomed to Nancy's excellent work. She's widely respected and acknowledged for her expertise in the field, if not feared. In my current work I deal with large dialysis companies regularly, and as some of you know, I was previously a nephrologist earlier in my medical career.

But in reading this material I had a thought that I think we are approaching this wrong. This is going to be a suggestion which has implications for the budget and the workforce of MedPAC so I hesitate, but let me just bring it up. I would accept everything that Nancy wrote and I think it's very well done.

But Congress passed a program to support the management of patients with end-stage renal disease. It's the ESRD program. It's not the dialysis program. I think over time the focus has become the dialysis expense. I think if you look at the total medical expense of patients with end-stage renal disease my bet would be dialysis is well less than 50 percent. These patients are admitted to the hospital very frequently. They have numerous surgical vascular procedures on the fistulas that they have for

access. They have a lot of comorbidity. After all, 40 or 50 percent of them have diabetes. That's how they got end-stage renal disease. Or they have longstanding hypertension and they also have other end organ damages, whether it's stroke or heart attack or peripheral vascular disease.

It just seems to me that it would be really helpful for MedPAC to step back and supplement what Nancy does with an analysis of some of the other expenses that are associated, and the trends. We're here to help provide access to high-quality efficient care for all the health care needs of these individuals, not just the dialysis treatments, which is kind of a technical thing.

I'm sure this has been done from time to time but I think it would be really helpful to step back, because sometimes what you make on the peanuts you lose on the potato chips. Sometimes you push more in one are for savings and you wind up saving it, but then you notice that other expenses go up. Like you can reduce pharmaceutical, some state programs reduce the number of prescriptions Medicaid patients could have and they saved money until they saw that hospitalizations rose in that population

because the people ran out of the drugs, so the state actually was spending more money.

I think we need a more holistic, if you will -- an overused term -- view of these patients and what their expenditures are rather than just singular focus on the dialysis treatment. That's just a general suggestion.

MR. HACKBARTH: I think it's along those same lines, I've heard people from the industry propose that there ought to be some component to the payment system that reflects the quality of the service, which may link to whether there are hospital admissions, et cetera. This does seem -- it's true of many chronic diseases. Maybe a little bit more in this case than others, but our focus on paying for individual units of service often seems to miss opportunities for improving care by looking more broadly as to what happens to a patient. So I agree conceptually with what you say.

MR. MULLER: I generally support Jack's suggestion and going back to one of the points I raised earlier, there really aren't that many areas where there's a lot of documentation on how well case management works. Everybody tries to talk about it increasingly. Dialysis is

one that there's been some experiments out in the Bay Area that goes on for a number of years. When you see the work that's being done both here and in other countries, just three or four areas, congestive heart failure, diabetes, asthma.

So when you think about the paucity of evidence behind case management in any kind of extensive way, and then the promise that people are trying to hold out for it, I think this is a good area in which to look, in part, as Jack mentioned. I too looked at the cost related to these patients, far less than half, I'd say far less than half are related to the dialysis itself, when you think of all the extensive number of hospitalizations. I seem to remember -- we had a big dialysis program where I used to be and I think on average they would have 14, 15 hospitalizations in the time they were with us in dialysis. They by and large would be five, six years on dialysis and have 14, or 15 hospitalizations. You can do the numbers on that pretty quickly and see how much it overwhelms the cost of dialysis treatment.

So I think both looking at that and thinking more broadly about the kind of evidence we can muster about case

management to see -- part by concern is, as we look at broader efforts to manage costs and to not just look at price and volume variations but also see what evidence there is inside the Medicare program of where case management would work, and I think this is certainly one of the three or four prime areas that would be a very fruitful way for us to go.

DR. NEWHOUSE: I'm not clear when Jack raised this, if you had it in mind that this was a June report thing on quality of care. whether you meant this to have implications for --

DR. ROWE: You now know as much about my idea as I do. I wasn't thinking of what chapter or what month.

DR. NEWHOUSE: Okay. I'm trying to square where this is with where the Commission has been. Where we've been on dialysis, or I think we should have been, is to risk adjust and to bundle. In a sense, Epo going off patent makes it easier to bundle because you don't have to worry as much about the stinting issue, or alternatively, what would you pay for some Epo in addition to the bundled rate?

What I'm wondering is why -- did the Congress

hear that and said, no, we don't like that, and that didn't get brought up here because we don't want to keep beating them over the head with it? Or was there no vehicle for it?

MS. RAY: The Congress asked CMS to develop a report on broadening the composite rate bundle. That study was due to the Congress in July of 2002. That study is still being reviewed within the agency. So the Congress did act upon this issue, and hopefully we'll be looking at CMS's study in the near future.

MR. HACKBARTH: So, Joe, you would like to see us make reference to our --

DR. NEWHOUSE: Yes. At least I think rather than just plod ahead with this --

MR. HACKBARTH: Good point.

MS. RAPHAEL: Just for consistency sake, we've looked at the margins for other parts of health care. I was wondering if we knew anything at all about the margins here, given that there's increased consolidation in the industry? There are four large chains that provide the majority of service, I believe, at this point.

MS. RAY: That's a good question. I'll get back

to you in January with that. Historically, ProPAC always looked at it, the payment to cost ratio, so that's what I have done. But I can also provide you with margins using the same calculations that the other folks do.

MR. HACKBARTH: Thank you, Nancy.

Next up is ambulatory surgical centers. Next up is ambulatory surgical centers.

MR. WINTER: Good afternoon. I'll be discussing our assessment of payment adequacy for ASC services and our approach to updating payment rates for 2004.

This chart provides some context for considering an update recommendation. It shows the growth in Medicare payments to ASCs from 1991 to 2001 in both nominal and 1991 dollars. In nominal terms, Medicare payments doubled between 1996 and 2001 from about $800 million to $1.6 billion.

Given that CMS plans to soon expand the list of procedures covered in ASCs we anticipate that spending will continue to grow rapidly. In fact ASC payments are projected to grow at an average annual rate of 11 to 12 percent between 2002 and 2007. Currently, payments to ASCs are less than 1 percent of total Medicare spending.

The first question in evaluating payment adequacy is whether the current level of Medicare payments is adequate relative to cost. Because the last survey of ASC costs was conducted in 1994 we have no recent data on costs. Thus, we would look at market factors in judging payment adequacy. These factors include the entry and exit of providers, growth in the volume services, and access to capital.

As we discussed last month, there has been rapid growth in the number of Medicare certified ASCs. The number of facilities doubled between 1991 and 2001, and increased by 50 percent from 1996 to 2001. Each year from 1997 through 2001 an average of over 270 new ASCs entered the market while about 50 closed or merged with other facilities.

The volume of procedures provided by ASCs to beneficiaries increased by over 60 percent between 1997 and 2001. This increase occurred despite annual updates to ASC rates of less than 1 percent between 1998 and 2002 as mandated by the Balanced Budget Act.

ASCs have strong access to capital, as shown by the growth in the number of facilities and the expansion

for-profit ASC chains. Two of the largest ASC chains have received favorable investment ratings over the past year. These firms have been acquiring new facilities and have experienced strong revenue and earnings growth.

These market factors lead us to conclude that Medicare payments to ASCs are more than adequate and that a reduction in the current rate might be warranted.

The next part of the update framework is to ask how much ASC costs will change in the coming, year. The first factor that will affect ASC costs is inflation and input prices. The ASC payment system uses the consumer price index for urban consumers to approximate changes in input prices. The CPI-U is currently projected to increase by 2.7 percent in FY 2004.

ASC costs may also increase due to scientific and technological advances that enhance the quality of care but also raise costs. Unlike the outpatient payment system, there is no pass-through payment mechanism to account for the cost of new technologies., However, the ASC payment system groups many procedures together into large payment categories. This means that the cost of a procedure could increase due to a new technology but still be accommodated

by the payment rate for its group.

In addition, it does not appear that the payment system has created barriers to the use of new technologies.

Finally, we are not aware of new breakthrough technologies that would significantly increase ASC costs. Thus, we do not make an allotment for S&TA costs. However, we plan to continue monitoring ASC payments to ensure that they are adequate to cover the cost of new technologies that enhance quality.

The final factor that affects ASC costs is productivity growth. MedPAC has adopted a policy standard for achievable productivity growth equal to 0.9 percent. By subtracting productivity growth from input price inflation, it appears that the cost of ASC services will increase by 1.8 percent in the coming year. We believe that current base payments are at least adequate to cover this increase in cost.

Here's a draft update recommendation for your consideration. For fiscal year 2004, the Congress should eliminate the update to payment rates for ambulatory surgical centers services. Under current law, payments would be updated by the increase in the CPI-U, which is

currently projected to be 2.7 percent. This recommendation is based on our conclusion that current Medicare payments to ASCs are more than adequate cover current costs and at least adequate to cover the increase in next year's costs.

We estimate that this recommendation would reduce spending by a small amount in fiscal year 2004, and by a small amount between FY 2004 and 2008. However, the five-year savings are at the upper end of this small category.

Now I'll move on to discuss a related issue. As we discussed at the last meeting, ASCs receive higher payment rates than outpatient departments for some surgical procedures, including the high volume procedures shown here. This table compares 2003 payment rates in the two settings for these procedures. We can think of no good reason why ASCs should receive higher payments than outpatient departments for the same procedure.

For example, we lack compelling evidence that ASC costs are higher than outpatient department costs. This disparity in payment rates leads to the following draft recommendation. The Congress should ensure that payment rates for ASC procedures do not exceed outpatient hospital rates for those procedures. This refers to the total

payment rates, the Medicare portion of the payment plus the beneficiary cost sharing.

This recommendation would help ensure that Medicare does not pay more than necessary for ambulatory surgical procedures. It would also a reduce financial incentives to inappropriately shift services between settings. We estimate that this recommendation would reduce spending by less than $200 million in FY 2004 and by less than $1 billion between 2004 and 2008.

This concludes my presentation. I look forward to any questions you might have been and your discussion.

MS. DePARLE: We had a fairly lengthy discussion of this at the last meeting, but I'm a little bit surprised at the data that you just gave us about the ASC rates because what I remember from the last session was that you provided us with a different table that had in fact some rates, and I thought was something around cataracts but it may not have been, and Bob even commented on how much higher the outpatient department payment was than the ASC. Am I misremembering that?

MR. WINTER: That's right, the table we showed last time was comparing rates for the five highest volume

ASC procedures and the number one procedure in terms of volume is cataract removal-lens replacement, which has a higher rate in the outpatient department than the ASC setting.

MS. DePARLE: Substantially higher, as I recall.

MR. WINTER: Actually, that difference has grown smaller over the last couple of years. We were showing you 2001 data last time and we now have 2003 data. I believe the difference is now in the range of about $200 or so.

MS. DePARLE: But it's still higher in the outpatient.

MR. WINTER: Still higher in the outpatient department. This table, I was just focusing on those procedures where the rate is higher in the ASC setting than the outpatient department.

MS. DePARLE: So what this recommendation is that we would lower all the ASC procedures down to the hospital rates?

MR. WINTER: Yes, that's right, where the ASC rate is higher than the outpatient rate.

MS. DePARLE: I guess I think we should have a discussion of the basis for that kind of -- are we certain

that all the hospital outpatient rates are the correct levels for these procedures? I don't know if we are.

MR. HACKBARTH: Let me take a crack at that. Are we certain that the hospital outpatient rates are right? The answer to that would be no. We never are.

DR. REISCHAUER: By right, you mean covering costs.

MR. HACKBARTH: Yes. The question here though is, is there a case to be made for the same service paying more to a freestanding facility than to a hospital outpatient department? I think a case can be made that there is no reason to pay the freestanding more. I'd like to hear what other people think, but my reasoning would be, first of all, the general, if not universal pattern of referral is that more difficult, more challenging, more risk cases are cared for in the hospital outpatient department where back-up is readily available and the like. So there's a systematic process for taking the easier cases to the freestanding facilities, at least in my experience.

So that's point number one. And frankly, I can't remember point number two for the life of me right now. We've been at this for too long.

DR. REISCHAUER: Just go straight to point number three the.

[Laughter.]

MR. HACKBARTH: The second point actually that I was going to make, now that that I've recovered from my lapse of consciousness, is a point that Ralph made at our last meeting. In addition to the patient selection process, through a variety of regulatory standards we impose higher cost on the hospital outpatient department. So through regulation we say they have to have higher cost, and they're taking more difficult patients, but we're going to pay more to a freestanding facility for the same service. To me that's an illogical thing to do.

MS. BURKE: I don't for the moment want to argue on either side of the issue, but I want to understand the follow-up to Nancy-Ann's question. I recall as well a discussion at an earlier meeting where we were shown numbers where the costs for the freestanding were higher? They were lower, correct? There was some that were both.

MR. WINTER: I can clarify this a little bit.

MR. HACKBARTH: They're not costs. They're payments.

MR. WINTER: We weren't comparing cost. We were comparing payment rates. I've looked at all the procedures, types of procedures represented in the latest claims data we have from 2001, and of those procedures there are about 1,000 of them, about 150, or about 12, 13 percent -- actually there are 1,200 procedures and about 150 of those the outpatient rate is lower than the ASC rate, so about 12 to 13 percent if you want just a sense of the total number of procedures, how that works.

MS. DePARLE: So in most cases the hospital payment is higher?

MR. WINTER: That's right.

MS. DePARLE: I think that's what I'm remembering from the last time.

MS. BURKE: You say in both cases. Is it the volume, or is it against the total number of procedures? Is the higher percentage in the actual number of procedures? I'm trying to understand --

DR. NEWHOUSE: It's volume weighted.

MS. BURKE: Is it volume weighted?

MR. WINTER: No, it's not volume weighted. I will go and do that analysis now. That's a good idea. I

suspect it's still going to be higher even when you volume weight it. That is, it will be higher in the outpatient department, given that the cataracts --

MS. BURKE: So it will be higher in the outpatient department. So I'm struggling to understand the presumptions here in terms of the freestandings being more costly as is cited here, and your presumption is to bring them down to the hospital. I'm just trying to understand the logic because I'm getting confused as to the earlier conversation and what's being presumed here.

MR. WINTER: We're not suggesting that the ASCs overall receive higher payments than the outpatient departments. We're saying there are certain high-volume procedures where that's the case, and perhaps might be encouraging shifting of services to the ASC setting. We might want to back and revisit whether ASC rates should be higher for any procedure than the outpatient department. But this was drawn to our attention because about seven or eight of the 10 highest volume procedures in the ASC setting, the ASC rate is higher than the outpatient rate.

MR. HACKBARTH: The reason that this has occurred, we have a payment system for ASCs that is an

unusual one. The rates are based on very old information which has been inflated by the CPI. That too, I guess, is part of the reason why I feel that it's a reasonable thing to do , to say that we shouldn't pay more than hospital outpatient department. These rates, these high ASC rates for these particular servers are an artifact of a weird system which ought to be changed. We can't change it overnight and this seems to me to be a reasonable short-term step.

DR. WOLTER: Just a couple of observations and questions. One is, are we going to look at the margins in these instances? I think with all the things on the table today and tomorrow, we get a robust look at inpatient margins but we tend not to get presentations on outpatient margins. We've got some very complex discussions coming up on things like IME and transfer rule, and it's very, very hard to come to a judgment on this particular recommendation unless we can see what the margins are in the outpatient hospital arena as well. At least I think it's a relevant question, especially given our conversation this morning, because I would certainly support equalizing and leveling

reimbursement across sites. But we should have some information about where the leveling ends up, I think.

DR. REISCHAUER: But this isn't going to affect hospitals at all because we aren't taking hospital outpatient down to ASC. We're only taking ASC payments that are above the outpatient rates down to what a hospital --

DR. WOLTER: No, I think I was more discussing the recommendation. If I remember, there's a recommendation here not to do an update; is that correct?

MR. WINTER: Yes.

MR. HACKBARTH: But that does not affect the hospital outpatient department. We will take up the update for hospital outpatient department services with the rest of the hospital piece.

DR. WOLTER: Thanks for that clarification. I just think it's an important point because we do have some areas in the course of today where we really are not seeing margin numbers, and yet, as we've said, we want to look at all of these things and try to have some understanding what the impact will be overall.

Then this is also somewhat a controversial area,

but the whole area of physician investment, whether it's in ASCs or whether it's in carve-out hospitals or imaging centers, if we are going to proceed in June or perhaps beyond that in looking at issues such as volume of services and quality, I think this is an area that deserves some exploration over time.

MS. ROSENBLATT: I just want to follow up on the question that Sheila was asking because if I'm understanding this correctly, and based on the procedures and what I remember from our previous discussion, you're talking about the 12 percent of the total number of procedures where the ASC is higher than the outpatient. But that 12 percent could represent like 90 or 95 percent of what's done in the ASC. Just looking at the list of procedures it seemed to me that that's the preponderance of what's done there. So the impact on the ASCs is a lot more than one would grasp from saying, it's 12 percent of the procedures. Don't we need to understand what the impact is going to be on a given facility?

MR. WINTER: Yes, that's good point and I will get that number for you for the next meeting. I can't be higher than 70 percent though because the cataract removal

procedure accounts for 30 percent of the volume. In that case, the outpatient rate is higher, so it's definitely less than 70 percent.

DR. MILLER: We don't think necessarily that it's even in that ballpark, right?

MR. WINTER: No.

DR. REISCHAUER: What if it were, Alice, and we were paying a whole lot more to create a kind of entity simply because our payments are high?

MS. ROSENBLATT: Do you change it overnight or do you want to transition --

DR. REISCHAUER: No, you might want to let them go out of business gradually without being --

[Laughter.]

MS. ROSENBLATT: That's my point. Let's understand the impact.

MS. DePARLE: I just want to note too, we had a bit of this discussion last, time, but the notion of not having a differential based on site of service or not creating incentives to do these procedures in one place versus another is something that is a well-tested idea. We did propose in 1998 to redo the payment system because the

payment system for ASCs was an early precursor of what we've ended up with on the outpatient side and the notion was it needed to be updated.

One of the reasons why Congress objected quite strenuously to that was because of the lack of data, cost report data, the kind of data that you would want to have to construct some new payment system. In fact Congress has now said that CMS cannot move forward without getting better data. I don't believe they have -- someone was saying they had begun the process. I don't think they have done a survey, have they, Ariel?

MR. WINTER: To our knowledge they haven't. The last official word on this was Tom Scully's letter to Pete Stark in April where he said, we haven't done the survey yet to revise the payment system.

MS. DePARLE: So, Glenn, this may just underscore your point that you can't change a payment system overnight. We're a long way from that, but I think there will be a lot of objections. We're short-circuiting that, is one way to look at it by saying, we'll just equalize everything. Maybe that is just a step toward something that some people would consider a fair payment system, but

others might see it as avoiding getting the data that is needed to construct a fairer payment system. I just wanted to make that point.

DR. NEWHOUSE: What if we had a third recommendation on data? It seems innocuous enough.

MR. DURENBERGER: I'm getting to the age where I can't remember what we did at the last meeting but I'm going to try to see if I can capture what we're trying to do here. If I understand the goal -- and if I use the Jack and Ralph rule -- the goal here is to pay for high quality health maintenance for people with, and then you fill in the blank, ESRD, or cataracts, or something like that. The policy statement or the policy process here is the differences -- or the statement of policy we've got to write, differences in payment that are driven by differences in cost of providing the service should not provide financial incentives to shift the site of care or something they like that.

Then there's a statement that says, on our way to defining what kind of payment system will provide that incentive, we recommend, whatever that recommendation was up there. I'm struggling for a context in which to do the

cap so people know where we're going.

MR. HACKBARTH: I think you've said it well. There's a long-term issue of reforming our payment system for services that are provided in multiple sites. For example, ASCs, hospital outpatient departments, and in some cases, physician offices. Those are interconnected issues, although in the past sometimes we've treated them like they're totally independent. So that's a major area for potential reform, but that's not going to happen quickly. In fact I think as you delve into it it's actually a fairly complicated issue, even from a conceptual level, let alone an operational level. So that's point number one.

Even given all that, having rates that are higher for freestanding facilities than hospital outpatient departments seems to me to be anomalous, given the patient selection issues, the regulatory issues, and the like. So we could say, we're not going to do anything until we've got the long-term reform in place. But what that means is allowing to persist, the movement of services from hospital outpatient departments to freestanding facilities at a higher cost to the Medicare program for at least some services with an adverse effect on the hospitals' financial

performance and viability with no gain to the Medicare beneficiaries in terms of quality, although admittedly it may be a gain in terms of service and ease of use and the like.

MR. DURENBERGER: I just want not to leave this -- if this is the stated policy goal, it has significance beyond just ASCs. If we think it's good payment policy for Medicare, that differences that are driven by differences in cost -- should not provide financial incentives to shift the site of care, or something like that. That means that if you actually want to pay more to put them in another setting, the money ought to come from someplace other than Medicare, conceivably. I'm searching for the policy here, which is that now on our goal should be that Medicare pays for a high quality health maintenance for people with ESRD, or cataract surgery or something like that --

DR. REISCHAUER: The appropriate site, because differences in patient's conditions, et cetera, might require a more high-cost --

MR. DURENBERGER: Absolutely, for that particular patient in that particular condition.

MR. HACKBARTH: Whether you want the policy to be

we pay the lowest rate consistent with high quality service, or equal rates, or equal margins on the different locations, there are a lot of different ways that you could cut this. I frankly don't know which is the right one.

If you want true neutrality, maybe the margin is what matters. You don't make more money in one location or the other so financial considerations are irrelevant. I don't know.

What I would ask is that we try not -- we avoid trying to answer this very, big complicated question right now and focus on the immediate issue of what we do in this situation where we pay more for ASCs than for hospital outpatient departments.

MR. WINTER: If I could just add something about the impact of this recommendation. We did a simulation of what the impact would be on total ASC payments using 2001 volume and we found that it would reduce payments by about 7 percent. So that gives you some idea of what the impact would be.

DR. MILLER: Just to clarify you said, you said 7 percent?

MR. WINTER: Yes.

DR. MILLER: Then there's just one other comment in terms of concern about the impact on the industry. Ariel said it but I think it's worth repeating, the growth in the number of ASCs is phenomenal right now, which would suggest that there is enough money on the street to pay for these services.

MR. MULLER: My question or comment is along those lines. We've now had a number programs we discussed today where there has been, it seems to me, some considerable growth in for-profit facilities. Have we ever taken the growth of the for-profit sector as any indicator of payment adequacy in our considerations? The spirit in which the for-profits are growing, do we take that as a marker of payment adequacy, have we?

MR. HACKBARTH: Growth in general we have used as a marker, and often it's for-profit facilities, but we don't usually break it down.

DR. NEWHOUSE: We often do break it down. I would have said where for-profit facilities are a relevant actor, they're more of a leading indicator because they're quicker to enter and to exit in response to incentives. But we have never really singled out their margins versus

non-profit margins, I think.

MR. HACKBARTH: I would agree with that, Joe.

DR. NEWHOUSE: I was quite going to underscore what Mark said, that we're certainly inferring that the margins are robust given the entry behavior here. That should govern, I think, our attitude toward the overall update factor, that plus some -- if we think they're too robust, we're still trying to make some kind of transition so market basket, or no update seems fine as a transition strategy to me. Then I assume we're talking about the OPD, the recommendation two of the OPD ceiling on top of that, which is also fine with me given that I think probably the overall size of the pot here is more than adequate.

DR. REISCHAUER: I have a question for you, Ariel. There's going to be an expansion in the number of procedures that ASCs will be allowed to do in 2003? How are those going to be priced?

MR. WINTER: That's a very good question. We're all eagerly anticipating that Federal Register notice which will tell us how they're going to price the new procedures they're adding to the list.

DR. REISCHAUER: But presumably once they're

priced then they will be under the ASC system and will, until the system is reformed, rise with CPI even if they're subject to declining costs because they're new kinds of procedures, in which case our second recommendation could become more important over time.

DR. NEWHOUSE: Are these differentially things that are now in the office?

DR. REISCHAUER: No, these are things that are in outpatient.

DR. NEWHOUSE: I thought we were talking about relaxing the 50 percent office rule, too.

MR. WINTER: That was the '98 proposal. We're not sure if they're going to finalize that or go back to the current standards. We really don't know until --

DR. NEWHOUSE: Because I could see an analogous thing coming on the office side, if we have a lot of things that are now office-based moving toward ASCs, which wouldn't seem to be that hard in areas where there's ASCs.

DR. REISCHAUER: In which case we might want to next year revisit this and say, you can't pay more than the office charge.

DR. NEWHOUSE: I'm wondering if we should

foreshadow some of that now, if this is the direction it's -- your question is a very good one on what the new procedures are. It's the whale two.

MR. MULLER: A lot of the growth in fact is turning the office-based ones into ASCs. That's what's happening.

DR. NEWHOUSE: That's what I thought.

DR. NELSON: There's just all whole host of those procedures that can't done, arguably cannot be done safely in the office.

DR. NEWHOUSE: I'm talking about stuff that is now done in the office.

DR. NELSON: They may be in some cases, but you can argue that they can't be done as safely.

DR. NEWHOUSE: They're being done in the office now but it's not safe?

DR. NELSON: I am saying that one could argue, as some gastroenterologists have argued, that the outpatient colonoscopy can be done in the office but there's a higher margin of safety if it's done in an OPD.

MR. HACKBARTH: We have some research questions for you and we'll take this up again in January. I

don't know about anybody else but I'm wearing out here.

Next on the agenda is paying for new technology. So we're moving from our discussions about specific update factors to a conceptual issue that we've discussed numerous times recently. In fact, Chantal, given that in this case I think we've got a draft chapter, as I recall, in the book that is pretty well developed and which we spent a lot of time talking about, I think we ought to be able to move through it pretty quickly. So your assistance would be appreciated.

DR. WORZALA: Understood. This afternoon we're going to talk about how Medicare pays for new technologies in its prospective payment system. As Glenn mentioned, we talked about this before and you've seen quite a lot of the material previously, and I'll try to be quick.

When dealing with new technologies, Medicare must balance two goals, paying adequately to ensure beneficiary access to care, and being a prudent purchaser. This is an old problem. It's been debated since the inpatient PPS was first implemented in 1983. We do, however, have new solutions in the form of inpatient add-on payments and outpatient new technology provisions that have been added

in recent years.

My presentation has two distinct parts. First I'll look at what Medicare is doing, and then I will look at what other payers are doing.

You've seen this slide previously. I think we've talked about the content many times. The notion is that a PPS makes a fixed payment for a bundled service. This gives providers considerable freedom to determine the mix of inputs, which allows many technologies to enter without any formal decisionmaking. The incentive here is to use new technologies that decrease cost, but it may slow the adoption of costly new technologies.

There are some constraints to prospective payment. I'll focus on the third one here, which is that prospective payment relies on coding and cost report data systems that involve multiple actors and take time to provide reliable information for setting payment rates. Therefore, the payment systems can sometimes be slow to incorporate the cost of new technology, potentially providing a disincentive to adopt them.

We should note that CMS has taken steps to accelerate these processes in the past year or two.

However, some manufacturers and providers suggest they're still too slow.

On the opposite side, however, it is difficult to find reliable and credible alternative sources of information for setting payment rates. Also some would argue that lags in setting payment for new technologies provides time to evaluate the technology's merits and to establish a price reflecting potential efficiency gains from using the technology over time.

Congress added specific mechanisms to pay for new technologies in both the inpatient and outpatient payment systems. While these special payment provisions are beneficial in that they help to ensure beneficiary access to new technologies and steer additional payments to hospitals using new technologies, they do have some drawbacks that are listed here. We've discussed these before. I won't go through them in detail.

On this slide are the provisions of the inpatient new technology add-on payments. They were described in detail in your briefing papers. Implementation of the add-on payments started in fiscal year 2003, so just about two months ago. There is a single drug, a treatment for

sepsis, that is currently eligible for add-on payments. Most observers do feel that the eligibility criteria are fairly stringent. They encompass newness, clinical, and cost considerations.

I won't go through the payment provisions and rather narrow in a little bit on the clinical criteria. Most observers, including our expert panel participants feel that additional payments for new technology should really be limited to truly new technologies that provide a clear clinical benefit. Consequently, I want to walk you through the clinical criteria for the inpatient add-on payments.

In broad brush, to be eligible for add-on payments a new technology must substantially improve, relative to technologies previously available, the diagnosis or treatment of beneficiaries. CMS payment and coverage staff collaborated to specify what that might mean, how it might be interpreted. They give examples such as providing a new treatment option altogether, or a treatment option applicable to patients that cannot be treated using existing technologies; technologies that offer a new ability to diagnose a medical condition or to

make a diagnosis earlier, either for everyone or for a subpopulation not helped by existing technologies.

Another example would be a technology that results in improved clinical outcomes such as reduced mortality, reduced rate of complications, decreased future hospitalizations or physician visits, or decreased symptoms such as pain or bleeding, or reduced recovery time.

It's important to remember that these clinical criteria are applied to a technology that is submitting an application for additional payment. This is not by any means a criteria for coverage.

Now I'm going to switch to the outpatient PPS. I think we've talked about this many, many times. I won't go through the details here of either the new technology APCs or the pass-through payments. I'm sure you're thankful for that.

I will, however, on the next slide, look at the criteria that are applied to technologies seeking additional pass-through payment. They are different for medical devices versus drugs or biologicals. Those are the three kinds of technologies that are eligible for pass-through payments, medical devices, drugs, and biologicals.

For medical devices, the criteria include newness, cost, and clinical benefit, but clinical criteria are very similar to those applicable to the inpatient add-on payments with the exception of some things targeted at physical attributes of the device that might make it a sort of generational change.

By contrast, for drugs and biologicals, only the newness and the cost criteria apply. We would argue that this represents an inconsistency in the treatment of technologies across drugs and biologicals versus medical devices within the outpatient PPS, so that effectively medical devices are subject to more stringent criteria than drugs and biologicals.

Similarly, there's an inconsistency in the treatment of the drugs and biologicals across payment systems with clinical criteria applying on the inpatient side but not on the outpatient side.

Given the need to target new technology payments to those technologies that are in some sense the most important, and our desire to achieve consistency of treatment within and across payment systems, we propose the following draft recommendation for your consideration.

The Secretary should introduce clinical criteria for eligibility of drugs and biologicals to receive pass-through payments. This recommendation should have no impact on spending since the pass-through payments are budget neutral.

At this point I will shift, unless there are questions, to a slightly different topic, which is the results of our research on the approaches taken by other payers in paying for new technology, and the expert panel that we convened on paying for new technology in Medicare. Again, you have seen these results previously. You've seen the final reports from our contractor.

What we have here is a list of approaches taken by other payers. I don't think I will go through them in detail except to note a couple of things, which is that everyone that we interviewed said that they do invest considerable resources in tracking technology, understanding the medical evidence regarding new technology's benefit, and they use that information. They look at costs as well. They spend a lot of time trying to understand cost effectiveness analysis, and really use that information to bolster their positions in negotiations for

price when they're purchasing new technologies.

Our discussion in the expert panel indicated that none of the strategies adopted by other payers is in fact easily adapted to Medicare because the program faces some unique constraints. The program is large; it covers over 40 million beneficiaries, so it has a large impact on the health care market. If Medicare were to adopt competitive bidding or other selective approaches, it could greatly affect the financial status of specific manufacturers, and also potentially have an impact on future innovation.

In addition, other payers often follow Medicare in setting their payment rates, so that leads to an even greater influence on the market.

Second, the Medicare program acts as an insurer, reimbursing hospitals and physicians for their services. As currently constructed, Medicare cannot negotiate directly with manufacturers to set prices for technologies. However, we would note that there is a competitive bidding demo underway and that may open up some new possibilities.

I think I will close here on saying that CMS really has limited administrative capacity and resources, financial resources to engage in the kind of the strategies

employed by other purchasers, who as I mentioned, invest heavily in tracking and analyzing technological advances.

Although the specific strategies that were identified by other purchasers are not easily adopted by Medicare, they do embody a common concept that we think could prove useful to the program. In paying for new technologies, other payers strive for value-based purchasing. That is, they limit purchases to technologies that have demonstrated clinical benefit, or they try to, and they make judgments about whether the additional benefits of a technology outweigh the additional costs.

When we convened the expert panel they expressed often that Medicare showed pursue value-based purchasing, however, there was no specific approach that was put forth for how that could be done or any agreement on how it could be done. We do know that there are serious methodological issues that arise with value-based purchasing: what is the level of evidence that's needed? What are the scope of cost and benefits that you need to include when assessing value? What threshold value would you set when evaluating a technology? Those are just a few of the questions that arise.

We do know that there are other challenges for the Medicare program in pursuing value-based purchasing. Past attempts by Medicare to introduce cost effectiveness analysis into the coverage process have been met with resistance.

Despite these challenges, value-based purchasing provides a mechanism to better balance the goals of paying adequately for new technology to ensure beneficiary access to care, and being a prudent purchaser. I think the introduction of clinical criteria for these additional new technology payments moves in that direction, but we may perhaps be able to move even further.

I'll stop there.

DR. NEWHOUSE: Chantal, I don't have any disagreement with what you just said, but I have a very strong disagreement with what's in the written materials to us, and it's on value-based purchasing where you suggest that that leads toward paying in accordance with the level of the benefit. We don't follow that elsewhere in the program or in general.

The water I get at my house has a very large benefit to be, but I don't pay anything close to the

benefit it has to me. And that's generally true through the economy. So while I'm happy to take clinical considerations into account in thinking about coverage, I don't want to think about payment in the same way.

Further, I think, as you know I have for a certain, I hope fairly limited class of devices and drugs, if we get there, I have suggested a rate of return cap and you, I think I would have said just took one particular tack on that and dismissed it too quickly on administrative grounds which is -- first of all, let me say where I think it's needed, and I don't think it's needed elsewhere. It's one where devices on patent, there's no good clinical substitute, and there's a demonstrated benefit, and there's a non-trivial Medicare share. So Medicare is basically facing something that it really wants to have and no alternative supplier.

I think that in that situation Medicare can't agree to pay whatever the manufacturer names. Who knows how we would calculate value, so I don't think your criterion works either. But you say, we can't do this because we would have to figure out the costs that were specific to that product. I don't know that we have to do

it that way . We could, for example, use the manufacturer's Medicare book of business which would be readily ascertainable.

I can find a lot of problems with that, but I can find a lot of problems in any procedure we use here. I think there is a real problem in this area and I don't think this is -- we can certainly -- we will face it.

The only other comment I had on the draft is an optics problem. You have a discussion in the text box of who will benefit from new technology payments and there's no mention of patients. I's all framed as which providers will benefit. If I were a patient reading this I would wonder how am I benefiting from all this. I think you might want to recast that.

DR. WORZALA: Poorly titled. I'll correct that.

MS. RAPHAEL: I just had one comment which is, I think whatever we do we have to recommend some increase in the infrastructure in CMS to deal with this, because we keep saying they have limited administrative ability, therefore they can't do X, they can't do Y. It's unlikely this would ever comes to pass. This is a very important issue. However we end up tackling it, it's not going to

happen unless there is some infrastructure and expertise that can take this on on a sustained basis.

DR. WOLTER: This is probably more looking out ahead over several years, but in addition to technology related decisions around specific devices or biologics, if we look at things like clinical knowledge systems and how over time they may imbed clinical knowledge, clinical pathways, help us with drug alerts, maybe create some efficiencies, to help us measure quality of care better, how does Medicare at some point look at the investment that would take and how it fits into our various payment mechanisms? I think it links back to the quality discussion also, obviously, that we had earlier in our sessions this year. It's a complicated topic but I think one over the next two or three years that we'll need to address in addition to the specific devices.

MR. DeBUSK: Joe, what product falls in that category where there's no competition? Do you have something in mind?

DR. NEWHOUSE: Let's try erythropoietin.

MR. DeBUSK: In the drug area. In the supply industry we're profit neutral in what we try to do.

[Laughter.].

MR. HACKBARTH: Any other comments on this?

MR. DURENBERGER: Can i just clarify that? I like the idea of the value approach. I don't get the analogy with drinking water, so I think it ought to be explored.

DR. NEWHOUSE: How would you do it if --

MR. DURENBERGER: I don't want -- you're so smart I can't debate you on this.

DR. NEWHOUSE: Let me ask you this, how would you apply value-based purchasing to what the government show pay for erythropoietin? You could say it's a very useful drug, it's a great drug and we should cover; it should be available to --

MR. DURENBERGER: So how about drug eluting stents, or we can go on and on with -- there's a variety of technologies we're talking about. The question is, is there a process to determine how much we should pay for it.

DR. NEWHOUSE: Yes, that's it. But it's not, I think, going the route of trying to figure out what is the benefit to the patient and we would therefore pay something that equaled the benefit.

MR. DURENBERGER: I don't want to discourage the approach to value.

DR. NEWHOUSE: So again, distinguish coverage from payment.

MR. HACKBARTH: As I understand Joe, he's not in disagreement with the point that in making coverage decisions that we ought to take into account value. Then the next step is, okay, it's in, what do we to pay for it? His point is trying to determine the value of pay on that base basis probably doesn't lead us to the right place, so we need another method. As he said his preferred one, at least in the case where it's one source -- least dispreferred -- what he likes best of a bunch of difficult options is that we look at the return on investment that the developer has made in it and we agree on some number for that.

Now that has a lot of difficult technical issues, I imagine, in some right but it's different than saying we're going to pay for its value.

MR. DURENBERGER: We're comparing something new with something not so new. Something that's in the process.

DR. NEWHOUSE: Then that's fine. Then there's a good substitute and we can have competition.

MR. HACKBARTH: So an important feature of what Joe is saying is that when there's no alternative to it. This is new and there's no substitute, it's on patent, one supplier, et cetera. Those are special cases but important cases.

MR. DURENBERGER: Like bottled water as opposed to water in the tap.

[Laughter.]

MR. HACKBARTH: Any other comments? I think this is a very good chapter. Chantal, thank you for your work on it.

Last item for the day is PPS in the inpatient psychiatric facilities.

DR. KAPLAN: The purpose of this presentation is twofold. First I'll answer questions you raised at the November meeting, and second I'll present major issues CMS needs to consider in developing a PPS for psychiatric facilities. At the end of my presentation you'll need to discuss whether there are additional major issues we need to raise. Your comments will be incorporated in the draft

letter report to the Congress and you'll review the draft at the January meeting.

As you know, inpatient psychiatric facilities specialize in treating patients with mental illness. To be admitted patients must be considered to be a danger to themselves or others. These facilities also provide treatment for patients with alcohol and drug related problems.

To review the chronology -- and we'll do this real fast -- the BBRA required CMS to design a PPS and then report on the PPS to the Congress. We are required to evaluate the impact of the PPS on which CMS reports. CMS issued their report in August. Our report is due to the Congress March 1st. However, we've decided to be more useful to CMS and the Congress we would submit a letter report to Congress in January that identified major issues for CMS to consider. When the CMS actually publishes the regulation on the PPS we'll comment on their proposal. Once the PPS is implemented we'll suggest refinements as necessary as part of our regular work.

Some basic volume and spending figures for 2000 are on the screen. About 300,000 beneficiaries used

specialty psychiatric facilities in that year. The majority of these beneficiaries were disabled. Some had more than one discharge. Medicare spends about $3 billion on specialty facilities. About 2,000 psychiatric facilities are Medicare certified, about 75 percent of these are hospital-based units.

Last month you had some questions about the distribution of facilities, especially government hospitals. On the screen you see a map of continental United States and these facilities. The red dots are government hospitals, the blue are freestanding hospitals, and the green dots are hospital-based units.

About 20 percent of beneficiaries live in rural areas, 22 percent of specialty psych facilities are in rural areas. Of all beneficiaries using specialty psychiatric facilities, about 60 percent are disabled, 98 percent of the disabled are under 65-years-old. About 15 percent of all beneficiaries using these facilities are aged 80 and older, and about 3 percent of all beneficiaries are involuntarily committed.

As you can see on the screen, rural hospitals have a larger share of patients age 80 and over.

Government freestanding hospitals are much more likely to have beneficiaries who have been involuntarily committed.

Other questions you had last month are, what is the distribution of facilities, and how does the Medicare caseload break down among the facility types? As you can see on screen, the majority of beneficiaries are treated in hospital-based psychiatric units. Government freestanding hospitals treat about 6 percent of beneficiaries. That was one of your main questions.

For the PPS, CMS plans to modify a regression model developed by Theory, the Health Economic and Outcomes Research Institute, with the American Psychiatric Association. On the screen you see a comparison of the variables used in the original APA model and the modified APA model. Both the original and the modified APA model use patient-specific and facility-specific variables to predict variation in per diem, patient-specific facility costs.

In your mailing material you have both the regression results and the impact analyses for the original and modified models. The original APA model explains 22 percent of variation in patient's per diem resource use;

the modified model explains 20 percent. Of course, with the per diem system the big source of variation resulting from length of stay is already removed.

The original model uses totals for days and charges; the modified model uses Medicare covered days and charges. For teaching, the original model uses the ratio of interns and residents to beds. The modified model uses the ratio of interns and residents to average daily census. The original model uses 12 broad categories for comorbidities such as drug and alcohol secondary diagnoses; the modified model uses four specific conditions: ESRD, COPD, diabetes and HIV.

The original model did not include beneficiaries treated in government freestanding hospitals; the modified model does include them. The original model did not the distinguish among different types of facilities; the modified model does. We'll discuss these last two differences in greater detail in a minute.

In all mailing material we discussed six major issues that CMS needs to consider in developing the PPS for specialty psychiatric facilities; four them are on the screen now. Two of the issues are fairly technical and are

about methods.

First, how per diem payments should decrease? Should it be block pricing or should payments decrease continuously?

Second, whether or not to transform cost variables? The latest research illustrates that with a large sample, not transforming is a better choice.

Two major issues apply to the implementation and administration of the PPS. First, how long the transition should be and whether facilities should have the option to move to 100 percent PPS payment before the transition is complete?

Second, whether the Secretary has the authority to update the PPS and adjust the update for case mix creep, if necessary.

The last two major issues that CMS needs to consider concern what hospital-based units and what government freestanding hospitals should be paid. CMS found a difference in cost between hospital-based units and other facilities and said that more costly units reflect the increased complexity of patients admitted from the acute care hospital with still unresolved medical problems.

However, in prior research by MedPAC, we found only 20 percent of patients in specialty psychiatric facilities are transferred from acute care hospitals.

The modified APA model shows hospital-based units have 18 percent higher costs compared to freestanding hospitals. Research on costs that acute care hospitals allocate to units reimbursed at cost found that 15 percent of those units costs resulted from hospitals over-allocation of overhead. Part of the difference in cost between hospital-based and freestanding psych facilities may also reflect cost allocation issues. CMS will need to estimate how much of the difference is related to cost allocation and the adjust payments accordingly.

Government freestanding hospital patients were not included in the original model. It would be best for those patients to be included in PPS, but payments need to be close to cost. The work that we've done so far with Theory's assistance does not give a clear answer as to what these hospitals should be paid. We think that we can make a contribution to knowledge by spending more time trying to parse the relationship of facility type to patient characteristics.

I have two questions for you. First, have we missed other major issues? And second, should we proceed with more research on the relationship of patient characteristics to facility types? This research probably would not be available for the January report. It's up to you.

Thank you.

DR. STOWERS: Sally, I've got a question. A lot of our moderate size hospitals have gero-psych units. Is that in this category?

DR. KAPLAN: Yes, they are specialty --

DR. STOWERS: As opposed to the typical psych or drug and alcohol. Are all of those categories under this psych then?

DR. KAPLAN: Those are specialty psychiatric facilities. Those are hospital-based units. There is a coefficient in the regression model for age which basically distinguishes between people who are over 65 and under 65.

DR. STOWERS: I just thought it might be interesting, at least somewhere in here, to lay that out, what types of hospitals -- maybe I missed it in the reading but --

DR. KAPLAN: No, we didn't specifically mention gero-psych units.

DR. STOWERS: I think it's very important here, especially as we look at why in some areas of the country we've got the older population, because the community hospitals tend to always have the gero-psych capability for dementia and Alzheimer's and that type of evaluation, while a medical evaluation is going on. It's a completely different animal in caring for that patient than the typical drug and alcohol or psychiatric hospital.

Apparently this takes care of that, but I just -- from a Medicare standpoint I think the gero-psych might want to be separated out, or at least acknowledged in there.

DR. NEWHOUSE: I had two comments, one on the length of transition and the option of moving to 100 percent. I think there's a fairly compelling case of problems in the system at the hospital level and that it would be better, even though it is going to be expensive, to let the hospitals that benefit go to 100 percent right away. One can make, I think, a fairly good case that they're now underpaid.

Then the transition is presumably because we think we're overpaying others but we're not going to make them adjust immediately to that. So basically the cost of this is that kind of transition.

On one of the typical issues -- maybe this is really a question for Karen Heller -- I don't understand the response on the continuous payment versus the -- or the payment decreasing continually by day or by stages. The response in the letter is, we would have to wait for the end of the stay to bill. But you don't really have to do that. You can always compute how much you're owed after 10 days and send a bill.

The second, you told me this morning when I talked to you privately that there were some clinical reasons. I don't really understand that either. Because if there's clinical reasons, there's clinical reason, but you can still pay for the incremental cost of the day. In fact I think -- I'm not an expert in this area but I think that maybe one of the reasons that things broke on weeks here was that private insurers, early on, limited payments to a certain number of weeks and people just got used to breaks on those weeks.

But either way, whatever it is, if the physician says he or she should stay there for two weeks, fine. I can still pay a continuously declining rate. There's nothing that interferes with that.

So I am still thinking that we should have a rate that that mirrors the cost per day. I'll just leave that out there.

MR. HACKBARTH: Others?

DR. KAPLAN: Then I will bring that back to you in January in draft letter report form.

Thank you.

MR. HACKBARTH: Okay, we are now to our public comment period. Let me repeat the usual groundrules. I'd ask people not to make lengthy presentations. Keep your comments brief and to the point, please. I think that's in our collective interest. You will quickly start to lose tired commissioners if you go on too long.

I'd also ask that if somebody before you has made the same point, that you not get up and repeat it. You can just get up and say, me too; I really believe that.

Go ahead.

MR. PYLES: With that admonition, my name is Jim

Pyles. I represent the American Association for Home Care, and I wanted to address some of the recommendations and comments made about the home health benefit earlier today.

When I appeared before you at the last meeting I indicated that the second-largest home health provider in the country might be driven into bankruptcy that very day. It was. And the third and fourth largest providers are much, much smaller. So we are about to lose another major home health provider.

If this commission were to recommend retention of the 15 percent, or 7 percent cut, and perhaps even recommend even further cuts in its March report, that would be truly a remarkable and shocking reversal of your recommendation of last March, which was to have this benefit attain some stability so that you could obtain some accurate data to know what further refinements should be made. The basis for your recommendation was that there was unprecedented volatility in the home health benefit; no evidence of gaming; and a need for a period of stability.

So what's changed? Greater volatility. On October 1st, the 15 percent cut, or the 7 percent cut did go into effect. Now there's a further threat perhaps of a

loss of the 10 percent rural add-on, and perhaps even a recommendation by this commission for further cuts.

Is the data better now? It's really not much better. There's all sorts of adjustments that are still being made in the prospective payment system, in the adjustments in the payments for short stays. The hospital-based cost reports were filed late, are still not available, so you don't have complete data there. Claims for the advanced beneficiary notice are not being processed yet. So the data is really not much better now.

Your staff indicated that $9 billion to $10 billion was spent on the home health benefit. The last time that happened was in 1993 -- 10 years ago. They said approximately 2 million beneficiaries get home health services under the Medicare benefit. That's 1 million less than in 1997. And we know that the 1 million that were severed from the benefit -- studies have shown and your staff has these studies -- show these were the sickest. These were not the patients who could do without the service or who were not qualified. These were the diabetic patients, the brittle diabetics. These were the COPD patients. These were the patients who could least afford

to do without it.

What is the effect of an across-the-board cut like the 15 percent cut, the elimination of the rural add-on, or another cut in the market basket? It always falls on the highest cost patients. You can do better now. You have a prospective payment system where you can calibrate, where you make the adjustment. But you just need to wait and get some data to know where to make those reductions or adjustments or whatever they are.

Market entry and access, I said the last time, there was a CMS policy that was forcing agencies to convert branch offices to providers. So if there is no reduction in providers observed, there really is a reduction in total providers because branch offices are being converted to provider status under the new CMS policy. So it has to be -- and you're going to see a reduction with the company that went into bankruptcy.

Impact on, residual impact of IPS, I would urge you to take that into account. How many home health agencies have extended repayment plans with CMS? Easy to find out. That will give you an idea of how many are financially vulnerable.

Access to rural home health. How many counties in this country no longer have any home health provider, or only have one, eliminating freedom of choice? That information is available. I would think that would be of interest to you.

Seventeen percent annual rate of growth was projected for 2002 through 2007. If the length of stay is down 60 percent, you must be expecting a massive influx of new Medicare patients. There's no evidence of that, unless they're going to fall out of the sky. I just don't know where -- it can't happen under PPS.

Final question I would ask is, is this benefit any more stable today than it was last March? It is far less stable. So I would urge you to reiterate your recommendation of last March, let this benefit stabilize, repeal the 15 percent or the 7 percent cut, get some accurate data, and make some good health policy in this area. It desperately needs it.

Thank you.

MR. CHINCHANO: I'm Dolph Chinchano from the National Kidney Foundation. As a patient-based organization, the National Kidney Foundation is concerned

about the relationship between reimbursement levels and access to care.

In particular, I would like to suggest that the Commission look at the impact on service areas where there are closures of dialysis clinics. It's my impression that there are closures, predominantly in rural areas and in innercity situations, both of which have significant potential damaging effect on access to care. In the rural area, if there is a closing, that they mean patients have to travel greater distances in order to get dialysis services. And in the innercity the question is, when a unit closes, whether there is another entry likely to enter into the marketplace.

So I would respectfully suggest that that might be another issue that the Commission looks at with respect to the reimbursement level for the composite rate.

Thank you.

MR. LANE: Larry Lane, Genesis Health Ventures.

On the SNF issues, three basic points. Staff has proposed a redistribution, "the Z factor" that is $1 billion which is 7 percent of the rate. They did not provide adequate supporting analysis. We think is

significantly different than we know. I think undermining that part of rate, that 7 percent on top of the 10 percent reduction that we just took on October 1 will significantly further destabilize the SNF sector.

Second, Medicare margins on chart 8 distorts reality. As Senator Durenberger mentioned, consideration must be given to the impact of Medicaid. Total post margins for freestanding facilities average approximately 0.5 percent. With the Medicaid cuts that are occurring or will occur we are probably in negative territory for many, if not at least half we model, of the facilities.

I'd also comment to comments on the chain or ownership. Ownership is not the variable that's driving margins. The variables that drive margins are occupancy, location, Medicare volume, percentage of Medicaid days. That's what determines the margins in this sector.

The third is, and somebody else will address is, the recommendation on the market basket to have a zero increase. When you're having a sector with 1.8 million employees with labor costs going up 6-plus percent the question is, where does zero put us, especially when -- and in some data, a paper we handed staff earlier, we've done

an analysis using CMS's own data that shows that this current year's market basket, the forecast estimates understated actual cost component going on with labor and market issues in their market basket. That has not been picked up in the rate structure.

Thank you, and thank staff for taking time meeting with us recently.

MS. GAMPEL: Gwen Gampel and I represent the major dialysis providers and the administrators of dialysis providers. I'd like to join in with NKF on the remarks on access to care in both rural and innercity facilities and make three additional points.

One, the Commission has to remember that any given dialysis facility, or in general, 70 to 100 percent of the total revenue comes from Medicare. So 70 to 100 percent is what the revenue is for any given facility on Medicare. So Medicare is the 800-pound gorilla for every dialysis facility.

So then I'd like to make the point about the productivity factor that was discussed here. I know you're using this 0.9 percent, but Nancy's own analysis showed you the proxies for productivity is the number of sessions, the

time on dialysis, and the staffing ratios. Basically Nancy told you, in terms of stations, it's constant from 2000 to 2001. In terms of dialysis times, it's gone up from 2000 to 2001.

When you look at the staffing ratios, Nancy told you that basically in terms of tech to all the other staff, it's pretty constant, and in terms of RNs to patients there was a slight increase. So the overall picture really is, when you look at all the proxies for productivity, they're pretty constant between 2000 and 2001.

So it's really hard for me to understand how you can use this 0.9 percent productivity offset. That's almost an entire percentage point off of market basket increase and that market basket -- you know, 2.7 percent is not a significant amount in the scheme of things here.

My third point is that we have to remember this is a very high-tech industry. That you really need very, very qualified staffs. The RNs -- the laws in the states require that the RN provide these IV drugs, that the RN is responsible for that patient's care. We can't retain or even hire new RNs today given that hospitals are stealing them because they can pay bonuses, because they've been

getting updates every year, and we have a zero in 2002 and a zero in 2003, and may be getting a zero in 2004. So how are we going to be able to have the qualified staff to provide care in this environment?

So I would really urge you to rethink this productivity offset and to begin to look at what Jack Rowe has said, that you've been squeezing down on that one-third of the ESRD dollar, which is the dialysis facility, and that 40 percent, that hospital dollar continues to grow because you're not investing in the dialysis side which could help you on vascular access, on cardio monitoring and so many other things that you'd have such a win for both Medicare savings, provider increases, and much better patient outcome.

Thank you.

MR. BURR: Doug Burr with Centennial Healthcare, also on the SNF issues. I'd like to, for a moment, just elaborate on some of the comments that Mr. Lane made regarding the Medicare SNF market basket, specifically in regards to some information that was published in the July 31st, 2001 Federal Register by CMS where it indicated that the historical projections of the market basket update were

actually less than the actual market basket update by 3.73 percent.

Now one of the fundamental issues in looking at whether the rates or the pricing match and trend with cost is assessing the adequacy of that market basket factor. In looking at the historical projections being short from the actual market basket updates by 3.73 percent, that results in about $12 a patient-day understatement in the current SNF payment rates. I think that that's one thing that needs to be addressed. I ask that the Commission address that when they're assessing the payment adequacy.

The second issue with regard to the market basket is the fact that the proxies that are used to forecast the cost increases should be reflective of what's actually happening in the marketplace in which skilled nursing facilities operate. In the area of labor and capital, the proxies that are being used do not fully recognize some of the increases in cost that are actually being incurred by skilled nursing facilities between 1998 and 2003 as is evidence by some studies and data that's been produced by Buck Consultants, and also by the fact that the proxy for capital makes the assumption that skilled nursing

facilities are a AA bond rated industry, when in reality current market forces show that they're not.

The third issue I just want to touch and comment on and respond to some comments that were made earlier today regarding the cross-subsidization of Medicaid by the Medicare program.

I do understand the policy implications associated with such a cross-subsidization, but we have an industry and a sector here that is serving several million people on a daily basis and the profession really needs assistance from this Commission or from someone to make a recommendation to assess the impact of the resources that are utilized across government payer sources. As a country, if we're allowing one payer source, or a disconnect between various payer sources to drive what we believe is adequate reimbursement for keeping an industry sector stable, then we're really misrepresenting what's occurring in the marketplace.

Medicare represents about 10 percent of the days in a skilled nursing facilities so therefore using a Medicare margin as a proxy to determine the adequacy of payments and the availability of capital in the skilled

nursing facility sector does not present the entire picture, which is why I believe that one of the things we should do is take a look at the total margin of the skilled nursing facilities because after the sunset of the 16.6 and the 4 percent add-ons this past October, we have a data analysis for 2,100 skilled nursing facilities that shows that the total margin of these facilities is 0.32 percent, which by itself may not be a significant issue for the Medicare population. However, given what's occurring in a number of states across the country, if Medicaid rates are frozen for a year, that will result in these facilities converting to a negative margin of about 2.7 percent, which over time would lead to a potential access issue for Medicare beneficiaries in skilled nursing facilities.

I'd like to thank the Commission for offering this time to make comments.

MR. MAY: Hi, Don May with the American Hospital Association. I will try to be brief since I'm the last one in line and keeping everyone from going home.

I'm, like a lot of the others who stood up here, am struck by the real differences in the staff recommendations that were presented today and the

recommendations that were in the March report. Just a few key points I'd like to highlight.

One, would really encourage the Commission and the staff to drill down into some of the data that was provided today. We saw some aggregate information. We didn't look at a lot of the typical breakdowns of types of providers; urban-rural, hospital-based versus freestanding, that we typically see at these meetings. As we make decisions about payment adequacy and an update that affects every single provider equally, we really need to look at some of those distinctions to see, is payment adequate for all facilities? It clearly isn't.

I know that there's isn't 2000 data out there yet for hospitals and we're hoping to see some soon. But we know from the 1999 data, and we can't think that it's changed dramatically, that hospital-based home health agencies have negative 14 percent margins, hospital-based skilled nursing facilities have negative 32 percent margins. So we clearly know that those payments, Medicare payments to those hospital-based facilities are not only not adequate -- not only -- they're not adequate. I'm sorry, I was trying to be eloquent and not doing a very

good job.

They are inadequate. They really are. To say that no update is appropriate seems to be missing a huge sector.

We also talked a lot about access today and there seems to be plenty of access. I would like to just point out that hospital-based skilled nursing facilities, there's a 26 percent reduction in hospital-based skilled nursing facilities. I know that came out today, but want to reinforce that.

If you look at the percent of hospitals that provide home health care, that has dropped from 49 percent. So half of all hospitals provided home health care in 1997. Only 37 percent provide it here in 2001. So there have been dramatic changes there and it has to affect access.

Would also like to talk about the rural add-on. If you look at hospital-based home health agencies, again, the only data I have with me, their Medicare margin was negative 18 percent. We also know and believe that hospital-based agencies are some of the primary caregivers of home health care in rural settings. To suggest that a 10 percent add-on is not needed in that kind of sector, I

just don't understand that and would really ask the staff to look at that in more detail and to provide some of the breakouts to be able to suggest -- and see some of the distinctions.

The last thing I'd like to just say is, we think about the update as covering cost from year to year. What we know is costs are going up. They're beyond providers' control to a large extent. We have a nursing shortage. There's liability premiums. Lots of different things that are affecting costs. To say that there's no need for an inflationary increase, given all these cost pressures, we just really don't believe that that can sustain and keep Medicare at a level where it is paying providers adequately if those costs aren't being covered.

Thank you very much.

MR. HACKBARTH: Okay, we're adjourned until 8:30 tomorrow morning.

[Whereupon, at 5:32 pm., the meeting was recessed, to reconvene at 8:30 a.m., Friday, December 13, 2002.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 13 2002

8:50 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.

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P R O C E E D I N G S

MR. HACKBARTH: Between now and lunchtime we're going to talk about a series of issues affecting Medicare payments for hospitals. There are two critical parts to this analysis and discussion. Part one is getting the right amount of total dollars in the system and, of course, normally we think of that in terms of setting an appropriate update factor for the coming year. That's true in all the various sectors of providers.

In the case of hospitals we're going to be spending quite a bit of time this morning talking about the second big issue which is the distribution of payments. So in addition to the right total expenditure level for hospitals, we need to try to make sure the payment system is as accurate and therefore fair as possible

This distribution of payments question is, of course, not a new one for MedPAC. Each of the distribution issues that we talk about this morning is an old friend of MedPAC's. We've talked about -- right, old acquaintance. I stand corrected, old acquaintance if not friend. We've done, in many cases, reams of analysis on some of these issues. They fall into two broad categories, of course.

One where Medicare may be overpaying for particular types of providers and the second category where Medicare may be underpaying

So that's the overall map, if you will, for the discussion about hospital payments. Have I missed anything there, Mark?

DR. MILLER: No, just maybe the order.

MR. HACKBARTH: The order that were going to take these things up is we're going to begin with the distribute issues, specifically with transfer payment policy which we touched on at our last meeting, and then the indirect teaching. That and then we will do a discussion of the rural distributive issues, many of which were identified in our June 2001 rural report. And then I can't read Mark's handwriting on the next one.

DR. MILLER: I think we're during the update, the inpatient update next, and then the outpatient update after that.

MR. HACKBARTH: Everybody hear that? So that's the plan.

Craig is first up, talking about transfer policy.

MR. LISK: Good morning. As you heard, I'm going

to discuss Medicare's payment policy, and more specifically, the expanded transfer --

MR. HACKBARTH: Craig, I'm going to interrupt because I forgot that one point that's particularly important to me. When we'd talk about the distributive issues, we're going to go through them one by one. But I actually look at that piece of the discussion as a package. If you're trying to make the payment system more accurate and fairer, you really need to look at those issues collectively. And so I urge the commissioners, as we discuss those issues, to try to think in terms of an overall package designed to improve the payment system.

Now having said that, it has been MedPAC's, tradition, if you will, to vote to one by one on specific policy recommendations. And we will do that when we get to voting in January. So the commissioners will not be asked to vote yes or no on an overall package but on the specific line items. But in your conceptual thinking about it, I would urge you to think in terms of a package.

Sorry, Craig.

MR. LISK: No problem.

So I'm going to discuss Medicare's expanded

transfer policy that was developed under the Balanced Budget Act that applies to short stay cases that are discharged to post-acute care settings and other hospital settings excluded from the inpatient prospective payment system. We provided an overview of this policy at the last meeting and today we will review some of the basic information concerning the policy and examine the potential impacts of expanding the policy to additional DRGs.

I'm going to start by reviewing the development of the transfer policy and how hospitals are paid for these cases. I will to discuss some of the rationales for expanding the policy and will then review some of the impacts of expanding the policy to additional DRGs and to swing bed providers -- for discharges to swing beds, sorry. We will finish the discussion with potential recommendations for you to consider.

The unit of payment under Medicare inpatient prospective payment system generally is the discharge. From the beginning of the inpatient PPS, Medicare has had a transfer policy that recognized that hospitals may not furnish the full course of care implied by a full DRG payment. The policy initially only applied to hospital-to-

hospital transfers with the transferring hospital paid a per diem payment up to the full DRG amount and the receiving hospital was paid a full DRG payment. As a reminder that DRGs may be different in the transfer and receiving hospital, it's based on the diagnosis for the patient at each hospital.

The transfer policy was based on the belief that it was inappropriate to pay the sending hospital the full DRG payment for less than the full course of treatment. Policymakers also felt at that paying the sending hospital the full DRG amount for transfer cases would create financial incentives for hospitals to transfer cases prematurely and they wanted to protect patients' care by providing appropriate incentives in the payment system.

When PPS began, use of post-acute care services was thought to be a complement, not a substitute for, inpatient care and they accounted for only a small portion of cases provided to Medicare beneficiaries. However, with growing evidence that hospitals were shifting a portion of care from the inpatient setting to post-acute care settings, the Congress in the Balanced Budget Act decided to expanded the transfer policy starting in 1999 to 10 DRGs

for discharges made to post-acute care settings and other hospital settings that are not part of the inpatient prospective payment system.

Congress was concerned that Medicare may, in some cases be overpaying for these patients who are transferred to post-acute care settings after a short inpatient stay. Growth in the availability and capabilities of post-acute care settings allowed the hospitals to shift some of the care once provided during the acute care hospital stay to post-acute care settings. Through the last decade we saw length of stay for Medicare patients drop substantially while use in spending for post-acute care also grew substantially. Hospitals also benefitted from this shift in care, as we saw inpatient margins for hospitals climb to record levels.

Some of the evidence of the shifting of care includes greater declines in length of stay in DRGs with heavy use of post-acute care. Hospitals operating post-acute care units were also shown to discharge patients sooner to these settings than other hospitals and actually use post-acute care more often.

Transfer cases under the expanded transfer policy

are paid a per diem. The per diem divides the full DRG payment by the geometric mean length of stay for the case. It's a graduated per diem payment so hospitals receive twice a per diem for the first day of care.

Some cases, though, have very high costs in the first couple days of care. So the payment was modified for DRGs with a substantial portion of costs in the early days of care, so these hospitals receive half a DRG payment for the first day plus a per diem payment. So they receive more than half of the full DRG payment on the first day of care for these cases. Cases can also qualify for outliers.

So the transfer policy is designed to at least cover the cost of care for short stay discharges to post-acute care settings. Analysis of the current policy, in fact, shows that payments on average are substantially above the cost of care for these cases under the expanded transfer payment.

The policy applies to discharge to PPS-exempt hospitals and units which include rehab hospitals long-term care hospitals, psychiatric hospitals and units, cancer, hospitals, and children's hospitals, discharge to skilled

nursing facilities and discharges to home health-care were there is a written plan for home health-care that starts within three days of discharge from the hospital. The policy does not apply to discharges to hospital swing beds.

In 2001, 30.5 percent of Medicare cases were discharged to one of these settings affected by the expanded transfer -- discharged to one of these settings not including the swing beds, the settings. For a matter of comparison, in 1994 22 percent of cases were discharged to these settings. And there was substantial growth from the early '90s to '94 as well. So as you can see there's been substantial growth in use heres.

Now swing beds were originally included, as I mentioned at the previous meeting, included in the proposed rule for implementing the expanded transfer policy. They were subsequently excluded due to industry concerns. For one, the conference agreement for the expanded transfer policy did not specifically mention swing beds and there was also concern about the financial impact on these hospitals. But CMS, or HCFA at that time, did leave the door open that they might consider expanding the policy to discharges to swing bands at a later date. This is

discharges to swing beds versus swing bed hospitals being exempt for other discharges. I want to emphasize that, too.

This next slide simply shows the basic distribution of what type of providers patients are discharged to in terms of post-acute care settings. Half are discharged to SNFs -- t his is 2001 data, by the way -- 32 percent to home health and 18 percent to PPS-excluded providers. Only two-tenths of a percent of discharges to post-acute care providers are to hospital swing beds

In terms of talking about the rationale for expanding the policy, in one case hospitals that have short space and are transferred, it would reduce the substantial overpayment of cases were some of the cost of care is shifted to these other settings. But it also would link acute and post-acute care payment systems blending these systems together. When PPS began, use of post-acute care providers was limited. It provided hospitals with a strong incentive to shorten hospital stays and growth in the availability and capabilities of post-acute care providers allowed hospitals to shift some of this care once provided in the acute care setting to these other providers.

The transfer policy helps to link Medicare's acute and post-acute care payment system by reducing the payment in the acute care hospital only when a case is shifted to another payment setting. and actually only for these short stay cases. I'll get to that a little bit later.

So it avoids a program paying twice for the same care. It also provides a more appropriate incentives for quality patient care. Per cases payment, as we said, provide incentive for discharging patients potentially sooner to post-acute care settings. But with the transfer payment matching payments more closely to the incremental costs of each day of it should make providers indifferent between keeping beneficiaries for an additional day or discharging them to another clinically appropriate setting.

It also provides a more equitable distribution of payments. The policy reduces payments only for cases were site of care substitution may have occurred, rather than reducing payments across all cases if we're talking about it in the context of appropriate payments in the entire system. Hospitals, on average, would be continue to pay more than cost of care for patients who were transferred to

post-acute care settings. And the averaging principal would still apply a across all other cases.

The policy provides a payment also reflecting the care provided during the acute inpatient stay, recognizing that use of post-acute care can begin at different points in similar patients care.

So for instance, hospitals with post-acute care units may be able to transfer cases earlier and so the payments would be adjusted to reflect that circumstance compared to a hospital that doesn't have easy access to post-acute care.

Another factor is that the weights in the DRGS with a large number of transfers to post-acute care may be artificially depressed in some instances. Expanded transfer policy would raise the weights in DRGs with a substantial portion of transfer cases, increasing payments to non-transfer cases and most transfers, in fact, in those DRGs.

My next slide provides an illustration in terms of how the impact of the transfer policy applies to a specific DRG in terms of where it applies. The geometric mean length -- this is DRG-14 for stroke and this is

typical of what happens under the expanded transfer policy. The geometric mean length of stay is 4.7 days in this DRG. The post-acute care mean length of care stay though, for discharges to post-acute care units are 6.7 days, substantially above the geometric mean length of stay.

Because the transfer policy provides a payment a graduate per diem payment, payments are reduced actually only for days that are three days or less. Hospitals start receiving the full payment when a case stays four days. So as you see where the mean length of stay is for post-acute care cases, it's only very short stay cases. It's only cases staying half the average for the post-acute care cases that have payments reduced under the policy.

Again, in general, payments are greater than the cost of care even with the reduced payment.

DR. ROWE: Can you say that again, that last line. Even if the payment is reduced, that is as a two day, someone has a TIA or stroke, but they're out right way.

MR. LISK: Payments are still higher than the cost of care, even though payments are reduced, payments are still above the cost of care.

MR. MULLER: The 6.5 post-acute is that additive to the stay in the acute facility or is that the total stay for that patient?

MR. LISK: It's a total stay in the inpatient setting, in the inpatient hospital setting.

MR. MULLER: So 6.5 is the inpatient.

MR. LISK: 6.7 days, is what the average length of stay is for cases that were discharged to post-acute care settings.

The average if we look across all cases is 5.8 days so part of the point here is the post-acute care cases tend to stay longer than average than cases that don't use post-acute care. And the short stay cases are unusual in some sense.

DR. ROWE: Would it be proper to describe what you're saying as a kind of post hoc risk adjustment,? That those very short stay cases, the stroke, there's something innate about them that they are obviously less severe or whatever? Is that what this is?

MR. LISK: What we know is that the cases are staying shorter than average but still care is being provided somewhere else after the inpatient stay. They're

full course of care couldn't be provided in the hospital, wasn't provided in the hospital.

MS. RAPHAEL: Do we know what differentiates a two day stay stroke patients from a 6.7 or 7 day stroke patients? Do you have any sense of the characteristics of these populations?

MR. LISK: No, basically we're not looking at that as part of this.

DR. WOLTER: Craig, do we know if the marginal cost of care in both the inpatient setting and the SNF setting are both covered in those short stay transfers?

MR. LISK: The issue would be then what category hey get plugged into in the SNF. If the SNF payment system is working that they get put into a higher category because they need more intensive care, then the SNF care would be paid potentially at a higher rate in that case.

But we're looking here, on the inpatient side, because we're talking about the inpatient portion of the payment, where we're seeing the overpayment fore care.

Now on the SNF side, SNFs are paid on a per diem basis, as well. So basically yes, it should be coming close on the SNF side. And if the SNFs do not want to take

the patient, then the hospital would be keeping the patient and the hospital would be paid more in that case.

DR. WOLTER: If the argument is that there's still coverage of marginal cost of care on the inpatient side, it would be nice to actually know what the combination does and I have not seen that analysis.

MR. SMITH: Craig, I want to make sure I understood your answer to Ralph's question. The 6.8 average length of stay is the some of acute and post-acute --

MR. LISK: No. This is just the inpatient stay. The average inpatient stay for discharge to post-acute care is 6.7.

MR. MULLER: The transfer policy under three, those are the proportion of the cases that on average stay 6.7, but a number of them stay under three?

MR. LISK: Yes. Of the post-acute care cases it's probably less than 20 percent. So it's only a small portion of these that did end up having payments reduced. And the fact is that the payments are higher than the cost of care for that case in the hospital setting.

DR. MILLER: I don't know if this helps. When we

worked through the issue, the way I kind of walked away understanding it is there is a whole set of post-acute transfers that occur for a given set of DRGs. And the point of this chart is to say most of them, the large percentage of them, fall with an average length of stay. In this particular instance that is at six or 6.5 days. But there's still a significance set of transfers that are occurring -- I think you just said 20 or 30-some-odd percent, that fall significantly below the geometric mean. And the notion of the policy is to try and tailor the payments for the circumstance of a given patient.

Your questioned on the patients and the characteristics of the patient I think is a really good one. But the other thing I think I tracked on when the policy is described to me is the notion that some hospitals may not be in the same circumstances and have the same ability to transfer and that some of the attempt of the policy is to address those situations at the short end. Is that all right?

DR. ROWE: Because if that's the case, Craig made an interesting comment earlier that some hospitals have their own post-acute care units that facilitates transfer.

And it does for a variety of reasons, not just for logistic or clinical reasons. For instance, if you have the stroke and your neurologist is coming to the hospital every day on rounds and he can swing by the post-acute care unit which happens to be in the same building, he can continue to see you. If you have to go to a nursing home that's 25 miles away or 15 miles away he's not going to get to see you. And if you're the patient or the family or the neurologist, that's much less good clinically.

So there are a whole variety of reasons why patients would go from the inpatient to the post-acute portion of a given facility quicker, not just that it happens to be financially beneficial.

But my question is that there is a statement in here that says the policy is designed to appropriately pay for circumstances faced by the hospital recognizing the access to post-acute services can vary and that the payment rate should be adjusted accordingly. You just referred to that. Do we know what proportion of these payment reduced short stay cases with respect to this DRG perhaps are, in fact, instances in which there is a facility in which there is a PAC included?

MR. LISK: We'll show you some information that kind of gets to your questioned here, down the road.

MR. HACKBARTH: What I'd to do, if we could, is let Craig get through all of the material. I think it will be more efficient if we do it that way. Craig, go ahead.

MR. LISK: So this next slide basically, though, shows how use of post-acute care varies across hospitals, that we see for instance some hospitals are -- about 10 percent of hospitals are discharging less than 10 percent of their cases to post-acute care. Whereas about 15 percent of hospitals are discharging more than 40 percent of their cases. And so there is a distribution here in terms of the proportion of cases that hospitals discharge to post-acute care.

Regionally we see differences in use of post-acute care as well, in terms of discharge to post-acute care with New England, for instance, discharging 46 percent of their cases to post-acute care settings compared to the west south central census division which transfers 23 percent. That's half of what it is in New England. So there's substantial variation regionally in use of post-acute care services.

Rural hospitals tend to discharge patients less, fewer patients to post-acute care as compared to urban hospitals, as well.

In terms of the current transfer policy, the current 10 DRGs accounted for 9 percent of Medicare inpatient PPS cases. Of all cases, 6 percent of cases are discharged to post-acute care. Within those 10 DRGs they account for 6 percent of all PPS cases into post-acute care settings. 1.7 percent of all cases, therefore, are short stay within these 10 DRGs. So in effect, only 1 percent of PPS cases under the current policy have payments reduced.

The key number here is if the policy was expanded there would be 4.7 percent more cases affected by the policy with payments reduced.

The net reduction in terms of our estimate of the current policy is a reduction in payments of about six-tenths of a percentage point. Last time we presented numbers -- this is based on 2001 data. Last time we presented you estimates for 1999 that said the estimate was seven-tenths so it has gone down slightly in terms of the payment impact.

As part of the proposed rule for hospital

inpatient prospective payment system in 2003, CMS considered two different proposals for expanding the policy to additional DRGs. One proposal would expand the policy to all DRGs and the other would expanded the policy only to 13 DRGs that have a high rate of use of post-acute care services. CMS received a large number of comments on this policy and in the final rule did not implement it.

But it's also important to note that in the proposed rule they actually didn't include the impact tables for this policy which, in effect, they would have had to put out another proposed rule if they attended in the final rule to put this policy in place. So I think they put this policy proposal forward to receive comments so I don't think there was intention of not necessarily implementing it this year in 2003.

They are considering, though, whether to implement the policy in 2004 and are doing some additional analysis at this time. That's one of the reasons why this is also an issue for us to consider because CMS will be potentially considering expanding the policy this coming year.

I want to move on now to discuss the financial

impact of expanding the transfer policy. Our analysis shows that adding 13 DRGs would reduce Medicare spending by about four-tenths of a percentage point.

DR. REISCHAUER: That's inpatient.

MR. LISK: Inpatient payments, yes. Would reduce Medicare inpatient spending, thank you.

Expanding to all DRGs reduces inpatient Medicare spending by about 1.2 percent.

The impacts are fairly uniform across most hospital groups. Regionally, there still is some variation in impacts but typically hospital groups, like rural and urban, the impacts from expanding the policy are similar. The impacts, though, depend on the proportion of cases discharged to post-acute care.

I also want to emphasize that these estimates also that I provide up here don't reflect any potential behavioral impact if hospitals decide that they're not going to discharge a patient as quickly as a result of the policy. This is assuming that the policy went into place in 2001 and what effect that had on these patients.

So this next slide shows the payment impacts of expanding the policy to all DRGs as related to the percent

of cases discharged to post-acute care with larger impacts on the hospitals that discharge a greater proportion of cases to post-acute care, as you can see. So hospitals that discharge less than 10 percent, the payment impact is approximately minus two percentage points. For hospitals that discharge 20 to 30, it's minus.9 -- nine-tenths of a percentage point. What did I say?

I'm sorry, two-tenths of a percent. For hospitals with 20 to 30 it's nine-tenths. For hospitals that transfer more than half their cases, it's minus 2.4 percent.

Preliminary Medicare inpatient margin data that also shows a relationship between the proportion of cases transferred to post-acute care and hospital financial performance with hospitals with high rates of discharge having higher margins than hospitals with low rates of transfer, also indicating that hospitals that transfer more appear to be benefiting more than hospitals that transfer less from the current payment system.

Finally I want to talk about discharges to swing beds. Only a small proportion of cases get discharged to swing beds and this is even true in swing bed hospitals.

In 2001 claims data shows that less than 6,500 cases were discharged to swing dance and just over 5,100 these were in swing bed hospitals. So from the swing bed hospital to a swing bed within the hospital.

The impacts on payment of extending the transfer policy to swing bed hospitals -- and this is if the policy would apply all to all DRGs -- is also small. In fact, 75 percent of swing bed hospitals would see payments fall by less than two-tenths of a percentage point if the swing bed policy were to apply to all DRGs. About half of hospitals actually would not see any reduction.

That's for swing bed hospitals that actually had discharges to swing beds. There are hospitals that are defined as swing beds, hospitals that don't have any discharges to swing dance. That's a little bit confusing but these results are based on hospitals that just have discharges to swing beds, Medicare discharges to swing beds.

MS. DePARLE: Craig, did you find any distributional impact of that policy ? This is what I raised the last time.

MR. LISK: No.

MS. DePARLE: Being convinced that rural hospitals might be affected.

MR. LISK: Right, if you're talking about -- as I said, three-quarters of the swing bed hospitals, and there's about 330 that we're talking about here -- three-quarters of the payment reduction would be less than two-tenths. And then 1 percent, which is only three hospitals, the payment impact would be greater than 1.5 percent of their payments. So there's some swing bed hospitals that would have a larger impact but it's relatively very few that would have that substantial an impact.

DR. MILLER: Can I just follow-up on that ? When you did your impact analysis, you said it was the same for urban and rural.

MR. LISK: Yes.

DR. MILLER: And just to Nancy Anne's question, if the swing data policy is in place it doesn't have a big impact on those effects?

MR. LISK: No.

DR. MILLER: I think that's your question.

MR. LISK: No, that's correct,. It would not.

I mean, the amount of money we're talking about

is less than $2 million, so in the greater scheme of things it's a small amount of dollars.

So finally, I want to leave you with the recommendation options for you to consider and we have two slides here. One is to expand the number of DRGs covered under the expanded transfer policy. Option A would add DRGs to post acute care transfer policy in 2004 as part of a three-year phase-in for expanding the policy to all DRGs.

And the second option is to apply the expanded transfer policy to all DRGs starting in fiscal year 2004. These recommendations would be to the Secretary since the Secretary is the one who has authority over this policy.

Under option A, the one-year impact under the option would between $200 and $600 million and the five-year impact would be between $1 and $5 billion. Option B, the one-year impact would be between $600,000 and $1.5 billion , and the five-year impact would be between $5 and $10 billion.

The second recommendation option for you to consider is to include discharges to swing beds in the expanded transfer policy. And the budget implication is again that it would decrease spending but it would be

small.

DR. ROWE: One or two questions and then a comment. One is the follow-up on my question, as Joe pointed out there is a table here on page 10.

But my question specifically then is of the 1.7 percent of cases currently that are transfers to post-acute care with short stays how many of those are transfers to institutional PACs? That is post-acute care settings that are part of the hospital ? That was my question. Do we know?

MR. LISK: I do not know that with this data.

DR. ROWE: The second question is you commented, as did Mark, that the policy effects -- that it's adjusted to take into account the proximity of access to post-acute. Is that a significant adjustment? Does that make a big financial difference. Do you know?

MR. LISK: The policy is tailored to the individual case, in terms of whether it's appropriate for --.

DR. NEWHOUSE: It's not adjusted Jack. There's no formal adjustment. He's just saying it's implicitly adjusted because hospitals that have something there might

transfer, and others don't.

DR. ROWE: I misunderstood. I thought you said they would get paid less by formula or something.

MR. LISK: No.

DR. ROWE: [off microphone] My general comment that I missed is that I see this as a part of a -- I think one of our problems is that sometimes we look at these policy issues as stand-alone issues. This is a part of a series of changes that we've been trying to make in the American health care system over the last 20 years to realign the site of care with the care that's needed. It used to be that all we had was sort of doctors' offices and hospitals and nursing homes. And we've built up a lot more home care capacity and we've built up a lot more outpatient capacity so we could have a continuum of care.

We're not there yet but the ideal is to align the allocation of the patient with the site that can best provide the care that patient needs, whether it's the hospice or what it is. Still too many people die in hospitals. We've got to get them out into other settings.

It seems to me that with this does is consistent with that movement of aligning the site of care and

avoiding some of these financially distorting incentives that would tend to keep people in the wrong site of care. That's sort of the way I see it because there might be a tendency to have financial reasons to keep a person in the site or to get them out quicker when they might better be still in a place. What we want to do is avoid all those incentives and have it just based on clinical and personal decision. That's the way I see this, if that make sense.

MR. LISK: That's a good summary and I think your other point also that was good, Jack, was you were talking about the neurologist, in terms of the discharge within the hospital. And that's a circumstance where because the neurologist, and there is a SNF unit of that hospital, the patient can be discharged quicker compared to some other spending and that's part of what we're getting it.

DR. ROWE: You have a hip fracture and your orthopedist can see you for an extra day or two. It makes a big difference.

MR. LISK: And if the SNF bed wasn't opened up they might not have discharged the patient to the SNF bed, and therefore the hospital would keep the patient for that extra day in that circumstance; correct.

DR. NELSON: If I understand it from the clinical standpoint there is a perverse incentive to not discharge a person to post-acute care if they're under the DRG. And I worry about this perverse incentive influencing the discharge decision when there's an alternative between just sending them home with no post-acute care or sending them to a facility where they receive post-acute care. The incentive is to do the former because the payment is greater. If my patients could really benefit from the post-acute care, I'd hate to be pressured to make a decision based on the financial consideration.

So my question is before we expand this, has there been any kind of outcome studies with respect to the 10 that are in place, such as readmission rates?

MR. LISK: For the current 10, in terms of the impacts of the current policy, there has been, in terms of use of post-acute care has actually -- since the policy has been in place -- increased from what was 65 percent of cases to now 67 percent. So post-acute care has actually increased.

There has been fewer short stay discharge -- slightly fewer proportion of those have been short stay

discharge. In '99 it was 30 percent, in 2001 it was 28 percent. So there was a slight decline but that is consistent with potentially the incentives that we want to not necessarily discharge people as quickly. So I think the current policy, in terms of those impacts, I think we have seen are positive and encouraging and have not had the effect that you're talking about.

DR. NELSON: For those 10 DRGs, people who are discharged home, are they remitted at a faster rate, implying that they would have benefited from post-acute care and didn't get it. That's what I'm time asking.

MR. LISK: For those I do not know the answer to that.

DR. REISCHAUER: The question is the effect of the policy and if fewer of are going home because more of them are going into post-acute care, there would be no reason to expect the policy would have affected the fraction of those who did go home who went back into the hospital, the effect of the policy.

DR. NEWHOUSE: Remember they didn't get home health either in this. Home health counts as post-acute care for this purpose. So these would be extremely short

stay patients going home just cold.

DR. STOWERS: Craig, my question is maybe a little more global to all the policy issues we're going to talk about. Its when you come to budget implication it says it would decrease spending. Obviously on this one item it would decrease spending. Are we saying that it would decrease Medicare spending overall ? And we talked about narrowing the gap and redistributing, kind of leveling the playing field, so to speak with these type items. Can someone explain that to me before we get on in to rest of these.

MR. HACKBARTH: That's the point I was making, Ray, about looking at these as a package. In a real sort of crude form what we're saying is that in the case of transfers or the very short stay transfers we're overpaying and so there would be a net reduction of payments in the system. But then through proposals later on that we'll be discussing there would be increases in payment that would affect some of the same hospitals. So you might lose something on short stay transfers but gain something on a change in the base rate or DSH, et cetera.

And that's why I think it is important to think

of these in terms of their aggregate effect as opposed to just pulling out one.

DR. STOWERS: Thank you, I just wanted to clarify.

MR. MULLER: Jack referred earlier to the efforts over the last decade or more to have more of a continuum of care inside the delivery system and therefore to get patients to the appropriate setting. If I understand the philosophy that we're stating here is that the institutions that have developed such post-acute settings, either in physical or problematic adjacency, in a sense would be penalized. And those that haven't done so will be rewarded because they won't be subject to the transfer rule.

So are we, in a sense, sending a philosophical statement that those who try to develop a continuum of care will be penalized and those that have not for a variety of reasons been able to do so will be exempt from this?

MR. LISK: No.

MR. MULLER: If you don't transfer, then there's no reduction.

MR. LISK; The hospital still -- I mean, in terms of the payment, if they send a to a SNF, they're going to

still receive reimbursement for sending the patient to the SNF. We're talking about two separate payment systems too, in terms of what's happening. We're talking about what's happening on the inpatient versus the outpatient, the SNF for instance. And if part of that care has been shifted to the SNF, then the hospital is getting the payment for the care that's been shifted to the SNF in that case, and we're adjusting the hospital paying to reflect that that care isn't part of the inpatient bundle of care anymore.

MR. MULLER: But yesterday the SNF margins were fairly negative. So in that sense, to go back to Glen's point about the overall payment between the hospital and the SNF, they go from a higher payment setting to a lower payment setting. So if you look at the institution as a whole it does go down by increasing the continuum of care.

MR. HACKBARTH: A couple points. The I see, it Ralph, is what we're trying to do is move towards neutrality, as Jack described, in terms of our payment policy and we haven't been neutral and we're trying to move in that direction so that it's a clinical as opposed to a financial decision.

Second, for a variety of reasons there may be

institutions that do not have the hospital-based SNF in the current system they are penalized for that by the compression of the DRG weights in those cases, those DRGs where there are lots of short stay transfers. So they don't have the opportunity and are getting whacked for it twice, so to speak, by the compression.

Third, I just want to pick up on your comment about SNF margins. Our data show that on Medicare the SNF margins are substantially positive for the freestanding. We have shown in the past that for the hospital-based they're negative but there are a lot of cost accounting issues there. So that one's a difficult number to get a grip

MR. MULLER: Reason I was referring to the hospital base is because those would then, give how you posed it earlier, that we should look at the provider in depth in different settings, you would look at the acute hospital and their hospital-based SNF together, as part of what I thought you said was the overarching way to at this. The freestanding would be in a different corporation. If you want to look at kind of an integrated set of books for the institution.

MR. HACKBARTH: If we look at an integrated set of books for the institution, the overall Medicare margins, including inpatients, hospital based SNF, et cetera, are positive not negative.

MR. MULLER: I thought I just heard you say -- I mean, we can do this one offline -- if the hospital-based SNF is negative, then the hospital that has tried to appropriately develop a continuum of care moves from a setting of which they now get less for the transferred patient -- though as Craig said there's still a positive margin on that -- to a portion of their activity that is negative in terms of margin.

MR. HACKBARTH: Again, there are real issues about trying to figure out what the margin is specifically on the hospital-based SNF line of business because of the artifacts of cost shifting, cost allocation.

MR. MULLER: I understand that. It's just a matter of if we're going to look at it as an integrated set, whether it's an inpatient, outpatient, SNF and so forth under one corporate entity. If we're going to say they're shifting it back and forth, at some point the shifting has to stop. It has to be recorded somewhere I

would assume.

So if we're saying for that sake of consistency that the margins are positive on the hospital cases that are transferred and we think it's appropriate to not have an economic incentive to transfer and therefore we will reduce it to this expanded policy but then these cases get transferred to a hospital-based SNF in which they have a considerable negative margin then, in fact, we may be stifling and retarding the appropriate transfer of patients.

MR. FEEZOR: Alan Nelson asked my first question, what was the clinical impact or impact on patients and I guess I would just remind us as we get to write up our evaluations and recommendations to try to always ask that question implicitly equally as fast as we do what are the financial implications on providers.

The second question, I think, was something following up that Craig, between now and January would like. Are there issues that may preclude this policy -- let's say we adopted a more aggressive transfer policy. Is there anything that might prevent that from being as effective as we think it might be? In other words either

what Ralph was mentioning in terms of how some institutions might perceive it or whether that would wreak any sort of capacity problems so that might not be the transfer that we might expect? Just take a look at that.

And then the final thing, Craig help me. Slide 9 you've got geographic breakdowns and after kibitzing with my colleague here I don't know what West North Central, West South Central, and Pacific, what all that means. Could you give me a quick primer?

MR. LISK: Let me think if I get this right. Which divisions, West, North Central --

MR. FEEZOR: West South Central and Pacific.

MR. LISK: West North Central would encompass, I think, North Dakota, South Dakota, in that general area of the country.

Pacific is California, Oregon, Washington, Alaska, Hawaii. And Mountain are Colorado, Arizona --

MR. FEEZOR: West is euphemistic there, I guess. Thank you.

DR. NEWHOUSE: Several comments. First to the commissioners, go back to what Glenn said at the onset and try to think of if you had a fixed sum of money, which

we're going to govern by the update factor, how would you set up the payment system at the case level? Because the spending impact here can, in principle, be compensated for on the update side. We may not want to do that for other reasons, but that's a different debate.

At the patient or case level, a couple of remarks. This basically weakens the incentive to discharge quickly to post-acute care, as people have said. So consider Jack's stroke patient with a neurologist and consider the nursing home that's 25 miles away because there's no unit in the hospital. This weakens the incentive to discharge of the nursing home 25 miles away. The neurologist may not want to agree to discharge that anyway but this weakens that.

On Alan's about pressure to go home with no post-acute, I haven't seen any data here or elsewhere, but I haven't heard anything about that for the 10 DRGs that this applies to. And one would have thought that something like that would have surfaced it was that was a significant issue there.

On Ralph's point, he's right, this is basically going to lessen the reward to the hospital for opening the

SNF unit. But those rewards are very high in the '90s, a lot of hospitals opened the SNF unit and I'm not persuaded that the ones that didn't are going to do it now. Also, I think most SNFs are freestanding anyway, so it doesn't apply there.

A couple of other comments. This clearly does seem to be a fairer system across hospitals. On the swing bed point, I'm happy to omit swing beds, it seems unenforceable to me. I mean, why would the same hospital, with a patient lying in the very same bed, in effect, agree to take a lower payment?

DR. REISCHAUER: On that last point, it's interesting that the swing beds weren't used more in this transfer policy. It says something about the basic honesty of rural hospitals.

Craig, did I hear you correctly say that of short stays with transfers we don't know what fraction go to hospital-based SNFs, as opposed to freestanding?

MR. LISK: That's correct at this time. We need the episodes database to do that.

DR. REISCHAUER: We obviously don't also know that of the business of hospital-based SNFs, how much of it

is attributable to these 10 DRGs? I mean, was the change in policy, the transfer policy, a significant explainer of the 26 percent reduction in hospital-based SNFs over the last few years.

MR. LISK: I think that's probably more the SNF payment policy than the transfer policy. There may have been some impact from the transfer policy but I believe it probably was the SNF payment system more than anything else.

DR. REISCHAUER: One of your draft recommendations here is to phase in this. How would it be phased in? Would you do it by DRGs?

MR. LISK: Right, I think the easiest phase-in is bringing in additional DRGs at a time. So like the 13 DRGs would be -- we estimate it's about four-tenths would be the first step in a three-year phase-in, for instance.

MS. ROSENBLATT: Craig, you were pretty emphatic in your statement that the reduced payment covers the cost of care. Can you talk about how you know that?

MR. LISK: I'm going by analysis that was done from both CMS and HER. When CMS did the initial 10 DRGs, it did graphs that showed what the average cost was for --

what the average cost of those cases were by the date of discharge and for the cases transferred to post-acute care and what the payment would be under the transfer policy. And there was a large separation between those.

Subsequent to that study Health Economics Research also did a study that looked at what the cost of care was for each of those cases relative to the payments under the expanded transfer policy. And it still showed, expanded transfer policy for those cases, short stay discharges that the profit before on a per case basis was about 30 percent and after was about 20 percent.

MS. ROSENBLATT: Are you saying that -- you used the word expanded in that. The original study was done on --

MR. LISK: These studies were done on the initial 10 DRGs, but if we to look at the overall dynamics of -- even if we go back to how analysis of the hospital-to-hospital transfer policy is, which is basically the basis of the payment. Going back there, those analysis also show that payments under the transfer policy are greater than the cost of care, mostly by providing the graduated per diem payment. If we didn't provide the graduated payment,

in terms of where the first day is paid more than the other days, then we likely would not be paying above the cost of care, at least for the first few days of care. But subsequently we would be paying more. We have not done any specific analysis on these other DRGs in terms of the cost /payment relationship of the DRGs not covered under the expanded transfer policy, though.

But we believe, based on how the current payment system acts, and because where the cases start receiving lower payment, there is no reason to believe that combined with the modified transfer policy for cases that have very high costs in the early days with the current policy for other DRGs that payments would not exceed the cost of care. And as part of any expansion, that would be part of the analysis that have to be undertaken in the other DRGs to determine whether maybe the modified transfer policy should be put in place for certain DRGs.

MR. SMITH: Let me try to follow-up on Alice's question. The system currently constructed assumes that hospitals will make money on some patients and lose money on some patients and that, on balance, the DRG will get it right.

What do we know, maybe using your chart on page 7, what do we know about the share of patients in the 10 DRGs whose length of stay causes the hospital to lose money? And how that compares to the share of patients who have short stays and are currently subject to the transfer policy.

There's a data point that's not on this chart which is when a patient starts costing the hospital money.

MR. LISK: And that is generally fairly well above where the average length of stay is reached.

MR. SMITH: I understand, but what I'm wondering is what share of cases within the DRGs subject to the transfer policy, what share of cases obviously not subject to the transfer policy get beyond that point?

MR. LISK: I am not sure.

MR. SMITH: Wouldn't we want know that to try to figure out whether or not we've got a system that is looking for averages that work by the law of large numbers, and now we want to lop off the bottom part of that without understanding what the relationship is between the bottom and the top part.

If everybody were in the middle, this would work.

We know they aren't. So we're looking to see whether or not we can fix what must be only half the problem or some fraction of the problem.

MR. HACKBARTH: David, I can't answer the numerical part of this but let me offer a conceptual comment. Yes, averaging is an important part of the system but I think it's also important to keep in mind that at high end we have an outlier payment policy.

MR. SMITH: That was my next question.

MR. HACKBARTH: One way to conceive of this is basically a short stay sort of outlier policy. And Julian can correct me on this when the system was first devised there were a lot of people who thought that we ought to have symmetry and have both a high cost outlier and a short stay outlier policy.

MR. SMITH: I think that might well make sense. It would just help me to wrap my head further around this to know something about the distribution on the other end, what share of cases reach outlier status.

MR. MULLER: The outlier kicks in several standard deviations. It doesn't take it right away. There's a gap.

MR. SMITH: I understand. The piece of information I'm wrestling with to try to understand whether we're rebalancing this in a sensible way is that share of cases between the point where the DRG covers costs and when the outlier kicks in. And what's the relationship between that and the share of cases that have short stays.

MR. PETTENGIILL: [off microphone] The policy takes a fixed pool of money, 5.3 percent of DRG payments and redistributes that money to the high cost cases in hospitals that have them. That's about 2.3 percent of cases getting about 5.1 percent of the money. So you're picking up a larger share of the high-end tail of the distribution than you would be giving up at the low end, or taking away at the low end with this policy.

However hospitals pay for the outlier policy. It's like an insurance policy. They, in effect, pay a premium that is equal to the reduction in the DRG payment rates used to offset the outlier payments which is not part of this.

MR. LISK: The last time I remember looking at -- now, this is on the post-acute care cases because I can't remember specifically what the proportion of cases was that

had payments above cost versus below cost. But if I recall it was at least three-quarters of cases payments were above costs on average. But it was at least that, so it was a smaller proportion of cases that have losses.

DR. ROWE: A lot of the discussion seems to be hypothetical about what the impact would be one way or the other and I just want to remind everyone that the material we have indicates that this has been, for reasons presumably other than pure policy reasons, this has been delayed three years? I mean this was initially proposed in fiscal year 2001, it was postponed for two years due to the BBRA. Then it was postponed another year because it was "inadequate due to limited time to analyze and respond to commentators." So we've got three years experience with this -- three extra years experience with this transfer policy on these 10 cases and I just haven't heard anything to indicate that -- I mean they're still a lot of hypothetical what this and this and that. But if there was some terrible thing that would happen from this I think we might have discovered it by now.

MR. HACKBARTH: [off microphone] I have too more and I'm sure we could continue at some length but we've got

some other issues that are also complicated issues. So we'll have the last two comments -- I'm sorry, I'm speaking to myself.

So we'll have Mary and Nick, go-ahead, and then we need to move on. But I'm going to ask Mark to read his list of questions that he's been taking down that we can try to come back and bring some more information to bear on this? So Mary.

DR. WAKEFIELD: Craig, you mentioned that rural hospitals tend to discharge fewer patients to post-acute care than urban hospitals and so without access to post-acute care they would be at something of a financial disadvantage compared to their urban counterparts who have access to post-acute care to discharge.

When I looked at the materials that were distributed to us, this table 5 which is the last page, you've got the last column were you're talking about changes in inpatient payments from expanded transfer policies to all DRGs. If you look into the last column, additional change in payments if the policy was expanded to all DRGs and there are negative signs in front of every category there, with I think about one exception. And so

all of the different rural categories have negative signs in front of them as well.

My question is that because we're also looking at this in the aggregate, not just this policy would it be the expectation that some of these resources would find their way back in the form of a higher base rate or something like that? Is that sort of what we're thinking here? Because I'm try to reconcile these negative on one hand with the explanation of I'm getting on the other.

MR. LISK: First of all, in terms the policy impact for the rurals and why they are similar to the other hospitals, even though they transfer less, there's another factor going on is that, in fact, that when they do use post-acute care they use it sooner. So they have -- for the short stay cases.

It appears as though the current 10 DRGs, though, they have a smaller impact from the current 10 DRGs. And I think that may be because if we talk about trach cases and hip replacements and some of the types of cases that are included in that 10, rural hospitals tend to not use those cases.

But whatever you're talking about any kind of

payment system change, whether it's payment system change that's a negative reduction across everybody, that can be done distributionally, or it can through updates, for instance. And so in that sense, if you're talking about the amount of money in the system payments otherwise might produce lower updates across all providers and that would then impact across all hospitals evenly. So those that transfer more would have the same effect of the policy like that versus those that transfer less would have the same impact in that situation.

In this case, if you did a policy like this those who transferred less would see a smaller impact than those who transferred more.

DR. WOLTER: I would just like to emphasize Davis' point because I'm concerned when you look at the data actually within a given DRG that's transferred, 80 percent of the time to 75 percent of the time those transfers occur after the mean length of stay is achieved. It's really only 20 or 25 percent of the time are they transferred early.

And so I'm worried about how the averaging will work out here over time. I'm not sure the outlier policy

entirely will make up for a policy in which, in essence, we moved to a per diem payment approach up to the mean length of stay.

And I'm also a little worried about statements like strong incentive for transfer if, in fact, 80 percent of the time in a given DRG the transfer occurs after the mean length of stay occurs. And when you look at the fact that 25 percent of hospital-based SNFs have exited over the last three or four years I'm wondering if there's a lot more going on clinically than there is financially in terms of why some of these patients are transferred.

I'm also concerned about the marginal cost of care discussion. In my own experience there are a universe of DRGs that drop a pretty good bottom line and a universe of DRGs that almost never do you even break even on. And it's sort of that averaging that's worked over time in the inpatient setting. If we focus on reducing the payment to cover marginal cost of care in a subset of DRGs but aren't looking at all of the DRGs, I'm not sure we're doing as effective a job as possible looking at how we might redistribute payment. In fact, I think that would be a more effective way to redistribute payment appropriately

than this particular transfer rule.

And then if we also want to look at the overall impact on Medicare margins we're about to look at some information later this morning showing other urban total Medicare margins at 1.3 percent projected for 2003 and rural total margins of negative 1.3 percent projected for 2003. Since both of those areas would be affected by about that same amount by this transfer policy possibly I think if this is not packaged with other appropriate changes such as wage price index changes or base rate changes that this could really create some problems. And so I'm worried about overall adequacy of payment as well if, for some reason, this were adopted in an isolated manner.

DR. ROWE: Nick, you mentioned that there's been a reduction of 25 percent in hospital-based post-acute care units recently or within the last period of time. I was under the impression that that was due to the fact that number one, there were many of these established when hospital censuses fell and there were empty wards and consultants are roving around the country showing us -- I was in the hospital business then -- how to convert these units to post-acute units.

And then some of them just weren't run well and couldn't compete with standard nursing homes. But then there's been an increase in volume in hospitals over the last couple of years and those units have kind of been squeezed out as more acute care beds have come back online.

So I was under the impression that those were the dynamics there, rather than a response to kind of transfer policy.

DR. WOLTER: I think it's all speculation. I don't think we have the information. What I'm hearing is hospital-based SNFs have negative margins and there's loose talk about accounting practices but haven't seen the data.

We're also beginning to hear that the hospital-based SNFs are taking a more complex type of patients, many of whom the RUG system doesn't line up well in terms of payment. So that I'm concerned that some of the issues here are actually on the SNF side of the equation in terms of incentives as to why some patients go there and others don't. I don't think all of the incentives are on the inpatient DRG side.

MR. HACKBARTH: We need to move on. Mark?

DR. MILLER: I'll try and do this very quickly which means I'm not going to have all of the specifics and, of course, there were different points in time when I was distracted but I heard Nick talking about the notion of marginal costs in both settings.

Jack was asking about the proportion of transfers that are in institutional settings.

I heard questions from Alan on anything that may happen between now and January and, I may have garbled this, but something on the regional effects, and I can trace back through and pick that up.

I also heard, from David I believe, sort of the loss and gained on the given sets of DRGS. And I some of that speaks to some of the things that you were saying at the end here, Nick.

I think that the set of kind of informational questions that I got. Did I miss any?.

DR. NELSON: In the three years of experience with the current 10, whether there is -- I mean, Joe hasn't heard of any but that doesn't mean that there haven't been some negative clinical impacts from people being discharged home because the incentive is to do that rather than post-

acute care.

MR. HACKBARTH: We did have the evidence that Craig presented that the number of discharges to post-acute care have actually increased and not declined. It's it either/or? You either go to home or post-acute care?

MR. LISK: I think it's kind of hard to differentiate those, when you see the numbers increasing its kind of hard to differentiate what happened even before policy and after policy of those that went home to distinguish those cases.

MR. HACKBARTH: I think based on Craig's data, by definition the number going home has declined. Now that doesn't, of course, answer the clinical question maybe were some of them worse off.

We do need to move ahead. What I'd ask is that if people have questions that they get them to Mark, and obviously as quickly as possible so we can prepare for the January discussion on this.

Lucky Craig continues to lead the presentation now on the indirect teaching adjustment.

MR. LISK: We're going to continue on here to talk about Medicare's indirect medical education

adjustment. The IME adjustment is a percentage and-on to Medicare inpatient PPS rates. The adjustment is based on a ratio of the number of residents a hospital has to the number of beds and it's a percentage add-on to the payment system reflecting the number of residents a hospital has based on this resident-to-bed ratio.

When the payment system was established back in 1993, the IME adjustment was empirically derived and doubled, and I'll get into the reasons for the doubling. The doubling was achieved by reducing the base rates for all hospitals. The adjustment was originally set at about 11.6 percent for every.1 increment in the resident-to-bed ratio. 11.6 is representing the doubling of the adjustment.

So why was this adjustment doubled ? Well, analysis that was done at the time of the -- before the PPS was implemented showed the teaching hospitals would perform poorly under the prospective payment system. But no analysis was done to say that the doubling was the empirically thing to do. The doubling was just the simple but basically arbitrary way of dealing with the situation that showed teaching hospitals were not going to perform as

well under the payment system. And this doubling got embedded into the -- basically got embedded into the payment system at that point in time.

But what has happened over time, the adjustment has come down. It was lowered with the implementation of the disproportionate share adjustment when that went into place and the IME reduction, in part, financed some of the disproportionate share adjustment when that was implemented

And then it held steady for many years, about ten years, at 7.7 percent or even a little bit more. The Balanced Budget Act though gradually reduced the adjustment over time from 7.7 percent to 5.5 percent in fiscal year 2001. It's also important point to point out under the Balanced Budget Act though that providers were also -- providers were for IME payments for Medicare+Choice patients. IME and direct GME payments were carved out of the payment system at that point in time and now are paid directly to providers. So a Medicare+Choice patients who goes to a teaching hospital receives an IME payment from Medicare for those cases now, IME and direct GME payment for those cases.

The BBA policy of phasing down to 5.5 percent

though, did not go into place immediately as both the BBRA and BIPA delayed the phasedown to 5.5 percent by holding adjustment at 6.5 percent through fiscal year 2002. So from 1999 to 2002 the adjustment was set at 6.5 percent.

The current adjustment though, in fiscal year 2003, is now set at 5.5 percent so it has gone down. This adjustment though is currently set more than the empirical cost relationship that we find. Inpatient operating costs increased about 2.7 percent for every 10 percent increment in the resident-to-bed ratio. This estimate is based on analysis that we did this past summer on 1999 data. This is different from previous estimates that we had provided the commission. The last time we came to you was when we were talking about the GME and IME report, the teaching hospital report, and that estimate was 3.2 percent at that point in time. That was based on 1997 data, so the adjustment has come down again over time.

DR. ROWE: This is based on what year?

MR. LISK: This is based on 1999 cost report data.

MR. HACKBARTH: The methods are the same.

MR. LISK: The methods are the same as we've used

in the past. Essentially we're allowing the IME adjustment to capture -- we're setting everything else in the payment system to what their components should be, as how they operate in the payment system and the IME adjustment is picking up any remaining variation that is in the payment system.

This, in effect, if you want to say what may be the true teaching effect it may be considered we're providing a higher estimate that what otherwise might be if we talk about hospital size as something that might affect costs. So if we accounted for hospital size this adjustment would likely be lower, but we're letting the teaching adjustment pick up effect of, for instance, of hospital bed size.

DR. ROWE: What was the adjustment in 1999?

MR. LISK: The adjustment that teaching hospitals received is 6.5 percent.

DR. ROWE: The data for that year suggested 2.7?

MR. LISK: The data for that year suggested 2.7; correct. So that's a substantial difference.

DR. STOWERS: Real quick, Craig, what's causing that IME to drop? A few years ago MedPAC had it at 4 and

then it went to 3 and now it's at 2.8.

MR. LISK: That's very good memory and the teaching hospitals have lower their cost per case over time more than other hospitals. They probably started from a higher cost base than other hospitals and have been more able to lower their costs faster than other hospitals over time.

DR. NEWHOUSE: Another factor is if, in fact, we think the residents aren't causally related to cost, adding residents residence is going to have the effect overall of lowering this number.

MR. LISK: That's another very good point.

DR. STOWERS: [off microphone] I just think there's a lot of misunderstanding about how they defined these calculations. I'll save that.

MR. LISK: This next chart shows what the adjustment level is at different resident-to-bed ratios and as you can see that -- this table helps you show the two things. One is from 2002, in terms of what the adjustment level, what the change in IME adjustment was to 2005, but also to show what basically is the subsidy portion of the payment for hospitals of varying sizes

I don't have on here, in your briefing books we have what the rate is at.75. And in fiscal year 2002 that would be about a 34 percent adjustment and the empirical estimate for that is 16 percent. Again, the current payment levels, providing an adjustment add-on, it's a little more than twice what the empirical relationship would show.

This next chart, though, shows what the distribution of IME adjustment percentages would be in 2003. About half of hospitals received less than a five percent adjustment, so they receive only a -- teaching hospitals, I should say, receive less than a 5 percent adjustment. 12 percent receive more than an adjustment of 25 percent. And that's basically hospitals that have a resident-to-bed ratio greater than.5.

This next table shows in 1999 the Medicare inpatient margins for major teaching hospitals, other teaching, and non-teaching hospitals. Here, showing what it is for all payments. And then if we remove what we call the "subsidy" portion of IME payments from payments, as we see the major teaching hospitals margins would be about 9 percentage points lower in 1999 if they did not receive the

IME subsidy portion. Inpatient; correct.

MR. MULLER: Last year, when we showed this, we took the DSH out, too. Why did you not take the DSH out this year?

MR. LISK: When we were showing the DSH, that was part of the payment adequacy discussion, and in this portion we wanted to show, since we're not talking about removing DSH payments at this point, that's why we were showing this with the removal of what the financial status would be with just IME payments above costs removed. The numbers with DSH would go down but teaching hospitals would still have higher inpatient margins than other facilities if DSH payments were removed.

MR. MULLER: Down by eight or nine points or something like that? I'm trying to remember.

MR. LISK: Unfortunately, I don't want to say exactly how much they go off right now, but they do down, but major teaching hospitals' margins would still be higher than other hospitals, even if those payments were not included here.

This next graph shows the trend in inpatient margins over time for the teaching hospital groups, the red

line being the major teaching hospitals. Throughout the '90s, actually, the margins rose to the late mid-1980s and then dropped off. This is the first of 2000 margin data that we will be showing you today and I wanted to briefly just explain that this data -- there is a slight bias in the sample of hospitals we have from the cost reports for 2000. Those proprietary hospitals are undersampled this year because of a number of reasons. There's also some regional disparities.

We've attempted to take account of this in our analysis by looking at regional and ownership groups and adjusting for missing hospitals because the missing hospitals do have a potential impact here, and looking at the regional ownership growth in costs and payments. And so they are included, so the missing hospitals essentially we're were simulating for the missing hospitals in our analysis.

It doesn't necessarily change the numbers appreciably though when we do this but we felt because of regional and ownership disparities we felt an obligation to make these adjustments.

It's important, I think, to note that what's

interesting here on the inpatient margins is that the inpatient margins for major teaching hospitals despite cuts in the teaching adjustment that took place starting in 1998, they have dropped down but they have remained steadier and have not dropped as much as the other teaching and the non-teaching hospitals in this last two years. So the next chart will actually show the numbers that we have for both 1999 and 2000, and we see basically major teaching hospitals' financial performance under Medicare remained about the same and the margins for both other teaching dropped somewhat and non-teaching a little bit, dropped somewhat as well, I think 1.5 percent and 2.3 percentage points.

Again, these are preliminary data so over time sometimes these margin -- if we got more complete data these margins might be a little bit different. We do have about 75 percent of hospitals in our margin database here.

The next slide though, shows the distribution of total margins. This is total hospital margins. I would emphasize that we have three sets of margins that we do and I don't have in this presentation the overall Medicare margin that I'm doing here today. In the paper, II do

have, I think, one table that has the overall Medicare margin but I'm not going to be presenting that in this presentation

MR. HACKBARTH: Craig, can I ask about that because, in fact, yesterday we had a specific discussion about what's the appropriate metric and we have been using the overall Medicare margin as the metric for evaluating hospital financial performance under Medicare. Is there some data reason why that's not here?

MR. LISK: There are two reasons. One is data, in terms of the completeness of the overall Medicare margin. The second is that we believe that when we're talking about a component of the inpatient payment system it's appropriate to look, at that point, at the inpatient margin when we're talking about the distribution of inpatient payments. If we look at overall policy impacts we may want to look at then the overall margin at that point in time of simulating the policy impacts on the provider. But if we're looking at the distribution issues about how out of balance the inpatient system may be we believe that the inpatient margin, at that point, is a correct dynamic to look at.

MR. HACKBARTH: That's the point that Jack made yesterday that I recall. Sorry.

MR. LISK: What we see here, though on the total margins is we see that teaching hospitals have seen a steady decline in their total margins over time and that, in fact, we see some leveling out of total margins for both other teaching and non-teaching hospitals, although non-teaching hospitals also continue to show a slight decline in 2000 relative to 1999.

It's important, though, to take note of why is there the steep drop, the continued drop for major teaching hospitals. I apologize because I didn't define major teaching hospitals earlier, and I'm sorry I didn't do that. Major teaching is defined as hospitals with a resident-to-bed ratio greater than.25, 25 residents per hundred beds. I apologize for not doing that earlier

One aspect here that we see is the drop in margins is greater for the public major teaching than the private major teaching. We see a much smaller decline for the private major teaching compared to the public major teaching, which lends some wondering about whether uncompensated care may be a factor here. It's not

completely clear.

We do have some other data from AHA that looks at a cohort of hospitals that is not -- for the 2000 it's not consistent with this data. If we look at the change in margins it showed about a body uniform decrease for all three groups, other teaching, not teaching, and teaching, a decline of about four-tenths of a percentage point decline in total margins from the AHA data for a cohort of hospitals.

So we have to say that this data, if we get more complete data it may change, there may be some sampling. In fact, there are a smaller number of major teaching hospitals that have negative total margins in 2000 compared to 1990. It's a small difference but it's a smaller number.

MS. DePARLE: Craig, when you say if we get more complete data, still the best we're going to do is up to 2000; right?

MR. LISK: This is the best we're going to do through January meeting two, so this is what we have to work with at this point in time.

What has historically happened, and I'll show you

this next chart which shows the all-hospital margin of 3.8 percent, when we discussed this last year at this time for 1999 this margin was 3.6 percent for all hospitals. For major teaching hospitals, when we were discussing it at this time, it was 2.4 percent and it's gone up to 2.8 percent. So over time, total margins, when we get a more complete sample of hospitals, tend to appear to rise. The late reporters and the missing hospitals and potentially some audits of the data tend to increase the margins over time. So I want to make you aware of those factors that may be playing a role here.

The fact is, when we go back to the previous slide, is that historically teaching hospitals have always had lower total margins than other hospitals and they've operated that way over at least the past decade.

DR. REISCHAUER: In January are we going to have no additional information about what's happened to private payer payments to hospitals? Because during the 2001-2002 period, because the general feeling is that they've picked up substantially.

MR. LISK: Right, but the AHA data actually indicates that for the major teaching hospitals actually,

there still was a decline. It may be that the pick up is occurring in 2001 and 2002 for these hospitals. So this may be -- 2000 may be the low point. In terms of the managed care backlash we may be seeing some rise in margins after that.

MS. DePARLE: But to Bob's question, will we have that information?

MR. LISK: We will have some information and Tim will be presenting, I think, some information from the NHIS data which is showing what the trends are on the total margins.

DR. ROWE: There are data available, with respect to the private payers' percentage change over the last year in payment for pharmaceuticals to physicians, outpatient, inpatient, specialty drugs, et cetera. Those data are easily available and I can refer you to sources to look at that. That might be informative. It might not. It depends on how the data line up with your data but we should be able to have that, at least.

You know, the basic pattern has been the pharmaceuticals have been the most significant piece over the last couple of years and last year, for the first time

hospitals replaced pharmaceuticals as the single greatest inflator, which is probably what you're referring to.

MR. LISK: I think the other important point on total margins, and when we look at inpatient margins, is that Medicare -- at least inpatient payments -- are not the issue here for driving the potential continued fall in margins, total hospital margins for major teaching hospitals.

In terms of the payments above the current cost relationship, and here I'm talking about where we are in 2003, the subsidy portion of IME payments accounts for about 2.5 percent of Medicare inpatient payments. And for major teaching hospitals this accounts for 6 percent of their payments, of their inpatient payments and 1.2 percent of their total revenues.

So other factors that may be affecting total margins for major teaching hospitals and why they're lower include provision of uncompensated care. Uncompensated care accounts for 10 percent of total costs for major teaching hospitals and 5 percent for other teaching and non-teaching. Here it's also an important distinction, there's a big difference between public major teaching and

private major teaching. Public major teaching uncompensated care is about 20 percent of their costs and the private major teaching is very close to the 5 percent that the other hospital groups experience.

The other factor is that private payer payment-to-cost ratios are lower so they don't contribute as much to the overall gain that these hospitals might receive from private payers because their payment-to-cost ratio is lower.

DR. NEWHOUSE: This is 1999 data?

MR. LISK: This is 1999 data, yes.

So some of the issues and concerns about the current IME adjustment is part of the IME payments are made like an entitlement where the subsidy portion is not targeted to any specific need and that, I think, is an important concern with the current adjustment in the subsidy. Teaching hospitals also have very high margins under Medicare inpatient PPS and the subsidy contributes to the wide variation in hospital performance under the Medicare payment system and provides some of these issues about differences in the margins between rural and urban hospitals. Even when we look at the large urban hospitals'

margins, major teaching hospitals are a major factor in why large urban hospitals' margins look higher, for instance. But the other side of the coin is that teaching hospitals do have lower total margins and so their performance is overall they are closer to a zero margin than other providers for their overall business.

So we'll leave you then to discuss the recommendation options. One is to potentially reduce the adjustment to 2.7 percent next fiscal year, to completely go to the IME adjustment down to the empirical level.

Option B would to reduce the IME adjustment by half a percentage point per year so it's gradually brought close to the empirical level. And for specifically for fiscal year 2004, bringing the adjustment down to 5.0 percent.

Under Option A, the one-year reduction would be over $1.5 billion. The five-year reduction would be over $10 million. If the adjustment was gradually phased down, the impact on spending would be $200 to $600 million over one year and $5 to $10 million over five years.

MR. HACKBARTH: I'm going to let Joe go first, he has to go catch a plane.

DR. NEWHOUSE: Thanks, Glenn.

I favor something like B. I haven't thought about the transition but I think the reason I'll say there shouldn't be a subsidy here, but there should be some transition.

The two reasons I would emphasize would be that the IME really is not the right vehicle if we want to address problems of uncompensated care or difficulties that teaching hospitals have competing in the private market. Teaching hospital status is correlated with uncompensated care but if we want to work on uncompensated care we ought to have a measure of uncompensated care, as we've talked about in the DSH discussion. I just don't think that Medicare can take on the issue of trying to confront the problems the teaching hospitals may have in the private market which potentially are excess capacity problem there, suggestive of it anyway.

And finally, I think if the Congress wants to subsidize teaching hospitals that it should be from general revenues. It shouldn't be from the Medicare trust fund. So as I say I would favor some transition down toward the empirical level.

MR. HACKBARTH: Can I get a show of hands of who wants in the queue?

MR. MULLER: If I look at page 15, it's entitled issues and concerns, for example it says the IME subsidy contributes to wide variation. It's intended to contribute to wide variation. It's a public policy statement going back 35 years, more explicit in 1983, that basically says that there be IME payments tied to teaching and if there's more teaching and more residents going on there will be more IME payments. So it's interesting that you, call it a concern when, in fact, it's intended to be that way.

Secondly, when you say teaching hospitals have high margins under Medicare inpatient PPS, a lot of this has to do with DSH because they also are, as was pointed out by Joe earlier, they tend to be more DSH providers. So a lot of the high inpatient margin comes from being DSH hospitals.

So it's interesting to me that you take two policy concerns that have been embedded there for 15, 20 years that are intended, in the sense, to reward people who do teaching -- not reward but pay appropriate for teaching and pay appropriate for uncompensated care and then call

them concerns because, in fact, the intent of the policy is to have variation.

MR. HACKBARTH: I think the reason that I think of them as concerns is that the original stated rationale for doubling the adjustment was some concern about whether the DRG system actually was properly measuring case-mix differences between teaching and other. The empirical experience indicates that, in fact, that was not problem.

MR. MULLER: Let me talk to that, because I think that largely comes, from my understanding from Craig, from just looking at this regression equation. We're using the same factor, I understand, in 1983 and now, basically the IRB ratio. So it isn't as if we have a different ratio or different measure of that than we did 20 years ago.

So to say that whatever our concern was then has somehow been answered since, I don't see that in how you calculate the equation, that you have any evidence for that. Basically we're using the same ratio then and we basically said that that proxy variable in '83 is all we had and that's the same proxy variable we have in 2002.

So I think -- again I think all of us here -- I'm definitely over my head on regressions very quickly here

but I think we should probably look at that because we really haven't changed the equation in any marked way since that time that Congress said that that proxy was not properly a sufficient expression of how to measure the effect of teaching in the system. So if we use the same equation now as we did 19 years ago, I don't see how we can say we now have empirical evidence that we didn't have then.

DR. NEWHOUSE: Ralph, I tell my students this was an exercise in misapplied econometrics. There were several technical mistakes made that had the effect that had the original proposal gone forward, the teaching hospitals would have been damaged. That is, in effect, the original proposal was below the empirical level, if you will. The Congress was trying to rush this through -- Dave may remember -- because the vehicle going through was the Social Security bill after the Greenspan Commission and there was a very small window to get it through. And rather than go back and fix the technical mistakes that would have brought it back to the empirical level, or calculated the empirical level the way Craig is now, Congress just doubled the adjustment and then we've kind of

been whittling away at it ever since.

MR. DURENBERGER: Thank you, Mr. Chairman. I'm nog going to pretend what went on 19 years ago but I remember enough to know that Joe would remember.

[Laughter.].

MR. DURENBERGER: And so I rely on him. In fact, I distinctly remember the period of time somewhere between '83 and '85 when we met and visited on this subject and I had by personal eyes open to -- what did we start with, 10 percent or 11, something like that, when I first had my eyes opened to that.

I wish Sheila were here because she's help me remember the time we sat on the floor -- I think it was in '85 or something they like that when we did one of these amendments and we were trying to figure all this other stuff out. So whatever I say is sort of like a small p political observation on this.

I can't find anything in the research, the analysis, and everything that I wouldn't agree on. And I would certainly agree with what you said, Joe, about the fact that if we want to pay for teaching we ought to pay for teaching and we ought to make the decision how much of

that comes out of a public or private payor; i.e., Medicare which was a decision we made and others didn't make back in the early '80s and how much of it ought to be paid for directly.

On the issue of uncompensated care and so forth, the Medicaid program and/or adequate programs to cover the uninsured, ought to pay for that out of either federal or state or some form of general revenue. I agree with that 100 percent.

So for me, dealing with the recommendations here, is a sort of like a timing question, just like the issue I raised yesterday with regard to the transition from hospital-based SNFs to freestanding SNFs and overall changes.

And not having current data I'm faced with trying to come to judgment about what I call managed care backlash meets uncompensated care and lower Medicaid payments. And I don't know how that's going to come out except when I think about it in my own community. If I compare a Mayo Clinic, which is a large powerful private organization, with the University of Minnesota making comparable contributions -- not better but more contributions to

medical education -- but carrying by statute and by probably the Constitution a major burden for uncompensated care in our community, facing a managed care backlash in which a lot on their subspecialty work is being done now in silos in the community and so forth, I wish I knew where that trend line was going on the overall margins. Because in my community we can't do without the major public hospitals, like in Minneapolis which is a teaching hospital. We can't do without the University of Minnesota.

We have 68 unoccupied faculty slots at the University of Minnesota today, which has happened over the last few years because we can't, in our particular environment, make this competition.

So what I'm saying is that it's not hard to come to a set of recommendations about what Medicare's policy ought to be relative to IME. But to say to this Congress coming up that they ought to start implementing it right now is something I really have difficulty doing without a lot better information about the impact, particularly on the public side of the hospital system. My judgment is sort of like a timing judgment as opposed to what is good public policy.

MR. HACKBARTH: Dave, an implication of that would be that you, in a perfect world, would like to see any change here linked to, for example, a rewriting of the DSH formula so that was a true measure of uncompensated care?

MR. DURENBERGER: Absolutely.

DR. ROWE: A couple of thoughts. As my colleagues know, and you heard me say yesterday, I'm uninformed by the inpatient margins. I think they're exaggerated for accounting reasons related to why the outpatient margins are underestimated. And I just think we should look at the institutions overall.

I would include the DSH payments. I think they're payments for clinical activities and so I'd include them.

I think the overall margins bother me and I'm unhappy with all the margins but the overall margins bother me because I think hospitals need to have some capital. They don't have -- these not-for-profit ones anyway, don't have ready access to capital, in my mind, for IT and other uses.

And the overall margins include, I think,

philanthropy and parking revenues and non-clinical kinds of activities. And I think it would be nice to have kind of the clinical margin, the overall clinical margin, as to what the enterprise is bringing in. What are the sources and uses of cash for taking care of patients, whether it's inpatient or outpatient, without some of this other stuff. And I know that some hospitals have a lot more of that other stuff than other hospitals. Some have big endowments, others don't, et cetera. But I think that's really the number that we're looking for because I think if they make money on other deals or parking or other things, they'll need that capital for other investments. particularly the not-for-profits.

So I don't know if we can ever get to that margin but those are my thoughts.

Joe is gone, but I disagree with Joe about the source of the subsidy. I'm in favor of a subsidy because I think we can't accurately measure the need and I obviously strongly support these institutions. But I think the idea of getting rid of the subsidy completely from Medicare -- because it shouldn't come from Medicare, it should come from general revenues -- is a little politically naive.

Unless there's an agreement that it's going to come from general revenues the next morning of something, just cutting out the subsidy -- if we think that's going to force Congress's hand I think we better look in the mirror again.

And so I think that that would not be logical to me in the system. It might be a reason to engage in conversations and a policy dialogue about what's the proper source. But to make reductions because you think it's going to force something else I think it is probably not right. So I would disagree a little bit about that with Joe.

MS. RAPHAEL: This is on this particular point because I guess putting together with Dave and Jack have said, for me there is a question of timing because I think the data makes clear there is a subsidy here. But I am very concerned about the issue of access in urban areas and the uninsured rates which I know, depending on private or public can range 5 to 20 percent, in some cases in public institutions I know of exceed 20 percent and are increasing as the number of uninsureds increase.

So for me that whole issue of how this would be

implemented and the timing and how we would make sure that what is fragile now is not going to become more fragile as a result of this is an important issue that I would like to kind of pay some attention to.

The other comment I have is that I think we need to be consistent because we're using total margins here but we're not using total margins when we look at SNFs and when we looked at home health-care. I think we just need to be sure that whatever we decide is the proper measurement, which might be total Medicare margins, should be used as we look at the different sectors that we're responsible for recommending updates for.

MR. HACKBARTH: I agree with that, Carol.

MR. SMITH: I can be brief, Glenn. David and Jack and Carol have said most of what I wanted to say, so let me associate myself with it.

But I think we need be careful with subsidy. It's has taken on a pejorative term in the culture, but we subsidize a lot of things and we use Medicare to subsidize a lot of things. The notion that we should subsidize uncompensated care or we should subsidize a small rural hospital that's a sole community hospital, it seems to me

those are both perfectly acceptable notions.

Either we need to somehow sanitize the notion of subsidy and admit we're for it and be clear about it or we ought to call these things something else. But to Joe's argument that we are inappropriately deviating from the ideal type in order to provide these subsidies strikes me as wrong on both ends, both politically naive as Jack said and these subsidies are appropriate public policy that Congress sensibly determined. And we ought to be careful to use a vocabulary that segregates some things as sensible and others as not because of what we categorize them as.

MR. HACKBARTH: The use of subsidy, I think, is a bit awkward and I think people have struggled with how to characterize this payment. Technically speaking, it's the payment above what is justified by calculating the resident-to-bed ratio. This is an add-on beyond -- that's a little unwieldy as a thing to say every time you bring up the subject. So I understand your concerned about subsidy.

My own feeling on this is that our role is to help the Congress and if there is a legitimate policy concern about uncompensated care, let's help them get to a policy that is targeted as precisely as possible on that

problem. My own uneasiness about IME for the last 20 years has been that the rationale sometimes floats around depending on the group talking about it. That always makes it concerned when we're talking about a lot of money. Let's decide what we want to support and let's write a formula that targets the money as precisely as possible. In fact, that's the spirit of this whole discussion about trying to make the PPS system fairer and a better, more targeted use of taxpayer dollars.

MR. SMITH: Glenn, I agree with that but it does seem to me that we ought to remind ourselves that this particular payment above empirical costs goes to hospitals that have the lowest total margins and provide the most uncompensated care. In an imperfect world that's not a bad match.

MR. LISK: I just want to remind you though that, in terms of where we saw the uncompensated care, it's going to all teaching hospitals and only a portion of them are providing a substantial amount of uncompensated care and that's the other issue that comes here. How really specifically effective is it at getting at that issue?

DR. REISCHAUER: My point was that it's a pretty

loose correlation here. There's a lot slopping around and maybe not to the right places. But there, as Glenn pointed out, some ambiguity here. We've been sort of very hard-nosed over the years in saying this is a payment that should be exclusively directed at the cost of delivering care in a teaching environment for Medicare patients. There are lots of advocates of this policy that say there are greater social benefits to teaching hospitals and this is a reward to them and then there are those who say well the excess really should be viewed as a kind of sloppy way of handing around some money for uncompensated care and other social objectives that society wants from these hospitals.

In a way what we need is clearer congressional intent, which is not likely to occur in our lifetime, before we can really go the next step.

I wanted to ask Jack, when you were talking about total Medicare margins and DSH and total margins, were you including DSH payments as an appropriate element of the total Medicare margins?

DR. ROWE: [Nodding affirmatively]

DR. REISCHAUER: Even though some of the

resources would be devoted to uncompensated care of non-Medicare eligible people.

DR. ROWE: I think that that number would more closely approximate the number that we really want to use than excluding the DSH completely, recognizing that there are many patients who would not be Medicare beneficiaries who might benefit from those clinical activities.

You could argue it either way. I would just come out in favor of including it. How would you feel, Bob?

DR. REISCHAUER: I would certainly include it in total margins but when I was asking whether Medicare was paying appropriately for all of the services that Medicare is providing to its beneficiaries I'm not sure I would include it.

DR. ROWE: I understand that. That's where I would come out. But I certainly would favor a total clinical margin number. And I think that would give us some more clarity. I'm not sure that number is available for the cost reports or whatever.

MR. HACKBARTH: Help me manage our time. I see Ralph's hand up. Are there others who want to address this topic?

MR. MULLER: Just briefly to Bob's comment. The original intent, at least of the '83 legislation -- was to recognize a variety of purposes and social purposes that advantage Medicare beneficiaries. I think sometimes defining it narrowly just as the presence of residence understates that broader purpose that was in the original intent. We use that ratio as a way of distributing the money and therefore that's what gets captured in the regression but by no means captures all the original language.

I think also, that original language does talk about the regional roles, the role of research, the progressive advancement of clinical care as a result of the roles they play both in local and national society? Those things are hard to measure, perhaps that's mushy. But they certainly aren't captured all by the intern-to-resident ratio. And that's why I think to then say that therefore, since we don't capture in that ratio they are not worthy of subsidy and therefore, they're a subsidy, I have some real difficulties with that use of language that way.

I do think Glenn, as I've indicated to you, we should spend some time offline looking at exactly how we do

these calculations and so forth, because they do lead to words that get fairly explosive at times and to see whether in fact they really are above the empirical level is something I'd like to see us explore more fully and it probably makes sense to do that in the next month or so.

MR. HACKBARTH: Mark, do you want to give us a quick rundown on what you've got?

DR. MILLER: On this one I haven't heard as many specific analysis follow-up. However, pretty consistently across several people the notion of which margins we're looking at and additional information on what's happening with private payers to make sure that we can have some proxy for what's going on there.

I think there was also a question about looking at the public hospitals specifically and getting a sense of what's happening there.

And then there was the expression of concern, is there anything we can locate in terms of access and uninsured rates in urban areas, which I heard from Carol.

And then just this last exchange on drilling down in the calculation.

Did I miss anything?

MR. FEEZOR: Mark, only in terms of what contribution is, say from private payers might be. Not just what it is, what trend line it might be.

DR. MILLER: That's what I was trying to capture with that thought.

MR. MULLER: I don't know whether Crick said -- are we going to have the 2000 inpatient Medicare margin or not by January? I lost track of that.

MR. LISK: We're just showing you the Medicare inpatient margin. You're talking about the overall -- I think you're talking about the overall margin.

MR. MULLER: Yes

MR. LISK: The Medicare overall margin we will be attempting to have for you for 2000. I will get into this discussion because we will be having it just bit later when Tim presents his data. There are issues with overall Medicare margins because of -- particularly for outpatient care, because major changes that were made in the payment system for outpatient care and hospitals reporting and cost reports. We are attempting to get an outpatient margin but with data changes that we've been having, issues of pinning it down, there were reporting -- one of the reasons why we

have a delay in the margins is hospitals were given another 18 months to submit their cost reports and how outpatient data is recorded in the cost reports is different from what it used to be.

If we have confidence in the numbers, we will be presenting you with a full-blown 2000 overall Medicare margin. But we have to resolve some of these issues and we've been working diligently for the past month, since we've gotten the data, to try to resolve these issues but we have not come to anything that we are comfortable with at this point in time for 2000. We can hope and pray that we will have something for you to resolve those issues. And we're working very closely with CMS to try to do just that.

But there a possibility that there is garbage in, in terms of the reporting, and garbage out. If that's the case, we will not able to report 2000 overall margins for you. We'll hope that that's not the case but we need to resolve these issues.

MR. HACKBARTH: Did you have a question that you wanted to add?

MR. SMITH: Just maybe a suggestion that either

we explain in the text a little further or have an addendum to this chapter on what makes up the IME and how it's calculated. That question keeps flying up in and out of the commission so this might be a great time to go back and explain that a little bit.

MR. HACKBARTH: Usually we handle that sort of thing in what we call a text box.

DR. STOWERS: That would be great, something like that.

MR. HACKBARTH: Well done, Craig, two difficult issues and you held up very well.

Now we are going to hand it over to Jack and I think what we're doing now is going to the other side of the distributive issues. There are cases that we've identified where we think particular types of hospitals may be underpaid by the current rules. Jack?

MR. ASHBY: In this session, we are going to review five recommendations that MedPAC made previously to improve rural hospital payments. Most of these were published in our June 2001 report. That was the big rural report, one what was followed up in our most recent March report. I also wanted to add though, that CMS has already

implemented one of our recommendations. That dealt with faster phaseout of select personnel categories from the wage index, so we won't spend time talking about that one.

That leaves four, all of which were actively considered by Congress in the last year but none has been implemented to date. So we would like to consider reissuing these recommendations, partially to emphasize that these are issues that still need to be dealt with, and in a couple of cases also so that we can detail out what sort of phase-in schedule we think is appropriate.

And I just wanted to emphasize the point that Glenn made. These four recommendations are part of the package that creates what we think is a reasonable distribution of inpatient payments. And all four of these would help rural hospitals and so indeed would tend to offset the impact of the transfer policy that we discussed earlier.

Just one more note before I get into the details and that is that because the commission has already agreed upon all four of these recommendations, I'm going to present them in more summary fashioned than we usually do. Those of you who were here a year-and-a-half ago remember

that we had extensive analysis and extensive discussion of each one of these but it's not clear that we need to go over all of that detail once again. But on the other hand if you have questions, do ask.

MR. HACKBARTH: I think that's a good point. For the new commissioners who did not participate in the deliberations over these, if you feel like you want to get more information, obviously feel free to contact Jack. If you haven't seen the rural report much of it is laid out there, of course, but I think it is more efficient not to review all of it again here today.

MR. ASHBY: Right, just going to summarize each one of them. The first recommendation dealt with implementing a low-volume adjustment. And this recommendation was based primarily on evidence from a multivariate analysis that low-volume hospitals have higher unit costs, all other payment factors held constant. But the relationship levels off at about 500 discharges. And just to clarify, this is 500 discharges across all payers. So these indeed are small hospitals. That's an average daily census of only about seven or eight patients. But we have to realize that 11 percent of the PPS hospitals are

that small, so this is not a really isolated situation.

I wanted to also point out that the low-volume hospitals, besides having higher unit costs, do in fact have lower Medicare inpatient margins and that's despite a couple of programs that we already have that are designed to help rural hospitals. This is the sole community hospital and the Medicare-dependent hospital programs. The trouble with those mechanisms though, is that they're not targeted to small hospitals particularly and indeed there are some hospitals that are missed by those adjustments.

We stimulated a low-volume adjustment based on the documented cost relationship. We came up with an adjustment that is linked to the line that runs from a zero percent adjustment at 500 discharges up to a 25 percent adjustment for one discharge. But also added a requirement that the low-volume hospital must be more than 15 miles away from another PPS hospital in order to qualify. We don't want to reward two small hospitals that are right next door each other because that proximity might, in fact, be the reason why they have low volume, as opposed to sparse population more generally.

The impact of our simulated adjustment would

raise payments for hospitals with less than 200 discharges by 8 percent and it would raise payments by about 4 percent for those between 200 and 500 discharges. I think you would agree those are sizable impacts for those individual institutions but because the hospitals are so small and they serve so few Medicare discharges we can give these particular hospitals assistance while still raising aggregate payments by less than .1 percent.

So in this next overhead you see the draft recommendation. It just says recently very simply we should enact a low volume adjustment but it should only be available to those more than 15 miles from another hospital. This would have, as I said, the small impact, less than $50 million in 2004.

The second recommendation had to do with reviewing and possibly reducing the labor share. Labor share refers to the proportion of hospitals' costs that are comprised of wages and benefits plus what CMS calls other labor related costs. These are really the issue. These services are purchased in local markets such that we would expect their cost to be driven by locally prevailing wages. And the labor share is used in applying the wage index and

is currently 71.1 percent. That means that 71 percent of the base payment rate is raised or lowered by the wage index.

Our rationale for this recommendation was that some of the categories that CMS considers labor related are, in fact, not always purchased in local markets. Some examples would be things like postage and delivery, accounting services, computer services, legal services, these sorts of things. They can be purchased locally but they also can be purchased from national vendors in which case they'd be paying the same price as anybody else.

Since the rural report came out we've also obtained additional evidence from a multivariate analysis suggesting that the labor share may indeed be set too high. But because the labor share differs by the circumstances of the hospital, it was not possible with the analytical techniques that we had available to us, to peg the exact right share. And for that reason we thought the best approach -- which you'll see in a minute in the draft recommendation -- was to recommend that CMS reevaluate the labor share and come up with the best single number. And I would point out that they've already started that process.

They're well into it, as a matter of fact, and we would expect them to come out with something in the next year.

The impact of this one, on average, it would modestly increase payments for rural hospitals and modestly decrease them for urban hospitals. We didn't quantify this because, of course, it depends on exactly were you set the labor share but it's going to be in the neighborhood of tenths of a percent increase for rurals, tenths of a percent decrease for urbans. But the implementation would be done budget neutral.

In the next overhead we see our draft recommendation, which says that CMS should reevaluate the labor share and come up with the appropriate specific figure. The budget implication is that overall spending would not change.

The third recommendation has to do with eliminating the differential in the inpatient base rate. Currently the base rate is set 1.6 percent lower for the combination of rural and the so-called other urban hospitals and that's relative to the rate for larger urban hospitals, large urban defined as areas that have more than a million people. But our cost analysis found that for

these two groups there, in fact, is no difference in the unit cost of care, all other payment factors held constant, and therefore there's really no rationale for any difference in base rates. We also point out that the margins are lower for rural and other urban hospitals, even after we take out the subsidies, the DSH and the subsidy portion of the IME, they are still lower for rural and other urban hospitals.

In terms of impact, eliminating the differential would, of course, raise payments for rural and other urbans by 1.6 percent. If we did this with new money, it would raise aggregate payments by .8 percent . This could be phased in, though, and if we phased in over two years it would raise aggregate payments by .4 percent for 2004.

We have a draft recommendation that would do that, raise the right to the level of that for larger urban hospitals phased in over two years. This would increase spending. It would increase spending in the first year by $200 to $600 million and over five years it would raise payments by somewhere between $1 and $5 billion.

The last one of our four has to do with disproportionate share payments. Here first we need a

little bit of background. MedPAC and ProPAC before it recommended a major reform in the disproportionate share payment system and that would bring uncompensated care into the calculation of low income shares. That is, we would distribute payments partially on the basis of uncompensated care. And then the second part of it was that we would use virtually the same distribution formula for all hospitals. That formula has always been tilted heavily in favor of urban hospitals.

But this overall reform cannot be implemented until we collect uncompensated care data and CMS is in the process of doing that as we speak. In fact, the first cost reports with uncompensated care data in them should be arriving in about another month or so. I unfortunately have to point out that how soon we'll be able to analyze those data depend on how soon the cost reports are processed and that has been a problem for us. So we don't really know when that will be exactly.

At any rate, as an interim measure until the uncompensated care data can be processed, we recommended that we continue to use the current measure of low income share but raise the cap, which by the way applies to most

rural hospitals, cap on the disproportionate share add-in from 5.25 percent to 10 percent. Now we have to remember that there is no cap for urban hospitals so the job will not be complete but we feel that the last step in equalizing DSH rates ought to be taken when we have the uncompensated care data to bring into the distribution.

In terms of impact raising the cap to 10 percent would increase rural hospital payments by 1.4 percent. Since rurals are a small portion of the total, it would raise aggregate payments by only .2 percent. This one, of course, could also be phased in and we are suggesting a phase-in schedule of five years which connotes a somewhat lower priority for this one relative to equalizing the base rates where we suggested a two year phase-in.

In this next overhead we see the actual recommendation that says raise the cap to 10 percent phased in over five years. This would, in 2004, have a small impact because of the phase-in. It would be less than $50 million. Over the five years it would be in the less than $1 billion category but towards the somewhat upper end of that category.

So that's the four recommendations and wondering

about any questions on how these work .

DR. STOWERS: Jack, ONE question. Eventually as we're calculating the uncompensated care, will we be considering the difference between what Medicaid pays and what hospital costs are as uncompensated care?

MR. ASHBY: We never call that uncompensated care because it in accounting sense it's not. But the formula that we recommended two years ago when we put this whole package together would indeed talk about low income share in terms of their share of uncompensated care and their share of Medicaid patients.

DR. STOWERS: So that would still come into play with Medicaid?

MR. ASHBY: Yes, that would still come into play. And also, by the way, their share of patients covered by any other indigent program. There are state level programs again that come into play. We wanted to capture all of them in the distribution.

DR. STOWERS: My second question was to Glenn and that's whether today we had the option of looking at these recommendations? And what I'm really referring to is the five year phase-in on the DSH payment, which looking

back on it and now knowing the relatively small fiscal impact overall, and yet the big effect that it could have on some hospitals, if we couldn't consider as a commissioned to kind of speed up that phase-in or whatever, since it is a relatively small amount of money?

I didn't know what our options were today or whether you wanted to get into today?

MR. HACKBARTH: Well, of course today we're not trying to decide on the final package, so January is the key discussion in that regard. Let me ask Jack and Mark whether they have any further comment about why a five year as supposed to a shorter time horizon?

MR. ASHBY: As I said, it suggests that when we're talking about committing limited resources that perhaps the most important of these is eliminating base rate differential. So we speeded that up to two-tenths and that has a significant cost attached to it. But if we thought that it could be accommodated within the cost of the overall package, obviously we could speed this one up.

MR. HACKBARTH: Is there an implicit statement in the five year transition about how quickly the formula is likely to be rewritten? We're talking about lifting the

cap on the old formula that we have problems with. You said data are being collected as we speak to rewrite the formula. Are you implying that that's unlikely -- the rewrite is unlikely to happen within five years?

MR. ASHBY: I hope that isn't the case. No, in fact, one might build an argument that it's better to get it implemented before we then go and bring the next phase on. We don't know how soon this is going to be. If the cost reports were a well-oiled machine we would have information a year from today to begin analyzing this. I don't think it's going to be that quick unfortunately, but I certainly hope that it won't be five years.

MR. HACKBARTH: So the bottom line is we can come back and look at that but I don't think we can productively look at it in isolation. We need to look at it as part of an overall package.

MS. DePARLE: Just a point of clarification, changing the DSH formula does not require a change in law?

MR. ASHBY: Yes, it does require a change in law. So this is a the Congress should type of recommendation here.

MS. DePARLE: So even if CMS gets the cost

reports in and has the new data, it's not like they themselves could just make a change.

MR. ASHBY: That's exactly right.

DR. REISCHAUER: I think I'm next on the list, so I'll recognize myself.

The discharges for the low volume threshold are total discharges, not just Medicare discharges; right?

MR. ASHBY: That's right.

DR. REISCHAUER: I was wondering if you had done two sort of back of the envelope simulations. You have the restriction that the hospital has to be further than 15 miles away from another hospital and we know that pressure will build to be reclassified or to have that relaxed. Did you see what would happen if you had no mileage threshold at all? It's a small amount of money, as it is, and I can't imagine it would be huge amount. Sort of just the danger zone --

MR. ASHBY: We did do that simulation and, in fact, it doesn't make a great difference in the budgetary impact . Of course, it's somewhat larger because you sweep in a few more hospitals but since they're all small hospitals it was not really a budget-driven decision. It

was more a conceptual decision that you really don't want to have two hospitals across the street from each other both being --

DR. REISCHAUER: I agree completely with the theory there.

MR. ASHBY: But dollar-wise, it's not really a worry.

DR. REISCHAUER: Along the same lines, we have a new threshold of 10 percent for DSH payments in rural areas and that increased average payments by 1.4 percent. What if we dropped it altogether and had no limit so it was a level playing field with the big urban hospitals?

MR. ASHBY: Right. It would then provide a substantially additional increase for rural hospitals but I really want to throw out a serious cautionary flat that. One of the problems with doing that is that you would give some hospitals a big increase only to take it back two years later when the uncompensated care data comes in. Dislocation is a problem.

But there's another problem besides that, and that is the current formula is not the right formula for the long-term. The current formula was designed with a

very specific end-run objective in mind and that was to help large urban public hospitals. So they made the rate a graduated schedule to give an extremely large adjustment for those hospitals at the very high end of it to make up for the fact that we're not covering their uncompensated care and to make up for the fact that they don't treat very many Medicare patients. Some of them have like 20 percent Medicare penetration.

Well, you take that formula and apply it out in rural areas where they have 70 and 80 percent Medicare and you would have some virtually humongous add-ons that go beyond prudent policy. So in fact we really don't want to just take the cap off altogether until such time as we can reform the system .

MR. HACKBARTH: I have Nick and Nancy Ann, but before we do that, let me just talk about time management. I think we need to adjourn no later than two o'clock, our scheduled time, because of plane schedules and the like. What I would propose we do is wind up the discussion on these proposals, which we've already analyzing and discussed at length, in the next five minutes or so, which would leave us about 45 minutes to talk about the update.

And then we can have public comment period and then a brief break for lunch and I think wind up by two o'clock.

So if that make sense to people, I will recognize Nick and Nancy Ann and Mary and then move on.

DR. WOLTER: Just quickly, I was wondering if critical access hospital conversion might at all mitigate the need for the low volume adjuster. And if at some time in the future we could see financial data about how critical access conversion is affecting the program.

MR. ASHBY: That's a very good point. It would indeed mitigate it and in fact, since our analysis took place, we've had some hospitals that have gone CAH. We do have that as a failsafe for those hospitals and that's probably a good thing.

I guess I'd like to point out that we think there's some advantage of the low-volume adjustment over the CAH AND WE would love to see this make it possible for some of the hospitals to stay in the Medicare program. We have to remember why we went away -- CAH has cost-based payment and let's remember why we went away from cost-based payment in the first place.

First of all, it kind of removes their incentives

to control their costs. But secondly, it has this sort of perverse situation where they can never have a positive margin. They're locked in at zero forever so they're never going to generate any money for capital replacement, which is critically important in rural areas.

So we'd love to see a scenario where these small rural hospitals actually have a fighting chance to generate a positive margin and we can do that by making the prospective rates more closely aligned to their real cost structure.

DR. WOLTER: That's why it might be interesting to do some follow-up analysis to see how they would both do financially over time.

MR. ASHBY: Right.

MS. DePARLE: Just a quick point on behalf of my former colleagues and also congressional staff. I would want to echo what Bob said about the 15 mile restriction in the draft recommendation, that we should really think hard before we put something in that's just going to demand and compel gerrymandering and all sorts of discussions that are going to be a waste of time.

MR. ASHBY: Just to understand what you're

saying, you're suggesting that for the small difference in dollars, we might do it without a limit and simplify the whole thing?

MS. DePARLE: I want see what it looks like, but if there's a way to stay true to the policy and try to provide this adjustment without having that kind of a designation, I think a lot of people will spend a lot of time around this.

DR. REISCHAUER: Nancy Ann, I would do it and then get rolled by the political system so that we, as analysts, have something to complain about.

MS. DePARLE: But you have to negotiate with everyone.

DR. WAKEFIELD: Just a statement on the transition components that we've got associated with DSH and with eliminating the base rate differential. It just seems to me that we have really well established with data the validity, if you will, of this package of recommendations and while I understand we're trying to be sensitive, obviously both the big picture expenditures as well as eliminating the base rate differential in a budget neutral fashion, where that is going to have an adverse

impact on another set of hospitals.

Nevertheless, I'd just point out this set of hospitals has been sitting out there since our rural report came out not advantaged by any of these recommendations, all of which are well founded, in terms of the data that support them today. So the transition is becoming more of greater concern to me as I don't see a response to what we've recommended in our rural report in Congress yet. A lot of discussion about it but no response. And t hat transition, depending on the point at which this might be adopted, and we're transitioning from that point forward. So it's just a concern about both the evidence we have here today to support this and our hospitals functioning out there at a great disadvantage.

MR. ASHBY: Just to make sure that we understand, though, the no eliminating the differential we are proposing to do with new monies here. We were not going to redistribute that.

DR. WAKEFIELD: Will you tell me that impact on urban hospitals, Jack, if that's the case with new monies?

MR. ASHBY: With new monies for eliminating the

differential, the impact on urban hospitals would be zero.

DR. WAKEFIELD: Well, even more then.

MR. HACKBARTH: What I'd like to do on the transition issues is look at those as we look at the whole package of recommendations as opposed to take them on one by one. Your point is well made, Mary, about there's already been a transition period, so to speak and they haven't been enacted and acted on.

MR. DURENBERGER: Mr. Chairman, can I make just one two cents observation?

I teach a lot of doctors and clinic managers who are getting MBAs, they're taking two-and-a-half years out of their life to get an MBA. And those who serve rural areas say the more we do critical area -- the more we do this sort of we've got a hit for this situation, we got a hit for that situation, the harder it is to really change the way health care ought to be delivered in rural communities. So I may have a slight disagreement with my friend from North Dakota, and I don't think it relates say to the DSH thing and so forth but it does relate to critical areas. In other words the more you establish in Washington that this year this hospital gets rewarded, that

one doesn't, the harder it is for them to do the kinds of things in rural areas that they'd like to do to change their own system.

MR. HACKBARTH: What I hear you saying is that the approach of creating special payment categories is not the best way to do go if, in fact, we can make it viable for rural hospitals to succeed within the prospective payment system by making the system better or

MR. DURENBERGER: I'm only speaking for people who are -- those people who I'm teaching. I may not be speaking for everybody else but these, I think, are the people that are out there trying to change the system.

DR. WAKEFIELD: If I could just say, I'm suggesting we get rid of some of these differences in terms of updates, differences in updates and also some of the difference pulled out of DSH payment. So it isn't to create new categories. It is to level that playing field a little bit.

MR. HACKBARTH: All right, we need to move on now to our update discussion. Thank you very much, Jack. Well done.

There are two pieces to the update discussion,

the inpatient and outpatient. As you recall, one of the implications of looking at the overall Medicare margin is sort of our index of financial performance is that our decision about the outpatient update becomes a lot simpler. We're not looking specifically at outpatient department margins which are skewed by all the accounting issues that we've referred to multiple times today. So in thinking about how to allocate time here, I'm going to focus primarily on the inpatient discussion.

Tim and David, fire when ready.

MR. GREENE: Good morning, I will be discussing the commission's approach to determining payment adequacy and update for hospitals. Because you heard so much about the payment adequacy approach yesterday, I'll try to be brief in my comments on the general approach in methodology and I'll focus on results specific to hospitals.

I'll then turn to a draft update recommendation for inpatient PPS and Chantal will follow me with a discussion of outpatient payment and an update recommendation for outpatient services.

Briefly, the first part of a process to determine the appropriate payment update is to determine the base

payment costs, determine whether the cost base is appropriate.

MR. HACKBARTH: Tim, can I just make a suggestion? I really apologize for being rude, but we've gone over the basic approach for all of the updates and I think we can skip over to that, to the factors specific to the inpatient update analysis.

MR. GREENE: My next sentence is we estimate current payments and costs beginning with base costs in 1999, the Medicaid cost reports for 1999, that Craig was referring to. We then project costs to 2003. We are considering the update for 2004, so we assume that all payment policy changes that would be in effect in 2004 are reflected in the 2003 model.

Growth in hospitals' Medicare cost per case was modest, less than the increase in the hospital market basket, from 1993 through 1998. In fact, from 1994 to 1996, growth was negative, costs per discharge was declining.

This has changed with costs per discharge growing more rapidly, 3 percent in 1999. We don't have numbers for 2000, but aggregate costs increased about 6.5 percent in

2000, and increase somewhat, about 1 percent, from the previous year.

In light of the time limitations and the limitations of inpatient cost per discharge, we looked at cost per adjusted admission, a more comprehensive measure of hospital costs. Costs per adjusted admission growth followed a similar pattern to cost per discharge growth, low increases in the 1990s with actual decreases in 1997 and 1998. In '99, costs per adjusted admission increased rapidly, about 3 percent, and continued at that rate through 2001.

This recent pattern of more rapid cost growth occurs in an environment categorized by three factors. First, declines in length of stay are slowing. Medicare length of stay continues to fall, but at a much slower rate. Hospitals were able to contain costs in the 1990s by reducing length of stay. From 1990 to 1999, hospitals cut Medicare length of stay 33 percent.

However, declines have showed since 2000 with length of stay falling 2 percent in '99, 1.6 percent in 2000, and less than 1 percent in the following year. This all applies upward pressure to cost growth.

Second, hospital industry wages grew less rapidly than growth in the overall economy until 2001. Now hospital industry wages are growing more rapidly than the overall economy, a major trend in change. This is applying major upward pressure to costs, possibly attributable to shortages in certain occupations, nurses, pharmacists and other health care fields.

Third, pressure from other payers to reduce costs has moderated in the last two years. When revenue pressure is reduced, the strong incentive that hospitals have to hold down costs is weakened.

MS. ROSENBLATT: Can I just -- I mean, that's just a strange statement to me, in thinking about what we heard yesterday. Could it be that it's just more of a shift towards PPO, away from HMO? Because I don't see the industry letting up on the negotiating. So I'd be real careful about language like that.

MR. FEEZOR: Alice, and Tim I don't want to get from your presentation but I think how it's presented of what's going on in the private market is a little bit sanitized here. There really has been a concerted effort and it is the product mix that's contributed, and a lot of

other things, but we can probably rework that in the narrative. Go ahead with your presentation.

MR. GREENE: Briefly, before we return to the general issue of overall financial performance, let me emphasize that we look at overall financial performance as background information for the payment adequacy update analysis. Overall performance, total margin doesn't directly address the adequacy and appropriateness of the Medicare payments relative to Medicare costs. Nonetheless, we discuss it and consider it in the analysis.

Now continuing what I was just saying about private payers, increasing pressure from private payers was generally credited with reducing cost growth in the '90s. Medicare payment-to-cost ratios decreased after 1997, but private sector payments were decreasing relative to costs for most of the second half of the decade.

In 1998 and 1999 both private and Medicare cost payments were declining relative to cost. However this turnaround in 2001 when private payments increased relative to cost and this has continued in 2001. As Alice was pointing out this has occurred in an environment where PPOs have become the prevalent form of insurance and, in

general, more restrictive forms of managed care have become predominant and we've seen many reports of hospitals successfully bargaining with insurers and obtaining more favorable payment rates.

Turning now to a brief discussion of total margins in the context of our discussion of overall financial performance, the total margin for all payers reflects the relationship of all hospital revenues to all hospital costs. Total margin reached a low point of 3.4 percent in fiscal 2000. This is the new data from the 2000 cost reports. It's the lowest level in a decade.

This drop may have halted. Preliminary information from the National Hospital Indicator Survey sponsored by MedPAC and CMS shows that total margin, according to that survey, appears to have leveled off. Margin stayed steady in fiscal year 2000 and 2001 and it appears to be staying steady in preliminary 2002 data. This suggests that the total margin for Medicare cost report for 2001, when it becomes available, will not show a decline, from the 3.4 percent number we saw. We can't say that with certainty but the suggestion from the survey data is that total margin is stabilizing.

This is the general background that I'll go over quickly. As you know, the payment adequacy approach considers volume change, entry and exit which in the context of hospitals basically means hospital closures, and access to capital which tells us how Wall Street judges of financial health of the industry. And at least indirectly something about the adequacy of Medicare payments.

We do consider three factors peculiar to Medicare, though. One is the overall margin, which we've been discussing, which we consider to be the key indicator in this area. Second, the inpatient margin. And third, the outpatient margin. I'll be giving some over view information on the inpatient margin. Craig gave you information specific to teaching hospitals. And Chantal will be coming up later and discussing outpatient margin results.

On the volume and entry/exit indicators, we looked at adjusted admissions as a measure of total hospital volume because it reflects both inpatient and outpatient activity. And our analysis here focuses on adequacy of payments for all Medicare hospital services, not just inpatient. Adjusted commissions grew steadily,

about 2 percent a year, from 1990 to 1998, then accelerated to over 4 percent a hear through 2001. This has been followed by what appears to be a slight decline at the beginning of fiscal year 2002 but that's preliminary information. I wouldn't want to really put great emphasis on it.

Total admissions and Medicare discharges also increased through 2001. In general, Medicare growth has been faster and again preliminary data from NHIS, National Hospital Indicator Survey, suggests a possible slowing down in admissions growth and Medicare admissions discharge growth in the current fiscal year.

Turning now to the entry/exit question which, as I said, means closures in the case of hospitals, from 1990 to 2000 there was a net reduction of 469 community hospitals across the country, a relatively small number on average over the period. This reduced the total bed supply by about 10 percent. This steady but slow reduction in the number of hospitals, number of closures, has continued. There were 64 closures in 1999, 64 again in 2000, and 41 in 2001. This really continues the trend we saw in the previous decade without the spikes that we saw in some

years in the 1990s.

The HHS Office of Inspector General has looked at closures in 1999 and 2000 and concluded that hospital closures in 2000 generally had modest effects on access to care. They note that on an average day in the year before closure there were 32 Medicare beneficiaries in each urban hospital that closed and 12 beneficiaries in each rural hospital that eventually closed. These are very small impacts when one of those hospitals closed. In any case, inpatient care was available within 20 miles for 86 percent of the hospitals and for all of the urban hospitals that closed.

Now David will be speaking about access to capital .

MR. GLASS: For-profit chains prior to the Tenent outlier controversy, there was strong support for the sector on Wall Street. Now there's somewhat lower expectations for evaluation, but still support for the sector because of continued higher admissions, good pricing, moderated labor and other costs going forward. This should lead to good cash flow and gains in earning per share. We judge the Tenent situation as probably not

contagious because the outlier is a much lower share of revenues for the other for-profit chains.

As far as capital spending and acquisition plans, those continue to be strong. One large chain spent $1.4 billion in 2001 and plans capital projects of $1.6 billion and $1.8 billion for 2002 and 2003. One of the recent acquisitions was for over $1 billion, and smaller chains are planning to spend hundreds of millions each. Altogether we would say this implies good access to capital for-profit chains.

Not-for-profit, again for the same reasons as the for-profit hospitals, the sector is consider promising. The non-profits should see increased admission, good pricing, better management, and will be moderated by and possible pressure on government prices and some expenses.

For those hospitals that are able to access the bond market, indications are good. Almost all are above investment grade and although there have been more downgrades than upgrades, that's primarily because of increased borrowing given the lower interest rates. The ratio of up to downgrades is higher than in the past few years, and in terms of actual dollars upgrades have

surpassed upgrades.

There's still some symptoms of limited access to capital perhaps, for those hospitals particularly that cannot access the bond market. The use of receivables financing where a hospital sells its receivables to finance cash flow has been highlighted by the recent bankruptcy of National Century Finance. And so if that's considered last resort financing, it's use may raise some questions. But interestingly, the hospitals that went into bankruptcy as a result of that bankruptcy were all for-profit hospitals

Another possibility is the expansion of the for-profit chains into rural and small urban areas by acquisition of not-for-profits might imply that it's a symptom of inability of those small hospitals to make sufficient capital investments and make themselves attractive to customers. To that's another possible symptom of limited access.

But for payment adequacy, the question is really is there enough money in the sector overall, not is every hospital doing well. We expect the capital market, if it's working, to discriminate between hospitals with and without financial viability. So as a sector, hospitals seem to

enjoy good access to capital.

MR. GREENE: The overall Medicare margin incorporates payments and costs for inpatient, outpatient, skilled nursing, home health, psych and rehab services for Medicare beneficiaries in the hospital, as well as graduate medical education and Medicare bad debt costs. The overall Medicare margin controls for shifting of costs by incorporating all services into one measure.

We're reporting a preliminary estimate of the overall margin. We modeled the overall margin using fiscal year 1999 cost reports as well as information on actual and forecasted changes in costs and payments. When or if data are available fro the fiscal year 2000 cost reports that are adequate for the non-inpatient services -- these are the issues that Craig was discussing earlier -- we intend to update this estimate and base in on 2000 data rather than the updated 1999 data that underlie this estimate.

We updated the data from 1999 using actual information for 2000, 2001 and some of 2002. I want emphasized that because the age of the 199 data is striking but we have to realize that are not just projecting. We're incorporating a great deal of real experience in these

calculations.

We modeled payments using specific payment factors for each hospital-based service. Our modeling takes account of several factors. We considered changes in actual costs. These are based on changes in costs per adjusted admission from the American Hospital Association for 2000, 2001, and forecast for the CMS market basket in 2002 and 2003.

Second, we considered payment updates already in law and in regulation.

Third, we took account of length of stay changes as they affect Medicare costs. These are based on the AHA annual survey in 2000 and 2001 and NHIS in 2002.

Finally, we considered policy changes from 2000 through 2003, as well as those scheduled to take effect in 2004. For example the update to home health payments is adjusted to reflect the end of special payments to rural agencies in April 2003.

We estimate the overall margin for PPS hospitals would be 3.5 percent in fiscal year 2003 if all policy changes scheduled for 2004 were reflected. This provides a context for the commissions' deliberations on the 2004

update, and reflects a decline from 4.7 percent in the 1999 cost report data and it contrasts with a value of 3.8 percent which the commission estimated for 2002 in last year's analysis and in the March 2002 report.

We emphasize that these results are preliminary. In addition, some policy changes that may otherwise push up the margin are not reflected. We'll be doing further work in any before January.

DR. ROWE: [off microphone.] Is DSH included in the --

MR. GREENE: Yes, in total payments.

Craig presented some information on the inpatient and overall margin for teaching hospitals in comparing between groups. This is the overall data, the historical data that we've seen many times before through 1999 and for 2000 the inpatient margin from the 2000 cost reports.

DR. REISCHAUER: [off microphone] That's the inpatient Medicare margin?

MR. GREENE: Yes, inpatient Medicare margin for PPO services.

As you can see, the inpatient margin declined between 1999 and 2000 to 10.8 percent. Though this is a

significant decline from 1997, it in many way returns the margin to the historical levels before 1995. This is important because there's tendency to focus very much on the short-term three-year declines and it's useful to look at the experience of the hospital industry under PPS in a longer time frame.

We only have information on the overall margin back to 1996 due to the data limitations, but as you can see you , the overall margin tracks the inpatient margin quite well and we would expect that it performed similarly in the pre-1996 period and that though we don't have a value for 2000 yet that it will probably follow similar trends.

Returning now to the update discussion. First by way of context, the update we're considering now is for fiscal 2004. Current law would set the update in 2004 as the market basket rate of increased. That's currently forecasted at 3.3 percent for fiscal year 2004. PPS payments were $86 billion in fiscal year 2001. That represents an increase at the rate of 3.6 percent from 1997 to 2001 and they're expected to increase at a rate of 6.4 percent 2001 through 2006.

Finally, there were 11.5 billion discharges for PBS hospitals in 2001.

The last step in payment adequacy and the first step in the update analysis is to beyond evaluating base year costs and to consider possible cost change that will impact on facilities in the coming year. The first place we look is at the hospital market basket, both historical and the forecast from CMS. Here the market basket increased, as you can see, at 3.9 and 3.6 percent in 2002 and forecast for 2003 and, as I just indicated, it's expected to go up slightly slower at 3.3 percent in the year that you're considering now for the recommendation.

Second, we considered the effect of technological change on hospitals. Our judgmental estimate is a half percent increase in costs due to technological change.

And finally, as people were saying yesterday, we take account of productivity growth or expected productivity growth and use a measure of multifactor productivity from Bureau of Labor Statistics. And again, as we said yesterday, the ten year average rate of growth there is.9 percent and we would take account of that, we suggest you take account of that in the update

recommendation.

DR. ROWE: Remind me what we did for HIPAA? Is that included in this technological change?

MR. GREENE: No, this is broad technological definition. We haven't decomposed it into components.

DR. ROWE: Did we ever put anything in for HIPAA compliance?

MR. GREENE; We did, I forget. I think it was a total of --

DR. ROWE: I remember we did Y2K years ago, we put something in.

MR. GREENE: I think we did a total of quarter percent for HIPAA, combined with several other things.

DR. ROWE: I see.

MR. GREENE: Finally, turning to a draft recommendation, we put all of the elements of the update framework together that I was just discussing in the previous slide and we have developed a draft recommendation for your consideration. It combines information on the expected increase in the market basket in 2004, our estimate of the general impact of technological change, and our estimate of the productivity offset. The net effect is

a 3.3 percent increase in the market basket, half a percent for technology offset by productivity for a recommended update of market basket minus 0.4 percent. That would be the draft recommendation. And our finding is that the recommendation would decrease spending in the $200 and $600 million range in the first year.

MR. HACKBARTH: It decreases spending because market basket is current law.

MR. GREENE: Market Basket is current law, so going below that would lead to lower payment and lower spending.

MR. HACKBARTH: If there's no objection what I'd like to do is have Chantal step up and do the outpatient piece and then we can discuss them together. They are closely linked in our analytic framework.

So Tim and David, don't go too far.

DR. WORZALA: Good morning.

I'm going to jump right in here and give you a little bit of context on the outpatient PPS. You'll recall that this is a relatively new payment system first implemented in August 2000. We are charged with making an update recommendation for calendar year 2004. This is a

payment system that is funded by Part B. and operates on a calendar year not a fiscal year in contrast to inpatient hospitals. The current law does result in an update equal to the increase in the hospital market basket. That was also the uptake for 2003. In 2001, spending on outpatient services accounted for $16.3 billion under the PPS. That includes both bene and program contributions. You'll recall that in the outpatient PPS beneficiaries do pay a much higher share of the total spending than in other sectors. Growth in outpatient spending was substantial in the early 1990s but slowed at the end of the decade. However, both CMS and CBO project increased growth moving forward of about 8 percent annually over the next five years

As Tim mentioned earlier we do an assessment of payment adequacy for the hospital as a whole, rather than by service line. And Tim did go through our analysis, I won't repeat any of that here. But I think it's fair to say that we believe the review finds no evidence of inadequate payment.

Looking specifically at the outpatient department, this slide shows that outpatient margins are

negative with the average across all hospitals being a negative 16.4 percent. We believe these large negative numbers are attributable mostly to the cost allocation issues we've discussed earlier. We do not believe that hospitals are losing significant amounts of money on each outpatient service they provide. We have noted these negative margins over a historical period of time but we haven't seen any precipitate decline in either the number of provide with outpatient departments or the volume of outpatient services.

The second column on this table shows our estimate of the overall Medicare margin which captures payments and costs for most Medicare services and puts the outpatient margins in the context of the hospital as all whole. I have to apologize, the numbers on the screen differ from what was in your handout, a little oversight on my part. The numbers in your handout are the projected 2003 numbers, whereas those on the screen are the actual 1999 overall Medicare margins. You do see a decline between 1999 and 2003, except for the rural hospitals. It's the same series of numbers but the actual numbers change because it's a different year.

As we've discussed, these are 1999 outpatient margins. The 2000 cost reports have been made available to us but we do see serious problems on the outpatient side. The 2000 cost reports span the implementation of the outpatient PPS and considerable revisions were made to the cost report form to accommodate this new payment system.

In addition, the initial implementation of the PPS was rocky at best and hospitals and intermediaries had a lot of difficulty submitting and processing claims. As a result, hospitals did not get in a timely fashion their PS&R reports with are an input into the cost report. And in recognition of all of this, CMS did give an 18-month extension for filing cost reports and that's a large part of the delay here.

So We're trying to delve into the details of all of the technical issues that we've seen arising in the analysis of the cost report and we'll just let you know what happens as we continue to work with that.

We do have one piece of more regarding outpatient costs and payments, and this comes from the 2001 outpatient claims. And if you look at those claims and try to calculate a payment-to-cost ratio from them, you come up

with the number around .84. So that would result in a margin that's very similar in 2001 to the 1999 figure that you have here.

And when you calculate that margin from the claims you're not taking into account any of the payments that come through upon cost report settlement, which would include the hold harmless payments for rural hospitals and the transitional quarter payments for all hospitals. So I would conclude from that that in 2001 the margins may, in fact, be higher than in 1999. And that would be consistent with a payment system which actually put additional money into the system.

The next step, looking at factors that might affect costs in 2004, I think you're fairly familiar with we're looking at here. The best measure of the change in hospital input prices is the hospital market basket. The best estimate for 2004 as a calendar year is 3.2 percent, slightly different than the fiscal year estimate.

You'll recall from yesterday that there are two provisions that directly address technology costs in the outpatient PPS. One those, the new technology APCs, cover technologies that represents a complete new service such as

a PET scan. And we do have about 75 services, if you count by HCPC codes, that are covered by the new tech APCs. This is not a budget neutral provision, so any time a hospital provides one of those services they receive an additional payment for it. Therefore, the costs of this type of new technology do not need to be factored into the update calculation.

The other provision, the pass-through payments, cover technologies that are inputs to an existing service. An example here would be contrast material for echocardiograms. This provision is budget neutral, however we're seeing few technologies currently eligible for pass-through payments. There are about two dozen drugs and five medical devices, and CMS reports few applications pending for review coming in 2003.

And also, we know that the budget neutrality requirement was not, in fact, enforced from implementation of the payment system through the first quarter of the 2002. In the year 2001, we know from the claims that pass-through payments accounted for about 8 percent of the total payments instead of the two-and-a-half percent that was limited by law. And this did result in excess spending of

about $750 million in 2001.

Also, I would note that looking forward to 2003, CMS does not project any pro rata reduction in the pass-through payments. So new technology spending through the pass-through payment is not expected to exceed the cap, and that's another measure of limited new technologies flowing through the system there.

Given that technology costs are accounted for directly, we don't need believe that they need to be factored into the update for 2004.

The final factor that we consider is productivity increases. We feel that the prospective payment system is designed to promote efficiency and to have a standard here of the ten-year average in multifactor productivity for the economy as a whole, 0.9 percent in 2004.

All that leads us to the following draft recommendation. For calendar year 2004, the Congress should increase payment rates for the outpatient PPS by the rate of increase in the hospital market basket less an adjustment for growth in multifactor productivity. This recommendation would decrease spending in comparison to current law. The one year impact of this recommendation

falls into the category of savings of less than $200 million. And over five years, the savings would be less than $1 billion.

MR. HACKBARTH: Ralph?

MR. MULLER: To both Chantal and Tim, the market basket increase of 3.2, 3.3, puzzles me a bit because we've heard things such as nursing shortages and salary increases therefore of 8, 9, 10 percent. Yesterday we talked about malpractice going up for physicians. Obviously it affects these settings as well. We talked last spring about blood products going up quite a bit . We know that the price of medications gets absorbed inside the inpatient DRG. So those are a couple of things that all strike me going up more than 10 percent, and I can recite more.

I'm just a little confused as to how you can have some major factors like that. I know the malpractice as about 5, 6 percent, and the nurses probably about 20 percent. How can you have a number of things that are going up 10 percent or more -- and again, some of these may be more anecdotal in certain cities more than everybody -- I just don't understand how that goes to 3.2 market basket update? How that calculates to a 3.2?

MR. GREENE: 3.2 does reflect numerous components. Labor costs are about half, but we're not seeing 10 percent growth in labor costs, even hospital wage increases, or forecast increases. I don't have, unfortunately, the employment cost index data on hand so I can't quote you exactly what the forecast increase is.

MR. MULLER: It's not 10 across -- in certain areas it's more so I was wondering how -- just what I listed there might add up to 25, 30 percent of a market basket, and I can probably list a few more. So if 25 percent of it goes up 10, it just makes it hard to figure out how you get down to 3.

MR. GREENE: Are you talking about liability insurance -- I mean, wages are half. Wages and benefits are half.

MR. MULLER: Some of the wages, like nurses and allied health. I've seen the listing of how you get up there. Again, I'd like to just look at that.

MR. LISK: On the market basket issue I just wanted to say that remember this is a forecast for 2004. We just ended fiscal year 2002 and the large increases wage increases were seen in the 2002 market basket. But you

have to remember this is what they're forecasting for 2004, not necessarily what's happening this current year.

MR. MULLER: So how would those increases that were taking place in 2002, which obviously are not yet incorporated in our base because our base is back in '99, 2000, help me then think through how we then deal with the adequacy issue because part of what we do in this multistage, we both make a calculation of adequacy of the base and then we make an estimate of the market basket. So help me understand then these increases that happened, Craig just said, in 2002, how does that inform our discussion of whether the base is adequate therefore, if there were increases of that magnitude.

MR. HACKBARTH: Can I add to that question? As I recall in the old update framework we used to have an adjustment for forecast error. If we made a mistake and missed a developing trend on wages, we would look back and say we missed that and we would have an adjustment in the update to reflect that. I think that's related here.

Certainly, we've all heard the anecdotes about very large wage increases. Are we confident that, in fact, they're being captured in these numbers?

MR. MULLER: I would also add, does that mean if there were some of these large increases I cited anecdotally, and I think it's good to look at what 100 percent of it looks like rather than just the nurses and the drugs and so forth. Does that, therefore, mean by our methodology we only capture that lets say three years later, in terms of understanding appropriate payment?

MR. GREENE: We do have information on the employment cost index for civilian hospital workers through the third quarter of fiscal 2002 and there we see a growth rate of 5 percent. That's the number that's most relevant in the hospital context and, in fact, the number that's reflected in the market basket as currently constructed. Market basket was revised to better reflect hospital costs in response to a MedPAC recommendation of last March.

And that's where it stands. We're not seeing very large increases. I can't tell you offhand what the forecast is for 2004 but that's the magnitude we're talking about and that applies to approximately --

DR. REISCHAUER; Ralph, even if it were 15 percent and it were wrong, you would be partially right in that we would look at this two or three years down the

pike. But the question we would ask is not did we mis-estimate the increase in the market basket three years ago, but did we mis-estimate it and were the hospitals incapable of taking some other compensatory action, such as wringing more productivity gains out of the system, so that their overall financing at this point wasn't adequate?

MR. GREENE: On your question about what this tells us about payment adequacy and costs, remember that we're talking about a base. We're most concerned with payments and costs in the year 2003. That's the now that we're talking about because the payment year we're talking about for the recommendation is 2004. So the comparisons we're making are, in this case, the updated 1999 payments to 2003. And that reflects both the historical and the forecast increases in wages and other factors.

MR. MULLER: I think Bob's point, as well, clarifies that. In a sense, when things are either spiking way up or spiking way down, we miss it for three years because what happens is our adequacy discussion now is either on '99 or 2000 and then with an estimate of what '04 might be. And like all estimates, you find out later whether you're right or not.

DR. WORZALA: On that point, you'll notice our methodology, when we project forward to 2003, we do use all the available information and there we're using actual cost growth as reported on the AHA annual survey for that. And you do see that our payment adequacy, our overall Medicare market does, in fact, fall between '99 and 2003. And part of that is, in fact, a reflection of the increased cost growth it has been reported in those surveys. So those cost increases are, in fact, reflected in our methodology when we're moving from '99 to 2003.

MR. MULLER: So the calculation of total margin on this chart --

DR. WORZALA: The overall Medicare margin.

MR. MULLER: The overall Medicare margin, you're saying therefore would reflect -- so we take the base in lets say '99, and let's say if 2000 was 5 percent rather than 3 percent, as you ran the costs forward from '99 that would be reflected?

DR. WORZALA: That's right, so we've got a drop from 4.7 percent overall Medicare margin in '99 to 3.5 in 2003. And much of that drop is, in fact, a reflection of those increased costs in addition to the payment side, as

well, changes on the payment side.

MR. MULLER: So in a sense, other things being -- I'm trying to find that chart, bear with me. Remind me again what page?

DR. WORZALA: If you want to look at my page four that would give you the overall Medicare margin. I believe you have there the 2003 numbers and I can put up here --

MR. MULLER: I wanted the one with the trend line. I'm sorry.

DR. WORZALA: These are the '99 overall Medicare margins there.

MR. MULLER: It's page 11 of 10. So in the sense that the overall Medicare -- I'm sorry, that just went through '99. I thought you had one that projected it forward to '03.

MR. GREENE: But on the cost growth information, as I indicated we used AHA cost per adjusted admission numbers. The historical numbers there we're applying to the 1999 base are at 2.1 percent growth in 2000 and 4.7 percent growth in 2001, which we then adjust for length of stay changes to get Medicare cost growth. That's the magnitude of the real cost.

MR. HACKBARTH: Tim, help me out then. Recently what has been the comparison between the increase in the cost per case and the market basket? For a long time in the 90's hospitals were able to hold their actual increase in cost per case between the market basket and that's why the margins widened. To the extent that that favorable gap no longer exists, I think Chantal was pointing out that's why you would see the margins declining. We had an acceleration of the increase in cost per case. So as we think, as a commission about whether market basket minus whatever is an appropriate update, we also need to have been our heads what we think is happening in this time period and the increase in cost per case.

So what do we think is happening in cost per case now?

MR. GREENE: We don't know about 2002. The NHIS cost per case data there is problematic. But looking at 2001, which is annual survey data, we see 4.7 percent costs per adjusted mission growth which we use combined with lengths of stay to tell us about a 4 percent growth, compared to 4.3 percent market basket growth, if that gives you an idea. 4.7 percent adjusted AHA, 4 percent after an

estimated Medicare cost growth based on the AHA data.

MR. HACKBARTH: How would that have compared to the market basket?

MR. GREENE: Market basket of 4.3, very close.

MR .HACKBARTH: So you're saying after the adjustment for Medicare the cost per case increase in 2001 was about the same or maybe slightly lower than the market basket?

MR. GREENE: Incidentally, on the update issue, the point that I didn't make was we tend to compare update to market basket or framing the uptake recommendation Congress legislation relative to market basket. We need to remember that historically the PPS update has rarely equaled market basket., I think three years, or two years and part of 2001, has the actual legislative update even --

MR. HACKBARTH: I realize that and often hear that in discussing these issues people on the Hill but it's important to keep in mind that that history of below-market basket updates was in the context of the below-market increases in cost per case. That's my whole point here, we need to watch that trend in cost per case and if that relationship that existed in the mid-1990s no longer

exists, we may have to get used to not having market basket minus something as the update, the right uptake.

MR. LISK: Before you moved off the market basket issue, in terms of Ralph's point, just to see what the current number is for 2004, that those numbers will be updated and the most recent number is -- that's a forecast at this point in time. So if there appears to be greater anticipated pressure in 2004 on wages, the market basket will eventually reflect that and the forecast should eventually reflect that if that is what is anticipated by the people who do the forecasting.

It's important to point out that when CMS does the update, they use the most recent forecast that's available, so that's going to be a forecast that's made six months from now to what we have today. So I just wanted to make sure people were aware of that.

DR. REISCHAUER: Tim, on the 2003 projected overall Medicare margin of 3.5 what would that be if we took DSH out?

MR. GREENE: I'm not sure. we haven't done that simulation.

DR. REISCHAUER: How big is DSH? Is it 1.5

percent, 2 percentage points?

MR. GREENE: On the overall margin I can't tell you,

DR. REISCHAUER; It would be useful, I think, to have that.

MR. HACKBARTH: We margins without IME and DSH last year.

DR. REISCHAUER: We have them in the charts, but this is for the projection.

My second question is I thought we were going to try and look at distributions a little and I was wondering if we had any ability to guesstimate how many -- what fraction of hospitals would have negative margins in 2003 and how that can compared to 1999 or whatever the last actual year we have. Because this is an industry where you can have a few fat cats that skew the average.

MR. GREENE: Our methodology is not hospital-specific so the methodology that gave us these numbers couldn't tell you the distribution by hospital. We intend to turn to our hospital payment model and we may be able, in that context, to develop hospital-specific measures but I'm not sure how robust the methodology is for this

forecasting and I would be cautious about making hospital distribution statements for 2003.

DR. WOLTER: Just a couple of things. One I just would add on to some comments yesterday about the technology update here. I think we're heading to a period where there may be some potential to invest in technologies, particularly clinical information systems, that can have a big impact in care. And I don't know we factor that into a . 5 percent update, and also how we compare that in this same year to the productivity factor which decreases things because those things don't always track in the same 12 moth period. But I think, looking forward to how we address that technology update, it may become more important than it maybe has been in the last few years.

And then secondly, I'm a little troubled by the outpatient analysis in terms of the current adequacy of payment. And if indeed there are accounting practices which clearly have made those negative estimates wrong, I'd sure like to see that information. And if the fact that people aren't exiting is also being used as some kind of a conclusion that current outpatient payment is adequate, I

guess I would at least raise the question that maybe it's really things like inpatient margin and IME that are allowing people to stay in that business.

And if we are going to use the rigor we've used to look at overpayment and what we need to do to reduce payment to marginal cost of care on the inpatient side, I'd like to see us do the same thing on the outpatient side, recognizing it's been tumultuous the last few years.

But I think to make decisions about IME and transfer payment without really understanding what's happening on the outpatient sign when you look at total Medicare margins of 3.5 percent, that's a difficult thing to do.

MR. MULLER: I think I remember the answer to your question.

I think at last year's numbers, I think if we took DSH and the IME above cost out there was about a 6.5 percent swing . In other words, if the margins last year were about 4.5, overall Medicare margins and if you took DSH and IME above out, it went to like a minus 1.8, so it was about a 6.5 swing.

And since you were saying earlier --

MR. ASHBY: [off microphone] That's the inpatient margin. The inpatient margin went down about six percentage points by taking those subsidies out. We didn't actually have the -- Craig is not allowing me to finish that sentence.

We did reduce it from the overall margin, as well.

MR. MULLER: About 6 percent; right?

MR. ASHBY: Yes.

MR. MULLER: So 6.5 percent, you take DSH and IME above cost out.

MR. HACKBARTH: The part that I wondered about Ralph was that the overall went negative. I don't recall, what's in the table there, Jack? Ralph said that he recalled that once you take out IME and DSH the overall Medicare margin went negative 1.something; is that right?

MR. ASHBY: Right, negative 2.

MR. HACKBARTH: For all hospitals.

MR. MULLER: So basically, insofar as one can argue since there aren't costs tied to the DSH, with a 3 5, you can argue its negative.

DR. REISCHAUER: The DSH aspect is a different

issue from the IME>

I just wanted to have a footnote on Nick's point. That was what kind of meaning we draw from the fact that hospitals haven't dropped outpatient services? And I was wondering do we know what fraction of outpatient services in the average hospital is given to Medicare beneficiaries as opposed to non-Medicare beneficiaries? Because if 85 percent of it is being provided to non-Medicare beneficiaries, then Medicare's payment, while important for an equity isn't going to determine whether you keep that unit or not.

DR. WORZALA: I should have those numbers at my the fingertip and I don't. I can tell you that it's higher than 50 percent. It's lower on the outpatient side than on the inpatient side however, and it's higher for rural hospitals than urban hospitals on the Medicare side.

I just wanted to say we have sort of one piece of research evidence on the allocation issues and it unfortunately is rather old data. But this was an attempt to look at "true accounting" versus the Medicare cost report accounting from inpatient to outpatient to understand the extent to which costs are being shifted from

one sector to another. And that resulted in, they thought, a shift of between 15 and 20 percent of costs over to the outpatient side. So it was significant.

That is dated information and unfortunately we don't have anything more.

MR. MULLER: But that was in -- since it comes from the inpatient, that would roughly change inpatient margin by 7, 9 percent as well; right?

MR. ASHBY: At the time it was for.

MR. MULLER: If we are, in a sense -- if we are overstating the negative margin on outpatient due to this cost accounting issue, then we're also overstating the inpatient margin? That's where it's being shifted from.

DR. WORZALA: Yes, just to accept the four, even though we don't know what it really is, that would take you in 2000 from the 10.8 to 6.8 on the inpatient side.

MR. MULLER: And it's probably more of a factor of maybe two-to-one, rather than four-to-one. Anyway, that's something we should look at. I mean, if we're going to say there's this problem on outpatient, we should also say it also overstates the inpatient.

MR. DURENBERGER: Mr. Chairman, this is sort of a

suggestion about the body of the report that leads up to the recommendations. To try to read or to try to be informed by the body of the report about what's really going on in hospitals in America today is very difficult. And so I think a lot of these questions are aimed, at least in part, at trying to help the reader define something about what's going on in hospitals in America today, the liability questions, and a lot of these other issues as well.

But one thing that doesn't get addressed there at all, and that is when you get down to the service level, the distinction between the fact that Medicare generally overpays for surgical -- and so you're going to get a lot of surgical -- and underpays for psych and medicine in general. And I've been spending a lot of time recently for other reasons with Paul Ginsberg and your former college, Glenn, on the Center for Studying Community Change. And just watching the phenomenon of the heart hospitals, four new ones in Indianapolis, $240 million worth in my community, on and on, and on, and on. Then you go to orthopedics and oncology and so forth.

So what's actually going on in America, at least in part because of the payment system, is a challenge community by community which will eventually be an access challenge. It may be expressed as cost but eventually it's access. Today, in my community the lack of, either at the hospital level or in a community level, of in or outpatient psych services is critical. I mean, it is just a really serious problem.

And BlueCross BlueShield nationally, and in our community, has done us all kind of a services, I think, in bringing to our attention the fact that we are all getting in our communities apparently what we're paying for; i.e., lots of heart hospitals and what not.

And I know how -- since this is my first time around this March report, I don't know how important it is to say something around the capacity, changes in the capacity issue, not just to say use the traditional measures for capacity but to say something about what we observe about changes in the capacity of what we traditionally know as the hospital system in America. And how either in the general update or in some other approach to DRGs, we have a challenge ahead of us in how we pay for

traditional hospital-based services.

Also, there's no mention in here of -- I mean, there are other ways to address this capacity issue. The emergency room comes up and that sort of thing. In our community we had 23 beds available on 9/11 in all of the hospitals in Minneapolis-St. Paul, 23 beds. And we obviously, like everybody else, have emergency room diversions.

So we got everybody in town together that does emergency rooms, for example. And the reason they came together quickly was they were afraid that the hospitals just might build greater emergency room capacity. And they said that's the wrong way to approach it. What we need to approach it as more of a productivity issue, how we deal with people in emergency situations or apparent emergency situations. And it's all internal, but it's that's also payment. What are we paying for when you come into the hospital?

The third one, I guess, that occurs to me is this whole ICT issue which doesn't get referred to here, and maybe because it doesn't need to be. But I would guess one of the major productivity and capacity challenges facing

hospitals today is the investment in information and communications technology in one way or the other.

So to me it's sort of like this looks like an opportunity while we're dealing with the change in costs across the board, also gives us an opportunity to speak to changes in the nature of the capacity and that if we have the information to do that or the ability to do that, it would behoove us to do that.

MR. HACKBARTH: In each of the last two meetings and before that as well, I guess, we've commented on the fact that hospitals are facing challenges from specialized institutions that seem to have identified particularly profitable lines of business. We've talked in various context about payment equity across different types of providers providing the same or very similar services.

Nick, I think earlier today, framed that as an important distributive issue, that we've taken up some distributive issues, but there are others that rest in how the various DRGs are priced. And to me that seems like a really very, very important set of issues that should be on the commission's agenda for the very near future. Exactly how to frame it so that we can bring the best analytic work

to bear, I'm not sure but that's something that I think is really, really important for the staff to help us with.

We need to move on now to our public comment period and then take our very quick break for lunch. I would ask the commissioners, anybody who planned on trying to cram some other thing into that period, if you could at least be with us for the first few minutes, I'd really appreciate that.

We'll do 10 to 15 minutes worth of public comments. Again, I apologize to the audience. We are up against a pretty fixed deadline at the end because up plane schedules.

MS. COYLE: Thank you, Carmela Coyle with the American Hospital Association. For obvious reasons, I won't be able to join you at your January meeting where you're making some decisions, so I just wanted to take a brief moment to outline and hopefully add to some of your thinking here today.

I guess I was overwhelmed by, and in some respects concerned by the number of unanalyzed and unanswered questions that were raised around the table today. What I'd like to do is issue-by-issue, and I'll

keep it brief, some things that you may want to consider.

First of all, in the area of transfers. I think staff presented the reason for the transfer provision originally being put in place, and talked about the concept of trying to prevent premature discharge. I guess what struck me is I didn't see anything presented to suggest that premature discharge continues to be a problem. The issue was was there something inappropriate going on. I'm not clear whether there is consensus or any sense that there either continues to be something that is inappropriate going on, in terms of premature discharge, or something that needs to be changed.

Second of all, I think while staff presented the rationale for expanding the transfer policy, they didn't explain the rationale for not expanding the transfer policy. Just a couple thoughts there. First of all, staff talked about the importance of having an incentive for providing quality care. I think some of you talked about the potential implications there of having a disincentive to move patients to the right setting, and I think that's important. Again the issue, are short stays appropriate or inappropriate? And I'm not certain we know the answer to

that.

Second, the rationale provided that this would reduce overpayment for these short stays. I think that that is again not clear. I guess the question I would ask, and some of this discussion around outlier payments, please don't believe that the outlier payment policy on one end offsets a transfer policy on the other end. The outlier payment policy is set to deal with high-cost cases, three standard deviations away from the average. The transfer policy is one day less than the average. The outlier policy is funded by reductions in the DRG payments. You're looking at a policy that potentially could remove $5 to $10 billion in Medicare payment to hospitals over five years. So I would ask you to consider that.

And finally it was suggested that this policy would improve equity. As you know, length of stay varies significantly. If you take a look in the United States for the Medicare population, the average length of stay is about 4.6 days, but that varies dramatically, as much as 8.4 days on the high end, four days on the low end. What kind of redistribution, what kind of incentives will this put in place? What kind of penalties for areas that have

had higher managed care penetration that may be penalized this.

What about the difference in patients? Do we know who these short stay patients are? Again,. is the care appropriate or inappropriate? So I wanted to raise that.

In addition, you talked about the fact that the cost covered payment, just a reminder, that was only for the 10 DRGs that this policy has been expanded to so far . You're considering expanding it to 500 DRGs and unless you know how those costs compare to payments, I just would encourage you to ask that question and have that analysis done.

Second, very quickly on the indirect medical education adjustment, the history here, if we all go back, and I'm afraid 10 years from now, 30 years out no one will remember where this thing came from. But clearly the concept of teaching and training physicians in the United States as a social good was part of the conversation; uncompensated care as a social good was part of the conversation. I would ask you to remember two things: $800 million in additional cuts to teaching hospitals have

just kicked in in October of 2002. Perhaps one thing to look at is the impact and if you could model the financial impact on major teaching hospitals of the $10 to $20 billion in cuts that your recommendation would suggest or propose into the future.

Staff presented that right now the total margin for major teaching hospitals is only 1.5 percentage points. What happens to that margin if this policy is put in place? What happens to the financial stability of those major teaching hospitals?

On the rural policy changes, we are supportive of the recommendations that staff has made. Would suggest as you consider equalizing base payments among rural and urban hospitals that that be done with new money. This commission last year considered trying to achieve that policy outcome through a differential inflationary update. Inflation hits everybody. It doesn't matter if you're urban or rural. That should be done with new money.

We were pleased at the recognition, the conversation around critical access hospitals where staff suggested that it was important that these facilities more than break even and able to replace their capital. But the

lack of consistency and those concerns not expressed around the one-third of hospitals losing money today, more than half of hospitals losing money in terms of treating Medicare patients, no concern about replacement capital there.

And finally around the update, the inpatient uptake. The AHA annual survey data was released earlier this week. It was shared with MedPAC staff. I think what you just saw were a suggestion that margins have remained flat. In fact, the AHA annual survey data for 2001 shows that margins dropped for the nation's hospitals nearly a half a percentage point. Also the data that was presented that suggested that basic market conditions are favorable in terms of access to capital would suggest one, you re-look at the for-profit analysis. Things have changed dramatically. Remember that only 14 percent of the nation's hospitals are for-profit. And as it relates to not-for-profit, Standard & Poor's 2002, six downgrades for every upgrade. Fitch, for the nine months ending September 2002, four upgrades, 17 downgrades. So I would ask you to take that data into account as you think about this.

Some confusion around the technology and the

productivity suggestions, and just really an open question to the commission. I thought that the commission had moved away from the concept of the pluses and minuses in terms of determining the update. Yet it seems that we're back to inflation plus a technology adjustment minus a productivity adjustment. And would just ask the degree to which the commission is certain that the right answer for technology is 0.5? As opposed to 0.6 or 0.7? And the degree to which the productivity adjustment and the right answer is 0.9, as opposed 0.8 or 0.7? Those two things offsetting one another make a significant difference. As you know, every percentage point is $1 billion paid or not paid to hospitals in a single year.

In terms of the suggestion that the PPS update has not equaled the market basket, hope that that does not factor into this commission's thinking. The PPS update has not equaled the market basket increase for 12 of the last 14 years but that decision is in the hands of the Congress? That is a federal budget policy decision and I hope not a Medicare payment adequacy decision.

One last point on outpatient, and I promise I'll be finished. The suggestion that there should be no

technology add-on on the outpatient update while one was considered on the inpatient side. Please remember that the additional technology add-ons on the outpatient side are only for certain technologies, those are significantly clinically different, those that are high cost, and only drugs and devices. So anything else in terms of technology, information systems, any kinds of procedural changes, imaging, is not accommodated in the outpatient payment system in a special payment way. So would ask you to consider whether a technology adjustment should be added on the outpatient side as was recommended on the inpatient side.

Thank you.

MS. FISHER: Thank you. I'm Karen Fisher with the Association for American Medical Colleges. And in compliance with the chair's admonition yesterday, in terms of what the AHA said, I will say me, too, and move on.

In terms of the total margin, though, I do want to amplify a little bit. The 1.5 percent margin occurred in 2000 when the IME was at a 6.5 percent reduction. Reductions that have occurred October 1st include not only the 15 percent IME reduction down to 5.5 percent, but an

increase in the outlier threshold, changes to the wage index that also affect payments to major teaching hospitals. And we also have an occupational mix adjustment that is in current law to be implemented in 2005 that is going to dramatically impact the Medicare payments for major teaching hospitals. So that's all on the Medicare side of what is occurring with major teaching hospitals.

And I think it was already brought out about the issuance of what's happening and the other aspects of the health care system with boutique hospitals and continuing financial pressures to constrain cost, the growing number of uninsured that are continuing, all of these are important factors for looking at this issue in terms of the role of the Medicare program.

In terms of two specific issues, if I'm understanding Jack Rowe's comments correctly about the clinical margins, I understand that to mean it would be helpful to look at operating margins, total operating margins, in addition to total total margins when looking at what's going on the health care system.

And in terms of the DSH issue, from a methodological standpoint we would agree that either DSH

payments should come out of the calculation of the Medicare inpatient overall margins or a portion of the cost that DSH was intended to cover should be put into the denominator. I think the latter is a lot messier because that starts to bring in non-Medicare costs, so methodologically it seems to make sense to get a better feel to what the Medicare payments are tended to cover, those Medicare DSH payments should come out. That is not meant to mean that Medicare's role in making DSH payments is not appropriate. This is solely a methodological issue in understanding the financial components of things.

And then, we appreciate the discussion about the timing of IME changes and the relationship of Medicare decisions and the role of the federal government in supporting these missions. Thank you.

MR. HACKBARTH: Thank you very much. We will reconvene at about 1:10 p.m.

[Whereupon, the meeting was recessed, to reconvene at 1:10 p.m.]

AFTERNOON SESSION [1:23 p.m.]

MR. HACKBARTH: The last item is on assessing beneficiaries' access to care. I apologize for the fact that this is going to be a truncated presentation and discussion of a very important issue, but I look outside and it's raining fairly hard and I know I've got to get to Dulles quickly, Ray does, and some others. So we are going to adjourn right at two o'clock. So fire away.

MS. MILGATE: In this session, we're going to take the discussion up a few thousand feet to look directly at one of the broad goals of the program and that is access to health care for beneficiaries. We've got two objectives for this session. One is to review the draft chapter that you had in your background materials; and two is actually to present one piece of the chapter that's never been presented at a commission meeting before and that's the analysis of the relative importance of different beneficiary characteristics on beneficiary ability to access care.

After both of our presentations, we'd look for your comments on the tone of the chapter anything we may have left out, any additional analysis that would be important to get the most complete picture of access in the beneficiary program.

We are were planning at this time for this to be the last time the commission sees this chapter in a public discussion forum, so would really appreciate your focused comments.

First, it's important to point out that evaluating access is a difficult And complex task. It's a

multidimensional issue and all of the various dimensions must be evaluated together in order to really get a complete picture of access. First, it's important to answer the question of whether the system has enough capacity to meet beneficiary needs. And even if it has sufficient capacity if, in fact, there are other barriers that may make it difficult for beneficiaries to obtain care? And even once they do obtain care, do in fact they obtain the appropriate care? Are all questions that must be asked.

At the same time the measures that we have for access are somewhat ambiguous. We have nationwide trends, but often that doesn't capture the regional variation which we found very well illustrated through the Center for Studying Health System Change survey of physicians. Different questions one access elicit different conclusions. For example, on the HSC survey, we found in Seattle that 55 percent of physicians were saying they weren't taking new Medicare beneficiaries but only 8 percent of beneficiaries said they delayed or put off care. So it was unclear, is there an access problem in Seattle or not?

In addition to different questions eliciting different conclusion, there's also the fact that different people answer the same question differently. For example, in our multivariate analysis, as you'll see, highly educated folks said that they had trouble accessing care at a higher level than those that were less educated. One could conclude there are access problems for highly educated folks, or one could conclude their expectations perhaps were higher than those who are less well-educated.

In addition, utilization data is hard to interpret. We see trends over time shows us a bit about much more or less care beneficiaries are obtaining, however we don't really know what the right level is. So for example it's hard to know if an increase in the use of ED services means that more beneficiaries are obtaining appropriate urgent care or if, in fact, this may mean they have some problems getting access to care on the ambulatory side.

Recognize the complexity of the subject, we've tried to evaluate access from as many perspectives as possible and I hope you'll see that in the chapter. So just to look at the various dimensions of access, the first

is whether there is sufficient capacity in the health care system to meet beneficiary needs. And what we found in looking at this, and really the data I guess that you've seen over last couple of days, is in general in 2002 there appear to be a sufficient number of providers. There seem to be a stable number of providers in the system, as well as there are some utilization trends upward. And even in the two providers sectors that we looked at in more detail, there were some problems that we found but nothing that in general seem to be an issue with sufficient numbers of providers.

However, we did find beneficiary needs will change in the future. The obvious statistic is there will be a dramatic rise in the number of beneficiaries. That will mean that everyone will need more services and that there may need to be more focus in the health care system on the needs of the elderly, perhaps more ability to look specifically at geriatric training, for example, for some types of providers. In addition, there will be a change in the demographics of the Medicare population which may alter utilization patterns? There will be more old old beneficiaries, those over 85 for example. There will be a

higher proportion of minorities. The prevalence of chronic conditions continues to increase, therefore there will be potentially more health status issues. And the proportion of women living alone will also increase which could also impact the types of services beneficiaries need.

The second question of whether beneficiaries are actually obtaining care, once again we find in overall measures beneficiaries in recent years are able to obtain care. And I'll just leave those statistics to really speak for themselves.

In addition, in comparison to a population close in age to the 65-plus elderly, those 45 to 64 in a 1998 NHIS survey had a more than double rate of folks that said they delayed care due to costs compared to Medicare beneficiaries. So even compared to those who are close in age, beneficiaries tend to say they have better access to care.

However, some beneficiaries have an easier time obtaining care than others and that's the analysis that Mae will talk about after I finish with the overview of the chapter. The three factors we found were most important were health status, income, and supplemental insurance.

They seem to be the most important factors influencing whether beneficiaries actually reported that they had access problems or not.

Whether beneficiaries are obtaining the appropriate care, there's a couple of indicators on this. Once again, it's very hard to measure but one of the indicators is whether beneficiaries are actually receiving enough preventive care. And I won't get into too much of the specifics but two examples are, for example, pneumococcal and influenza vaccines where we find while there is quite an increase in the rate of beneficiaries getting these services, still in 2001, 30 percent of beneficiaries did not receive a flu vaccine and 49 percent did not received pneumococcal vaccine.

There's also concerns about other types of preventive services that manage a condition, for example diabetes and other conditions that I won't go into a detailed statistics on those. But significant portions of beneficiaries are not receiving those services, as well.

It's to CMS's credit however, that some of this increase could perhaps be due to efforts on CMS's part because they have focused on some of these particular

services and trying to increase the prevalence of the use of the services.

Another indicator we looked at was trends in the use of ED services and found that use of emergency department services by certain populations may suggest a lack of availability of ambulatory services elsewhere. We saw tremendous growth in the 1990s of African-American use of the emergency room compared to other beneficiaries and found that, in fact, most of that use and a lot of the growth in the 1990s overall was due to illness-related use, not necessary injuries and not primary or preventive care. Most of the services that were delivered were categorized as urgent and not non-urgent services so it's not trivial use of the emergency department.

So that's our overall look at beneficiary access. Because of recent changes in payment policy, the commission has also focused on access to care for two specific providers. The first one we looked at was access to physicians services, and again I'll go through fairly quickly because you heard a lot of this in yesterday's presentation. But overall we found that access is good, 96 percent of physicians are accepting some or all

beneficiaries. However there is the some selectivity in whether they will accept all new beneficiaries. And we found, both on our survey which was conducted after the rate reductions of 2002, and the HSC survey which was before the rate reductions, that both found that there were fewer physicians willing to take all new Medicare beneficiaries.

However, this wasn't exclusive to Medicare. They were also concerned about taking all new patients from other types of payers.

We also found that physicians -- and this was on the MedPAC survey -- were equally concerned with the administrative burden of Medicare as reimbursement. So while they may be being more selective, it's not clear that it's only because of the reimbursement changes that they may be being more selective.

And, as I noted previously in the data slide, this does tend to vary by market. The HSC found differences across markets.

In terms of access to post-acute care, once again it looks like there are sufficient numbers of providers. The entry and exit is stable for skilled nursing

facilities. You see some decrease in hospital-based, but the increase in freestanding really overwhelmed that decrease in hospital-based, in terms of numbers. And then utilization is up for skilled nursing facility services. While there's been a drop in the percentage of Medicare beneficiaries that use home health services, the level is actually back down to the pre-dramatic rise that led to the BBA changes that kind of curtailed some of the growth in home health.

We did find though, through looking at the OIG survey of discharge planners, and a MedPAC focus group of discharge planners that there is some concern about the ability to place more complex patients. The MedPAC focus group told us that 5 to 25 percent of the time they had difficulty placing some of these complex patients.

What they said, though, they meant difficult placing was fairly wide range, from one day delay to perhaps not placing these people at all. And it was unclear from their discussion whether, in fact, staying in the hospital a longer period of time actually meant that the patient had worse outcomes. And we've had some discussion through the last two days of whether it might

mean that or not.

While not usually a focus of the commission, the other type of health care professional we looked at in terms of access was access to nurses and other health professionals. Because the shortage of nurses and other types of health professionals could impact the timeliness and appropriateness of care to Medicare beneficiaries, we fell like it was important to say something about this trend in the health-care market. As has been talked about before and you've seen a lot of media on it, the supply of nurses simply is not keeping up with demand. There's 6 percent in the year 2000 and this is expected to grow a lot in the next few years. Essentially the problem is the demand is increasing a lot faster and the supply is actually decreasing. There was a decrease in the numbers of people entering into nursing schools of 26 percent between 1995 and 2000.

While some have suggested that perhaps this is just another cyclical nursing shortage, as there have been in the last few years, the experts on the subject suggest that market forces alone, as in past shortages, may not be enough. Basically if you're going to increase wages you

would either try to attract those nurses that are already in the workforce to work in settings or else try to attract new nurses. And the fact is that 82 percent of nurses who have licenses are already working in nursing and, as I said before, there's really not a dearth of people coming into nursing schools. So in addition to that, the experts say that it's not just wages that is a problem, it's also working conditions. And so increasing waitress may not be enough to get more nurses to work in health care settings.

In addition to nurses, hospital administrators also say that there are shortages into two other areas and that's clinical pharmacists and imaging technicians.

So that's the overview of the chapter. There's a lot more detail in the chapter. I'd ask again that you hold your comments on the chapter generally to after Mae's presentation of the beneficiary characteristics that impact access.

DR. NALL: I'll try to be very brief.

We undertook a study to look at different beneficiary characteristics and that's what I'm going to report today. This slide shows you the beneficiary characteristics that we looked at in our study and they're

also summarized in table 1 in the access chapter.

We looked at five outcome measures, each one representing a different dimension of access to care. Very briefly, to get a large enough sample size we pooled four years of the most recent MCBS data, from '96 to '99, and we excluded ESRD and institutionalized beneficiaries from our analyses. Basically we did five separate logistic regression analyses to look at the influence of the various characteristics on each of these five outcome measures.

Our major findings. The overwhelming majority of aged Medicare beneficiaries do not report access problems and, all other things being equal, those that were in poor health, those with lower incomes, and those that do not have supplemental insurance report poor access to care. The third finding is that the disabled under-65 report substantially higher levels of access problems compared to aged beneficiaries.

The majority, as you can see 90 percent or more, of aged Medicare beneficiaries do not report access problems across the five measures that we used in this study.

Specifically, after controlling for differences

in age, race, ethnicity, socioeconomic status, insurance coverage, and other beneficiary characteristics, beneficiaries who were in excellent health were only 20 percent as likely to report trouble getting care; 30 percent as likely to report delaying care; and 32 percent as likely to report not seeing a doctor compared to beneficiaries in poor health.

Secondly, compared to those in poverty, beneficiaries with the highest income were only 25 percent to 50 percent as likely to report delaying care due to costs and about 75 percent as likely to report not seeing a doctor, not having the usual source of care, or not having a usual doctor.

And finally, all other things being, equal, those with supplemental coverage were only 13 percent to 75 percent -- depending on the type of additional coverage and also on the specific measure examined -- to report access problems compared to beneficiaries with Medicare coverage only.

Basically compared to those with traditional Medicare coverage only there was little difference in access to care based on the type of supplemental insurance

reported. In other words, the adjusted odds ratios were similar for the four supplemental insurance categories for most of the outcome measures. Within the Medicare program M+C appears to mitigate reported access problems where M+C enrollees appear less likely to delay due to costs and more likely to report having a usual source of care, a usual doctor, and getting care when they need it.

In terms of the role of race and ethnicity and socioeconomic status have been widely reported. Because they're so close intertwined it's difficult sometimes to isolate the respective role of each. It appears that in our study income may be the more powerful determinant of overall access to care. After controlling for all other differences in beneficiary characteristics, racial differences were minimized in four of five of our access measures but they were highly significant in influencing whether a weather beneficiary reported a usual doctor.

Compared to whites, African-Americans were one-and-a-half times more likely to report not having a usual doctor. Similarly, all other things being equal, Hispanics were almost twice as likely to report not having a usual doctor and almost one-and-a-half times as likely to report

not having a usual source of care compared to whites.

Finally, we did a separate analysis to examine access to care among the under-65 disabled population, also using the '96 to '99 pooled MCBS data. This slide shows you the unadjusted proportions of each population that reported an access to care problem. So in other words, without adjusting for the fact that the disabled are younger but also sicker, poorer, more likely to have no supplemental insurance coverage, the disabled population reports substantially higher levels of access problem compared to the aged population. And in future work we'll be bringing the commission a multivariate analysis similar to the one that I just presented for the aged that looks at the disabled population and we're also going to disaggregate them by type of disability, cognitive vs. physical disability, et cetera, and look at that in a little bit more detail.

Now, we'd like to get your comments overall about the chapter or about the analysis in particular.

MR. HACKBARTH: Very well done, thank you. think you.

MR. DURENBERGER: Thank you, I agree, and I have

a couple of comments. One, if you go right to the very last paragraph, and this is sort of like the setup for my comment, it refers to this older population or something like that. It says aged or older or something, the very last paragraph in the report.

My comments are that I don't think you can over-accent the problems facing people with disabilities. I would just try to find a way to make that an important part. Otherwise, you could read this and you could say well, you know, things are going pretty well out there. And none of it sounds like what you hear when you go back home and you listen to people talk about "the system." This doesn't sound like those kinds of experiences, but it reads a little bit like it.

That is one suggestion, and particularly within the disability community, people with mental illnesses. At least you'll get credit someday for alerting us to that problem when we start shifting the way in which Medicare pays so that we start paying for some of these kinds of services for that part of the disabled population. But I would just urge you to maybe differentiate a little more than you have, although it was well done here, and to

emphasize the important role we play for the people with disabilities, whether under 65 -- which is a growing part of it, including mental illnesses -- and/or the older.

And then with regard to the ethnicity, I like the way you emphasized the gender issue because nobody else emphasizes that. I mean, it's like 72 percent of people are women and that should be re-emphasize, not like a statistic but there's lots of implications there.

And the third one is when we're talking about the ethnicity and so forth. The world in which I live in, which is supposed to be part of Scandinavia or something like that, is really the Latin, Asian, African and so forth. And so the cultural diversity is not so much in our community the traditional African-Hispanic-Caucasian. It has a whole different impact on the way medicine is practiced. It's the communications issue, the language issues, the traditional approaches to health and health services, and so forth. And so to the degree that the dimension becomes part of our conversation about access, I think it would be helpful to us. Thank you.

DR. NELSON: It's obvious but I'll say it again, that any kind of data from '01 and earlier has to have a

huge asterisk on it, that those studies were done during the times when there were updates that were regarded by many as adequate, at least in '01.

DR. WOLTER: I'm somewhat interested in the area of preventive care in Medicare, and to the extent that the beneficiaries perceive they have access to preventive care. And I know at times there's been a sense that preventive care has been a little bit more difficult through Medicare. I know that certain things have to be linked to a specific diagnosis and sort of general annual physical and preventive care is more difficult or has been in the past. Is that not true anymore, Nancy Ann?

MS. DePARLE: I'm agreeing it's not covered, general or annual physicals.

DR. WOLTER: I think over time that would be an interesting thing to look at. And then as a specific, I think you mentioned that in Medicare+Choice there is maybe a better sense of access. With reference to preventive care it would be interesting over time to see it those plans make access to preventive care a little bit easier than it is in the fee-for-service program. That might be worth tracking.

MR. STOKES: DR. WAKEFIELD: I know historically we haven't really talked a whole lot about workforce issues beginning in the domain of Medicare and we're talking a lot about access to physician services and the extent to which they're taking patients, et cetera. You gave a little bit of a nod, I think -- and I don't know if we can keep it there or strengthen it just a little bit -- to the changes in demographics that will drive, I think, the need for more physicians who are geriatricians, more nurse practitioners who are geriatric NPs, more psychologists who specialize in older Americans health care, mental health needs, et cetera, et cetera.

And while I know we don't try and drive what goes on in the education side, nevertheless I just think we would be remiss if we didn't make that connection even as a comment, to say more workforce is a very fine thing but we're most concerned about a workforce that can adequately meet the needs of this population. And that's a statement that I think we've shied away from -- at least from my perspective, historically and it really merits mention, at the least.

I also just wanted to say I appreciate the

inclusion of a nursing commentary here. I think it does make a different, obviously, as well as shortage of other health care providers. Again historically that's not a piece of what we necessarily tend to focus on, And while it's beyond our focus on access, there certainly have been some excellent studies over the last two years, both in nursing homes as well as in hospitals, linking thinking access to an adequate nursing workforce to patient outcomes. These aren't fly by night studies or limited studies. They are extremely good, linking access and quality.

So just my point being I'm glad we're also including a nod in that respect, as well.

MR. DURENBERGER: If we're going to use the word appropriate, I'd like to expand it beyond prevention and so forth, but this may not be the place to do it. In other words, take Jack

MR. STOKES: Wennberg's last six months of life, and take Sun City, Arizona versus the other two, that's my definition of appropriate. A lot of care is inappropriate in that period, as it is in other places. I suspect we're not ready to go into that.

MR. HACKBARTH: Okay, I think we're done. I apologize again for having such a tired group of commissioners to work with, but very well done, an excellent piece of work.

Okay, thank you all and we'll see you again in January.

[Whereupon, at 1:48 p.m., the meeting was adjourned.]