MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, October 29, 2004
9:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA

Mandated report on specialty hospitals (DRG profit, patient selection)
-- Julian Pettengill

MR. PETTENGILL: Good morning.

The Medicare Modernization Act requires MedPAC to study physician-owned specialty hospitals and report to the Congress in March of next year. Under this mandate, we have been asked to compare the costs of care in physician-owned specialty hospitals and in community full service hospitals, the extent to which each hospital treats patients in specific DRGs, and the mix of payers in each type of hospital.

We've also been asked to analyze the financial impact that specialty hospitals have on community hospitals and how the current DRG payment system should be updated to better reflect the costs of care.

At the last meeting in September, Ariel, Carol and Jeff presented information on federal laws governing physician investment in hospitals and other facilities, characteristics of specialty hospitals and the markets in which they are located, preliminary findings from our analysis of payer mix and findings from our site visits to three markets that have specialty hospitals.

Today I'm going to present preliminary findings on three issues related to physician-owned specialty hospitals. The first one is whether Medicare's hospital inpatient payment system may be creating financial incentives for specialization by setting payment rates that are more profitable for some diagnosis related groups than for others.

To answer this question, we estimated costs, payments and relative profitability for DRGs that are important to physician-owned specialty hospitals. To measure relative profitability, we calculated a payment-to-cost ratio for each DRG. That is, we took all the payments for all the cases in the category and we divided them by all the costs for the cases in the category. Then we divided all those payment-to-cost ratios by the overall average payment-to-cost ratio. This results in a set of numbers for all DRGs that are centered around one. The numbers show whether patients in each DRG, on average, are more or less profitable than the overall average.

For example, suppose that payments in DRG 105 were 10 percent greater than costs. We would have a payment-to-cost ratio of 1.1. If the overall average payment-to-cost ratio were 1.04, then we would have a relative profitability ratio of 1.06, 1.1 divided by 1.04.

The second question is whether relative profitability may differ across patients with different severity of illness within DRGs, thus creating financial incentives to select less severely ill patients. To answer this question, we estimated a similar measure of relative profitability for patients grouped in the all-patient refined DRGs. Now all-patient refined DRGs, called APR-DRGs, are similar to DRGs but they make better use of secondary diagnoses to distinguish patients in four severity levels.

There are roughly 350 APR-DRGs, four severity classes per APR-DRG, and those classes are characterized as minor, moderate, major and extreme severity.

Again, we calculated a payment-to-cost ratio for each severity class within an APR-DRG and we divided them all by the overall payment-to-cost ratio, which gives us a measure that tells us about the national average relative profitability of patients in each such category. It really tells us whether there are differences in profitability within DRGs.

The first two questions are about the payment system. The third question is about what physician-owned specialty hospitals actually do. Do they treat a relatively favorable selection of patients? That is, those who are expected to be relatively more profitable than the average?

To answer this question, we constructed two measures of expected relative profitabilty for each hospital. These measures are designed to isolate the effect of each hospital's mix of Medicare cases given the national average relative profitability values for each DRG and APR-DRG severity class.

Thus, if each hospital had the national average relative profitability in each DRG and each APR-DRG, would its mix of cases be relatively more or less profitable than the overall Medicare average? That's the question. These measures don't tell us anything about a hospital's actual performance, only whether its Medicare case-mix is drawn primarily from relatively more or less profitable categories.

These questions are all motivated by the potential for some kind of a misalignment between payments and costs, either across or within DRGs. How might this happen?

Differences in relative profitability across DRGs must arise from the case-level features of the payment system, primarily the DRG relative weights and the outlier payment policy. The DRG weights are intended to measure the relative costliness of typical patients in each DRG. At the beginning of the prospective payment system in 1983, the DRG weights were based on costs estimated at the claim level, using charges and other information from the claims, and data from the hospitals' annual cost reports.

In 1986, CMS changed to using charges alone. This decision was based on research which showed that cost weights, cost-based weights and charge-based weights were very similar.

Although the claims are needed in either method, they are somewhat more timely than the cost reports and the process of estimating the weights is much simplified if you use just the claims and the charges. But over time weights that are based on charges are vulnerable to the effects of hospitals charging practices.

We know from the cost-to-charge ratios on the cost reports that hospitals typically set higher markups for ancillary services such as tests and supplies and so forth, operating room time, than they do for routine and intensive care, which would be room, board and routine care, and they maybe also raise these sets of charges at different rates over time.

Distortions in the weights also may occur if costs grow at different rates but hospitals fail to reset their charges accordingly.

The next slide shows the results of a simulation exercise we ran just to show what happens if you have different charge inflation rates with DRGs that have different mixes of services. Here we have two DRGs, each with a different service composition. In DRG A, 70 percent of the charges are typically for ancillary services such as imaging, operating room time or supplies. 30 percent are for routine services, room, board and routine nursing care.

In DRG B the shares are reversed. So it's 30/70 instead. For this illustration, we assume that costs increase at the same rate over time. In these circumstances, if hospitals were to raise their charges for ancillary services just 1 percent more faster per year than those for routine services, the DRG weights would diverge as shown on the slide even though these DRGs would continue to have equal costs. The difference in the weights is 4 percentage points after 10 years and 8 percentage points after 20 years. Because the costs remain equal, the diversion of the weights translates directly into differences in relative profitability between the two DRGs.

The same kind of discrepancy in relative profitability can occur if costs change at different rates. Cost growth may vary between DRGs because of changes in productivity growth or input price inflation that affect one DRG differently than another. In this instance, DRG weights would not diverge because nothing's happened to the charges. But because the costs diverge, the weights become less accurate in measuring the true relative costliness of each type of patient. As a result, the relative profitability would rise for DRGs that exhibited slower cost growth and it would fall for those that exhibited faster cost growth.

We have two more sources here in our list. Distortions in measured relative costs for typical cases among DRGs can also arise because of the way we treat outlier cases in calculating the relative weights. Most outlier cases are included in the weight calculation. Because outlier cases and related charges are very uneven across DRGs, including them can create an upward bias in the weights for high cost categories where most of them occur.

Finally, we can have profitability differences within DRGs because of the definitions of the categories. The DRGs are broadly defined and they include subgroups with very different severity of illness and cost of care.

The next slide gives an illustration for one DRG. This table shows an example of differences in estimated relative costliness for cases included in the four severity classes of APR-DRG 165. As I mentioned earlier, they are similar to DRGs but we have four levels of severity.

The cases in this APR-DRG come almost exclusively from DRG 107, which is bypass with cardiac catheterization. Here we see the cost per discharge can vary from 70 percent of the average for the overall category to 170 percent of that average. Our preliminary cost estimates for other DRGs suggest that this pattern of escalating costs is consistent among the severity classes within DRGs. Because the current DRG payment rates don't change nearly as much as the costs do, however, that makes substantial differences in relative profitability very likely within most DRGs.

To examine whether Medicare's payment rates are more profitable for some DRGs than for others, we estimated relative profitability across DRGs in APR-DRG severity classes. We focus on relative profitability here because we want to know whether payments are being allocated appropriately across patients. That is, consistent with the expected differences in relative costliness. We used more than 10 million Medicare claims and matching cost reports to estimate costs and payments for each claim. We estimated costs by multiplying charges on the claim by the cost-to-charge ratio for the corresponding department in the hospital. We estimated payments for each claim using our hospital inpatient prospective payment system payment model.

Then we used the estimated costs and payments to calculate payment-to-cost ratio for each DRG and APR-DRG severity class and then divide them by the overall average. This yields a relative profitability ratio for each DRG and APR-DRG severity class. The next two slides show supplementary results for these measures for DRGs and APR-DRGs that are important to physician-owned specialty hospitals.

This one shows estimates for DRGs and APR-DRGs that are important to physician-owned heart hospitals. The top six above the heavy line are surgical DRGs, and I'll

name them for you. Valve without cath is 105. Bypass with cath is 107. Bypass without cath or angioplasty is 109. Percutaneous procedure with stent is 517. Percutaneous procedure without stent is 518. And 116 is pacemaker implant.

The last two below the line are medical DRGs that are less likely to be treated in a physician-owned heart hospital. These are heart failure and shock, 127; and arrhythmia with comorbidity or complication, 138. Let's walk through one of them, taking 107 as an example, bypass with cath.

The relative profitability ratio for this category is 1.093 or 9.3 percent above the average. If the national average payment-to-cost ratio were 1.04, then we would expect payments to be 13.7 percent above costs in this DRG.

Except for DRG 116, pacemaker implant, all of the surgical DRGs are relatively more profitable than the national average. Medical DRGs are relatively less profitable. The last four columns show the estimates for severity classes in the corresponding APR-DRGs. For these APR-DRGs, the minor and moderate severity patients, those in classes one and two, are relatively more profitable than the average. This is true even in the medical APR-DRGs, that overall are less relatively profitable than the national average.

Patients in the major and extreme categories, on the other hand, are generally relatively less profitable than the average. It's important to remember these are national estimates for the DRGs overall. They don't tell us anything about actual performance of physician-owned hospitals or any other hospital group. They do indicate that under current policies some DRGs and subgroups within them are financially more attractive than others. Consequently, hospitals have a potential opportunity and a strong financial incentive to influence the mix of patients they treat.

The next one shows comparable preliminary estimates of relative profitability for categories that are important to physician-owned orthopedic hospitals. the first three above the line, again, are surgical DRGs: major joint and limb reattachment, 209. Most of those are hip replacements. Other hip and femur except major joint with comorbidity or complication, which is 210. And back and neck procedures excluding spinal fusion with comorbidity or complication, that's 499.

The last two DRGs below the line are medical DRGs, again less likely to be treated in a physician-owned orthopedic hospital, hip fracture and medical back problems are these two. Only one of the DRGs, back and neck procedures, is relatively more profitable than the average here, 499 with a value of 1.04.

All but two of these DRGs, however, have low severity categories within them, patients within them, that are relatively more profitable than the national average. Again, our preliminary findings suggest that under current policies relative profitability differs across and within the DRGs. As a result, hospitals have an opportunity and an incentive to influence the mix of patients.

Next we turn from relatively profitability of the DRGs in the APR-DRGs at the national level to what physician-owned specialty hospitals do. We have two questions on patient selection. Do physician-owned specialty hospitals focus on DRGs with above average relative profitability under Medicare? Within DRGs, do they treat groups of patients that are expected to be relatively more profitable than the average? That is, do they treat a favorable selection of Medicare patients across and within DRGs?

To answer these questions, we wanted measures that would isolate the effects on relative profitability of a hospital's mix of Medicare cases across and within DRGs. We calculated two measures, one for DRGs and one for APR-DRGs. Assuming that each hospital had the national average relative profitability in each DRG, the first measure tells us whether a hospital treats a relatively more or last profitable mix of Medicare cases compared with the national average.

Similarly, assuming that each hospital had the national average relative profitability for each APR-DRG severity class, the second measure tells us whether a hospital treats a relatively more or less profitable mix of cases across and within DRGs. By comparing the two measures we can separate the impact of selection across the DRGs from that within.

Again, it's important to note that these measures don't tell us about hospitals actual profitability. They only tell us whether the cases that a hospital treats are relatively favorable in the sense of coming from DRGs that are expected to be more profitable.

This table shows the preliminary results from these measures for physician-owned specialty hospitals and peer comparison hospitals. You may remember from the last meeting that peer hospitals have a high concentration in the same clinical category but they're not physician-owned.

The first column is the measure based on the DRGs. The last column is the measure based on the APR-DRGs, and the middle column is the difference between the two. The first thing to note is the national average relative profitability is 1.0. the common sense of that is that if you have the national average relative profitability in each DRG and APR-DRG category, then the national average mix of cases is neither favorable nor unfavorable.

For heart hospitals, however, the 1.06 in the first column means that, on average, physician-owned hospitals treat Medicare patients in DRGs that are relatively more profitable than the national average. They also treat a favorable selection of patients within DRGs. This is the 1.03 in the middle column. So that overall their expected relative profitability is 1.09 or 9 percent above the relative profitability of the average Medicare patient.

Peer heart hospitals also have a favorable selection of DRGs, but not as favorable as the physician-owned hospitals. But peer hospitals also have a slightly unfavorable selection within DRGs, at 0.99, so they end up with an expected relative profitability value of 1.03. It's still above average, but it's not as high as for the physician-owned hospitals.

The physician-owned orthopedic hospitals, in contrast, have a definitely unfavorable selection of DRGs but that's more than counterbalanced by their favorable selection within them. So that overall they end up above average.

Peer orthopedic hospitals have an equally unfavorable selection of DRGs but their selection within DRGs is only slightly favorable, so they end up still below average.

Physician-owned surgical hospitals start with an average selection of DRGs but they have a very favorable selection within DRGs and therefore end up well above average. The peer surgical hospitals start with the same roughly average selection across DRGs and they have a slightly favorable selection, a somewhat favorable selection within the DRGs as well, so they end up overall above average.

Now I'd like to briefly recap the findings, first on relative profitability and then on selection. Among the DRGs we looked at, those important to physician-owned heart, orthopedic and surgical hospitals, the evidence suggests that current payment policies create differences in relative profitability both across and within DRGs. Surgical DRGs are generally relatively more profitable while medical DRGs tend to be relatively less profitable than the overall average. Within DRGs, patients in low severity groups tend to be relatively more profitable. Conversely, those in high severity groups tend to be relatively less profitable. Consequently, hospitals appear to have financial incentives to specialize and to treat low severity rather than high severity patients.

On selection, the preliminary evidence suggests that physician-owned heart, orthopedic and surgical hospitals treat a significantly more favorable selection of patients than the average community hospital or than peer

hospitals that have a high concentration of patients in the same specialty but are not physician-owned.

I'd be happy to take any questions or comments.

DR. SCANLON: I think these are an incredibly powerful analysis that you provided and raises real questions about our calculation of the relative DRG weights.

I guess I can think of us is moving toward the direction of both reinstituting the use of costs in this process; and secondly, the idea of using something like the APR-DRGs.

I want to ask you in terms of either of those things what the concerns would be about those two steps? There is always questions raised about how quickly DRGs are adjusted to reflect new technologies. So the idea that we would have a lag in cost report information that could be used is going to be a bone of contention. And I would think about getting around that by thinking about using the most current cost report data that were available, even knowing it's lagged, combined with current charges as a way of creating a hybrid that could be somewhat more up-to-date, certainly better in terms of accuracy with respect to relative profitability than the current situation which has ignored costs for so long.

With respect to the APR-DRGs, I guess there is the issue of burden and reliability, and I'd like to hear about what might be the field's perspective on the readiness to adopt them today.

DR. MILLER: Can I say one thing before you go into the specifics? The other thing that's changed recently in the inpatient PPS is the technology add-on. So there is that, which is a little bit different feature than has been the case.

MR. PETTENGILL: On using the cost data there are two concerns basically. One is the issue of timeliness that you talked about. That's important in a way, because the charging practices that hospitals engage in, raising their charges over time, tend to lower the cost-to-charge ratios. So if you try to mix cost-to-charge ratios from the cost reports with more recent claims, you end up applying ratios that are too high, thus overestimating costs. Now if that's consistent across all services, no problem. It doesn't affect the relatives. But it may not be.

The other issue there is that when you do this you are limited by the data you have. You have cost-to-charge ratios for departments that are fairly broad, for the most part, within hospitals. You are applying those cost-to-charge ratios to charges for services that are more narrowly defined. In some cases, there is not a match. The cost-to-charge ratio will really not be appropriate for the particular service. It will be either too high or too low, so you end up either overestimating costs or underestimating

them.

What this does, among other things, is it tends to cause some compression in the weights. That is, the weights will not have as much variability across patient categories as the real costs vary. And that's an issue. How strong that effect is is hard to tell because obviously we don't have the true data.

On the APR-DRGs or something like them, the principal difference between the APR-DRGs and the DRGs is how you handle secondary diagnoses. The concern at CMS has always been the gameability of the APR-DRGs, that you can manipulate what you report. You can change reporting practices. That may or may not be largely a onetime effect. It might actually play out over a few years if history is any guide. But that's the concern that most people have.

And there's also the problem of having some categories that have relatively few cases, where you always have difficulty setting the weight. Currently CMS sets the weights differently for categories that have less than 10 cases. If you use something like APR-DRGs, you would have more such categories.

I think there were also issues raised over time about whether all of the APR-DRGs are equally fruitful. If you look at the differences in costs between the first and second severity category, sometimes they're not very large. So it's possible that instead of using like 1,250 or thereabouts categories, you can use a smaller number and get pretty much the same bang for the buck.

All of these problems, I think, are addressable to some degree but they would still remain. I guess in the end you have to think about how do the limitations of these methods compare with the limitations of the current method or some other alternative that somebody might dream up.

DR. SCANLON: I agree with you completely on that. I think it's an issue of the trade-off, recognizing that there's not going to be a perfect measure but that we can potentially improve upon what we're doing today. I also think there are probably additional analyses that can be done to guide us in terms of understanding what the improvement might be and what the trade-offs of particularly the hybrid that I suggested might be, in terms of its accuracy and trying to make the updates more current. Thanks.

DR. WOLTER: I saw a reasonably credible analysis in the last month that said that about 80 percent of the profits in the not-for-profit world come from four or five service lines, which I believe is related to this analysis that we've just seen. I do think that although specialty hospital is the issue before us right now, there are huge capital investment strategies currently being enacted in the not-for-profit world around these four or five service

lines. I would say our imaging conversation yesterday is in this picture.

It would be a good thing, from my standpoint, to look at some way of redistributing payment so that there is an equal desire to deal with geriatrics and mental health and pneumonia in the elderly. I worry about that, although I don't know a fix-it. Bill, we'll need your thoughts on how to fix this.

MR. MULLER: I second Nick's comments, but I would say again, in this very excessive analysis there are some hints as to how to do it, which is to perhaps do some onetime reweighting of the ancillary-driven DRGs, vis-à-vis the more nursing driven DRGs. The more technical people can think about how to perhaps do onetime reweighting of this as the analysis indicates 20 years of cumulative effect of reweighting ancillaries gets you the result that Nick and Bill have just spoken to.

I think the analysis also indicates that in hospitals that have a wider range of activity, some of what you just indicated Nick is mitigated by having patients across the range. So one of my concerns that this analysis points out is that the system here really rewards patient selection rather than our goal of efficiency and effectiveness inside the system. And that way it is really destructive of the whole payment system.

So I want to say we often couch our words, but this really destroys our payment system to have this go on. I think something has to be done about it rather than just evaluate it for a long period of time. So I think just our discussion on quality indicated that we should move with some urgency. I really think we have to move with some urgency here to not reward this kind of behavior which undermines the overarching program.

So again I think I would recommend this primer on DRGs should contain this. Not that everybody goes around reading the MedPAC website, but for all of you in the audience I'd read this one. This is one of the best excavations I've ever seen on how the DRG system works.

I think it gives us all some good reasons to move towards changing some parts of it that encourage the wrong kind of behaviors. Because in fact, as we know, the financial incentives inside the Medicare system, are powerful when they, in this case, divert so much from what we really want to do. It just has to be stopped and I think we have to look at what we can do, whether it's Nick's goal of having equal money for geriatrics or mental health compared to CABGs.

But I think we saw this in Medicare Advantage, in terms of patient selection, and we're seeing it here. I think I really undermines the whole Medicare system when we reward section of patients rather than rewarding effective

care. So I think just like we've come out in terms of effective care, we really have to come out against the gaming of the system by selecting the less ill and concentrating resources on the less ill when, in fact, resources should be there for the entire population.

DR. REISCHAUER: There is a tendency in these kinds of discussions to look at the evidence and draw motivational conclusions. And within DRG selection it is perfectly possible that more complex cases are, in a sense, "better served" in a full-service facility and the "selection" is occurring for that reason. And so I think we want to be careful that we don't overinterpret the evidence that we have in front of us. The system clearly is flawed in the sense of the payment incentives and that is causing behavior which should be expected if we think we have an efficient economy here. And there are other explanations for some of this behavior, as well.

MR. HACKBARTH: What's striking to me is that both Nick and Ralph, if I understand them correctly, are saying this is an issue not just in specialty hospitals but really across the hospital sector, not-for-profit, for-profit, specialty, general hospital. This is a more fundamental issue.

I agree with you. You create the incentives. The whole principal of the system is that people are going to respond to incentives.

So I think Ralph and Nick --

MR. MULLER: My point is that the issue is somewhat mitigated when you take care of a broad range of patients. And therefore the ones where you're at 0.9 on payment-to-cost balance out the ones where you're 1.5. Not perfectly and maybe not -- obviously, as Mary has often pointed out -- in every last hospital in the country. But by and large, if you have a fuller range, some of that is mitigated.

DR. STENSLAND: Just to echo what Bob said, on our site visits we found pretty much what you said. Many of the surgical hospitals and the orthopedic hospitals specifically told us we don't think it's appropriate for us to treat these higher severity patients and they had explicit criteria not to. The heart hospitals give a different statement, that they were more wide-open in terms of who they would treat. I guess you can see some of that reflected in the data we have up there. It just really matches up with what we saw in our site visits.

DR. SCANLON: I was going to respond in the sense that the important part of this analysis to me was not necessarily the chart that's up there now, which showed what's happening within the specialty hospitals but the earlier chart which showed what was happening with respect to across DRGs and also within the APR-DRGs because that's

more the issue of our overall system and how we're paying all hospitals.

I agree with Ralph that the hospital that serves enough patients, that there's going to be an averaging out and this has been the premise behind the DRGs.

The data here, though, cause you to pause and ask how many hospitals are going to have a sufficient caseload to be able to average out. We really need to be concerned about being able to deliver all of the services. And so it's that earlier chart, which is independent of any motivation. It comes back to our setting the payment rates that we really need to focus on, too. I know you agree.

DR. REISCHAUER: There's a problem. There's no question about it.

DR. MILLER: Can I make one small point on this? And I agree that there shouldn't be attribution. But the last table that was up there did compare the physician-owned to peer hospitals and the effects are larger, although we haven't statistically gone through and determined whether those effects are different in any kind of statistical way, I believe.

MR. MULLER: This is going to certainly dampen the investments in orthopedic hospitals.

DR. MILLER: We put the peers up there because we were trying to see whether the effect was more peculiar to the concentration.

DR. REISCHAUER: But aren't some of the peers associated with full-service hospitals?

DR. MILLER: Yes and I was just about to hit some of the caveats. That, as well as the level of concentration in the peer hospitals is not as concentrated as the specialty hospitals. On a continuum between community and the specialty, the peer falls between that. So it's not a perfect comparison by any means.

DR. STOWERS: Just so I understand it, is the one taking all hospitals? Would that be the average profitability?

MR. PETTENGILL: Yes.

DR. STOWERS: So that would really be the community hospital because they're the huge majority?

MR. PETTENGILL: It's the national average with all of hospitals in.

DR. WOLTER: This is just a question and it may not be an easy thing to get at, but is there any way to look at utilization rates in physician-owned, peer and full-service hospitals, just to see if there's any difference there? It may be very difficult to do.

DR. STENSLAND: That's coming up on the agenda where we'll look at the utilization rates to see if the moving in, say of a heart hospital, effects the total utilization in the market. And also, what types of things

get done to patients. Is there a shift in the physician practice patterns once the physicians become owners of the hospital?

DR. BERTKO: Just to do the obvious follow up to Nick's question here, if in fact we get a bunch more surgical suites in any kind of hospital and cardiac things, is there supply-induced demand here that increases cost in the whole system, let alone just for Medicare?

MR. MULLER: I thought this analysis, as I indicated and other commissioners have too, is so powerful. One of the things that we've been concerned about in general, not just inside this topic, is how much the cost of the overall program is being driven by the very appropriate revolution in technology. I think there's at least evidence here that we're exacerbating that by rewarding technology more then we reward nurses. I think one of the things we have to look at that I think your data gives you a great lead into is if, in fact, that is one of the great drivers, whether it's around the imaging conversation we've had over the last six months, around drug costs, around the argument I've been making around the proliferation of all kinds of devices driving costs, if we then not just have that great technology, which I think we should feel great about that that's going on, but also reward it disproportionately to rewarding hiring nurses and social workers and nutritionists and so forth then, in fact, our system causes even more explosion to go on.

So I think the data we have here should also be used in our overall analysis of how the payment system is driving the overall growth in costs, especially in the technology-related areas rather than in the more people-related areas and the costs of those which I think there's at least, if not surface, at least some preliminary evidence here that we kind of underreward the hiring of nurses and we over reward the inclusion of MRIs.

DR. CROSSON: I would just like to compliment the staff on the study, too. This is very helpful, very clear and very concise. I just have a question to think about the complexity or difficulty of resolving this, trying to find a solution. Because it seems like in order to find a solution, you have to have one that rebalances between DRGs but also one that rebalances within DRGs.

And so would the consideration be with respect to rebalancing between DRGs, how broad would that need to be? And would we be looking at rebalancing within all DRGs? Or would this be something that's targeted at what appears to be areas of concern now or might be areas of concern? Because it seems like you could design something that was relatively narrow or something that was relatively broad. And if it was relatively broad, it would come with a lot of costs and difficulties. So have you thought about that yet,

or is that the next meeting?

DR. MILLER: The way this is going to play out is we have some additional analysis coming up on the mandate, like the cost associated with specialty hospitals relative, the impacts on the community hospitals. We have tried to get at this notion of is there a whole community impact? It's going to be hard but we're trying to get at that question.

And then we're going to start cranking through policy options and they will be organized into payment and other kinds of options. I think your notion of broad versus narrow, I'll be honest, for myself I've been thinking about it mostly broadly. How would you recalibrate DRGs if you were going to go in and do it? I think we could take some time to see whether there are more narrow fixes. But maybe we could come to you with kind of a thought process of narrow to broad.

I will say I think technically it's a little bit more difficult to do it narrowly because you're always balancing across a set of cases. We can at least give it some thought.

MS. DePARLE: Just to clarify, Mark, I was just looking back at the text of the paper that you wrote. I, and I'm sure other commissioners, have received a lot of mail about this issue, and some of it from specialty hospitals who are presenting information about higher quality that they believe occurs in their settings, better outcomes. There are some studies, I think, that have been done that they're offering up on that.

That is not one of the things we were asked to look at; is that right?

DR. MILLER: It's not specific in our mandate; is that correct?

DR. STENSLAND: Right.

DR. MILLER: It's not, but we are taking a shot at it. That word is chosen very carefully because this is very hard to do.

Arnie, you made a suggestion at the last meeting or the meeting before to talk to some of the specialty societies and see whether they have information available on the specific set of hospitals that we're looking at. And we have been exploring that. A lot of it hasn't worked out but we're not quite finished yet and we have some things that we have in play.

The other thing that I think we're trying to do, and I say this very carefully and looking at Carol, we're doing some transfer work. We're going to be looking at trying to look at transfers between hospitals to see whether there's any pattern there. We don't have okay, here's the quality measure, I have enough cases, I'm going to compare them. That kind stuff, that's not going to happen.

DR. REISCHAUER: Can I just make a comment on the quick fix versus the more comprehensive approach and remind us all that this is an issue where rapid change is occurring. There's a moratorium. There is a lot of capital that might want to be invested in a particular area. And sort of asking for a comprehensive reform, which takes five years to implement, not to slip back into yesterday's analogy, but the cows will be long gone from the barn at that point. And then, in a sense, the game is over because the politics of the situation changes.

MR. HACKBARTH: Okay, we're going to have to move on. Thank you very much, excellent work.

Our last item is to review some preliminary work on the update recommendations for hospital, physicians, skilled nursing facilities and outpatient dialysis.

I would ask that the people who are leaving the room do so quickly and quietly so we can proceed.

Jack, are you going to lead the way?